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## Insurance

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# *Insurance*

by *Robert A. Seligson\**

Any discussion of California insurance decisions and developments in the past year must perforce start with the fall of 1966, since 1967 was the year in which the insurance industry was confronted with greatly expanded rules on the duty to defend, the duty to settle within limits and rising above all, like a Colossus sprung from the deep, the tortured decision of *Pacific Employers Insurance Company v. Maryland Casualty Company*,<sup>1</sup> which threatened to convert policies written for totally different purposes into automobile liability policies at the drop of a hat and with nary a premium.

## **The Duty to Defend**

The duty to defend was the first field to occupy the attention of the supreme court; the battleground was the case of *Gray*

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1. 65 Cal.2d 318, 54 Cal. Rptr. 385, 419 P.2d 641 (1966).

*v. Zurich Insurance Company.*<sup>2</sup> Dr. Gray, while driving his automobile, almost had a collision with an automobile operated by Jones. Jones “approached Dr. Gray’s car in a menacing manner and jerked open the door”;<sup>3</sup> and Dr. Gray then struck Jones. “Jones filed a complaint alleging that Gray ‘willfully and intentionally assaulted’ him. . . .” Gray’s insurer, Zurich, refused to defend Gray, since its policy excluded “. . . bodily injury or property damages caused intentionally by or at the direction of the insured.”<sup>4</sup> Gray unsuccessfully defended the case on the theory of self-defense; there was a judgment of \$6,000 actual damages, but no punitive damages. Gray then sued Zurich, claiming a breach of its duty to defend. The trial court rendered judgment for Zurich; the supreme court reversed and remanded the case to the trial court to take evidence solely on the issue of damages alleged in the complaint, including the amount of the judgment in the Jones suit and the costs, expenses and attorneys’ fees incurred in defending that action.

The court held that an insurance carrier must defend a suit that potentially seeks damages within the coverage of the policy and ruled that in determining whether an exclusionary clause in an insurance policy will be applied, the question is whether the insured might reasonably expect the insurer to defend him. The court indicated that an insurer refuses to defend only at its peril and stated that the remedy for a carrier, which feels that there is no coverage under the policy, is to defend on a reservation of right basis and to raise the noncoverage defense in a subsequent action afterwards, if the injured party prevails in his action against the insured. Notwithstanding the exclusion in the policy, the court held that the insurer was required to pay not only the costs of defense, but also the judgment against its insured, apparently on the basis that the insurer has more money than the insured and can better afford to employ competent counsel to defend the case against the insured.

2. 65 Cal.2d 263, 54 Cal. Rptr. 104, 419 P.2d 168 (1966).

3. 65 Cal.2d at 267 n. 1, 54 Cal. Rptr. at 106 n. 1, 419 P.2d at 170 n. 1.

4. 65 Cal.2d at 267, 54 Cal. Rptr. at 106, 419 P.2d at 170.

The opinion contained considerable dictum that indicates the court's basic attitude toward complicated language and the use of "fine print" in insurance policies. The court terms an insurance policy an "adhesion contract" and stated that obligations arising from such a contract inure not only from the consensual transaction but from the relationship of the parties. Thus, the duty to defend depends not merely on the objective standard of the language in the policy, but rather on the subjective standard whether the insured might reasonably expect that he is entitled to a defense.

*Lowell v. Maryland Casualty Company*<sup>5</sup> also involved the duty to defend under a comprehensive liability policy. Here too the insurer refused to defend an action that alleged that the insured unlawfully and maliciously assaulted the plaintiff, on the basis that its policy provided that an assault and battery would be deemed an accident ". . . unless committed by or at the direction of the insured."<sup>6</sup> The insured prevailed in the assault and battery action and then sued the insurer for costs, expenses, and attorneys' fees incurred in defending that suit. The supreme court reversed the lower court's judgment for the insurer and instructed the trial court to take evidence solely on the issue of damages. The court rejected, however, the insured's claim for recovery of attorneys' fees incurred in the action against the insurer, Maryland Casualty Company, stating that it saw no more reason for allowing plaintiff to recover attorneys' fees in this case than in actions for enforcement of other kinds of rights.

