

Cal Law Trends and Developments

Volume 1970 | Issue 1

Article 17

January 1970

Insurance

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Recommended Citation

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Insurance

*by Robert A. Seligson**

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Published by GGU Law Digital Commons, 1970

The author extends his appreciation to Arthur T. Mathews, student at Golden Gate College, School of Law, for his assistance in the preparation of this article.

I. Automobile Insurance

A. *The Duty To Investigate Insurability*

In recent years, the California Supreme Court has time and again stressed the obligation of reasonable conduct that insurers owe to the public as well as to their insureds. This can be seen in the Court's decision in *Gray v. Zurich Insurance Company*,¹ where the Court held that the duty to defend under a liability policy was measured not on the mere objective standard of the language in the policy, but rather on the subjective standard of whether the insured might reasonably expect that he was entitled to a defense. Justice Tobriner's decision in *Gray* relied heavily on the doctrine of the adhesion contract, holding that in view of the disparate bargaining status between insurer and insured, the Court had to ascertain that meaning of the contract which the insured would reasonably expect. The opinion concluded:

In summary, the individual consumer in the highly organized and integrated society of today must necessarily rely upon institutions devoted to the public service to perform the basic functions which they undertake. At the same time the consumer does not occupy a sufficiently strong economic position to bargain with such institutions as to specific clauses of their contracts of performance, and in any event, piecemeal negotiation would sacrifice the advantage of uniformity. Hence the courts in the field of insurance contracts have tended to require that the insurer render the basic insurance protection which it has held out to the insured. This obligation becomes especially manifest in the case in which the insurer has attempted to limit the principal coverage by an unclear exclusionary clause. We test the alleged limitation in the light of the insured's reasonable expectation of coverage; that test compels the indicated outcome of the present litigation.²

1. 65 Cal.2d 263, 54 Cal. Rptr. 104, 419 P.2d 168 (1966).

2. 65 Cal.2d 263, 280, 54 Cal. Rptr. 104, 115, 419 P.2d 168, 179.

The concept that language in insurance policies and conduct of insurers should be interpreted and judged by the standard of reasonableness in view of the public nature of an insurance contract was, of course, not new to either Justice Tobriner or to the Court. Four years before *Gray*, Justice Tobriner, in *Steven v. Fidelity and Casualty Co. of New York*,³ applied the adhesion contract doctrine in interpreting a policy of airplane trip insurance sold by means of a vending machine. Here too, the Court determined that the insured's reasonable expectation in taking out the insurance was to obtain insurance protection for the entire trip, and that a policy issued to cover the trip would likewise cover reasonable substituted transportation necessitated by emergencies such as weather conditions and mechanical failure. In holding that the insurer was bound to provide the coverage that the insured might reasonably expect at the time he purchased the policy, Justice Tobriner stated:

We must view the instant claim in the composite of its special and unique circumstances. To equate the bargaining table, where each clause is the subject of debate, to an automatic vending machine, which issues a policy before it can even be read, is to ignore basic distinctions. The proposition that the precedents must be viewed in the light of the imperatives of the age of the machine has become almost axiomatic. Here the age of the machine is no mere abstraction; it presents itself in the shape of an instrument for the mass distribution of standard contracts. The exclusionary clause of that contract, upon which the insurance company relies, is an unexpected one. Its application in some circumstances would be unconscionable. It is placed in an inconspicuous position of the document. In view of all these characteristics its rigid application would cast an unexpected burden upon the traveling public and would prefer formality of phrase to the reality of the transaction.⁴

3. 58 Cal.2d 862, 27 Cal. Rptr. 172, 377 P.2d 284 (1962).

4. 58 Cal.2d 862, 884, 27 Cal. Rptr. 172, 186, 377 P.2d 284, 298.

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Justice Tobriner's devotion to the concept of reasonableness in interpretation of insurance policies was further defined and enunciated in *Insurance Company of North America v. Electronic Purification Company*,⁵ reported in last year's edition of *Cal Law—Trends and Developments*.⁶ Once again, the Court rejected an interpretation of a policy exclusion that would have destroyed the insured's principal objective in purchasing the insurance. In language that bears repeating, since the people who write insurance policies seem to be totally oblivious to the problems they create, Justice Tobriner pleaded:

The instant case presents yet another illustration of the dangers of the present complex structuring of insurance policies. Unfortunately the insurance industry has become addicted to the practice of building into policies one condition or exception upon another in the shape of a linguistic Tower of Babel. We join other courts in decrying a trend which both plunges the insured into a state of uncertainty and burdens the judiciary with the task of resolving it. We reiterate our plea for clarity and simplicity in policies that fulfill so important a public service.⁷

