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The courts of Tennessee were confronted by a number of interesting problems of insurance law during 1962. For the most part, the results were neither startling nor unsettling. There were, however, decisions that seem to qualify previous opinions, sometimes without citation, and there was one very troublesome opinion concerning credit life insurance.

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I. SELECTION AND CONTROL OF RISKS

A. *Defining the Risk*

1. *Vendee of Automobile Covered by Omnibus Clause of Vendor's Liability Policy.*—Carson Deuberry owned a delivery truck which was the described vehicle in an automobile liability policy issued to him by State Farm Mutual. During the period of the policy, Deuberry agreed to sell the truck to Adell Butler for $200. Butler was without funds and could not make any payment on the vehicle at the time the contract to sell was entered into. Deuberry nonetheless gave possession of the truck to Butler, but retained the title certificate, which under section 59-1038 of the Tennessee Code Annotated is prima facie evidence of ownership. The apparent understanding of the parties was that when Butler could make a significant payment on the truck, Deuberry would transfer the title to him in the normal fashion.

While this arrangement continued, Butler was involved in an accident as the result of his negligent operation of the truck. The accident resulted in the death of plaintiff's husband, and she successfully prosecuted a personal injury action against Butler. Since he was judgment proof, plaintiff brought this action against State Farm Mutual on the theory that Butler was an additional insured within the coverage of the omnibus clause of the policy issued to Deuberry. Both the federal district court and the Court of Appeals for the Sixth Circuit[1] agreed with plaintiff's argument. The court of appeals found that Butler was not the "owner" of the truck within the meaning of that term as defined by the Tennessee statute, but that Deuberry remained the owner. The court cited testimony of the parties to the contract to sell indicating that this was their intention.[2] Therefore, Butler was simply using the truck with Deuberry's permission, and as such was an additional insured.

This case is interesting largely because it neither cites nor distinguishes an earlier decision of the Tennessee Supreme Court, *Home Indemnity Co. v. Bowers*,[3] which might have led the attorneys of the jurisdiction to anticipate a different result. In that case, the court held that a vendee under a conditional sales contract was not an additional insured within the coverage of the vendor's policy under the omnibus clause. The two cases are not necessarily in conflict. For one thing, the vendee in the *Bowers* case was a party to a conditional sales contract, not merely to an executory contract to sell. More important, in the earlier case, the Tennessee court discussed at some length a California decision[4] which held that a conditional vendee was

1. Benton v. State Farm Mut. Auto. Ins. Co., 306 F.2d 179 (6th Cir. 1962).
2. *Id.* at 181.
3. 194 Tenn. 560, 253 S.W.2d 750 (1952).
4. Votaw v. Farmers Auto. Inter-Ins. Exch., 15 Cal. 2d 24, 97 P.2d 958 (1940).

covered under the omnibus clause of his vendor's policy, and distinguished it, in part on the ground that the parties had not yet executed the formal documents necessary to satisfy the California Owners Responsibility Law. Similarly, in the instant case the parties had not even attempted to execute the formal documents necessary to register title in Butler's name.

One should be cautious in relying on this decision. The court of appeals is careful to point out that section 59-1038 refers ouly to prima facie ownership.[5] In a case in which it is clear that the parties intend at least equitable ownership to be in the vendee under their agreement, it is probable that the *Bowers* principle would be applied, regardless of failure to execute a new certificate of title. To hold otherwise would be excessively formalistic.[6]

2. *Fire Policy Coverage of Appertaining Structures.*—Plaintiff insured in *Bowlin v. Federated Mutual Implement & Hardware Insurance Co.*[7] based his claim on one of the extended coverage provisions available as a rider on the standard fire policy. The clause provided that the insured could apply up to ten per cent of the face amount of the policy covering his house "to cover private structures appertaining to the premises described for that dwelling and located thereon . . . ." The structure which burned was a barn located across the street from the insured dwelling. Plaintiff insured had once lived in a house on the same side of the street, and on the same parcel of land, as the barn. In 1948 he had sold this previous dwelling and the land on which it was located and had moved into the insured dwelling. The purchaser of the insured's former home apparently had not wanted the barn or the land on which it stood, so insured had retained title to the structure and at the time of loss was using the barn for storage purposes.

The court, speaking through Chief Justice Prewitt, held that the barn was not an appertaining structure within the meaning of the policy. It did so because the structure was not on the same lot as that described in the policy, pointing out that certainly no deed conveying the dwelling would be held to convey title to the barn as an appertaining part of the same property. The chief justice noted that a contrary holding would create grave uncertainty about the coverage afforded under such clauses. If this structure was held covered, why

5. The Tennessee courts have frequently permitted the presumption created by the statute to be rebutted. See, *e.g.*, Callis v. Capitol Chevrolet, Ine., 26 Tenn. App. 309, 171 S.W.2d 828 (M.S. 1943).

6. The few cases that have involved this type of fact situation would indicate that this is the proper rule. See Annot., 36 A.L.R.2d 668 (1954). An analogous problem is treated in Hardware Mut. Cas. Co. v. Shelby Mut. Ins. Co., 213 F. Supp. 669 (N.D. Ohio 1962) (garage liability policy).

