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INSURANCE LAW

by

Arno W. Krebs, Jr.*

I. LIABILITY INSURANCE

Personal Injury Protection Coverage. During the past year two cases were decided interpreting the scope of personal injury protection coverage¹ that merit inclusion in the Survey. *Slocum v. United Pacific Insurance Co.*² dealt with the definition of an income producer. *Creighton v. Fidelity & Casualty Co.*³ dealt with the double recovery problem when there are two policies in force.

In *Slocum* a Texas appellate court was faced for the first time with deciding who was an income producer within the terms of article 5.06—3 of the Texas Insurance Code.⁴ The statute does not define “income producer.” The PIP endorsement 243 does, however, define an income producer as “a person who at the time of an accident was in an *occupational status* where such person was earning or producing income.”⁵ The plaintiff in *Slocum* was an engineering student who had accepted summer employment. During the weekend preceding employment, however, he was injured in an automobile accident and did not report to work as planned. He had worked the previous summer. The insurance company denied his claim, and this suit resulted.

The trial court granted the insurer’s motion for summary judgment. The court of civil appeals, however, reversed and remanded. The court held that neither the statute nor the policy definition of income producer could be construed to deny recovery of lost income to one who had accepted a firm offer of employment, was to report to work at a definite time and at a set rate of compensation, but was prevented from doing so by an accident. Thus, a fact question was raised as to whether plaintiff was an income producer as that term is defined in the policy.⁶

In *Creighton* the question as to whether PIP coverage is an indemnity provision was before the court. The insurer had written two policies of insurance, one for John Creighton and one for his adult daughter, Lynn. Both policies provided \$5,000 in PIP coverage. Lynn resided at all material times in the same household as her father, who was the head of the household. John Creighton’s daughter, Rafaela Creighton, age thirteen,

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1. TEX. INS. CODE ANN. art. 5.06—3 (Vernon Pam. Supp. 1963-1979).

2. 577 S.W.2d 805 (Tex. Civ. App.—Houston [14th Dist.] 1979, no writ).

3. 581 S.W.2d 815 (Tex. Civ. App.—Fort Worth 1979, no writ).

4. TEX. INS. CODE ANN. art. 5.06—3 (Vernon Pam. Supp. 1963-1979).

5. 577 S.W.2d at 806 (emphasis added by the court).

6. *Id.*

also resided in the same household, and was covered by both policies. Rafaela was involved in a hit-and-run accident that resulted in damages of \$4,966.32. Fidelity & Casualty, the issuer of both policies, paid this amount. The plaintiff filed suit alleging that because premiums had been paid for each policy, the benefits of each policy should be paid in full though the result would be a double recovery under the circumstances.

The trial court entered judgment for the carrier and the court of civil appeals affirmed, holding that the benefits paid under PIP could not in the aggregate exceed the actual loss sustained as computed under the policies.⁷ The court noted that the question would be more difficult had the PIP loss exceeded the policy limits of \$5,000 and reserved judgment on that situation. The court further noted that the PIP coverage under each policy was \$5,000, twice the statutory maximum. The court stated that its decision was based not only on the policy but also on the statute. Neither the policy provisions nor the statutory provisions allow the stacking of coverages to exceed the actual loss suffered.

Uninsured Motorist's Coverage. The only uninsured motorist case that merits inclusion in this survey deals with the definition of "resident of the same household" under the terms of the policy. In *Hartford Casualty Insurance Co. v. Phillips*⁸ the named insured sued her insurer to recover for injuries sustained by her son caused by an uninsured motorist. The named insured, a divorcee, had custody of her minor son, aged fourteen, by court order. The minor lived with his father, however, through an agreement between the parents and without a change in the custody order. He went to school in the district where his father lived, was taken as a dependent on his father's tax return, and kept most of his clothes and had his meals at his father's home. He also had clothes at his mother's home, however, and ate there when he was with his mother. The jury found that the minor plaintiff was a resident of her household, and the court of civil appeals affirmed. The court held that a person, particularly a child, can have more than one residence as distinguished from a domicile.⁹ Although the named insured was his legal custodian and could have required her son to live with her, that she did not do so did not prevent him from being a resident of her household.¹⁰ Further, the finding that he was a resident of his mother's household would not have prevented a similar finding with regard to his being a resident of his father's household.¹¹

Legislative Changes. The Texas Legislature amended section 4(b) of article 5.06—1 of the Texas Insurance Code¹² as it pertains to recovery of property damages. Section 4(b) previously provided that if the insured

7. 581 S.W.2d at 816.

8. 575 S.W.2d 62 (Tex. Civ. App.—Texarkana 1978, no writ).

9. *Id.* at 63.

10. *Id.* at 64.

11. *Id.*

12. 1979 Tex. Sess. Law Serv., ch. 626, § 1, at 1418 (Vernon).

had both collision coverage and uninsured or underinsured property damage coverage, recovery could only be had "under the coverage which is subject to the lower deductible amount."¹³ Section 4(b) as amended provides that if the insured has both collision coverage and uninsured or underinsured property damage coverage, the insured may recover under the policy coverage chosen by him. In the event neither coverage is alone sufficient to cover all damages from a single occurrence, the insured may recover under both coverages. In no event, however, shall the insured have the right to recover more than the actual damages suffered less the greater of the deductibles that may be applicable to either of these two coverages.¹⁴

Conditions. The Texas courts were again faced with problems arising out of the insured's failure to notify the insurer of an accident as required by the liability insurance policy.¹⁵ In *Broussard v. Lumbermens Mutual Casualty Co.*¹⁶ suit was brought against the insurer by the insured and the judgment creditor who had recovered in a personal injury suit against the insured. The personal injury plaintiff sustained serious personal injuries while on the premises of the insured. The president of the insured learned of the accident on the same day but did not give notice to his liability insurance carrier until he was served with suit papers twenty months later. The only reason that he did not report the accident was because he thought the injured person was being taken care of by his workers' compensation carrier.¹⁷ The court stated that because the facts were not in dispute, the question as to whether notice was given as soon as practicable was one of law. The court held that this was not as soon as practicable as a matter of law and further held that the excuse that the injured person was being taken care of by his workers' compensation carrier is legally insufficient.¹⁸

A similar failure to comply with policy conditions occurred in *Shelton v. Ray*.¹⁹ The insurance company was not advised of the accident and subsequent suit until after the default judgment was taken against the insured. The policy was issued on February 16, 1976, and the accident occurred on March 25, 1976. The State Insurance Board issued its new prejudice endorsement on May 1, 1976.²⁰ The court held that the law in effect on the

13. *Id.*

14. TEX. INS. CODE ANN. art. 5.06—1, § 4(b) (Vernon Pam. Supp. 1963-1979). This amendment was effective on Jan. 1, 1980.

15. *See, e.g., Dairyland County Mut. Ins. Co. v. Roman*, 498 S.W.2d 154 (Tex. 1973).

16. 582 S.W.2d 261 (Tex. Civ. App.—Beaumont 1979, no writ).

17. Compliance with the provisions that notice be given as soon as practicable is a condition precedent under the policy and a breach thereof voids coverage. *Members Mut. Ins. Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972). This accident occurred before the new endorsement was issued by the state insurance board on May 1, 1976, under which prejudice must be shown for late notice to void coverage. *See note 20 infra.*

18. 582 S.W.2d at 263.

19. 570 S.W.2d 419 (Tex. Civ. App.—El Paso 1978, no writ).

20. This endorsement, which was issued pursuant to the supreme court suggestion in *Members Mut. Ins. Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972), provides:

As respects bodily injury liability coverage and property damage liability coverage, unless the company is prejudiced by the insured's failure to comply

date of issuance of the policy was controlling. Consequently, the insurance company had a good policy defense and was not liable for any judgment.²¹

The personal injury plaintiff, who filed this suit for collection of the judgment, asserted that the company had waived its rights to defend on the merits. The plaintiff argued that if the company had consented to the granting of a new trial, it could have avoided any harm from the default judgment. Thus, the case could have begun anew without prejudice to the insured or the company. The court held that because the company was not a party to the default judgment, it could not consent to setting aside the judgment. Further, judgment had already been entered against the insured for amounts in excess of the policy limits. Thus, had the company gotten the judgment set aside and a subsequent judgment been even larger, the insured would have had a cause of action against the company. The court indicated that had the company been advised of the judgment before it became final, it might have had the duty to set the judgment aside if it could have reduced the insured's liability to within the policy limits. The company was not advised of the judgment, however, before it became final and never had an opportunity to settle the case as the plaintiff had never agreed to reduce the claim to an amount within the policy limits.²²

The many problems arising out of the failure to forward suit papers and the failure to give notice of an accident is further illustrated by *National Savings Insurance Co. v. Gaskins*.²³ James Gaskins's daughter was allegedly injured by substances used by a pest control company insured by National Savings. Gaskins filed suit against the insured, and National Savings in turn filed a declaratory judgment action against the insured and Gaskins. The insurance company alleged that it had no duty to defend the insured because timely notice was not given, the incident was not covered by the terms of the policy, and the employee-defendant was not a named insured.

The personal injury plaintiffs filed a motion for summary judgment to National's declaratory judgment action, claiming that there was no justiciable controversy with the company on its duty to defend. A declaratory judgment is not available unless there is a justiciable controversy between the parties.²⁴ The court granted the plaintiffs' motion and severed the cause so judgment would be final, and the company appealed. On appeal the personal injury plaintiffs alleged that there was no justiciable controversy because they were not party to the insurance contract and did not care who, if anyone, defended the insured. Further, they had no interest adverse to the company. The insurer alleged that there was a justiciable

with the requirement, any provision of this policy requiring the insured to give notice of action, occurrence or loss, or requiring the insured to forward demands, notices, summons or other legal process, shall not bar liability under this policy.

570 S.W.2d at 420.

21. 570 S.W.2d at 421.

22. *Id.*

23. 572 S.W.2d 573 (Tex. Civ. App.—Fort Worth 1978, no writ).

24. *Id.* at 574.

controversy because the personal injury plaintiffs had an interest in whether they would be able to collect any judgment they might recover against the insured and they would sue the company directly to collect an unsatisfied judgment. Therefore, a real and adverse claim existed. The company relied upon the United States Supreme Court case of *Maryland Casualty Co. v. Pacific Coal & Oil Co.*,²⁵ which held in a similar fact situation that there was a justiciable controversy.²⁶ This court held, however, that though the test for justiciability used in the *Maryland Casualty Co.* decision may have been the same as that used in Texas, the Texas Supreme Court has construed the Texas Constitution as prohibiting judicially rendered advisory opinions.²⁷

The company also argued that since a breach of a notice provision operates as a defense, both to the duty to defend as well as to the duty to pay, all those interested in resolution of the issue should be parties to the suit. Otherwise, the personal injury plaintiffs would not be bound by the determination, and the notice defense could be relitigated.²⁸ This could lead to different courts reaching different results on the same issue. The court stated that since no judgment had been granted to the personal injury plaintiffs, it would be an advisory opinion as to whether or not the personal injury plaintiffs could collect the judgment because the question of the insured's refusal or inability to pay had not yet arisen. The court observed that "a considerable amount of judicial wheel spinning for nothing" would result in deciding the controversy.²⁹

A considerable amount of judicial wheel spinning will result, however, based on the opinion in this case. The court does not recognize the reality that few insureds will respond to a judgment. Consequently, the personal injury plaintiff will necessarily have to file suit against the insurance company to recover the judgment. Since the controversy exists and the suit has been filed, the court should join the third of three interested parties and litigate the entire matter in one proceeding, rather than basing the decision on the distinction that the personal injury plaintiff is not a party to the contract between the insured and the insurer and that no judgment has been entered and, consequently, there is no controversy.