In *Stolte, Inc. v. Seaboard Surety Company*,<sup>7</sup> Seaboard had paid judgments to persons injured as a result of the use of a crane by Stolte, lessee of the crane from Seaboard's insured. Seaboard then sued Stolte on a theory of implied indemnity and on a "hold harmless" agreement that appeared in the lease. Stolte cross complained, claiming that Seaboard was required to provide coverage and defense to the lessee as an "additional insured." The court held that even though Sea-

5. 65 Cal.2d 298, 54 Cal. Rptr. 116, 419 P.2d 180 (1966).

6. 65 Cal.2d at 301, 54 Cal. Rptr. at 118, 419 P.2d at 182.

7. 250 Cal. App.2d 169, 58 Cal. Rptr. 477 (1967).

board would be required to provide coverage and defense for Stolte for any liability imposed by way of implied indemnity, if that cause of action were dismissed, Seaboard could maintain its action on the "hold harmless" agreement.

The supreme court's decision in *Gray v. Zurich* was motivated by the court's concern over cases where insurers have refused to defend claims that might potentially fall within the terms of their coverage. Because of this concern and the court's conception of an insurance policy as a public service contract, the court ignored the exclusion provision of the contract, which on its face would seem to have covered the situation presented by the jury's verdict of bodily injury caused intentionally by the insured. The subjective standard announced by the court in determining the duty to defend is one that, by its very nature and emphasis upon the reasonableness of the expectation of the insured, will unquestionably force insurers into taking over defenses that would previously have been rejected on a denial of coverage. On balance, the writer believes that the court's decision will have a decidedly salutary effect. The writer, however, does not feel that the court fully appreciates the conflict of interest problems that can and do arise under such situations, and he is concerned about the misuse and misapplication of the court's decision by parties seeking to obtain insurance coverage and defense for actions that clearly fall without the scope of the coverage. For example, the writer has already observed tenders of defense to insurers made by parties charged with attempted murder, attempted rape and libel. If the insurer is required to defend these and every other kind of criminal and intentional activity on the part of its insureds, there will have to be a redefinition of the concept of insurance and a corresponding adjustment in the rate of premium that must be borne by the public.

### **The Duty to Settle Within Limits**

As broad and sweeping as the court's decision was concerning the duty to defend, it was matched by the rules set forth in *Crisci v. Security Insurance Company*,<sup>8</sup> involving the duty

<sup>8</sup>. 66 Cal.2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967).

of a liability insurer to settle a claim against its insured within policy limits. The supreme court held therein that the test for determining whether an insurer considered its insured's interests, before rejecting an offer to settle a claim against the insured, is whether a prudent insurer without policy limits would have accepted the settlement offer. It is not necessary to show that the insurer has in any way been guilty of actual dishonesty, fraud, or concealment. Liability is imposed on the insurer for failure to meet its duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing. The size of the judgment recovered in the personal injury action, when it exceeds the policy limits, although not conclusive, furnishes an inference that the value of the claim is the equivalent of the amount of the judgment and that acceptance of an offer within those limits was the most reasonable method of dealing with the claim. The court held that the evidence supported a finding of the defendant's breach of duty to consider plaintiff's interest in proposed settlements and that the defendant's alleged belief that the claimant had no chance of recovery for mental suffering could be found to be unreasonable. The facts supporting this reasoning are that it appeared that defendant's attorney and the claims manager agreed that an award, if any, to the claimant for psychosis would be at least ten times the policy limits; that the defendant knew that the claimant's accident could have caused psychosis; and that reputable psychiatrists supported the claim. The insurer had rejected a \$9,000 settlement demand at a time when its insured offered to pay \$2,500 towards settlement. The insurer was only willing to pay \$3,000 for the plaintiff's physical injuries and was unwilling to pay anything for the possibility of a plaintiff's verdict on the mental illness issue. The policy limit was \$10,000 and the ensuing plaintiff's verdict was for \$100,000.

The significant portion of the court's decision concerns the argument by an amicus curiae that whenever an insurer receives an offer to settle within the policy limits and rejects it, the insurer should be liable in every case for the amount of any final judgment whether or not within the policy limits.