7. 357 S.W.2d 337 (Tcnn. 1962).

not a storage building three blocks away, or six or eight, or even a mile distant? There is considerable force in this argument based on the need for certainty. The courts of this and other jurisdictions have been unable to achieve certainty in the interpretation of a similar fire policy coverage provision, that covering "additions" to the basic structure; the resulting decisions have been confusing at best.[8]

3. *Loss Due to "Negligence of Repairer" Within Marine Policy.*— The continued development of Tennessee rivers and lakes by TVA and other agencies will bring about the widened use of marine insurance in this jurisdiction. Insurance agents and attorneys unfamiliar with these policies may find them troublesome since most marine policies originated in the context of ocean-going marine traffic. The often antiquated language of these policies is not always well suited to the risks that exist on inland waterways. The difficulties that can result are illustrated by *Russell Mining Co. v. Northwestern Fire & Marine Insurance Co.*[9] Defendant in this case issued a time-hull policy to cover a barge moored to the bank of Chickamauga Lake used by plaintiff in its coal mining operations. To keep the barge pumped out, electric water pumps were installed in two of the barge's compartments. One of plaintiff's employees was engaged in wiring an electric motor for a coal crusher at the barge site. In order to do his work properly, he turned off the master switch at the location. The pumps were, therefore, receiving no current. When the employee left at the end of the day, he did not turn the switch back on. By morning, the barge had shipped so much water that it sank. Plaintiff filed a claim which defendant refused to pay, and this suit resulted.

Plaintiff's claim is based on the Inchmaree clause of the policy, providing, inter alia:

> This insurance also covers loss of or damage to the vessel named herein directly caused by . . . breakdown of motor generators or other electrical machinery . . . [or] negligence of charters or repairers (other than the assured in both cases) master, mariners, or pilots: Provided that such loss or damage has not resulted from want of due diligence by the assured, the owners or managers of the vessel, or any of them.

The standard marine policy was early held to cover only "perils of the sea," so that accidental damage occurring during loading, repairing, and the like was not covered.[10] The Inchmaree clause was added to close this gap. Defendant argued that since this was the basic intention of the clause, it "has no application to an unmanned, moored

8. See 4 APPLEMAN, INSURANCE LAW AND PRACTICE §§ 2324-28 (1941); Annot., 19 A.L.R.2d 606 (1951).

9. 207 F. Supp. 162 (E.D. Tenn. 1962).

10. VANCE, INSURANCE 927-28 (3d ed. Anderson 1951).

barge on inland water."[11] The court conceded that the policy was not drawn "to insure floating barges moored upon inland creeks in the twentieth century"[12] but rejected defendant's argument that the clause was inapplicable. Defendant chose the policy it issued; it undoubtedly had greater familiarity with marine risks than the plaintiff insured. It would therefore be inequitable to allow the defendant to say that the language it selected to use was inapplicable because drawn to suit another type of risk, especially since it had kept the same policy in force on the barge for over four years.

Defendant also interposed two other defenses. It argued that the negligence which caused the loss was not that of a "repairer (other than the assured . . . .)" but was the negligence of the insured in allowing the barge to become so rusted that without the pumps it was in danger of sinking. In all standard marine policies, the insured is held to make an implied warranty of seaworthiness.[13] This means simply that the vessel is "sufficiently strong and tight to resist the perils reasonably incidental to the voyage for which she is insured . . . ."[14] In this case, the court found as a matter of fact that for the very limited purpose for which this barge was afloat it was seaworthy, so long as the pumps were working. Therefore the proximate cause of the loss was turning off the pumps. Within the meaning of the policy, the employee wiring the motor was a "repairer other than the assured" because for the purpose of that clause the term "the assured" includes ouly the principal officers and managers of the named insured, not employees of a lower rank.[15] The court also indicated that even if the cause of the loss was not the negligence of the repairer the loss would still be covered under the language about breakdown of electrical machinery.

Finally, the defendant argued that there had been a want of due diligence on the part of the insured. In part, this argument seems to have been based on the rusting of the barge which the court had disposed of on the issue of seaworthiness. It was also based, however, on the fact that plaintiff's weighman who was in charge of the barge had not checked on the pumps before leaving the barge at the end of the working day. On this issue the court held simply that the weighman was not of managerial level, although the barge was primarily in his care, and that under maritime law his negligence could not therefore be ascribed to the insured.

4. *Definition of Confining Sickness.*—In *Prudence Life Insurance*

11. 207 F. Supp. at 165.
12. *Ibid.*
13. Marine insurance is unique in having implied warranties. See PATTERSON, ESSENTIALS OF INSURANCE LAW 299-301 (2d ed. 1957).
14. VANCE, INSURANCE § 169 (3d ed. Anderson 1951).
15. See 4 APPLEMAN, INSURANCE LAW AND PRACTICE § 2689 (1963 Supp.).