The last case involving interpretation of the conditions of the policy is

25. 312 U.S. 270 (1941).

26. There were three bases for that court's decision: (1) state law permitted direct action by the insured party against the insurance company to satisfy an unpaid judgment; (2) the injured party could prevent the policy lapsing by performing the notice conditions; and (3) if the claimant were not kept in a suit it would be possible for different courts to come to conflicting decisions in their interpretations of the policy. *Id.* at 273.

27. 572 S.W.2d at 575; *see* *Firemen's Ins. Co. v. Burch*, 442 S.W.2d 331, 333 (Tex. 1968), in which the court held that declaratory judgment was unavailable to allow the determination as to whether the casualty insurer had the duty to pay a judgment prior to the entry of such judgment.

28. Those who are not a party to a declaratory judgment action cannot be bound by the results. TEX. REV. CIV. STAT. ANN. art. 2524-1, § 11 (Vernon 1965).

29. 572 S.W.2d at 576 (quoting *Firemen's Ins. Co. v. Burch*, 442 S.W.2d 331, 333 (Tex. 1968)).

*Gulf Insurance Co. v. Texas Casualty Insurance Co.*³⁰ Glastron Boat Company and its truck driver were covered by separate policies issued by Gulf on a truck rented by Glastron and Texas Casualty on the semi-trailer being towed. The driver was involved in an accident that resulted in one death. Gulf wanted to settle this suit for \$200,000. Numerous settlement conferences were held between the attorneys for Gulf and Texas Casualty, but to no avail. On October 7, 1971, Texas Casualty advised Gulf by letter that it would not participate in any settlement.³¹ Four days later Gulf demanded that Texas Casualty assent to the reasonableness of the settlement without prejudice to the questions of coverage to be later determined. Texas Casualty was given forty-eight hours to assent or be liable for all costs of settlement and expenses. Texas Casualty never responded, and Gulf proceeded to settle the case. The matter was closed by a "friendly suit"³² in which the federal court judge heard testimony, reviewed the evidence, made findings of negligence and damages, and entered judgment. Just prior to the hearing on the friendly suit, Glastron and the driver transferred their claims against Texas Casualty to Gulf; Gulf was subrogated and assigned to their rights on October 14, 1971.

Both policies contained a no-action clause that provided that no action would lie against the company until the insured's obligations to pay were determined by actual trial or by written agreement of the insurer, the claimant, and the company.³³ Each policy also contained a subrogation clause whereby the insured was to do nothing after loss to prejudice the rights of the insurer.³⁴

Gulf brought suit against Texas Casualty based on the subrogation agreement. The court held that a friendly suit was not an actual trial, which is required under the no-action clause, and, consequently, Texas Casualty had no liability for the settlement or any portion thereof.³⁵ Further, the insured, Glastron, and the driver breached the subrogation provi-

30. 580 S.W.2d 645 (Tex. Civ. App.—Fort Worth 1979, writ ref'd n.r.e.).

31. The letter provided that "it would be in order for your company to proceed to make such settlement as it feels to be indicated under the facts without any assistance or permission from this Company." *Id.* at 649.

32. In a "friendly suit" the court renders judgment in a determination of whether to approve an agreement brought to the court by the parties as opposed to judgment based on litigated issues. *Id.* at 648.

33. The no-action clause provided:

No action shall lie against the company, unless, as a condition precedent thereto, there shall have been full compliance with all the terms of the policy, nor until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the company

Id. at 647.

34. The clause specifically provided:

In the event of any payment under this policy the company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

Id.

35. *Id.* at 647-48.

sion in the Texas Casualty policy.³⁶ The court further held that Texas Casualty had not waived its policy defenses or conducted itself in such a manner as to be estopped to rely on these defenses. Texas Casualty was not advised of the friendly suit or the hearing thereon and, further, Texas Casualty had notified Gulf that if it effected a settlement it would be without assistance from Texas Casualty.³⁷

As in *Maryland Casualty Co.*, the court, based upon a literal reading of the insurance policy, held that Texas Casualty had no liability. Again, however, the court failed to recognize the practicality that should be applicable in this situation. It has rewarded an uncooperative and intransigent participant, in this case an insurance company. The court's stated goal of encouraging settlements has been left in the wake since few insurance companies will undertake the burdens of their brethren in such situations.

Though there are possible distinctions, it appears that this decision is contrary to at least the spirit of the decision in *Employers Casualty Co. v. Transport Insurance Co.*³⁸ The Texas Supreme Court there held that the settling insurer could recover a pro rata part of the settlement under the doctrine of contractual, conventional, or equitable subrogation.³⁹ The court did not discuss the no-action clause or the possible breach of the subrogation provision by the insured. Further, the decision in *Texas Casualty* is contrary to *Gulf Insurance Co. v. Parker Products, Inc.*⁴⁰ and *Liberty Mutual Insurance Co. v. General Insurance Corp.*⁴¹ In *Gulf* the insurer unconditionally refused to defend and denied coverage. The insured settled and brought suit to recover the amount of the settlement. The Texas Supreme Court held that the insurance company could not rely on the no-action clause⁴² "after it is given the opportunity to defend the suit or to agree to the settlement and refuses to do either on the erroneous ground that it has no responsibility under the policy."⁴³ In *Liberty*, as in *Texas Casualty*, two insurance companies were involved and the same decision was reached as in *Gulf*.

Coverage. In *Travelers Insurance Co. v. Volentine*⁴⁴ the insured garage owner sought a declaratory judgment against his insurer for a determina-

36. See *Foundation Reserve Ins. Co. v. Cody*, 458 S.W.2d 214 (Tex. Civ. App.—Dallas 1970, no writ); *Millers Mut. Fire Ins. Co. v. Mitchell*, 392 S.W.2d 703 (Tex. Civ. App.—Tyler 1965, no writ); *Gulf Ins. Co. v. White*, 242 S.W.2d 663 (Tex. Civ. App.—Dallas 1951, no writ). The identical legal principle in these cases exists in this case:

[I]f the insurer which has contracted that it is to receive the rights to subrogation is denied that for which it contracted by the action of its insured there is material breach by the insured; and because of the breach the benefit otherwise applicable or payable to him may not be enforced against the company.

580 S.W.2d at 648.

37. *Id.* at 649.

38. 444 S.W.2d 606 (Tex. 1969).

39. *Id.* at 610.

40. 498 S.W.2d 676 (Tex. 1973).

41. 517 S.W.2d 791 (Tex. Civ. App.—Tyler 1974, writ ref'd n.r.e.).

42. This clause is identical to that of the instant case.

43. 498 S.W.2d at 679.

44. 578 S.W.2d 501 (Tex. Civ. App.—Texarkana 1979, no writ).

tion as to whether the insurer was obligated to defend him in a suit brought by a customer. The customer had sued for property damage resulting from the destruction of a car engine allegedly due to the insured's defective performance of a valve overhaul job. The policy provided coverage for the insured in situations in which property damage was caused by an occurrence arising out of garage operations.⁴⁵ First, the insurer contended that there was no coverage because the alleged defective performance of the work was not an accident. The court stated that defective performance of the work might or might not be considered an accident; however, the destruction of the entire engine as the result of the malfunction of one of the repaired valves was unexpected and unintended and constituted an accident within the meaning of the policy provisions.⁴⁶

Secondly, the insurer contended that the policy did not apply because of the exclusion for property damage to work performed by or on behalf of the named insured.⁴⁷ The court held that this exclusion did not apply, however, because the language did not exclude coverage for damages due to work performed. It only excluded damages to the work performed.⁴⁸ The court stated correctly that the obligation to defend must be based on the allegations of the petition. No allegations were made that the garage owner performed any work on the engine except the valves. Other parts of the automobile engine would, therefore, constitute "other property" under the rule interpreting this exclusion.⁴⁹ To the extent that these other parts were damaged or destroyed, the insured had coverage under the policy.⁵⁰

The trial court had further based its decision on exclusion (a) of the policy regarding incidental contracts and warranties of fitness. This exclusion provided that there would be no coverage for liability assumed by the insured under any contract or agreement, except an incidental contract, but that this exclusion did not apply with regard to warranties of fitness of the named insured's products.⁵¹ The exclusion was held by the court of

45. Occurrence was defined within the terms of the policy as follows: "[O]ccurrence" means an accident, including continuous or repeated exposure to conditions, which results in *bodily injury* or *property damage* neither expected nor intended from the standpoint of the insured." *Id.* at 503.

46. *Id.*

47. This exclusion stated as follows: "This insurance does not apply, under the Garage Liability Coverages:

(k) to *property damage* to work performed by or on behalf of the *named insured* arising out of the work or any portion thereof, or out of materials, parts or equipment furnished in connection therewith;" *Id.* (emphasis in original).

48. *Id.*

49. The court noted the uniform rule that a liability policy containing such an exclusion does not insure against repair or replacement of the insured's own defective work or product, but the policy does cover the insured's liability for damages to other property resulting from the defective condition of the work, even though injury to the work product itself is excluded. *Id.* at 503-04.

50. *Id.* at 504.

51. This provision provided that the policy would not apply:

(a) to liability assumed by the *insured* under any contract or agreement except an *incidental contract*; but this exclusion does not apply to a warranty of fitness or quality of the *named insured's products* or a warranty that work performed

civil appeals to remove breach of implied warranty of fitness, quality, or workmanship from the specific exclusion relating to contractual liability and did not grant or extend coverage.⁵²

In *Southern Farm Bureau Casualty Insurance Co. v. Adams*⁵³ the insureds, farm operators, sought a declaratory judgment to determine whether the insurer had a duty to defend them in an action brought by a third person. The policy in question was a Farmer's Comprehensive Personal Insurance policy that contracted to pay all sums that the insured would be legally obligated to pay as damages caused by an occurrence during the policy period. The policy excluded, however, coverage "(c) to *bodily injury or property damage* arising out of the ownership, maintenance, operation, use, loading or unloading of: (1) any aircraft;" and "(n) to *property damage* arising out of any substance released or discharged from any aircraft . . ."⁵⁴ The suit against the insureds and the aviation company was brought to recover for damages allegedly caused by negligent use and distribution of a chemical spray discharged by an airplane that the insured did not own. The spray was, however, for the insured's cotton crops.

The insurance company contended that exclusion (c) applied, even though the plaintiff insured did not personally use the aircraft. The word "use" was not defined in the policy, and the court therefore applied the settled rule of law that insurance policies will be interpreted and construed favorably to the insured and strictly against the insurer.⁵⁵ The court stated that in the instant situation it was reasonable to conclude that the Farmer's Comprehensive Personal Insurance policy was sold to afford comprehensive insurance coverage against the liability of the insureds in their farming business and that the exclusion was inserted to exclude liability arising out of the personal pursuits of the insured. The court stated that if the construction of the insurance carrier were applied, it would render one policy exclusion, exclusion (n), meaningless because everything intended to be excluded by exclusion (n) would have been excluded by exclusion (c). The construction contended for by the insureds reconciled these exclusions. The insureds argued that exclusion (n) meant that there was no coverage for "property damage" arising from aerial spraying but that exclusion (c) meant that there was coverage for "bodily injury" arising from aerial spraying, at least when performed, as in this case, by an independent contractor.⁵⁶

*Security Mutual Casualty Co. v. Johnson*⁵⁷ is one of three permissive use cases decided during this survey period. Timothy Johnson brought suit to

by or on behalf of the *named insured* will be done in a workmanlike manner

Id. (emphasis in original).