In considering this argument, Justice Peters, speaking for the court, stated:

Obviously, it will always be in the insured's interest to settle within the policy limits when there is any danger, however slight, of a judgment in excess of those limits. Accordingly the rejection of a settlement within the limits where there is any danger of a judgment in excess of the limits can be justified, if at all, only on the basis of interests of the insurer, and, in light of the common knowledge that settlement is one of the usual methods by which an insured receives protection under a liability policy, it may not be unreasonable for an insured who purchases a policy with limits to believe that a sum of money equal to the limits is available and will be used so as to avoid liability on his part with regard to any covered accident. In view of such expectation an insurer should not be permitted to further its own interests by rejecting opportunities to settle within the policy limits unless it is also willing to absorb losses which may result from its failure to settle.<sup>9</sup>

The court noted that the proposed rule of strict liability is a simple one to apply and avoids the burdens of a determination whether a settlement offer within the policy limits was reasonable. It further stated that the proposed rule would also eliminate the danger that an insurer, faced with a settlement offer at or near the policy limits, will reject the offer and gamble with the insured's money to further its own interests. Finally, the court noted that it is not entirely clear that the proposed rule would place a burden on insurers substantially greater than that which is present under existing law. Considering Justice Peters' decision in this case, there seems to be some truth in the latter statement. One wonders whether the insurance industry will not have to raise their minimum limits to a level sufficient to compensate for the danger of excess judgments.

<sup>9</sup> 66 Cal.2d at 430-31, 58 Cal. Rptr. at 17, 426 P.2d at 177.

The court also held that the insured was entitled to damages from her insurer for her mental suffering caused by virtue of the insurer's failure to settle the case within limits. The court held that an action against an insurer based upon its alleged bad faith sounds both in contract and in tort and, therefore, the plaintiff may avail himself of the rules of compensation in tort cases and may recover for mental suffering occasioned by the tortious conduct of the insurer in failing to settle within the policy limits. One who loses his property and suffers mental distress as a result of another's tortious conduct may recover not only for the pecuniary loss but also for his mental distress. This is justified on the basis that among the considerations in purchasing liability insurance is the peace of mind and security it will provide in the event of accidental loss.

It would seem that the result in *Crisci* was warranted by the facts presented therein since the insurance company did not act reasonably. However, the implications and dangers presented by the court's decision are again considerable. For example, take the situation of a drunken pedestrian who walks out into the street in the middle of the block between two parked cars directly into the path of a motorist, who though traveling within the speed limit, is unable to avoid the accident. The pedestrian is seriously and permanently injured, and the motorist has a minimum limits policy. Must the insurer of the innocent motorist offer to settle the claim for the policy limits in order to avoid the possibility that the plaintiff's severe injuries may induce the jury to render a substantial verdict? If a reasonable individual would not have succumbed to the threat of a large verdict, then the writer does not believe that a reasonable insurer that has followed the same course of action should be held strictly liable for a judgment in excess of limits.

### **General Comprehensive Liability Policy: Automobile Coverage**

The results in *Gray* and *Crisci* may be justified on the basis that serious problems require dramatic solutions. However, the same may not be said of the court's decision in *Pacific*



*Employers Insurance Company v. Maryland Casualty Company*,<sup>10</sup> which the writer believes to be the worst insurance law decision to be rendered by the court in many years. In *Pacific Employers*, the court, relying on California Vehicle Code section 16451<sup>11</sup> and *Wildman v. Government Employees Insurance Company*,<sup>12</sup> held that a general comprehensive liability policy afforded automobile coverage for an accident that occurred away from the premises of the named insured and that the policy was required to afford coverage to a permissive user. The case involved an accident that happened in 1959 during a loading operation at the Libby plant. Pacific insured the truck that was being loaded. American Mutual, a defendant, had a comprehensive general liability policy on the lessor of the forklift that was being used by Libby employees in the loading operation. The American policy did not purport to cover permissive users and excluded liability arising from the ownership or operation of "automobiles while away from the premises . . . or the ways immediately adjoining."<sup>13</sup> The court held that the phrase "ways immediately adjoining" was ambiguous and that where a policy provided for coverage of liability arising out of a "substantial" use of the public ways by an insured's automobile, California Vehicle Code section 16451 required coverage "within the continental limits of the United States"<sup>14</sup> and the statute in

10. 65 Cal.2d 318, 54 Cal. Rptr. 385, 419 P.2d 641 (1966).