Co. v. Hoppe[16] the Western Section of the Tennessee Court of Appeals was called on to determine the meaning of the term "confining sickness"[17] under a disability policy providing for monthly benefits of unlimited duration in case of total disability resulting from such sickness. In 1951, plaintiff insured suffered a coronary thrombosis while residing in St. Louis and was hospitalized there. He was paid benefits for some time under other provisions of the policy. In June 1957, plaintiff moved to Memphis. He remained totally disabled, but no longer required regular attendance of a physician (although he still consulted physicians from time to time), and was able to go outside the house some five times between June 1957 and the commencement of this action.

Was defendant insurer liable under these facts to make payments to the plaintiff for a total disability resulting from a confining sickness? In a dictum, the court indicated that if Tennessee law were to be applied, plaintiff would recover.[18] The rights under this contract, however, were held to be controlled by Missouri law.[19] After a consideration of conflicting Missouri decisions, the court found that recovery should be denied. Obviously, the case contributes little to the Tennessee law of insurance. It simply underscores the truth of the black-letter statement in *Vance on Insurance*: "The terms of [disability] contracts vary a great deal and on many important points the courts are not agreed as to the interpretation which should be placed on the agreement which the parties have made, even in some instances where the language is identical."[20]

B. *Exceptions and Representations*

1. *Interpretation of Insanity Exception in Hospitalization Policy.*— Rapid changes in modern medicine with regard to mental illness have frequently brought about confusion and uncertainty in the law. *Interstate Life & Accident Insurance Co. v. Houston*[21] confronted the Court of Appeals for the Western Section with one of these problems, which was accorded what may be a deceptively simple solution. Plaintiff was insured under a hospitalization policy which contained

16. 352 S.W.2d 244 (Tenn. App. W.S. 1962).

17. The definition in the policy contains two elements. Insured must be confined "continuously within doors" and require "regular visits by a legally qualified physiciau or surgeon." *Id.* at 245.

18. This dictum is clearly correct. In Brandt v. Mutual Benefit Health & Acc. Ass'n, 30 Tenn. App. 14, 202 S.W.2d 827 (M.S. 1947), recovery was allowed under nearly identical facts.

19. The conflict of laws principle involved is not discussed by the court at any length. See Gray v. Aetna Life Ins. Co., 178 Tenn. 88, 156 S.W.2d 391 (1941); Roberts v. Winton, 100 Tenn. 484, 45 S.W. 673 (1898).

20. VANCE, INSURANCE § 205 (3d ed. Anderson 1951).

21. 360 S.W.2d 71 (Tenn. App. W.S. 1962).

this exception: "No benefits will be paid for hospitalization: . . . (4) resulting from insanity." For about three months plaintiff was hospitalized in two Memphis hospitals suffering from an illness she and her witnesses were unable to describe with much clarity. An expert witness called in the case, the senior resident in psychiatry at Gailor Psychiatric Hospital, diagnosed plaintiff's illness as schizophrenic reaction, paranoid type. He further testified that the term "insane" is no longer in use in psychiatry. That profession instead uses the terms "neuroses" and "psychoses" and related language.[22] The witness stated that plaintiff suffered from a psychosis, a serious mental illness.

On the basis of this testimony, the trial judge found the term "insanity" to be ambiguous and on the ground that all ambiguities in insurance contracts are to be resolved in favor of the insured, went on to define insanity as a "complete condition of derangement" and concluded that plaintiff did not suffer from such a derangement. He therefore permitted recovery. The court of appeals, speaking through Judge Bejach, reversed. The court determined that in keeping with the notions of modern medicine the term "insanity" as used in this policy should be held to include that type of "illness treated by psychiatrists, which relates to the malfunction of the mind, as distinguished from illness of and injury to the body."[23] In making this determination, the court was guided not only by reference to a number of standard legal and non-legal dictionaries, but by chapter 127 of the Public Acts of 1957 which amended title 33 of the Tennessee Code to provide that wherever the term "insane" appeared in that title, the term "mentally ill" should be substituted. In doing so the court stated that "it thus appears to us that by legislative enactment, the terms 'insanity' and 'mental illness' are made synonymous with each other."[24] Within the context of this decision this interpretation is probably correct, since mental illness which would require hospitalization is no doubt usually of a severity such that it would in layman's terms be called "insanity." One must be cautious, however, in attempting to extend the force of this decision. "Mental illness" is a broad term; for the purposes of the code it is made a substitute for "insanity" only in a single title. It is probably doubtful that the courts would find it proper to include within the term "insanity" some of the less disturbing neuroses which still fall within the concept of "mental illness."[25] In all probability, therefore, it would be best to regard this decision as standing for the proposition that the term "insanity" used in a hospitalization policy includes those mental diseases

22. *Id.* at 72.
23. *Id.* at 75.
24. *Id.* at 77.
25. Note the wide variety of ailments, some serious, some not, discussed in chapter 17 of LAWYERS' MEDICAL CYCLOPEDIA (1959).

which would be decribed by psychiatrists as severe mental illness, such as psychosis. Further and more refined definition may be required in future cases.

It should also be pointed out that the decision in *Houston* does not overrule the earlier decision in *Raulston v. Mutual Benefit Health & Accident Ass'n*[26] which held that "if the assured is physically disabled by the disease within the meaning of the policy . . . the fact that he becomes mentally infirm [as a result] does not deprive him of the benefits to which he is otherwise entitled."[27] The opinion in *Houston* indicates by its silence on the point that no argument was made to the effect that plaintiff's hospitalization was basically caused by physical illness, of which the mental illness was but a consequence.