The most important decision in the insurance field in 1969 was *Barrera v. State Farm Mutual Automobile Insurance Company*,⁸ another Tobriner opinion enunciating the requirement of reasonableness by insurers in fulfilling their responsibility to the public. The Court held that an automobile liability insurer must undertake a reasonable investigation of the insured's insurability within a reasonable period of time from the acceptance of the application and the issuance of the policy. This duty directly inures to the benefit of third persons injured by the insured; where the insurer has breached the duty, it will be precluded from rescinding its policy on the ground of misrepresentation or fraud by its insured in procur-

5. 67 Cal.2d 679, 63 Cal. Rptr. 382, 433 P.2d 174 (1967).

6. Seligson, INSURANCE, *Cal Law—Trends and Developments* 1969, pp. 493, 505.

7. 67 Cal.2d 679, 691, 63 Cal. Rptr. 382, 390, 433 P.2d 174, 182 (1967).

8. 71 Cal.2d 659, 79 Cal. Rptr. 106, 456 P.2d 674 (1969).

ing the policy. The Court analogized the insurer's duty to undertake a reasonable investigation of the insured's insurability after issuance of the policy to its extracontractual duty to act promptly on applications. It rejected the argument that the injured person "stands in the shoes" of the insured; and it further held that on satisfaction of a judgment attained by the injured third person, the insurer possesses a remedy against the insured for his misrepresentations.

The Court of Appeal in *Barrera* had held that an automobile liability insurer in California could not rescind its policy, no matter what the facts, and that its only remedy was to cancel the policy on giving the requisite notice. This would have placed an impossible burden on insurers, since it does take a fair amount of time to get information from the Department of Motor Vehicles regarding an individual's past driving record. The Supreme Court's decision rejected the Court of Appeal reasoning, and held:

If the insurer does undertake a reasonable investigation of insurability, it retains the statutory right granted in section 650 of the Insurance Code to declare the rescission of the policy because of the material misrepresentation of the insured. When the insurer fails, however, to conduct such a reasonable investigation it cannot assert such a right of rescission. The insurer cannot complain of the denial of the statutory right, when its conduct is culpable and it directly contributes to the presence on the highway of a financially irresponsible motorist.⁹

In this case, State Farm's policy was in effect for one year, seven months before the accident and two years before it rescinded the policy. It had paid a prior claim involving the comprehensive coverage. In a remarkable show of judicial restraint, the Supreme Court remanded the case to the trial court for a determination of whether the insurer had conducted a reasonable investigation within a reasonable period of time. The Court stated that factors to be taken into ac-

9. 71 Cal.2d 659, 678, 79 Cal. Rptr. 106, 114, 456 P.2d 674, 682 (1969).

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count in assessing the reasonableness of the insurer's course of conduct in failing to investigate the insured's driving record were, inter alia, the cost of obtaining the information from the Department of Motor Vehicles, the availability of this information from the department or elsewhere, and the general administrative burden of making such an investigation. These factors must be weighed against the importance of the protection of innocent members of the public against the consequences of automobile owners driving with voidable liability policies.

Of course, if the obligation imposed upon insurers by *Barrera* is to be fair and just, it necessarily requires that insurers be able to obtain the information they need in order to determine the truth or falsity of the information that the insured has given to them. Claims have been raised in the past that information regarding an individual's prior driving record should be made confidential and not available to insurers. In 1968, Vehicle Code section 1806 was amended so that the Department of Motor Vehicles only maintains records showing the driver's convictions and the traffic accidents for which he was cited for a violation under the Vehicle Code. If, for one reason or another, an individual has not been convicted of a charged offense, the department will presumably not maintain or disseminate information regarding the incident. Likewise, if the driver was not cited by the investigating officer, he may be able to misrepresent his prior accident record; and the insurer will have no means for obtaining information regarding the misrepresentation even if it undertakes its investigation in accordance with the *Barrera* decision. Under Vehicle Code section 1807, the Department is not required to maintain records relating to drivers of motor vehicles after the records are, in the opinion of the director, no longer necessary, except that records of convictions shall be maintained so long as they may form the basis of license suspensions or revocations as prior convictions, or together with other records of conviction constitute a person a "negligent driver." If the Department advances its time table for destruction of records in accordance with section 1807, the carriers may find themselves unable to check the truth or falsity of the insured's ap-

plication. Since the obligations imposed by *Barrera* will result in increased costs that will be borne by the general public, it is imperative that the public preserve the sources of information available to insurers. The rule of reason is a two-way street; certainly this would seem to be a reasonable requirement if *Barrera* is to be fairly applied.