11. Cal. Vehicle Code § 16451: "An owner's policy of liability insurance shall [1] insure the person named therein and any other person, as insured, using any [2] *owned* motor vehicle with the express or implied permission of said assured, against loss from the liability imposed by law for damages arising out of ownership, maintenance, or use of such motor vehicle within the continental limits of the United States to the extent and aggregate amount, exclusive of interest and costs, with respect to each motor vehicle, of ten thousand dollars (\$10,000) for bodily injury to or death

of each person as a result of any one accident and, subject to said limit as to one person, the amount of twenty thousand dollars (\$20,000) for bodily injury to or death of all persons as a result of any one accident and the amount of five thousand dollars (\$5,000) for damage to property of others as a result of any one accident." [Emphasis in original.]

12. 48 Cal.2d 31, 307 P.2d 359 (1957).

13. 65 Cal.2d at 325, 54 Cal. Rptr. at 388-89, 419 P.2d at 644-45.

14. 65 Cal.2d at 323, 54 Cal. Rptr. at 388, 419 P.2d at 644.

the Wildman case, *supra*, required coverage for permissive users. The court stated:

In the instant case there is no question but that the forklift is expressly covered, at least as to some operations including its use on 'ways immediately adjoining' the insured's premises. In construing the policy in light of this phrase we do not deem it relevant that the policy be categorized as an 'automobile' or any other type policy. The label is unimportant. What is important is whether the policy, whatever its label, provides liability coverage to automobiles while operated on a public highway. If so, then the carrier has exposed itself to the application of the *Wildman* principle by purporting to furnish the crucial coverage.<sup>15</sup>

It is interesting to note that in deciding the question of the duty to defend in *Gray v. Zurich*, the court placed great stress and importance on the label of the policy. In this case, one month later, the court held that the label was unimportant.

In the aftermath of this decision, numerous claims have been made that homeowners' policies; owners', landlords', and tenants' policies; and other such policies containing personal liability endorsements and offering what was thought to be limited automobile coverage for the "premises and the ways immediately adjoining" are, by virtue of the legal legerdemain utilized in the *Pacific Employers* decision, converted into automobile policies furnishing coverage for accidents occurring miles away from the insured's premises. Confronted by the possibility that their policies might be interpreted to be automobile policies, some insurers have deleted the coverage that was previously furnished to insureds without additional cost. The public is confused, since it cannot conceive how a homeowners' policy can be held to be an automobile policy. Yet, if the court's decision in *Pacific Employers* is applied literally, the personal liability endorsement contained as a part of the standard homeowners' policy could be found to afford automobile coverage without con-

<sup>15</sup> 65 Cal.2d at 325-26, 54 Cal. Rptr. at 389, 419 P.2d at 645.

sideration having been given to this exposure from an underwriting standpoint.

It should be noted that in 1963, the requirements of the Financial Responsibility Laws, including California Vehicle Code section 16451, were amended so as to apply only to certified policies. Inasmuch as the court's decision rested in part on the requirement in section 16451 of coverage for the "continental limits of the United States," it would seem that the decision no longer applies to cases where the policy was issued and the accident occurred after September 20, 1963. At the present time, several superior court decisions have already drawn this distinction; and unquestionably the point will be decided in the near future by the appellate courts.

The first appellate court limitation of *Pacific Employers* was handed down in the case of *Home Indemnity Company v. Mission Insurance Company*.<sup>16</sup> In that case, Home had issued a comprehensive liability policy which afforded "Automobile" coverage under Coverage A, and "Except Auto." coverage under Coverage B. Because of various endorsements, the court held that the automobile coverage, Coverage A, did not apply. Mission claimed that Coverage B of the Home policy afforded automobile liability coverage on the basis of the decision in the *Pacific Employers* case. The B coverage in the Home policy contained the standard clause that stated that the policy did not apply to the use of "automobiles if the accident occurs away from such premises or the ways immediately adjoining."<sup>17</sup> The court held that where the policy purports to cover automobile liability in one part and general liability in another, the application of the *Pacific Employers* case would serve to rewrite the policy to the exclusion of the specific provisions that were applicable to the automobile coverage. The court could not find any authority for such procedure, and it refused to apply the *Pacific Employers* case to the Home policy.

The writer does not believe that there is any sound basis for distinguishing the *Home* case from the situation where one

16. 251 Cal. App.2d 942, 60 Cal. Rptr. 544 (1967).

17. 251 Cal. App. at 952, 60 Cal. Rptr. at 552.

company has issued both an automobile policy and a homeowners' policy to the same insured. Nor should there be any true distinction between the situation where two different companies have written the automobile and homeowners' policies. The rationale should be the same, since the insured has taken out the automobile policy to protect against automobile accidents, and the homeowners' policy for an entirely different purpose. In *Gray v. Zurich*, the court indicated that the reasonable expectation of the parties was important. Clearly, the individual who has paid a nominal premium for personal liability coverage under a homeowners' policy should not reasonably expect that he has purchased automobile liability insurance for accidents occurring away from the premises.