2. *Oral Warranty Not Within Exclusion Clause of Garage Liability Policy.—Kern v. Transit Casualty Co.*,[28] a decision of first impression is of limited importance because of the relative rarity of its facts. Plaintiff garage owner was covered by a garage liability policy which contained this usual exclusion clause: "This policy does not apply . . . to liability assumed by the insured under any contract or agreement except, under coverages A and B, (1) if in writing, any lease of premises agreement or (2) a warranty of goods or products." One of plaintiff's customers purchased an automobile from him but returned it when he discovered the brakes were defective. Plaintiff agreed to repair the brakes and later returned the car to the customer, telling him that the brakes had been fixed. When the customer applied them while driving shortly thereafter, the brakes locked and an accident resulted. The customer then sued plaintiff, who called on defendant insurer to defend the action and pay any judgment resulting. Defendant refused, on the grounds that plaintiff's liability fell within the exclusion quoted above. Plaintiff then retained an attorney and defended the suit. The customer's action was successful and a judgment was rendered against plaintiff. He then brought this action, later prosecuted by his trustee in bankruptcy, demanding (1) compensation for attorney's fees and other expenses incurred in defending the personal injury action, (2) payment of the judgment, and (3) reimbursement for his expenses in bringing the instant action.

Defendant's principal argument was based on the words "if in writing" which is contended applied equally to leases and to warranties. The court found, with excellent reason, that it was at least equally logical to regard this phrase as applying only to lease agreements. Thus an ambiguity was present and, applying the usual principles of interpretation of contracts of adhesion, must be resolved

26. 22 Tenn. App. 101, 118 S.W.2d 881 (E.S. 1938).
27. 22 Tenn. App. at 107, 118 S.W.2d at 885.
28. 207 F. Supp. 437 (E.D. Tenn. 1962).

against the insurer. As a result, the insurer was held obliged to pay the judgment. The insurer further argued that even if required to pay the judgment, it should not be held liable for the expenses incurred in defending the suit, since its refusal to defend was made in good faith. The court properly rejected the argument. It is the general rule that a refusal to defend in this type of situation is wrongful even though made in good faith.[29] Therefore, the insurer is liable for breach of its contract to defend and must respond by paying the expenses of defense. The defendant insurer was not, however, required to pay the attorney's fee for conducting the instant action. It was not specifically obligated to do so by contract or statute. Had the insurer been found guilty of bad faith, the court indicated that it would have allowed recovery under Tennessee Code Annotated section 56-1105. In this case, however, the court saw no evidence of bad faith and refused to apply the statute.

3. *Misrepresentations by Applicant; Contracting Disease After Inception of Health Policy a Valid Condition Precedent.—Hermitage Health & Life Insurance Co. v. Buchignani*[30] offered two alternative grounds of decision. Plaintiff applicant for an insurance policy allegedly failed to reveal to the agent who filled out his application the names of all physicians who had examined him in the recent past. At all events, not all the names were filled in on the application and the plaintiff did not call the omission to defendant insurer's attention when a copy of the application was returned to him with the policy, although he had ample opportunity to inspect the policy. The court cited previous Tennessee authority to the effect that in the absence of fraud by the agent a person who enters into a written contract will be presumed to have read the contract. Thus plaintiff would be guilty of material misrepresentations.

The health policy issued on the basis of the application also provided that in order to qualify for benefits, the cause of the disease resulting in insured's loss must originate more than 15 days after the inception of the policy. Such policy provisions are permissible in this state.[31] In this case the disease causing the loss apparently had manifested itself long before the inception of the policy, although not so seriously as it did after the policy was issued. Finding this provision of the contract a condition precedent, the court denied recovery.

The most interesting problem suggested by this clause—the precise meaning of the term "cause"— was not presented in the instant case.

29. See Annot., 49 A.L.R.2d 694, 701-02 (1956). The annotation is cited with approval in the instant case.

30. 354 S.W.2d 94 (Tenn. App. W.S. 1962).

31. Dees v. National Cas. Co., 17 Tenn. App. 183, 66 S.W.2d 603 (W.S. 1933).

There has been some disagreement among jurisdictions as to the time at which one should say the disease has accrued within the meaning of like clauses,[32] and we may expect further litigation on the subject in Tennessee.

II. MAKING AND MODIFYING THE CONTRACT

A. *Insurer Held Estopped To Rely on Coverage Limitation Because of Agent's Conduct*

Plaintiff insured in *Miller v. Monticello Insurance Co.*[33] operated a machine shop. He needed to obtain a loan and in order to do so put up the machinery in his shop, including a portable welding machine, as collateral. The bank which made the loan required insured to take out a fire policy insuring the machinery with a loss payable clause in its favor. Insured got in touch with defendant's agent whose office was near the machine shop and requested that he provide the coverage. As a result, the policy in this case was issued. It provided fire and related insurance on the described machinery "while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against but not elsewhere." The location described was the building in which the machine shop was located. While the portable welding machine was being used at a place some 17 miles from the shop, it was destroyed by fire. The company denied liability on the grounds that the machine when injured was not located as described in the policy.