52. *Id.* at 505.

53. 570 S.W.2d 567 (Tex. Civ. App.—Corpus Christi 1978, writ ref'd n.r.e.).

54. *Id.* at 568-69 (emphasis added).

55. *E.g.*, *Provident Washington Ins. Co. v. Proffitt*, 150 Tex. 207, 239 S.W.2d 379 (1951).

56. 570 S.W.2d at 569-71.

57. 584 S.W.2d 703 (Tex. 1979).

recover the amount of a judgment rendered against him for damages to a pickup truck driven by him. Eugene George was employed by W.H. McColm and was given a truck to drive home each night and to use on the weekends for both business and personal reasons. George apparently permitted his friend Johnson to use the pickup frequently, requiring only that Johnson replace gasoline. This arrangement had been in effect for approximately a year and one-half. In fact, Johnson believed that the pickup belonged to George. The accident occurred while Johnson was driving the vehicle and struck a lamppole. McColm filed suit against Johnson to recover for property damages.

At the time of the collision, Herman Johnson, Timothy's father, had a policy of personal injury and property damage liability insurance with the defendant, Security Mutual. The policy, however, did not include collision or comprehensive coverage. Security Mutual refused to defend Timothy or to pay the judgment. The policy did not apply to property "in charge of" the insured.⁵⁸ The trial court entered judgment for the insurance company, but the court of civil appeals reversed. The supreme court reversed and rendered judgment for the insurance company. In so doing the court stated that Timothy Johnson had sole control of the pickup at the time of the collision and was the only person present with an operator's license. The court stated that in the ordinary meaning, one "in charge of" personal property was one who has possession of it, has the right to exercise dominion and control over it, and is actually exercising physical control over it. Therefore, the exclusion as to property "in charge of" the insured was applicable in this case.⁵⁹

The court further noted that normally a liability policy does not cover damage to the insured's property or property within his control. If an insured desires such coverage, he must secure collision or comprehensive coverage and pay an additional premium. There was no collision coverage in effect at the time of the accident, and the insured could not have expected such coverage under the provisions of the policy.⁶⁰

The second permissive use case is *Gulf Insurance Co. v. Bobo*.⁶¹ In this case William C. Avett agreed to sell his pickup truck to David Havens. Havens took delivery of the vehicle prior to the sale but had a wreck before the sale was completed. Two women injured in the collision recovered judgment against the seller's insurance company on a jury's finding that the buyer was an additional insured under the terms of the policy. At the time of the accident, possession had been delivered and all that remained to be done was to "get the papers fixed."⁶² The court stated that the only interest necessary to the validity of an automobile liability insur-

58. This provision specifically provided: "This policy does not apply . . . (i) to injury or destruction of . . . (2) property rented to or *in charge of the insured* other than a residence or private garage." *Id.* at 704 (emphasis added by the court).

59. *Id.* at 705.

60. *Id.*

61. 580 S.W.2d 914 (Tex. Civ. App.—Fort Worth 1979, writ granted).

62. *Id.* at 915.

ance policy is that the insured may incur liability because of the operation and maintenance or use of the automobile.⁶³ There was no doubt that Avett was an insured under the policy, but the question was whether Havens was an additional insured.⁶⁴ At the time of the events giving rise to Havens's liability he was using Avett's truck with the consent of Avett. The court of civil appeals stated that if there is a named insured, by the provisions of an automobile liability policy, anyone using the vehicle described by the policy with the insured's consent, either explicit or tacit, is an additional insured by the policy provisions. That the named insured might believe that the user was not subject to instructions from him is immaterial.⁶⁵ The supreme court granted a writ of error on numerous points, including: (1) whether Havens was an insured under Avett's policy; (2) whether Havens had permissive use of the vehicle within the terms of Avett's policy; (3) whether Avett had the control or requisite ownership of the vehicle to grant permission to Havens to use the vehicle; and (4) whether Avett retained an insurable interest in the vehicle.⁶⁶

The last permissive use case is *Coronado v. Employees National Insurance Co.*⁶⁷ In this case, Hernando Sotello, a unit operator for White Well Service, was to drive his crew in a company pickup from the company yard in Wickett to Monahans, where they lived. Disregarding standing company rules, they stopped at a bar, drank beer, went to another bar, played pool, and continued to drink beer. After midnight, Sotello left the second bar in the pickup and was involved in a collision in which another motorist was killed. The motorist's widow recovered judgment against Sotello and then brought suit against Employees National to collect on its comprehensive automobile liability policy issued to White Well Service. After a jury trial, judgment was rendered n.o.v. for the insurance company against the widow, and the court of civil appeals affirmed. The court held that even though there was some evidence that Sotello's employer knew that on at least two prior occasions he had used the pickup to go into an unauthorized place with his crew, there was no evidence of express or implied permission to use the vehicle at the time in question. The supreme court has granted a writ of error⁶⁸ to decide whether there was no evidence to support the jury verdict that Sotello had implied permission to use the pickup at the time of the accident.⁶⁹

63. *Id.* at 916 (citing *Gulf Ins. Co. v. Winn*, 545 S.W.2d 526 (Tex. Civ. App.—San Antonio 1976, no writ)).

64. The applicable language of the policy reads: "III. Definition of Insured. (a) With respect to the insurance . . . the unqualified word 'insured' includes the named insured and . . . also includes any person while using the automobile . . . provided the actual use . . . is by the named insured . . . or with the (his) permission" 580 S.W.2d at 916.

65. *Id.*

66. 22 Tex. Sup. Ct. J. 552 (Sept. 28, 1979).

67. 577 S.W.2d 525 (Tex. Civ. App.—El Paso 1979, writ granted).

68. 22 Tex. Sup. Ct. J. 409 (June 15, 1979).

69. After the survey period ended, the Texas Supreme Court affirmed the court of civil appeals decision. 23 Tex. Sup. Ct. J. 110 (Dec. 15, 1979). The court agreed "with the lower courts that at the time of the accident the employee had materially deviated from the scope of the permission granted him by the company." *Id.* at 111.

*Houston General Insurance Co. v. Lane Wood Industries, Inc.*⁷⁰ involved the interpretation of the assignment of interest clause in a policy.⁷¹ Lane Wood purchased the manufacturing operation and other assets of Ranada, including its prepaid insurance that had been obtained from Houston General through its agent, Smyers. This liability policy showed Ranada as the named insured. Four days before the expiration of the policy, an accident occurred that resulted in a lawsuit. The insurer refused to defend Lane Wood in the suit, which resulted in a substantial judgment. Lane Wood in turn brought suit against Houston General for the amount of the judgment plus defense costs and against the insurer's local recording agent, Smyers, for negligence in failing to maintain or secure coverage.

Subsequent to the purchase of Ranada's assets, Lane Wood continued to hold out the operation to the public as Ranada. Smyers was aware that Ranada had sold out, but he assumed it to be a stock sale. Houston General's records indicated that it learned of the sale approximately four months before the accident. Even after learning of the sale, Smyers and his employees continued to service the policies, and Houston General paid other claims for property damage under the policy and also paid some workers' compensation claims.

The court held that Houston General was estopped to deny coverage and that their ignorance that the sale was of assets and not stock did not defeat Lane Wood's cause of action. The court also held that Houston General had constructive knowledge of the facts.⁷² Houston General and its local recording agent had notice of the facts sufficient to put it on inquiry as to the nature of the sale. They did not inquire and continued to accept premium payments and to service the insurance.⁷³

The court of civil appeals also affirmed the judgment against the agent, Smyers, who contended that Lane Wood did not rely upon him as its insurance agent during the policy period and had no course of dealing with him that would entitle Lane Wood to rely on him. Smyers contended that in order to impose a duty upon an agent, the agent must ordinarily provide insurance protection for the client without consulting with the client. The court disagreed, however, and held that Smyers had a duty to investigate the sale and was charged with notice that the sale was an asset sale. This was particularly true since Smyers admitted that he wondered whether coverage was still in force after he found out that Ranada had sold out.⁷⁴

70. 571 S.W.2d 384 (Tex. Civ. App.—Fort Worth 1978, no writ).

71. This clause provided: "Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon." *Id.* at 388.

72. The court observed that:

Where a person, with actual or constructive knowledge of the facts, induces another by his words or conduct to believe that he acquiesces in or ratifies a transaction, or that he will offer no opposition thereto, and that other, in reliance on such belief, alters his position, such person is estopped from repudiating the transaction to the other's prejudice.

Id. at 389 (quoting *Champlin Oil & Ref. Co. v. Chastain*, 403 S.W.2d 376, 385-86 (Tex. 1965) (emphasis added by the court)).

73. 571 S.W.2d at 389-90.

74. *Id.* at 392-93.

Smyers further contended that the rule requiring expert testimony to establish the standard of care in medical malpractice cases should also be applied to insurance agents. No expert testimony was introduced in this case to establish a standard of care. The court, however, held that expert testimony was not required as to the normal and customary practice when an agent finds out that there has been a sale by the corporation insured under the policy. This is a matter within the realm of ordinary skill and diligence.⁷⁵

II. PROPERTY INSURANCE

*Allstate Insurance Co. v. Chance*⁷⁶ involved the admissibility of evidence to determine the value of household goods destroyed in a fire. The insured had brought an action to recover damages for household goods and a dwelling covered by a fire insurance policy. She prepared a list of household goods showing the item, the approximate cost, the age of the item, and where it was purchased. The trial court allowed the list in evidence, and the jury awarded the insured \$6,000 for loss to household goods. The court of civil appeals held that the mere approximate cost of an item of personal property was not proper or competent evidence to prove the actual cash value of the items at the time of loss.⁷⁷ The court further held that the plaintiff was not entitled to recover attorneys' fees pursuant to article 3.62 of the Insurance Code under a fire insurance policy.⁷⁸ The supreme court in a per curiam opinion reversed and rendered.⁷⁹ The court held that the list and testimony of the insured were admissible under well established Texas case law.⁸⁰ The supreme court stated the rule as follows:

Thus, the rule is that where household goods have no recognized market value, the trier of fact may consider, in determining the actual value to the owner at the time of loss, the original cost, the cost of replacement, opinions of qualified witnesses, including the owner, the use to which the property was put, as well as any other reasonably relevant facts.⁸¹

The court added that the court of civil appeals correctly held that the insured was not entitled to recovery of attorneys' fees under article 3.62.⁸²

In *Ormsby v. Travelers Indemnity Co.*⁸³ the court was faced with defining the term "explosion" in a homeowner's property damage policy. The plaintiff had discovered a broken copper water line that had apparently burst on one side, causing substantial water damage to the inside of his

75. *Id.* at 394-95.

76. 582 S.W.2d 530 (Tex. Civ. App.—Beaumont 1979), writ *ref'd n.r.e. per curiam*, 23 Tex. Sup. Ct. J. 60 (Nov. 7, 1979).

77. 582 S.W.2d at 531.

78. TEX. INS. CODE ANN. art. 3.62 (Vernon 1963) provides as a penalty that the insurer must pay attorneys' fees if it delays payment on a claim, but this provision is inapplicable to fire insurance. 582 S.W.2d at 533-34.

79. 23 Tex. Sup. Ct. J. 60 (Nov. 7, 1979).

80. See *Crisp v. Security Nat'l Ins. Co.*, 369 S.W.2d 326 (Tex. 1963).

81. 23 Tex. Sup. Ct. J. at 60.

82. *Id.* at 61.