### **Life Insurance: "Good Health" Provisions**

During the past year, the supreme court decided two cases that substantially affect the interpretation of "good health" provisions contained in the applications for life insurance policies. These cases are *Metropolitan Life Insurance Company v. Devore*<sup>18</sup> and *Harte v. United Benefit Life Insurance Company*.<sup>19</sup> In the *Metropolitan* case, after the insured executed his application for life insurance, which contained a "good health" provision, and completed a medical questionnaire, his private physician discovered that he had arteriosclerotic heart disease. The insured was not told of his condition but was hospitalized for rest for a few days, after which he continued his normal activities until his death over 2 years later. Approximately 1 month after he got out of the hospital, the policy was delivered to him, at which time he signed an "Application Amendment," which purported to ratify the statements in the original application as of the date of the amended application. The court held that the amended application was ambiguously worded and was reasonably understood by the insured to mean that by signing, he was confirming the statements therein as of the date of the original

<sup>18</sup>. 66 Cal.2d 129, 56 Cal. Rptr. 881, 424 P.2d 321 (1967).

<sup>19</sup>. 66 Cal.2d 148, 56 Cal. Rptr. 889, 424 P.2d 329 (1967).

application, not the date of the amended one. Furthermore, the court held that a "good health" provision does not bar recovery where the applicant believes in good faith that his health has not materially changed between the time of application and delivery. The insured cannot be charged with the uncommunicated knowledge of a third person, such as his physician. He cannot prevail, however, when a disease predated the application, if the latent condition had become manifest before delivery and he had knowledge of the seriousness of his condition.

In the *Harte* case, after the execution of the application for life insurance, but before delivery of the policy, the insured's doctor discovered that the insured had inoperable cancer. The insured's wife was informed, but he was not. He was told that he had an obstruction of the bowel but that only minor surgery would be required to remove it, that a biopsy taken was negative, and that the obstruction would be removed and he would "be all right." The court restated the rule set forth in *Metropolitan* and held that although the insured's wife was her husband's agent for the purpose of accepting the policy, her uncommunicated knowledge was not imputed to her husband for the purpose of determining whether he acted in good faith, since his good faith had to be determined on the basis of whether he had actual knowledge. Moreover, the court held that there was no evidence to indicate that the agent (the wife) was guilty of fraud to be charged to the principal (the husband), since she had not read the application and could have been led to believe that liability on the policy was conditioned only on medical approval of the insurer's examining physician.

There was also an interesting court of appeal decision in the life insurance field, involving concurring causes of injury. In *Shafer v. American Casualty Company*,<sup>20</sup> the defendant's policy provided that it would pay for the death of the insured through accidental means but excluded coverage for death resulting from "disease." The insured had an automobile

<sup>20</sup> 245 Cal. App.2d 1, 53 Cal. Rptr. 446 (1966).

accident that caused a bruise on his arm and shock. At the time of the accident, he had a preexisting condition of arteriosclerosis in his coronary arteries. He died 2 days after the accident from a heart attack caused by coronary thrombosis. The court held that the death was caused by a concurrence of the shock sustained in the accident and the arteriosclerosis. Judgment for plaintiff was affirmed on appeal. The court held that the presence of a preexisting disease or infirmity will not relieve the insurer from liability if the accident is the proximate cause of death. Recovery may be had even though a diseased or an infirmed condition appears to have contributed to the cause of the death, if the accident sets in progress the chain of events leading directly to death, or if the accident is the prime or moving cause of the death.

### Group Insurance

The growth of group insurance obtained by employers for their employees has resulted in increasing litigation. During the past year, two significant decisions were rendered by the California Supreme Court in this field. In *Elfstrom v. New York Life Insurance Company*,<sup>1</sup> the court held that the employer acts as the agent of the insurer in performing the duties of administering group insurance policies. In filling out an employee's application and certificate for group insurance and inserting misstatements contained therein as to the employee's eligibility for coverage, the employer and its representative in charge of administering the group insurance policy were held to be agents of the insurer. The employer's errors in administration were therefore attributable to the insurer. The court noted, however, that an insurer may avoid a policy where the insured misrepresents material facts in the application to the insurer.