There was some conflict in the testimony as to whether defendant's agent discussed coverage of the welding machine in particular with plaintiff. No conflict existed, however, as to the fact that plaintiff asked the agent to write coverage on all his machinery. On the basis of these facts, plaintiff's action was dismissed by the trial court, apparently on the ground that plaintiff's proper remedy was an equitable action for reformation of the policy before bringing suit thereon. The court of appeals reversed, holding that it would be unnecessary to bring an action for reformation, since a jury could properly find from the testimony that the insurer had waived this restriction on coverage and was estopped to deny coverage of this welding machine.

This result is both just and proper. The reason an insurer should be estopped to deny coverage when an insured has asked for full

32. See Helm v. Reserve Life Ins. Co., 230 S.W.2d 566 (Tex. Civ. App. 1950); 1 APPLEMAN, INSURANCE LAW AND PRACTICE § 406 (1941).

33. 361 S.W.2d 496 (Tenn. App. W.S. 1961).

coverage and the insurer has issued only limited coverage without pointing this out to the insured has been eloquently stated in *Vance on Insurance:*

> After all, the man on the street purchases his insurance policy in very much the same way he purchases his automobile or his reaper or other chattels. He knows no more about the making of a contract of insurance than he does about the making of an automobile, and he naturally relies upon the skill and good faith of those who hold themselves out to be experts in such matters, by advertising their wares for sale. It would seem to be the clear duty of the insurer, professing to draw an instrument protecting the applicant's property against certain defined perils, to exercise due diligence to supply a policy which will effect the purpose intended. Any damage caused to the applicant through the agent's mistakes or negligence in making inquiries that he should know to be pertinent should rest on the insurer. The situation seems to be strikingly analogous to that expressed in the familiar rule of the law of sales to the effect that a vendor supplying an article which he knows is to be used for a specific purpose impliedly warrants that the article furnished is suitable for that purpose.[34]

B. *Forbearance To Cancel Policy Held Valid Consideration for Rider Limiting Coverage*

In September 1959, John M. Johnson was issued a policy of automobile liability insurance by defendant insurer. The classification used for the policy was I-B, which is that used when there are no drivers under 25 in a household. In November of that year an agent of the company learned that insured's stepson was living in his household, and that the stepson was under 25. The agent then went to insured and, at the agent's request, insured signed an endorsement providing: "in consideration of the premium charged it is understood and agreed that there shall be no coverage under this policy while the automobile insured is driven by Charles Sherron . . . ." On February 5, while Sherron was driving the insured vehicle, he negligently injured a third party who recovered a judgment against him and his stepfather. Plaintiff now sues for recovery of the amounts paid out as a result.[35]

The sole point at issue is whether the endorsement was invalid for lack of consideration. The consideration recited in the endorsement papers signed by plaintiff was "the premium charged," obviously meaning the willingness of the insurer to undertake the risk for this particular premium rate. Plaintiff had, however, already paid the premium at the time the endorsement was executed. The only other basis for finding consideration in this set of facts was the fact that

34. VANCE, INSURANCE § 89, at 540 (3d ed. Anderson 1951).
35. Johnson v. Central Nat'l Ins. Co., 356 S.W.2d 277 (Tenn. 1962).

defendant insurer did not exercise its privilege to cancel the policy. It was stipulated by the parties that if plaintiff had not agreed to accept this endorsement, the insurer would have done so; had this been done, sufficient time would have elapsed prior to the accident so that the contract would not have been in force.

While it is generally held that an agreement to accept such a rider requires consideration in order to bind the insured, the jurisdictions are split on the question of whether forbearance to cancel can serve as consideration.[36] The majority rule is apparently in accord with the instant decision. Missouri, however, has held that such forbearance is not consideration for such an agreement because the insurer has given up nothing; the company still retains the power to cancel even after refraining to cancel at the time it added the rider to the policy.[37] It is submitted that the decision of the Tennessee court in the instant case is proper. First, a contrary holding would probably not result in anything other than a "paper" change in the procedures of liability insurers. As the opinion points out, the company could simply cancel the existing policy, return the premium, and issue a new policy containing the desired rider, accepting the check it had just given the insured as the initial premium payment on the newly issued policy. Requiring this red-tape approach seems to this writer neither helpful nor desirable. In the second place, even if one feels that no consideration was given by the insurer it is at least arguable that the basic elements of an estoppel are present in this kind of situation. If the insured's expression of willingness to accept the rider can be regarded as a representation—which does not seem strained—then surely the company's forbearance to cancel could be thought of as conduct in reliance to the company's detriment.

One important limitation on the effect of this decision must be noted. In order to serve as consideration, the forbearance to cancel should be bargained for; and to establish estoppel, the forbearance to cancel should be foreseeable conduct on the part of the insurer. Thus, neither approach would be appropriate unless at the time the endorsement is added the insured is made conscious of the fact that if he does not agree to the rider his policy will be cancelled. Insurers would be well advised, therefore, to spell out in the endorsement documents the fact that forbearance to cancel at that time is conduct bargained for by the insured.