83. 573 S.W.2d 281 (Tex. Civ. App.—Waco 1978, no writ).

house, and assumed that the pipe had frozen and burst, flooding the house. The policy insured against damages caused by an explosion. The insurance company contended that this was not an explosion as that term is defined in article 5.52 of the Texas Insurance Code.⁸⁴ Prior to allowing the plaintiff to put on his expert, the court instructed a verdict for the defendant.

The expert would have testified that a domestic hot water heater, such as was involved in the instant case, was neither a fired pressure vessel nor an unfired pressure vessel, which meant that the burst copper pipe in question was not connected to any boiler or vessel that would fall within the exclusion in article 5.52. The court stated that the definition to be applied to "explosion" was to be construed as understood by ordinary men and that there was a jury question as to whether the instant occurrence was the result of an explosion.⁸⁵

In *Pennsylvania National Mutual Casualty Insurance Co. v. Murphy*⁸⁶ the insured brought suit against the company to recover under an inland marine cargo policy for damages suffered as the result of a theft. The insured had purchased sporting apparel from a Mexican manufacturer and had arranged to accept delivery of the goods in San Antonio. Prior to going to San Antonio, he purchased the policy in question, which contained a theft endorsement covering the shipment. There was no coverage for loss or damage to any shipment under the control of the insured after the transporting vehicle had remained in any dock, depot, station, or terminal for more than seventy-two hours after the arrival of the vehicle at such location. Upon arrival in San Antonio from Houston the insured checked into a motel and rented a truck. Later that evening he transferred the goods from the Mexican manufacturer's vehicle to the truck, parked the truck in the motel parking lot, padlocked it, and retired to his room for the night. The truck was broken into during the night, and the goods were taken. The company contended that the goods were not in transit, but the jury found to the contrary and judgment was entered for the plaintiff. The court of civil appeals affirmed, holding that where a policy provision is ambiguous, the interpretation most favorable to the insured will be adopted. The apparel was held to be in transit as long as the property was in the course of being delivered to the place to which it was being shipped.⁸⁷

In *Hochheim Prairie Farm Mutual Insurance Association v. Champion*⁸⁸

84. TEX. INS. CODE ANN. art. 5.52 (Vernon 1963). The relevant portion of this article states:

The term "explosion" as used above shall not include insurance against loss of or damage to any property of the insured, resulting from the explosion of or injury to (a) any boiler, heater, or other fired pressure vessel; (b) any unfired pressure vessel; (c) pipes or containers connected with any of said boilers or vessels

85. 573 S.W.2d at 284.

86. 579 S.W.2d 58 (Tex. Civ. App.—Houston [14th Dist.] 1979, writ ref'd n.r.e.).

87. *Id.* at 61-62.

88. 581 S.W.2d 254 (Tex. Civ. App.—Corpus Christi 1979, writ ref'd n.r.e.).

the plaintiff had obtained a policy from the defendant that provided for coverage against loss due to various causes, including hail. Although the policy had been issued, the work on the insured buildings had not been completed when a severe hail storm damaged both the roofs and the sides of the structures. The builder replaced the roofs free of charge, and the insurance company pleaded this as a mitigation of the damages. The trial court refused to allow introduction of evidence on this point. The court of civil appeals reversed and remanded for a new trial. The court held "insurance against *loss*, as opposed to a contract to pay on the happening of a certain event to be one for indemnity."⁸⁹ The purpose of a contract of indemnity is to insure against actual pecuniary loss sustained by the insured.⁹⁰

In *Rogers v. Aetna Casualty & Surety Co.*⁹¹ the plaintiff was in the process of having a poolhouse constructed. The construction of the poolhouse was approximately ninety-nine percent complete at the time a fire broke out, severely damaging the structure. The plaintiff was covered under a homeowner's policy that provided for coverage for dwelling extensions "used in connection with the occupancy of the dwelling."⁹² Aetna contended that the policy did not provide coverage because the construction had not reached a sufficient stage of completion. The court held that the test to determine commencement of coverage under the dwelling extension clause was when the structure had reached a sufficient stage of completion so as to be capable of use for the purposes for which it was constructed. In the instant case, gear was stored therein, appliances were connected, and the pool heater was in operation. The only things remaining to be done were the finishing touches, such as a few plumbing hookups and installation of some larger pieces of furniture. Thus, the poolhouse had reached the stage of completion necessary to satisfy the test.⁹³

Aetna further contended that the insured did not comply with the policy provision requiring the filing of a proof of loss. Substantial compliance with this provision is necessary and a condition precedent to coverage. Aetna was notified of the loss on the morning after the accident, at which time the insured indicated that he would not be making a claim under the policy. He subsequently changed his mind, however, and Aetna's investigators were at the scene on at least two different occasions. Also, within a two-month period after the fire Aetna received five letters from the insured detailing all information necessary for the claim. Aetna did not object to the proof of loss at any time during its negotiations. The court held that the proof of loss filed by the insured was sufficient. Furthermore, when defective proofs of loss are furnished a company, it must, within a reasonable time, object to such proofs so that the insured can cure such defects.

89. *Id.* at 257 (emphasis by the court).

90. *Id.*

91. 601 F.2d 840 (5th Cir. 1979).

92. *Id.* at 842 n.1.

93. *Id.* at 843-44.

Otherwise, the company waives this defect.⁹⁴ The court further held, contrary to Aetna's contention, that a proof of loss does not evidence the extent of loss and that the plaintiff was entitled to recover damages even though they were greater than shown in the proof of loss, the dispute having been one of evaluation.⁹⁵

Legislative Changes. Article 5.46(A) of the Insurance Code⁹⁶ was amended by the 1979 Legislature. Pursuant to the amendment, any peace officer of any political subdivision may request and receive from an insurance company investigating a fire loss of real or personal property in excess of \$1,000, the following information: Any insurance policy relevant to the fire loss; policy premium payment records; history of previous claims made by the insured for fire loss; material relating to the investigation of the loss including statements; proof of loss or other relevant evidence.⁹⁷

Prior to the 1977 amendment, article 5.46 provided that no action taken by the state fire marshal in investigating a fire could affect the rights of a policy holder.⁹⁸ In addition, the results of any investigation could not be given in evidence in any civil action, nor could any statement by any insurance company, officers, agents, or adjusters of any policy holder made to the fire marshal be admitted in any civil action for damages.

The 1977 amendment totally changed the thrust of this statute and provided that any fire marshal, state or local, and any chief of any established fire department could be required to testify as to any information in his possession regarding the cause of a fire loss in any civil action for damages against an insurance company.⁹⁹ The 1977 Act further provided that an insurance company shall notify fire investigation authorities of a suspected incendiary fire,¹⁰⁰ and in the absence of fraud or malice is not liable for damages in a civil action or subject to criminal prosecution for furnishing information or taking any other action necessary to supply information pursuant to this section.¹⁰¹ The 1979 amendment made only one change, that being to add the term "any peace officer in Texas" to those who may request information from insurance companies.

III. LIFE, HEALTH, AND ACCIDENT INSURANCE

Misrepresentations and Waiver. In *Washington v. Reliable Life Insurance Co.*¹⁰² the supreme court addressed questions concerning (1) validity of a

94. *Id.* at 844-45.

95. The value of items that are not claimed on the proof of loss, however, cannot be recovered. *Commercial Union Assur. Co. v. Preston*, 115 Tex. 351, 282 S.W. 563 (1926).

96. 1979 Tex. Sess. Law Serv., ch. 515, § 1, at 1099 (Vernon).

97. TEX. INS. CODE ANN. art. 5.46 (Vernon Pam. Supp. 1963-1979).

98. *Id.* art. 5.46 (Vernon 1963).

99. *Id.* art. 5.46(E) (Vernon Pam. Supp. 1963-1979).

100. *Id.* art. 5.46(B). The insurance company is also required to provide the same information as is currently required by the 1979 amendment to article 5.46. See note 97 *supra* and accompanying text.

101. *Id.* art. 5.46(C).

102. 581 S.W.2d 153 (Tex. 1979).

release signed by the beneficiary, (2) waiver of the good health clause, and (3) misrepresentation. Three \$1,000 life insurance policies were purchased from the defendant by A.W. Washington, insuring his mother four months before her death. They were purchased from two agents and had different provisions, and different facts applied to each policy.¹⁰³

The evidence was clear that for the four and one-half months preceding the death of the insured, she was very sick and was being treated for various maladies including congestive heart failure. She was in a hospital from September 16 to October 11, 1974, and upon her discharge went to the home of A.W. Washington. At that time she signed applications for Policies A and B, which were issued respectively on October 21 and October 15. Shortly thereafter she moved into the home of her sister, Viola Smith, where she was visited by agent Jones, and an application for Policy C was taken, which was issued on October 28. Her condition deteriorated, and she died in January 1975.

In April 1975 agent Armstrong called upon A.W. Washington and persuaded him to sign a release form in exchange for the return of the premiums paid on Policies A and B. No such release was ever taken on Policy C. The check was issued, but Washington refused to cash the check, mailed it back, and demanded full payment under the policies. By return letter Reliable stated that it was voiding the check because it should have named the Jackson Funeral Home as co-payee. Reliable further refused to make payment upon Policy C, and thereafter Washington filed suit. The trial court, based on the jury verdict, entered judgment for the beneficiary. The court of civil appeals reversed.¹⁰⁴

The supreme court distinguished *Great Southern Life Insurance Co. v. Heavin*,¹⁰⁵ noting that in *Heavin* the policy specifically allowed a return of premiums instead of benefits, which was not true in the instant case. Further, in *Heavin* the beneficiary accepted and kept the money tendered whereas, in this case, Washington returned the check and demanded full payment. Moreover, Reliable voided the check and never tendered a correct check to Washington. Therefore, as a matter of law, there was a failure of consideration to support the release.¹⁰⁶

103. The Supreme Court charted the policy provisions as follows:

<u>Policy</u>	<u>Agent</u>	<u>Good Health Provision</u>	<u>Covered By Release</u>	<u>Application Attached to Policy</u>
A	Armstrong	Yes	Yes	No
B	Armstrong	No	Yes	Yes
C	Jones	Yes	No	No

Id. at 155.

104. 570 S.W.2d 24 (Tex. Civ. App.—El Paso 1978).

105. 39 S.W.2d 851 (Tex. Comm'n App. 1931, holding approved). The court in *Heavin* held that the repayment to the beneficiary of the amount of the premium paid on a life policy and the acceptance of such premium with full acknowledgement that the repayment was in full payment of all claims under the policy would bar recovery in the absence of a valid defense. *Id.* at 852.

106. 581 S.W.2d at 157.