In *Walker v. Occidental Life Insurance Company*,<sup>2</sup> the court held that an insurer issuing a group insurance policy, to which is attached the privilege of converting to individual insurance within a stated period from the termination of

1. 67 Cal.2d —, 63 Cal. Rptr. 35, 432 P.2d 731 (1967).

2. 67 Cal.2d 526, 63 Cal. Rptr. 45, 432 P.2d 741 (1967).

employment, is required to give the employee-insured notice of such termination either directly or through its employer-agent. Although the insurer may delegate this task to the employer, it may not avoid the responsibility for notification simply by routine reliance on a bookkeeping entry of the termination date in the employer's record.

An insurer's wrongful rejection of a dismissed employee's application to convert \$10,000 of his \$22,000 group life insurance into individual insurance, did not, on the insured's death shortly thereafter, however, entitle his beneficiary to the full \$22,000 benefit. Although the prompt rejection of the smaller application under the mistaken belief that it was untimely would have made it futile for the insured, before the conversion period in fact expired to apply for the full amount available for conversion, there was no evidence that he intended or desired to do so. The beneficiary was therefore entitled only to \$10,000, less the insurance premiums that would have been payable had the application been granted.

### **The Duty of the Insured to Cooperate With the Insurer**

In *Campbell v. Allstate Insurance Company*,<sup>3</sup> the supreme court had held that prejudice was no longer presumed from an insured's refusal to cooperate with his insurer; and so it was claimed that under that decision, it was not necessary to cooperate with Allstate. In 1967 the court of appeal decided a case which demonstrated that this was not true. In *Allstate Insurance Company v. King*,<sup>4</sup> Allstate's insured, who was the defendant in a personal injury action, appeared at his deposition but failed to appear at the trial. The jury rendered a verdict in favor of plaintiff. Allstate then brought a declaratory relief action, and the court affirmed the judgment, declaring that the company was not obligated to pay the judgment against its insured, since the insured had breached the cooperation clause of the policy by his failure to attend the trial. The evidence indicated numerous unsuc-

3. 60 Cal.2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963).

4. 252 Cal. App.2d 755, 60 Cal. Rptr. 892 (1967).

successful attempts to locate the insured as well as expert testimony by three well-qualified trial lawyers who testified that the defense would be substantially prejudiced by the absence of the defendant, particularly where no reasonable excuse could be offered for his absence.

### **Automobile Insurance: Exclusion of Coverage for Injuries to the Insured**

There has been a considerable amount of litigation in the past year involving exclusions of coverage in automobile liability insurance policies for bodily injuries sustained by the insured. In *Farmers Insurance Exchange v. Frederick*,<sup>5</sup> Farmers insured a pickup truck owned by Frederick. The Farmers policy afforded coverage for bodily injury liability to any person, arising out of the ownership, use, operation, and control of the described vehicle. The policy further provided that coverage did not apply “to bodily injury to the insured or any member of the family of the insured residing in the same household as the insured.”<sup>6</sup> The policy defined the word “insured” to include “the named insured and his relatives”<sup>7</sup> as well as permissive users. Frederick, the named insured, was injured while he was an occupant in his pickup truck at the time it was being operated by a permissive user. In a two-to-one decision, the Los Angeles Court of Appeal held that the word “insured” referred to the person who actually drives the vehicle, and consequently, the exclusion did not prevent the named insured, Frederick, from recovering against a permissive user afforded coverage by the terms of the policy. In an excellent dissent, Justice Herndon pointed out that the exclusion utilized essentially the same terminology found in California Vehicle Code section 16454, which provides, “Any motor vehicle liability policy need not cover any liability for injury to the assured. . . .” He further argued that the majority’s construction of the term “insured” (to mean the driver) was senseless, since no exclusion under

5. 244 Cal. App.2d 776, 53 Cal. Rptr. 457 (1966).

6. 244 Cal. App.2d at 779, 53 Cal. Rptr. at 458.

7. 244 Cal. App.2d at 779, 53 Cal. Rptr. at 458.



a liability policy is required to prevent a person from seeking to establish his own liability for his own injuries. Both the majority and the dissent recognized that California law provides that a motor vehicle policy need not cover any liability for injury to the insured.