36. The few cases in point are discussed in Annot., 52 A.L.R.2d 826 (1957). See also 13 APPLEMAN, INSURANCE LAW AND PRACTICE § 7603 (1943).

37. Rice v. Provident Life & Acc. Ins. Co., 102 S.W.2d 147 (Mo. App. 1937).

C. *Fire Insurance Agent Held Not To Be Agent of Insured for Purpose of Cancellation*

Moore v. New Amsterdam Casualty Insurance Co.[38] involved the issue whether an agent who had been told to obtain coverage on a certain risk had also been empowered to cancel the policy originally taken out and obtain another in its stead. The evidence concerning the extent of the agent's power was both conflicting and ambiguous. Finding the insurance agent involved to be a "soliciting agent" rather than a "broker" under the facts of the case, the court employed the Tennessee statute making soliciting agents the agents of the company rather than of the insured in matters relating to the policy.[39] The court's extended discussion of the testimony in the case indicates that the same result would probably have followed even in the absence of the statute. The strongest evidence of authority to cancel was testimony that insured instructed the agent to "keep me covered." As has been said in *Appleman on Insurance:* "Usually, however, an agent to procure a policy has no authority to cancel it, even though he may have custody of the policy or have authority to keep the property insured."[40]

III. Government Regulation

In *Long v. National Bureau of Casualty Underwriters*[41] the Supreme Court of Tennessee indicated the broad scope of the powers of the commissioner of insurance. Two insurance rating bureaus filed requests for increased rates with the commissioner, basing their request on the combined experience of well over one hundred insurers. The commissioner held a hearing upon the requests, and then denied them, stating his reasons in writing as required by section 56-603(e) of the Tennessee Code. The reasons stated were principally that it would be unjust to grant a request to so large a group of insurers when many were already making an adequate profit and would make what the commissioner regarded as exorbitant profits if the request were granted. The power of the commissioner to approve and disapprove rates is given by a statute passed in 1945 which also provided for the licensing of rating bureaus.[42] Under the statute, insurers who file as members of the bureau are bound by the group rate established as a result, but an individual company may request a variation for itself if it so desires.[43] To do so it must make the same

38. 199 F. Supp. 941 (E.D. Tenn. 1961).
39. Tenn. Code Ann. § 56-705 (1956).
40. 16 Appleman, Insurance Law and Practice § 8723, at 146 (1944).
41. 354 S.W.2d 255 (Tenn. 1961).
42. Tenn. Code Ann. § 56-604 (1956).
43. Tenn. Code Ann. § 56-610 (1956).

type of filing, reflecting its individual experience, which the rating organization must file for a group rate. The statute provides in general terms that rates shall be "fair, reasonable, adequate and not unfairly discriminatory." Prior to this language the statute lists various factors which the commissioner should consider in making his determination: loss experience, catastrophe hazards, reasonable margins for profit and contingencies, policyholder's dividends (participating policies only), and "all other relevant factors within and without the state."[44]

In this case the court reversed a decision of the trial court directing the commissioner to reconsider his decision. The court indicated its continued approval of the *Craig*[45] decision by holding that the only question for the court in a case of this sort is whether the commissioner exceeded the scope of his authority. It then apparently found that under the statute just quoted, the variation in experience between companies was a relevant factor, and therefore within the authority of the commissioner to consider. The weight to be accorded various factors was held to be for the commissioner, not the courts, and in the absence of a showing of illegal arbitrary action, his decision must be upheld.[46] The opinion seems to imply that the action was not unduly arbitrary because of the opportunity available to individual insurers to request variant rates.

IV. NEGOTIATION AND SETTLEMENT

A. *Enforcement of Arbitration Provision for Appraisal of Loss*

In *Case v. Hanover Fire Insurance Co.*,[47] the court properly enforced the provision of a fire policy which called for arbitration of the amount of loss in case of disagreement between insurer and insured as a condition precedent to bringing an action on the policy.[48] Two

44. TENN. CODE ANN. § 56-602 (1956).

45. North British & Mercantile Co. v. Craig, 106 Tenn. 621, 62 S.W. 155 (1901).

46. The Tennessee court's reluctance to interfere with the commissioner is shared by many jurisdictions. The general pattern of decisions has been summarized thus: "Ratemaking is not essentially a judicial function, but where the duty imposed upon a public official by statute is to establish a rate that is adequate, just, and reasonable, it is the duty of the court to see that a rate of that description is promulgated by him . . . . A court in reviewing rates as fixed or approved by state authorities . . . will not disturb such rates unless such authorities exceeded their powers, acted unreasonably, based their action upon a mistake of law, made a finding contrary to or unsupported by the evidence, or set a confiscatory rate . . . ." 2 COUCH, INSURANCE § 21:38 (2d ed. 1959). As this passage indicates, a number of courts are willing to exercise a more general power of review than is the case in Tennessee, but few are willing to encroach very far upon the commissioner's discretion.

47. 359 S.W.2d 831 (Tenn. App. W.S. 1962).