Policies A and C contained identical good health clauses.¹⁰⁷ The parties stipulated that the insured was not in good health within the meaning of the terms of the two policies on their effective date. The beneficiary alleged, however, that the company had waived the good health clauses as a matter of law because the agents knew that the insured was not in good health at the time the applications were procured. No special issues were requested or submitted to the jury on this point. Consequently, the beneficiary was required to prove as a matter of law that waiver was established.¹⁰⁸ The testimony indicated that at the time the application for Policy A was obtained by agent Armstrong, he was not aware that the prospective insured was not in good health and, in fact, believed she looked pretty good at the time. Consequently, this testimony failed to establish as a matter of law that the agent knew the prospective insured was not in good health. With regard to Policy C, however, agent Jones did not testify although the sister of the deceased testified that the insured looked "durn near dead."¹⁰⁹ The sister further testified that she told the insured in the presence of the agent that the insured would not be accepted for coverage because of her poor health, but the agent stated that the insurance company would pay. The supreme court, based on the foregoing testimony, held as a matter of law that Reliable had waived the good health provision of Policy C.¹¹⁰

At the trial of the case, although Reliable had submitted issues regarding misrepresentations both to agents Armstrong and Jones, the jury failed to find that the deceased had made misrepresentations concerning her health to either agent. Consequently, issues 2 through 5 dealing with whether the representations were related to material facts relied upon by the company and made by the insured with intent to deceive were not answered. Since the applications were not attached to either Policy A or C, this misrepresentation point had no application to these policies.¹¹¹ Since the application was attached to Policy B, it would be grounds for voiding the policy if the jury found that the insured intentionally tried to deceive the company, but the jury did not reach that issue in this case. Based on the numerous foregoing findings, the court held that the beneficiary was not entitled to recover under Policy A and that the causes of action

107. The good health clause provided: "This Policy shall become effective on the Policy Date if the Insured is then alive and in good health, but not otherwise." *Id.*

108. Waiver is an affirmative defense upon which the beneficiary has the burden of proof. *Texas Prudential Ins. Co. v. Dillard*, 153 Tex. 15, 307 S.W.2d 242 (1957).

109. 581 S.W.2d at 158.

110. The court applied the rule established in *Collora v. Navarro*, 574 S.W.2d 65 (Tex. 1978). That court stated that evidence given by an interested witness raises an issue of credibility upon which the jury must pass. An exception may arise when the testimony is clear, direct, and positive, is free from internal inconsistencies or contradictions, and is uncontradicted by other testimony or circumstances. *Id.* at 69.

111. When an application is attached to and made a part of the policy and is accepted and retained by the insured, the insured is presumed to have knowledge of its contents and to have ratified any false statements in the application. 581 S.W.2d at 160 (quoting *Odom v. Insurance Co.*, 455 S.W.2d 195 (Tex. 1970)).

as to Policies B and C should be reversed and remanded to the trial court for a new trial.

*Coverage. Bomar v. Trinity National Life & Accident Insurance Co.*¹¹² involved the validity of a policy provision limiting coverage. The insurer issued a major medical policy to Thomas Bomar effective July 10, 1976, to July 10, 1977. At that time his daughter was living at home; she married, however, shortly after the effective date of the policy. In January 1977 she was hospitalized, and a claim for medical benefits was made. The claim was refused by the insurance company. The policy provided coverage for dependent members of the insured's family, including unmarried children. Coverage of unmarried children terminated upon marriage or attaining the age of twenty-four years.

The trial court held that this provision was ineffective under articles 3.70—4 and 3.70—7 of the Texas Insurance Code.¹¹³ Article 3.70—4(b) provides that the provisions of the Insurance Code govern when the policy provisions conflict with any provision of the Code.¹¹⁴ Article 3.70—7 provides that if a policy contains a provision terminating coverage on the basis of age limit or otherwise within a period for which a premium is accepted by the insurer, the coverage provided by the policy will continue in force.¹¹⁵ The supreme court, reversing the court of civil appeals,¹¹⁶ agreed with the trial court and held that the term "or otherwise" in the Code necessarily overruled the language of the policy that would terminate the coverage upon marriage of a child. The policy coverage therefore continued in force and the insurer was liable for the medical benefits.

*Life Insurance Co. v. Overstreet*¹¹⁷ involved the determination of the effective date of a life insurance policy. On March 15, 1972, the company issued an endowment policy on the life of Maxie Overstreet, showing March 15 as the effective date of the policy. On April 13, 1972, a check was forwarded for the premium, which the company received on April 17 and applied on April 18. On April 15, 1973, the Overstreets had not paid the premium for the second year, and the policy was terminated. It was later reinstated because the premium was paid on April 25, 1973. On April 24, 1974, Maxie Overstreet died. The insurance company maintained that the third-year premium was due on March 15, 1974, the anniversary date of the effective date as stated in the policy. Since the thirty-one-day grace

112. 579 S.W.2d 464 (Tex. 1979).

113. TEX. INS. CODE ANN. arts. 3.70—4, —7 (Vernon 1963).

114. *Id.* art. 3.70—4(b).

115. *Id.* art. 3.70—7 states:

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts the premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted.

(Emphasis added.)

116. 572 S.W.2d 790 (Tex. Civ. App.—Tyler 1978).

117. 580 S.W.2d 929 (Tex. Civ. App.—Fort Worth 1979, writ granted).

period commenced on that date and expired on April 15, 1974, the death fell outside that period. The beneficiary contended that the date of the premium payments determined the effective date of the policy.

The trial court found that the policy became effective April 18, 1972, and consequently annual premiums were due each April 18 thereafter. Therefore, the policy was in effect because the insured died within the thirty-one-day grace period. The court of civil appeals affirmed, holding that where the stated effective date of a policy is intended to be different from the date on which coverage became effective, it must be clearly stated in the policy.¹¹⁸ The supreme court has granted writ of error.¹¹⁹

In *Empire Life Insurance Co. v. Moody*¹²⁰ the question as to insurable interest in the life of the insured was before the court. Shearn Moody, Jr. was the principal stockholder, chief executive officer, president, and chairman of the board of Empire Life Insurance Company of America. Moody owned an undivided one-eighth life estate in the income from a trust created by the will of Libbie Shearn Moody. He assigned to Empire full and complete title to forty percent of his undivided one-eighth life estate. Under accounting principles, Empire could not carry its interest in the trust as an asset of the company except to the extent that its value was covered by insurance on the life of Moody, since the income would necessarily terminate upon his death. For the purposes of making his trust an asset of Empire, Moody applied for and obtained life insurance from three different companies in the sum of \$12,000,000. After Empire became the beneficiary of the policies, it carried the Moody life estate interest as an asset at values that ranged from \$14,213,440 in 1965 to \$4,250,000 in 1975.

In 1972 Empire experienced serious financial difficulties and was placed in receivership. Subsequently, Empire reached an agreement with Protective Life Insurance Company under a Treaty of Assumption and Bulk Reinsurance. Empire was required to transfer to Protective all of its assets except \$2,000,000. Empire also agreed to assign to Protective \$4,350,000 of the proceeds from the life insurance policy. Shearn Moody filed suit to have the assignment of the insurance policy proceeds declared void because Protective did not have an insurable interest in his life. The trial court entered a judgment for Empire and Protective. The court of civil appeals dismissed the case,¹²¹ stating that this was not a justiciable controversy under the Texas Uniform Declaratory Judgment Act.¹²² The supreme court held that there was a justiciable controversy and then examined the insurable interest question.

The court held that Protective owned by assignment a life interest in the Moody Trust, a major asset of Empire, from which substantial income had been received during the years of ownership. Because the income would now be paid to Protective until Moody's death, Protective had a present

118. *Id.* at 933.

119. 23 Tex. Sup. Ct. J. 5 (Oct. 3, 1979).

120. 584 S.W.2d 855 (Tex. 1979).

121. 570 S.W.2d 450 (Tex. Civ. App.—Eastland 1978).

122. TEX. REV. CIV. STAT. ANN. art. 2524—1 (Vernon 1965).

insurable interest in the life of Moody to the extent of the asset value assigned.¹²³ It has been held that three classes of persons have an insurable interest in the life of another: (1) someone so closely related by blood or affinity that he or she wants the other to continue to live, irrespective of monetary considerations; (2) a creditor; and (3) one having a reasonable expectation of pecuniary benefit or advantage from the continued life of another.¹²⁴ The court added that its decision was supported by Texas Insurance Code article 3.39,¹²⁵ which states that a life insurance company may invest in certain life income interests, provided satisfactory evidence is presented that the interest is supported by life insurance in an amount not less than its admitted value.

The court also held that Empire continued to have an insurable interest under article 3.49—1.¹²⁶ In this instance Moody applied for the policy in question and designated Empire as the beneficiary and owner. Under the provisions of the statute, Empire as the beneficiary and owner thereafter had an insurable interest.¹²⁷

*Aetna Life Insurance Co. v. Bocanegra*¹²⁸ involved an election of remedies between health insurance benefits and workers' compensation benefits. The plaintiff was hospitalized in 1975 while employed by Clegg Company. During her hospitalization she filed a claim for workers' compensation benefits, alleging a work related injury. The workers' compensation carrier disputed liability but subsequently settled the claim for \$12,000 for lost wages and impaired future earning capacity.

The plaintiff then filed this action against her health insurance carrier to recover her medical expenses under the group policy held by her employer, this time alleging a nonoccupational injury or disease. Judgment was rendered for the plaintiff. The court of civil appeals held that since the plaintiff had recovered workers' compensation benefits on the grounds that her injury was work related, the doctrine of election of remedies now precluded her recovery of medical expenses under the allegation of a nonoccupational disease or injury. The court added that the plaintiff should not be permitted to assert formally the existence of one state of facts in a claim against one party, accepting benefits in satisfaction of that claim, and then maintain an action against another party on the ground that the facts first

123. *Drane v. Jefferson Standard Life Ins. Co.*, 139 Tex. 101, 161 S.W.2d 1057 (1942).

124. *Id.* at 104-05, 161 S.W.2d at 1058-59.

125. TEX. INS. CODE ANN. art. 3.39 (Vernon Pam. Supp. 1963-1979).

126. *Id.* art. 3.49—1 (Vernon 1963). Section 1 provides:

Any person of legal age may apply for insurance on his life in any legal reserve or mutual assessment life insurance company and in such application designate in writing any person, persons, partnership, association, corporation or other legal entity, or any combination thereof, as the beneficiary or beneficiaries, or the absolute or partial owner or owners, or both beneficiary and owner, of any policy or policies issued in connection with such application; and with respect to any such policy or policies any such beneficiary or owner so designated shall at all times thereafter have an insurable interest in the life of such person

127. 584 S.W.2d at 860.

128. 572 S.W.2d 355 (Tex. Civ. App.—San Antonio 1978, writ granted).

asserted did not exist. The supreme court has granted a writ of error on the question of the doctrine of election of remedies.¹²⁹

In *Freeman v. Crown Life Insurance Co.*¹³⁰ the beneficiary brought suit seeking recovery of accidental death benefits under a group policy for death of the insured, who was killed in an automobile collision while driving under the influence of intoxicating liquor. The policy provided for recovery of benefits for accidental bodily injuries, which were not defined in the policy. There was no intoxication exclusion. The insurance company refused to pay the accidental death benefits on the ground that the insured's voluntary act of driving while intoxicated rendered his death nonaccidental. The trial court agreed.

The appeals court observed that in a suit to recover accidental death benefits, proof that the insured died by violent and external means raises a presumption that the death was accidental.¹³¹ This presumption, however, is rebuttable.¹³² The only evidence upon which the company relied to rebut the presumption that the death was accidental was a stipulation that at the time of the collision the deceased was driving while intoxicated. The company contended that since such an act is a criminal act, inherently involving substantial risk of harm, death is a readily foreseeable consequence and is therefore not accidental within the contemplation of the policy.¹³³

The court held that the mere fact that a person's death may have occurred because of his negligence does not prevent the death from being accidental within the terms of an accident policy.¹³⁴ It is only when the consequences of an act are so natural and probable as to be expected by any reasonable person that it can be said that the victim, in effect, intends the result and therefore it is not accidental. The insured must have known or anticipated that his conduct would, in all probability, bring about his death.¹³⁵ The court stated that although driving while intoxicated was a serious violation of the law and extremely dangerous, it was not an act that the violator could reasonably know would result in his own death.¹³⁶

The insurance company also relied upon decisions holding that the death or injury of a person that occurs while such person is engaged in the commission of a serious crime is not accidental within the meaning of an insurance policy.¹³⁷ The court distinguished these cases on the grounds

129. 22 Tex. Sup. Ct. J. 476 (July 5, 1979).