Since the *Frederick* decision, the court of appeal has given effect to the exclusion in three cases. In *Farmers Insurance Exchange v. Geyer*,<sup>8</sup> the court applied the exclusion with respect to a claim for injuries made by the named insured, holding that Vehicle Code section 16454 specifically authorizes the unqualified exclusion of coverage for injuries to the assured, and a policy that excludes coverage to the named insured is proper and must be applied. In *Farmers Insurance Exchange v. Brown*,<sup>9</sup> the policy provided that it did not apply to the liability of any insured for bodily injury to the named insured and defined the term "named insured" to include a spouse of the policyholder if a resident of the same household. Mr. Brown was the named insured, and Mrs. Brown was fatally injured while riding in her husband's car. The court held that Mrs. Brown was a "named insured" under the policy, that the exclusion was valid and operated so as to preclude coverage for the claims of her heirs for her wrongful death. Finally, in *Hale v. State Farm Mutual Automobile Insurance Company*,<sup>10</sup> which involved a collision between husband and wife driving the two family automobiles, the court held that the claim of the wife against her husband for her own injuries was excluded from the policy issued on the car driven by the husband. It also rejected the wife's uninsured motorist claim, since under both the policy definitions and California Insurance Code section 11580.2,<sup>11</sup> a vehicle owned by the named insured or any resident of the same household does not qualify as an "uninsured motor vehicle."

8. 247 Cal. App.2d 625, 55 Cal. Rptr. 861 (1967).

9. 252 Cal. App.2d 120, 60 Cal. Rptr. 1 (1967).

10. 256 Cal. App.2d 206, 63 Cal. Rptr. 819 (1967).

11. See 256 Cal. App.2d at 210, n. 4, 63 Cal. Rptr. at 822-23, n. 4.

## Uninsured Motorist Coverage

Uninsured motorist coverage was responsible for more decisions in 1967 than any other area of insurance law. In *Katz v. American Motorist Insurance Company*,<sup>12</sup> the court held that where an automobile is insured but the insurer has become insolvent after the accident, the automobile is an “uninsured motor vehicle” within the meaning of Insurance Code section 11580.2. The effect of this decision has subsequently been modified by the amendment of section 11580.2 to provide that the solvency protection under uninsured motorist coverage is applicable only to accidents occurring during a policy period in which the insured’s motor vehicle coverage is in effect and where the liability insurer of the tortfeasor becomes insolvent within 1 year of such accident.

Another recent decision has affirmed the proposition that California has a statutory policy of uninsured motorist coverage and that deviations from the provisions contained in the statute will not be permitted. In *Lopez v. State Farm Fire and Casualty Company*,<sup>13</sup> the policy contained a provision excluding from uninsured motorist coverage a relative who owns an automobile. The court held this provision to be void as conflicting with the applicable statute and stated that the argument that it was reasonable to exclude one who did not insure his own car “would better be addressed to the Legislature.”

Several cases were decided involving the 1-year statute of limitations set forth in California Insurance Code section 11580.2(h)<sup>14</sup> for uninsured motorist claims. In *Pacific Indemnity Company v. Superior Court*<sup>15</sup> and *Republic Indemnity*

**12.** 244 Cal. App.2d 886, 53 Cal. Rptr. 669 (1966).

**13.** 250 Cal. App.2d 210, 58 Cal. Rptr. 243 (1967).

**14.** Cal. Ins. Code § 11580.2(h): “Prerequisites to suit. No cause of action shall accrue to the insured under any policy or endorsement provision issued pursuant to this section unless within one year from the date of the accident;

(1) Suit for bodily injury has been filed against the uninsured motorist, in a court of competent jurisdiction, or

(2) Agreement as to the amount due under the policy has been concluded, or

(3) The insured has formally instituted arbitration proceedings.”

**15.** 246 Cal. App.2d 63, 54 Cal. Rptr. 470 (1966).

*Company of America v. Barn Furniture Mart, Inc.*,<sup>16</sup> it was held that the statute of limitations for uninsured motorist claims is not affected by those disabilities, such as minority and insanity, that toll other periods of limitation. The statute of limitations, moreover, is a matter for the court rather than the arbitrators provided for under the statute; and it has been held error for the trial court to refuse to enjoin a claimant from proceeding to arbitration, where it was clear that no demand to arbitrate had been made within 1 year from the date of the accident.<sup>17</sup> However, where the claimant sent a letter to defendant demanding coverage and filed an action for declaratory relief to determine coverage within 1 year from the date of the accident, she was held to have complied with the statute of limitations requirement of formally instituting arbitration proceedings within 1 year from the date of the accident.<sup>18</sup>

Finally, in *Fireman's Insurance Company v. Diskin*,<sup>19</sup> where the tortfeasor's insurer became insolvent more than 1 year after the date of the accident, it was held that the failure of the claimants either to sue the tortfeasor or to institute arbitration proceedings within 1 year from the date of the accident barred their claims, despite the fact that the accident happened in a state which had a 4-year statute of limitations period for suits for personal injuries.