48. To be a condition precedent to bringing an action on the policy, the policy must show that this is the intention of the parties. VANCE, INSURANCE § 155, at 880 (3d

companies were involved. After negotiating with insured concerning a loss, they were unable to reach agreement as to its extent. They then sent a joint letter demanding arbitration and naming their appointee to the arbitration panel. According to testimony accepted by the court, insured refused to accept delivery of the letter. As pointed out by the court, it is unlikely that such a joint letter would be an effective demand in this state.[49] Later, however, individual letters were written by each company for the same purpose and an adjuster was sent with these to the insured's house. Insured refused to take the letters after talking with the adjuster, but they were left on a table in her house, to her knowledge. Under these circumstances it was undeniably correct for the court to hold that proper demand had been made on insured and that she was obliged to submit the matter to arbitration as provided by the contract.

Insured attempted to raise an objection on trial to the person named by the insurers as arbitrator on the grounds that he was not a competent disinterested person. The court stated that it found no evidence to indicate the arbitrator named was not appointed as provided by the contract, but did not dwell on the point at any length, apparently because insured did not make the objection sufficiently early.

B. *Allocating Proceeds of Credit Life Policy*

Kincaid v. Alderson[50] involved a type of policy becoming more prevalent in the United States, credit life insurance. The use of such insurance is somewhat different from that of most life policies, and a consideration of the purpose of such contracts suggests a possible criticism of this decision. The facts of the case were relatively simple. *A* purchased a mobile home and, in order to pay for it, executed a chattel mortgage to *B* to secure a note for $6,439.20. Installment payments of $107.32 a month were to be made on the note. This sum included payments of premiums on a credit life policy on *A*'s life, proceeds payable to *B* to the extent of the unpaid amount on the note, the rest to be paid to *A*'s representative. After about two years, *A* sold the trailer to *C*. *C* paid *A* $600 and executed a title bond by which he assumed the remainder of the debt owed to *B*, $4,982.80. *C*

ed. Anderson 1951). Such an intention may, in Tennessee, be inferred from a consideration of the entire policy. Palatine Ins. Co. v. Morton-Scott-Robertson Co., 106 Tenn. 558, 573-75, 61 S.W. 787 (1901). The policy in the instant case contained language sufficient to meet the requirement. 359 S.W.2d at 833.

49. Palatine Ins. Co. v. Morton-Scott-Robertson Co., 106 Tenn. 558, 576-77, 61 S.W. 787, 791-92 (1901), holding a joint demand by eleven insurance agents invalid.

50. 354 S.W.2d 775 (Tenn. 1962). See the discussions of this case in Lacey, *Creditor's Rights—1962 Tennessee Survey*, 16 VAND L. REV. 709-11 (1963); Wade *Restitution—1962 Tennessee Survey*, 16 VAND. L. REV. 859, 860 (1963).

then made regular payments to *B* of $107.32 a month. A few months later, *A* was killed. *B* was paid by the insurer. *C* brings this suit against *A*'s representative to clear his title to the mobile home, on the grounds that the payment to *B* should be regarded as discharging *C*'s debt.

The Supreme Court of Tennessee, through the distinguished late Chief Justice Prewitt, denied relief to *C*. The court characterized the situation after the sale of the trailer to *C* in terms of suretyship, *C* being the principal debtor and *A* the surety. It is a familiar rule that if a surety pays the debt of the principal, the principal must reimburse the surety.[51] The court applied the rule to this case, holding *C* liable to *A*'s widow for the amount paid *B* by the insurer.

The suretyship rule announced by the court is undeniably correct, and one cannot quarrel with the court's adoption of the rule that a principal debtor has no insurable interest in the life of his surety.[52] But one feels that the court's opinion does not sufficiently indicate the possibility that certain opposing principles may also be applicable. Comment *e* to section 76 of the *Restatement of Restitution* states:

> The right to indemnity is not precluded by the fact that the payor has been given securities by the principal obligor, out of which he is privileged to reimburse himself. He cannot, however, retain the securities after recovering full indemnity. If he disposes of them or if they are lost as a result of his fault, his indemnity is reduced to the extent of their value.

It is submitted that this principle may apply to this case. Credit life insurance serves a purpose closely akin to that served by collateral securities. While it is true that such policies protect the cestui que vie's family from the dangers of a heavily indebted estate, the person really interested in seeing the insurance taken out is the creditor.[53] This is obvious in the instant case from the fact that it was the creditor who saw to it that the policy was arranged for and included the amount of the premiums in the monthly payments on the note.

Moreover, it is disturbing that the court dismissed summarily the argument by *C* that the execution of the contract by which *C* agreed to pay sums including insurance premiums should be considered as

51. RESTATEMENT, RESTITUTION § 76 (1937).

52. There are virtually no cases on point, but a leading text on the basis of a single decision announces the proposition accepted by the Tennessee court. VANCE, INSURANCE § 31, at 199 (3d ed. Anderson 1951). Of course if the transaction in this case be viewed as an assignment of the policy, insurable interest is no problem. See Grigsby v. Russell, 222 U.S. 149 (1911).