130. 580 S.W.2d 897 (Tex. Civ. App.—Texarkana 1979, writ ref'd n.r.e.).

131. *Id.* at 899 (citing *Republic Nat'l Life Ins. Co. v. Heyward*, 536 S.W.2d 549 (Tex. 1976)).

132. *Home Benefit Ass'n v. Briggs*, 61 S.W.2d 867, 869 (Tex. Civ. App.—Waco 1933, no writ).

133. The company relied on *Hobbs v. Provident Life & Accident Ins. Co.*, 535 S.W.2d 864, 866-67 (Tenn. Ct. App. 1975) to support its contention. The court noted that the majority rule is to the contrary, citing *Miller v. American Cas. Co.*, 377 F.2d 479 (6th Cir. 1967).

134. 580 S.W.2d at 900.

135. *Id.* (citing *Hutcherson v. Sovereign Camp, W.O.W.*, 112 Tex. 551, 251 S.W. 491 (1923)).

136. *Id.*

137. *See, e.g., Ritchie v. John Hancock Mut. Life Ins. Co.*, 521 S.W.2d 367 (Tex. Civ.

that in each of these instances the conduct of the insured was such that death was invited, expected, imminent, and foreseeable. It was not the illegality of the act but the inevitability of the result that controlled. The court added that the weight of authority and the trend of recent decisions allows the innocent beneficiary to recover unless the policy was obtained in contemplation of the illegal conduct.¹³⁸ The court added that there was no proof that the deceased's intoxication had any causal relationship to his death. All that was proven was that he had been intoxicated and killed in an accident. Thus, even if the court were to hold that the act of driving while intoxicated rendered the resulting death nonaccidental, it must still be proven that such intoxication did, in fact, cause or contribute to the death.¹³⁹

The last coverage case is *Kentucky Central Life Insurance Co. v. Fannin*.¹⁴⁰ The beneficiary brought suit to recover unpaid accidental death benefits from three life insurance policies and an automobile accidental death policy. The insurance company contended that the life insurance benefits were not payable since the death resulted from suicide. The policy excluded accidental death benefits if death by suicide occurred within two years after the date of the issuance of the policy. The automobile accidental death policy excluded benefits unless the loss of life resulted from bodily injuries directly and independently of all other causes and was not caused or contributed to by suicide. The jury found that the death was the result of an accident and not suicide. The trial court entered judgment for the beneficiary, and the court of civil appeals affirmed.

The appeals court found no evidence that the deceased was in ill health or that she ever had indicated any propensity toward self-destruction. Her sister-in-law testified that they had previously discussed death, at which time the deceased had indicated that she would use a gun if she were going to commit suicide, because people frequently do not die in car wrecks. Further, she testified that her sister was very much afraid of pain. Her family testified that the deceased was a careful driver and had never driven over eighty miles an hour. On the day of her death she asked her son, his friend, and her unmarried daughter to go with her to the grocery store. Only her daughter accepted. The deceased did not drive directly to the grocery store but drove in an opposite direction. She and her daughter talked and laughed as she drove. The deceased laughed deeper and more continuously than her daughter had ever heard, but her daughter attributed this to a joke she had told her mother. During the trip the car reached speeds of up to 110 miles an hour. The daughter asked her mother to slow down, which she did, but then she slowly accelerated again. They were on

App.—Waco 1975, no writ) (insured injured during a burglary); *Spencer v. Southland Life Ins. Co.*, 340 S.W.2d 335 (Tex. Civ. App.—Fort Worth 1960, writ ref'd) (insured killed by police officer when insured drew shotgun from truck).

138. 580 S.W.2d at 901; see *American Mut. Benefit Ass'n v. Joshua*, 200 S.W. 260 (Tex. Civ. App.—San Antonio 1918, no writ); *Annot.*, 43 A.L.R.3d 1120, 1126, § 4 (1972).

139. 580 S.W.2d at 901.

140. 575 S.W.2d 76 (Tex. Civ. App.—Amarillo 1978, no writ).

a road which, to the family's knowledge, the deceased had never previously driven. They were approaching a stop sign at this high rate of speed when the car hit a dip in the road, became airborne and came to rest 519 feet from where it had left the road. The insured was killed, but her daughter survived. The investigating officer concurred with the daughter's estimated speed of 100 miles an hour and stated that such a speed would be unsafe on that road.

The insurer asserted that since the deceased was voluntarily and intentionally operating her vehicle in excess of 100 miles an hour approaching an intersection, it was inconceivable that she would not anticipate that she might receive injuries that would result in her death. Consequently, the death was not accidental. The court examined the evidence in light of *Republic National Life Insurance Co. v. Heyward*.¹⁴¹ The court in that case held that injuries are accidental,

if from the viewpoint of the insured, the injuries are not the natural and probable consequence of the action or occurrence which produced the injury; or in other words, if the injury could not reasonably be anticipated by insured, or would not ordinarily follow from the action or occurrence which caused the injury.¹⁴²

The court stated that there is a presumption of self-preservation. There is nothing in the act of driving at an excessive rate of speed and failing to stop at a stop sign, though both are violations of the law, that could per se be calculated to produce bodily injury or death. This may occur, but it is not logical that death is a natural consequence of either act. Since the deceased had not previously traveled the road and was not aware of the dip, she could not reasonably have anticipated the unexpected danger the dip represented. Consequently, there was sufficient evidence to support the jury's finding on this issue.¹⁴³

The insurance company next contended that there was a failure to show that death resulted directly, and independently of all other causes, from bodily injuries received in an automobile collision. The insured argued that the cause of death was not established by a death certificate or medical testimony, and thus there was no competent evidence of the true cause of death. The court held that the true cause of death may be established by circumstantial evidence.¹⁴⁴ The deceased was alive before the car wreck and immediately thereafter she was dead, with her body broken up and demolished. Despite the fact that the deceased had high blood pressure and was overweight, from the evidence the jury could reasonably conclude that these conditions did not materially contribute to her death, and that the death was a direct result of injuries received in the automobile accident.¹⁴⁵

Lastly, the company asserted that the beneficiary had not proven that

141. 536 S.W.2d 549 (Tex. 1976).

142. *Id.* at 557.

143. 575 S.W.2d at 80-81.

144. *Id.* at 81.

145. *Id.* at 82.

the death was not a result of suicide. The court stated, however, that the evidence submitted did not rebut the presumption against suicide. The fact that she was driving at 110 miles an hour and disregarded the stop sign intentionally did not rebut the presumption. The test is not whether the actions of the deceased were intentional but whether the happening that produced the accident resulting in the death was intentionally or accidentally encountered.¹⁴⁶

Legislative Changes. During 1979 the legislature first amended the Medical Assistance Act of 1967¹⁴⁷ and then repealed the Act by enacting the Human Resources Code,¹⁴⁸ which retains the same general purpose of the original Act, namely to enable the state to provide medical assistance on behalf of needy individuals and to enable the state to obtain all benefits for those persons provided by the Federal Social Security Act¹⁴⁹ or any other federal act with funds available for such purposes.¹⁵⁰ Section 32.024 of the Human Resources Code provides for a broadening of the eligibility requirement for medical assistance by including persons who receive financial assistance from the state, as well as other related groups of persons for whom medical assistance is required by federal law¹⁵¹ and other persons financially unable to meet the cost of medical services, if federal matching funds are available.¹⁵² The previous eligibility provision in section 8 of the Medical Assistance Act had been modified by a 1979 amendment¹⁵³ to include a notice provision. The amendment provided that any person who applied for or received medical assistance was required to inform the Department of Public Welfare at the time of the application, or at any time during eligibility and receipt of services, of any unsettled tort claim that might affect medical needs and of any private accident or sickness insurance coverage that might become available.¹⁵⁴ The applicant/recipient also had to inform the department of any injury requiring medical attention that was caused by the act or omission of some other person.¹⁵⁵ This notice provision was retained in section 32 of the Human Resources Code.¹⁵⁶

The Code also retains the subrogation provision of the original Act by providing in section 32.033 for subrogation of the Department of Public Welfare to the recipient's right of recovery for personal injuries caused by the negligence or wrong of another person¹⁵⁷ to the extent the medical care

146. *Id.*

147. 1967 Tex. Gen. Laws, ch. 151, §§ 1-24, at 310.

148. TEX. HUMAN RESOURCES CODE §§ 1.001-121.009 (Vernon Pam. Supp. 1979).

149. 42 U.S.C. § 1396d (1976).

150. TEX. HUMAN RESOURCES CODE § 32.001 (Vernon Pam. Supp. 1979).

151. *Id.* § 32.024(a).

152. *Id.* § 32.024(b).

153. 1979 Tex. Sess. Law Serv., ch. 783, § 2, at 1987 (Vernon).

154. *Id.* at 1986.

155. *Id.*

156. TEX. HUMAN RESOURCES CODE § 32.033(b) (Vernon Pam. Supp. 1979).

157. *Id.* § 32.033(a).

services were paid for or rendered by the state.¹⁵⁸ The Code continues to provide that the recipient's claim for damages for the personal injury are not grounds for denying or discontinuing medical assistance.¹⁵⁹

The legislature also passed two other provisions¹⁶⁰ directly affecting accident and sickness insurance policies that are issued subject to chapter 20 of the Texas Insurance Code.¹⁶¹ The legislature provided in article 21.49—9 that no individual or group accident or sickness insurance policy may include a provision that excludes or limits coverage of the insurer from paying benefits covered by the Medical Assistance Act. Article 21.49—10 states that each individual or group accident or sickness insurance policy shall provide for payment to the Texas Department of Human Resources for the actual cost of medical expense the department pays through medical assistance, if the insured is entitled to payments for the medical expenses by the insurance contract.

In 1977 the legislature passed Texas Insurance Code article 21.52,¹⁶² providing that the insured under a health insurance policy¹⁶³ could use the services of a doctor of podiatric medicine¹⁶⁴ when the medical or surgical procedures scheduled in the policy were within the scope of the license of that doctor. The Act went on to provide that there could be no classification, differentiation, or discrimination in the payment schedule or payment provisions between the services performed by a doctor of podiatric medicine and the same services provided by other medical practitioners whose services were covered by the policy. Any policy provision to the contrary is invalid. In 1979, the legislature amended article 21.52 and added to this list of approved practitioners doctors of optometry¹⁶⁵ and doctors of chiropractic.¹⁶⁶

IV. DECEPTIVE TRADE PRACTICES AND THE INSURANCE CODE

Several cases involving deceptive trade practices as related to insurance law were decided during this survey period, including the supreme court opinion in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*¹⁶⁷ The

158. *Id.* § 32.033(e).

159. *Id.* § 32.033(c).

160. TEX. INS. CODE ANN. art. 21.49—9 to —10 (Vernon Pam. Supp. 1963-1979).

161. These provisions were effective September 1, 1979, and apply to all accident and sickness policies issued, delivered, renewed, extended, or amended on or after January 1, 1980.

162. TEX. INS. CODE ANN. art. 21.52 (Vernon Pam. Supp. 1963-1979).

163. Section 1(a) defines a health insurance policy as: "any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital contract, providing benefits for medical or surgical expenses incurred as a result of an accident or sickness."