### **Reimbursement for Medical Services From Proceeds of Personal Injury Action**

One of the most frequent criticisms aimed at the traditional system of handling automobile accident cases today is that some people collect twice or even three times for their medical expenses while others do not recover at all. Multiple recovery of the same bills is permitted under the collateral source rule and the refusal to permit subrogation to medical payments insurers. In *Peller v. Liberty Mutual*

<sup>16</sup>. 248 Cal. App.2d 517, 56 Cal. Rptr. 609 (1967).

<sup>17</sup>. See *Key Ins. Exch. v. Bragini*, 250 Cal. App.2d 143, 58 Cal. Rptr. 408 (1967).

<sup>18</sup>. See *Calhoun v. State Farm Mut. Auto. Ins. Co.*, 254 Cal. App.2d 441, 62 Cal. Rptr. 177 (1967).

<sup>19</sup>. 255 Cal. App.2d 598, 63 Cal. Rptr. 177 (1967).

*Insurance Company*,<sup>20</sup> it was held that an automobile insurer which had paid out, under the medical payments provision of its policy, was not entitled to subrogate for those payments against the tortfeasor. One of the most significant decisions in the past year may turn out to be the case of *Block v. California Physicians' Service*,<sup>1</sup> where California Physicians' Service was held entitled to be reimbursed from the proceeds of a personal injury action filed by the plaintiff for the medical services which California Physicians' Service had already furnished to the plaintiff. The court held that the group service agreement, which provided that the member would reimburse California Physicians' Service to the extent of the benefits conferred, and granted a lien to the extent of the benefits, where the member was injured through the act or omission of another person, was valid and in conformity with public policy. The court held that this was not a subrogation or assignment of a personal injury cause of action, since California Physicians' Service had no rights as against the third-party tortfeasor, but merely a contractual right against the member should he recover. The court noted that California Physicians' Service is a nonprofit enterprise sanctioned by the legislature for the purpose of providing medical service at minimal cost; and it held that the plaintiff should not be allowed a double recovery at the eventual cost to the other participating members.

It is not clear whether the result in the *Block* case will apply to organizations other than nonprofit corporations incorporated under California Corporations Code section 9201. However, the writer believes that if we are to change our present system so as to ensure the payment of medical bills incurred by injured victims of automobile accidents, an integral part of the change in our system will have to be the abolition of the collateral source rule and the adoption of a rule that will permit subrogation by medical payments carriers.

20. 220 Cal. App.2d 610, 34 Cal. Rptr. 41 (1963).

1. 244 Cal. App.2d 266, 53 Cal. Rptr. 51 (1966).

### **Conclusion**

The cases decided in the past year demonstrate the need for greater consideration by insurers of the interests and rights of their insureds and greater understanding on the part of the courts of the problems faced by insurers. The field of liability insurance is a business; for each extension of coverage and broadening of liability, there is a price that the public must pay. If the insurer is required to defend, afford coverage for, and settle within limits, lawsuits not within the anticipated scope of the policy against its insureds, we shall either have to forego our traditional system of tort compensation (which the writer certainly does not advocate) or pay an ever-increasing amount in premium dollars to cover the cost of these expanding rules of law. If homeowners' policies are to become automobile policies through transformation at the hands of the courts, the companies will either have to eliminate automobile coverage entirely or charge a premium that is commensurate with the additional risk imposed by the courts.

In its idealism and desire to protect the individual against the corporate entity, the courts have adopted new concepts and rules which have been painted on with a broad and sweeping brush. While change may be desirable and even necessary, certainty and stability are also important. It is only by having and maintaining rules that are fair to the insurer as well as to the insured, to the defendant as well as to the plaintiff, that we can best secure and protect the interests of the public and guarantee equal justice to all.