53. For a popularized discussion of credit life insurance, including comments on its abuse, see BLACK, BUY NOW, PAY LATER ch. 11 (1961). The widespread use of this insurance as a type of collateral is indicated by the fact that 96 per cent of New York bank loans in 1962 were covered by credit life policies. 17 PERSONAL FIN. L. Q. REP. 61 (1963).

affecting an assignment of the policy. The court said simply that since *B* arranged for the policy and was the beneficiary of it, *A* had no interest in the policy to assign. This line of reasoning seems questionable. Since *A* was to pay the premium, and since his heirs would receive benefits from the policy in the event the unpaid debt was less than the amount of the insurance, *B* should be regarded simply as *A*'s agent for the purpose of taking out the policy.[54] Taking this view, *A* clearly had an assignable beneficial interest in the policy and the court should have examined the transaction between *A* and *C* to determine whether such an assignment took place.

This decision does not unduly trouble one's sense of justice. The amounts paid as premiums by *C* were undoubtedly quite small (though certainly at least this amount should be allowed *C* if *A* is to have full benefit of the proceeds). Moreover, *C* will not in the long run pay more than he anticipated would be necessary to pay when he purchased the mobile home. But the decision is disturbing in its adherence to certain technical principles in the absence of the reasons supporting those principles. To say that *A*'s death caused payment of *C*'s debt is not necessarily to say that *A* paid the debt. If *A* had paid a lump-sum premium for the policy that would be true; but under these facts *A* paid only term premiums sufficient to keep the policy alive for the length of time during which he was making monthly payments on the note. He was not paying for the insurance when he died; *C* was. Still more disturbing, however, is the absence of any examination of the character and purpose of this type of insurance. Life insurance is a marvelously flexible instrument for the achievement of many ends. If it is to be used as security, should not the courts consider the possibility of treating it like other forms of security and applying to it the same rules that would be applied to analogous types of collateral? This writer views the situation in this way: By paying premiums on a life policy whose cestui que vie was *A*, *C* placed in his creditor's hands a thing of value—a potential right of recovery under contract. That right was exercised. When it was, *C* should have been given the benefit.

C. *Insurer's Duty To Settle Under Liability Policy*

One of the most troublesome types of cases that can be brought under a liability policy is an action by an insured alleging that be-

54. VANCE, INSURANCE § 123 (3d ed. Anderson 1951) states that where the creditor takes out the policy, the contract should be regarded as purely between the creditor and the insurer. However, in the same section, the writer notes that the weight of authority is *contra*, and that it "naturally follows that these courts give any excess of the insurance money over the debt and charges to the personal representative of the debtor." *Id.* at 739-40. Since that is precisely what this policy provided, one can see no objection whatever to employing the agency approacb.

cause of an insurer's wrongful failure to settle the insured has been damaged by an award above policy limits and asking that the insurer be required to pay this additional amount.[55] Such a case was *Perry v. United States Fidelity & Guaranty Co.*[56] Plaintiff insured was sued by a third party, who alleged damages resulting from the negligent operation of insured's tow truck. After investigation, the insurer decided that there was no liability under the facts. It therefore made a very small offer of settlement and declined the injured party's settlement offer of a much larger amount. The injured party's suit was successful, resulting in a judgment beyond the face value of the policy. Insured then brought this action against the insurer to recover the balance of the judgment over the policy value. In the trial court, a verdict was directed for the defendant.

Insured urged two grounds of reversal on appeal. One was that the judge directed the verdict on the grounds that insured was required to show bad faith rather than negligence on the part of the insurer. In answering this, the court quoted the statement made in the *Norris* case[57] to the effect that in such cases bad faith must be shown. To amplify what it means by bad faith the court outlined six points which it regards as a guide for determining bad faith.[58] Reading these points, one is struck by the similarity between the language used and that which might be used if negligence were the test. The insurer is charged, for instance, with the duty to make an "honest and fair investigation" and to take into consideration the application of the relevant rules of law. It is then for the insurer to "exercise reasonable judgment based upon those elements whether or not the claim should be settled." This idea of "reasonable judgment" immediately brings negligence concepts to mind. However, the court also says that "having so investigated, a mistake of judgment would not constitute bad faith."[59] The ambivalence of this language leads one to the conclusion that the court is formulating a standard for determining the presence of bad faith which is not so rigorous as to require a showing of intentional disregard of insured's interest, but is more rigorous than an ordinary negligence standard.[60] If this surmise is correct, it may require several more decisions, including some by the state supreme court, to delineate the standard precisely.

Insured's second assignment of error was the usual one to the effect

55. See Keeton, *Ancillary Rights of the Insured Against his Liability Insurer*, 13 VAND. L. REV. 837 (1960). The article contains a discussion of several relevant Tennessee cases.

56. 359 S.W.2d 1 (Tenn. App. W.S. 1962).

57. Southern Fire & Cas. Co. v. Norris, 35 Tenn. App. 657, 250 S.W.2d 785 (E.S. 1952).

58. 358 S.W.2d at 7.

59. *Ibid.*

60. See Keeton, *supra* note 55, at 841-42.

that the evidence was insufficient to support a directed verdict. The court reviewed the testimony at great length. From this review it seems unlikely that insurer could be regarded as having acted negligently or in bad faith although a jurisdiction adopting the negligence view might possibly have allowed the jury to assess the importance of the loss of one item of physical evidence.