164. Section 1(a) includes a: "D.P.M., podiatrist, doctor of surgical chiropody, D.S.C., and chiropodist."

165. TEX. INS. CODE ANN. art. 21.52; § 1(c) (Vernon Pam. Supp. 1963-1979). Included are the optometrist, doctor of optometry, and O.D.

166. This was defined to mean one licensed by the Texas Board of Chiropractic Examiners to practice chiropractic. *Id.* § 1(d).

167. 577 S.W.2d 688 (Tex. 1979), *aff'g* 566 S.W.2d 724 (Tex. Civ. App.—Austin 1978). A discussion of the court of appeals decision was included in Krebs, *Insurance Law, Annual Survey of Texas Law*, 33 Sw. L.J. 303, 327 (1979).

plaintiff was insured under a policy that provided only limited coverage for vandalism and malicious mischief. This was a renewal of earlier identical policies. The insured testified that prior to the first policy's being written, he had a lengthy conversation with the agent and was assured that he had total coverage for vandalism. Immediately after such loss occurred, the agent and his secretary confirmed that the damage was covered under the policy. The insured undertook the necessary repairs. Subsequently, Royal Globe denied the claim.

At trial Royal Globe contended that the agent had no authority to make statements and representations that were binding upon Royal Globe. The trial court found, however, that the agent was at all times an agent for Royal Globe as that term is defined in article 21.02 of the Texas Insurance Code.¹⁶⁸ The court also held that the agent, by his statements that all damages were covered, committed a deceptive trade practice. The court of civil appeals affirmed, holding that the agent's statement was a violation of both article 21.21 of the Insurance Code¹⁶⁹ and section 17.46(b)(12) of the Deceptive Trade Practices Act.¹⁷⁰

The supreme court affirmed on different grounds. The court first looked at section 16 of article 21.21, which provides that an action may be brought by any person injured by the deceptive trade practices of another.¹⁷¹ Such practices include those enumerated in section 4 of article 21.21,¹⁷² those declared illegal by the rules and regulations of the Insurance Board,¹⁷³ and those defined by section 17.46 of the Deceptive Trade Practices Act.¹⁷⁴ The court stated that the agent in this case was a local recording agent as that term was defined in article 21.14, section 2.¹⁷⁵ The court held that article 21.02¹⁷⁶ did not authorize an agent to misrepresent policy coverage

168. TEX. INS. CODE ANN. art. 21.02 (Vernon 1963).

169. *Id.* art. 21.21, § 4(1) (Vernon Pam. Supp. 1963-1979).

170. TEX. BUS. & COM. CODE ANN. § 17.46(b)(12) (Vernon Supp. 1980).

171. TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Pam. Supp. 1963-1979).

172. This section includes as an unfair trade and deceptive act the misrepresentation and false advertising of policy contracts, including statements misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby.

173. Texas Insurance Board Docket No. 18663, issued on Dec. 3, 1971, declared illegal those acts done by the insurer, principal, agent, employer, or employee, or anyone acting in the capacity or connection with the insurer. Further, it declared to be a deceptive act the misrepresentation of an insurance policy, the making of any untrue statement of material facts or the omission of same, the making of a statement that may mislead a reasonably prudent person, a material misstatement of law, or the failure to disclose any matter required by law to be disclosed.

174. Section 17.46(a) declares as unlawful false, misleading, or deceptive acts or practices. Section 17.46(b) is a "laundry list" of specific deceptive acts. Section 17.46(b)(12) prohibits representing that an agreement confers or involves rights, remedies, or obligations that it does not have or involve.

175. TEX. INS. CODE ANN. art. 21.14, § 2 (Vernon 1963) defines a local recording agent as "a person or firm engaged in soliciting and writing insurance, being authorized by an insurance company . . . to solicit business and to write, sign, execute, and deliver policies of insurance, and to bind companies on insurance risks"

176. *Id.* art. 21.02 generally provides that anyone who solicits insurance, takes applications for insurance, and generally acts as an agent shall be held to be the agent of the company for which the act is done or the risk is taken, as far as it relates to the liabilities, duties, requirements, and penalties set forth in the Insurance Code.

and to bind the company to terms contrary to those of the written policy.¹⁷⁷ A company that authorizes an agent to sell policies, however, may not escape liability for misrepresentations made in violation of article 21.21 or section 17.46 by establishing that the agent had no actual authority to make such misrepresentations. The court stated that section 1 of the insurance board regulations¹⁷⁸ includes acts done directly or indirectly, irrespective of whether the person is acting as an insurer, principal, agent, or in any other capacity or connection with the insurer.¹⁷⁹ Further, article 17.46(c)(2)¹⁸⁰ of the Deceptive Trade Practices Act provides that in construing the Act, the legislature intended that the courts should be guided by the interpretations of section 5(a)(1) of the Federal Trade Commission Act.¹⁸¹ Numerous federal decisions have held that actual authority is not a defense if the agent is acting within the apparent scope of his authority.¹⁸²

The court therefore held that the local recording agent for Royal Globe had authority under article 21.02 and article 21.14 to sell insurance for the company and, consequently, to represent the coverage afforded by the policies. If his representations were false, as the trial court found, these acts constituted a deceptive trade practice under article 21.21, section 16 of the Insurance Code and section 17.46(b)(12) of the Deceptive Trade Practices Act.¹⁸³

The insurance carrier also alleged that the insured was not injured and did not suffer damages as a result of the misrepresentation. The court agreed that the post-loss representations of coverage did not injure the insured. The evidence was clear that the insured would have repaired the damages to his building regardless of the post-loss representations. Injury did occur to the insured, however, by the representation of the agent that the initial policy provided full coverage for vandalism. The injury was that the insured believed he was covered by a policy of insurance when in fact he was not.¹⁸⁴

The court in *St. Paul Insurance Co. v. Bonded Realty, Inc.*¹⁸⁵ confronted the issue of whether an error and omissions policy provided coverage for the insured's deceptive trade practices. The insured, a realtor, had committed two deceptive trade practices in the sale of a house: he had knowingly withheld facts regarding a defect in the design and construction of the roof and had misrepresented the age of the house. The issue presented was whether such an act was included under the policy that covered negli-

177. 577 S.W.2d at 693.

178. Texas State Board of Insurance, Regulation in Respect to Insurance Trade Practice, Advertising and Solicitations, Docket No. 18663 (Dec. 3, 1971).

179. 577 S.W.2d at 693.

180. TEX. BUS. & COM. CODE ANN. § 17.46(c)(1) (Vernon Supp. 1980).

181. 15 U.S.C. § 45(a)(1) (1976).

182. *See, e.g.,* Goodman v. FTC, 244 F.2d 584 (9th Cir. 1957); Standard Distributions, Inc. v. FTC, 211 F.2d 7 (2d Cir. 1954).

183. 577 S.W.2d at 694.

184. *Id.*

185. 578 S.W.2d 191 (Tex. Civ. App.—El Paso), writ *ref'd n.r.e. per curiam*, 583 S.W.2d 619 (Tex. 1979).

gent acts, errors, and omissions and excluded coverage for dishonesty, intentional fraud, or malicious acts.¹⁸⁶

The trial court granted summary judgment for the insured; however, the court of civil appeals reversed, holding that the insured was not insured against his unlawful acts and that no negligent act or omission had been proven. The supreme court concurred in the result, but did not agree that all unlawful acts are necessarily excluded from coverage under the policy.¹⁸⁷ Thus, the supreme court implied that there will be insurance coverage for those acts that are unlawful under the Texas Deceptive Trade Practice Act, if these acts are not knowing or intentional misrepresentations. The court of civil appeals did not discuss the question as to the type of damages, actual damages, treble damages, or attorneys' fees, that might be covered under the insurance policy.

The plaintiff in *General Accident, Fire & Life Assurance Corp. v. Legate*¹⁸⁸ brought suit under the Deceptive Trade Practices Act¹⁸⁹ for treble damages and alternatively under article 3.62—1 of the Insurance Code¹⁹⁰ for statutory penalty and attorneys' fees. The insured was injured in an automobile accident and notified his agent. The agent advised him that he did not have personal injury protection coverage. Two years later, the agent advised the plaintiff's attorney of the same fact, but three days later the plaintiff's attorney received a memorandum from the agent stating that his client did, in fact, have such coverage. Nonetheless, the plaintiff's counsel filed this suit. The defendant answered and tendered into court the maximum benefits under that coverage. The trial court entered judgment for treble the policy limits and graduated attorneys' fees, concluding that the denial of personal injury protection coverage invoked the provisions of the Deceptive Trade Practices Act and Regulation No. 18663 of the State Board of Insurance.¹⁹¹

The court of civil appeals reversed and held that the plaintiff was suing to recover under provisions of a contract of insurance breached by the defendant upon its denial of coverage. Such denial did not terminate or lessen the insurer's obligations under the policy and did not extinguish any of the plaintiff's rights thereunder. The insurer's breach formed the basis for the institution and maintenance of the suit for the enforcement of the contractual rights created by the insurance policy. Consequently, the Deceptive Trade Practices Act and the Insurance Code were not applica-

186. The policy provided coverage as follows: "To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages arising out of the conduct of their business as real estate agents and caused by any negligent act, error or omission of the Insured." The policy excluded "any dishonesty, intentional fraud, criminal or malicious act." 578 S.W.2d at 192.

187. 583 S.W.2d at 620.

188. 578 S.W.2d 505 (Tex. Civ. App.—Texarkana 1979, writ ref'd n.r.e.).

189. The deceptive trade practice action was brought under TEX. BUS. & COM. CODE ANN. §§ 17.46(a), 17.50(a)(4) (Vernon Supp. 1980) and TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Pam. Supp. 1963-1979).

190. TEX. INS. CODE ANN. art. 3.62—1 (Vernon 1963).

191. See note 173 *supra*.

ble.¹⁹² The court remanded the case to the trial court for a decision as to whether attorneys' fees and statutory penalties were recoverable under article 3.62—1 of the Insurance Code.¹⁹³

Claiming a disability as a result of a fire, the insured in *Lone Star Life Insurance Co. v. Griffin*¹⁹⁴ brought suit on a disability policy to collect the benefits allegedly due. The insured testified that he had been overcome by smoke inhalation in a fire and was unable to work because of difficulty in breathing. His doctor testified that as a result of the inhalation of the smoke and fumes the insured was totally unable to do his work as a pharmacist. The doctor who examined the insured on behalf of the company testified that the insured was at worst only partially disabled and attributed this condition to fifty years of cigarette smoking. He concluded that the insured could do all the work of a pharmacist but could not do any sustained heavy lifting.

The insurance policy provided that the company would pay the insured \$1,000 per month for sixty months for total disability resulting from an accidental injury. It would pay \$1,000 per month for twenty-four months for total disability resulting from sickness. Initially, the company paid several monthly payments, noting on each check that the payment was for accidental injuries. Without any additional medical information and for undisclosed reasons the check code was later changed to indicate that the disability payment was for sickness and not an accident. The payments were discontinued after the twenty-fourth payment, and the insured received a letter advising him that this was the final and maximum benefit under the aforementioned disability.¹⁹⁵ The insured then filed suit for anticipatory breach, asking for payments due under the policy, statutory penalties, attorneys' fees, and treble damages under the Deceptive Trade Practices Act.

The insurer contended that there was no rescission of the policy or refusal to perform. It had only denied that the facts as presented entitled the insured to recover under the policy. The court of civil appeals stated that it was clear that the letter sent by the insurer was more than a denial based upon the facts and found that there was an anticipatory breach.¹⁹⁶ The court also concluded that the trial court erred in finding the insurer had violated the Deceptive Trade Practices Act because its actions did not constitute unconscionable conduct and false and misleading misrepresentations as to the benefits provided by the policy.¹⁹⁷ Under the provisions of

192. 578 S.W.2d at 507.

193. *Id.*

194. 574 S.W.2d 576 (Tex. Civ. App.—Beaumont 1978, writ ref'd n.r.e.).

195. The letter stated: "We are enclosing a benefit check in the amount of \$1,000.00 for the benefit period January 16, 1977 to February 15, 1977, which represents the maximum and final benefit for the aforementioned disability.

"If we can be of further assistance to you, please do not hesitate to contact us." *Id.* at 578 n.3.

196. *Id.* at 579.

197. *Id.* at 580. The court came to the same conclusion on the deceptive trade practices allegation as the court in *General Accident, Fire & Life Assurance Corp. v. Legate*, 578

the insurance policy, the insured had certain rights and the insurer had certain obligations. Breach of the policy obligations by the insurer did not extinguish the insured's right to be paid.¹⁹⁸ Consequently, there was no violation of section 17.50(a). Furthermore, unlike the insured in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*,¹⁹⁹ here the insured did not contend or prove reliance to his detriment upon statements made by the insurer.

The court added that there was no violation of the Insurance Code that would give rise to treble damage recovery under article 21.21, section 16(b)(1).²⁰⁰ Article 21.21—²⁰¹ provides remedies for injuries suffered as a result of unfair claim settlement practices but does not confer a private cause of action upon an individual injured by an unfair settlement practice. Rather, the State Board of Insurance, upon a finding of statutory violation, is empowered to stop such unlawful practices by means of a cease and desist order.²⁰²

Lastly, the court held that there was no authority for trebling the twelve percent penalty and reasonable attorneys' fees that were authorized by article 3.62 of the Insurance Code.²⁰³ Article 3.62 treats the twelve percent penalty and attorneys' fees separately from the amount of the loss. Both treble damage statutes, the one in the Insurance Code and the one in the Deceptive Trade Practices Act, provide that when their provisions are violated an insured or a consumer is entitled to "three times the amount of actual damages plus court costs and attorneys' fees reasonable in relation to the amount of work expended."²⁰⁴ The court modified and affirmed judgment for the present value of the unpaid payments that had matured and those to accrue, plus twelve percent penalty and the attorneys' fees.²⁰⁵

In response to the insured's suit under the Deceptive Trade Practices Act, the insurance company in *Dairyland County Mutual Insurance Co. v. Harrison*²⁰⁶ filed a plea of privilege to be sued in the county of its principal place of business. The insured had purchased an automobile liability policy through an insurance agency, a defendant but not a party to the appeal, so that an SR-22 form²⁰⁷ could be filed for the plaintiff's son pursuant to

S.W.2d 505 (Tex. Civ. App.—Texarkana 1979, writ ref'd n.r.e.). See notes 188-91 *supra* and accompanying text.

198. 574 S.W.2d at 580.

199. 577 S.W.2d 688 (Tex. 1979); see notes 167-84 *supra* and accompanying text.

200. This statute provides that three times the amount of actual damages plus court costs and attorneys' fees are recoverable. TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Pam. Supp. 1963-1979).

201. *Id.* art. 21.21—2.

202. *Russell v. Hartford Cas. Ins. Co.*, 548 S.W.2d 737 (Tex. Civ. App.—Austin 1977, writ ref'd n.r.e.).

203. TEX. INS. CODE ANN. art. 3.62 (Vernon 1963).

204. TEX. BUS. & COM. CODE ANN. § 17.50(b)(1) (Vernon Supp. 1980); TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Pam. Supp. 1963-1979).

205. 574 S.W.2d at 582.

206. 578 S.W.2d 186 (Tex. Civ. App.—Houston [14th Dist.] 1979, no writ).

207. This is a form required by the Texas Department of Public Safety to show proof of financial responsibility in the form of an insurance certificate issued by a liability insurance company.

the Texas Motor Vehicle Safety Responsibility Act.²⁰⁸ The form was filed and a policy was issued. Prior to the expiration of the policy, the insured contacted the agent and informed him that she was concerned that the policy would expire before she could renew it; therefore, the SR-22 would lapse and her son would lose his driver's license. The agent assured her that the SR-22 would not be allowed to lapse. She sent a check payable to the insurance company on March 23, 1977, based upon the oral assurances of the agent that a new policy would be issued. On April 4, 1977, however, Dairyland cancelled the policy, and the SR-22 lapsed. As a result, her son's driver's license was suspended.

The trial court overruled the insurance company's plea of privilege, and the court of civil appeals affirmed, relying on section 17.56 of the Deceptive Trade Practices Act.²⁰⁹ The court held that under this section it was sufficient for the insured to have alleged the cause of action under section 17.50 in order to maintain venue in a county where the defendant resides, has his principal place of business, or has done business. The cause of action need not be proven. The insurance company contended that the insured did not allege a cause of action because she was not a consumer as that term was defined in section 17.45(4).²¹⁰ The court disagreed and held that an insurance policy was a service purchased or leased for use.²¹¹ Further, the court held that section 17.50(a)(4) was also applicable in this situation.²¹² The court stated that a person would, in fact, have to seek or acquire a policy of insurance in order to be adversely affected by the unfair acts or practices defined in the Deceptive Trade Practices Act. Accordingly, the court held that insurance policies are included within the coverage of section 17.50 of the Act.²¹³

Miscellaneous Cases. The court was faced with the constitutionality of article 5.82 of the Insurance Code²¹⁴ in *Wallace v. Homan & Crimen, Inc.*²¹⁵

208. TEX. REV. CIV. STAT. ANN. art. 6701h (Vernon 1977).

209. TEX. BUS. & COM. CODE ANN. § 17.56 (Vernon Supp. 1980) (venue).

210. That provision defines consumer as follows: "An individual . . . who seeks or acquires by purchase or lease, any goods or services." *Id.* § 17.45(4).

211. The court relied on the definition of services in TEX. BUS. & COM. CODE ANN. § 17.45(2) (Vernon Supp. 1980).

212. This subsection provides: "(a) A consumer may maintain an action if he has been adversely affected by . . . (4) the use or employment by any person of an act or practice in violation of Article 21.21, Texas Insurance Code . . . or rules or regulations issued by the State Board of Insurance under Article 21.21, Texas Insurance Code . . ." *Id.* § 17.50(a)(4).

213. 578 S.W.2d at 190.

214. 1975 Tex. Gen. Laws, ch. 330, § 1 at 864 (repealed, 1977 Tex. Gen. Laws, ch. 817, pt. 4, § 4103, at 2064). This article provided:

Sec. 4. Notwithstanding any other law, no claim against a person or hospital covered by a policy of professional liability insurance covering a person licensed to practice medicine . . . or a hospital licensed under the Texas Hospital Licensing Law, . . . whether for breach of express or implied contract or tort, for compensation for a medical treatment or hospitalization may be commenced unless the action is filed within two years of the breach or the tort complained of or from the date the medical treatment that is the subject of the claim or the hospitalization for which the claim is made is completed, except

Article 5.82 substantially shortened the statute of limitations for actions involving claims against a person or hospital covered by a policy of professional liability insurance. The accident occurred sixteen years before the passage of the statute. Had this statute not been passed, the plaintiff's claim would not have been barred by the limitation statutes otherwise applicable.²¹⁶ The plaintiff contended that the statute was void because it was retroactive and did not afford a reasonable time to bring suit on actions not yet barred by limitations.²¹⁷ The court recognized that the legislature has the right to provide a shorter period of limitations for an existing cause of action and to create a statute of limitations for causes where none previously existed, as long as it allows a reasonable time after the law becomes effective to bring suit for actions that are not then barred.²¹⁸ Had this statute of limitations not allowed a reasonable time from its effective date to bring suit on actions not yet barred, it would be unconstitutional; however, that was not the case here.²¹⁹

In *Locomotive Engineers & Conductors Mutual Protective Association v. Bush*²²⁰ the insurance company, a Michigan corporation, had contracted with the insured, a railroad employee, to provide per diem payments for lost wages if he became unemployed because of discharge or suspension as a penalty or disciplinary measure. There was, however, a policy exception that excluded coverage when the discharge was related to knowingly disobeying orders, rules, or instructions. The policy further provided that the cause of discharge assigned by the employer would conclusively determine the liability of the insurer. This was the clause at issue. The employee was discharged for knowingly disobeying safety rules. He filed suit, and the trial court held that the provision stating that the cause assigned by the employer would conclusively determine the liability of the insurance company was null and void as against public policy. The court further held that the policy should be governed by the laws of Texas. The court of civil appeals agreed with the trial court, holding that pursuant to articles 21.42 and 21.43 of the Insurance Code, Texas law applied.²²¹

that minors under the age of six years shall have until their eighth birthday in which to file, or have filed on their behalf, such claim. Except as herein provided, this section applies to all persons regardless of minority or other legal disability.

215. 584 S.W.2d 322 (Tex. Civ. App.—El Paso 1979, writ ref'd n.r.e.).

216. See TEX. REV. CIV. STAT. ANN. arts. 4671-4678 (Vernon 1952) (injuries resulting in death), art. 5526 (actions to be commenced within two years), & art. 5535 (persons under disability) (Vernon 1958). In the instant case the plaintiff was a minor at the time of the accident, and the applicable statute of limitations would not have run as of the filing date had article 5.82 not been applicable. 584 S.W.2d at 323.

217. See TEX. CONST. art. I, § 16.

218. 584 S.W.2d at 323-24 (citing *Wright v. Hardie*, 88 Tex. 653, 32 S.W. 885 (1895); *Williams v. Reed*, 160 S.W.2d 316 (Tex. Civ. App.—San Antonio 1942, writ ref'd w.o.m.)).

219. 584 S.W.2d at 324.

220. 576 S.W.2d 887 (Tex. Civ. App.—Tyler 1979, no writ).

221. *Id.* at 889. TEX. INS. CODE ANN. art. 21.42 (Vernon 1963) provides:

Any contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance, and governed thereby

The court of civil appeals disagreed with the holding that the provisions in question were against public policy.²²² The insured argued that the provision would preclude the courts from construing and making fact finding conclusions under the contract. This could lead to collusion between employers and the insurance company, thereby precluding policyholders from effectively having any coverage at all. The court defined a contract against public policy as a provision or stipulation that is illegal or that is inconsistent with or contrary to the best interests of the public.²²³ Parties to an insurance contract, however, may adopt any legal form in the absence of statutory prohibitions. Insurers may limit their liability and impose whatever conditions they please upon their obligations, not inconsistent with public policy.²²⁴ The court stated that it was difficult to perceive harm to the general public for two parties to contract as in this case. There was no evidence of any collusion between the employer and the insurance company or that the employer even knew that the insured had the policy. The court held, therefore, that the provision did not violate public policy and the insured was not entitled to recover.²²⁵

Id. art. 21.43(a) (Vernon Pam. Supp. 1963-1979) provides:

The provisions of this Code are conditions upon which foreign insurance corporations shall be permitted to do business within this state, and any such foreign corporation engaged in issuing contracts or policies within this state shall be held to have assented thereto as a condition precedent to its right to engage in such business within this state.

222. 576 S.W.2d at 890-91.

223. *Id.* at 890.

224. *Id.* at 890 (quoting *Hatch v. Turner*, 145 Tex. 17, 193 S.W.2d 668 (1946)).

225. 576 S.W.2d at 891-92.