B. Breach of Cooperation Clause

In the 1963 case of *Campbell v. Allstate Insurance Co.*¹⁰ the State Supreme Court overruled prior cases that held that prejudice was presumed from an insured's violation of a cooperative clause. The Court further held that the burden of proving that a breach of the cooperation clause resulted in substantial prejudice was on the insurer. In *Billington v. Interinsurance Exchange of Southern California*,¹¹ the Court extended *Campbell* by ruling that in order for the insurer to show that it was prejudiced by the failure of the insured to cooperate in his defense, it must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor. "A less stringent standard," the Court stated "would not be consonant with our holding in *Campbell*."¹²

Perhaps the most significant aspect of the *Billington* decision is not the holding but rather the fact that the Court rejected so many arguments advanced by both the plaintiff and the various attorneys appearing as amici curiae on behalf of the plaintiff. First, the Court held that the insurer's refusal to accept settlement proposals made by the plaintiff within the policy limits did not estop the insurer from relying on the defense of the insured's breach of the cooperation clause, especially where no bad faith was shown in the insurer's handling of the insured's defense or in its failure to negotiate a compromise settlement. The Court rejected plaintiff's reli-

10. 60 Cal.2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963).

11. 71 Cal.2d —, 79 Cal. Rptr. 326, 456 P.2d 982 (1969).

12. 71 Cal.2d —, —, 79 Cal. Rptr 326, 331, 456 P.2d 982, 987.

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ance on a statement in *Crisci v. Security Insurance Company*¹³ that perhaps an insurer could be liable for any judgment exceeding the policy limits if it refuses an offer of settlement within those limits. It would be unwarranted in applying the proposed rule where the insurer was unable to maintain any defense to the action on behalf of the insured as a result of the insured's failure to cooperate in his defense. Next, the Court held that just because the insured was covered under the assigned risk plan, the insurer would not be precluded from raising his violation of the cooperation clause as a defense. In this regard, Justice Mosk, speaking for the Court in *Billington*, stated:

This contention is based upon the erroneous premise that assigned risk policies are the equivalent of compulsory insurance.¹⁴

The Court also rejected plaintiff's reliance on the provisions of the Financial Responsibility Law,¹⁵ noting:

If a court finds that there was a substantial likelihood that the insured would have prevailed had he cooperated in his defense, there is little danger that an innocent plaintiff will be denied recovery by the insurer's reliance upon the cooperation clause.¹⁶

Amici curiae claimed that the insurer's attempt to disclaim liability because of an insured's breach of a cooperation clause amounted to a cancellation and that a cancellation may not affect accidents which occurred prior thereto. The Court disposed of this argument with the terse comment that "no case to our knowledge has viewed the breach of such a clause as a cancellation."¹⁷ Similarly, the Court rejected the contention that a cooperation clause defense was in derogation of the coverage required by Vehicle Code sections 16451 and 16452 and *Wildman v. Government Employees' Insurance*

^{13.} 66 Cal.2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967).

^{14.} 71 Cal.2d —, —, 79 Cal. Rptr. 326, 332, 456 P.2d 982, 988 (1969).

^{15.} Vehicle Code §§ 16000 et seq.

^{16.} 71 Cal.2d —, —, 79 Cal. Rptr. 326, 335, 456 P.2d 982, 991 (1969).

^{17.} 71 Cal.2d —, —, 79 Cal. Rptr. 326, 334, 456 P.2d 982, 990.

Company.¹⁸ It also held that even if the insurer has certified to the Department of Motor Vehicles within twenty days following the accident that its policy was in effect at the time of the accident, it may still rely on the cooperation clause where discovery of the breach of cooperation could not be made within the 20-day period. Finally, the Court held that if the insurer has been found to encourage noncooperation or to have shown lack of diligence in seeking the insured's presence to participate in his defense, it will be precluded from relying on the cooperation clause.

As indicated above, this writer believes that it is significant that the Court rejected so many technical arguments advanced by counsel for the claimant, while at the same time adopting a rule that justly places on the insurer the burden of showing that the insured's failure to cooperate prejudiced the company in its effort to persuade the jury or judge to find in the insured's favor in the prior action. It would appear that the Court is willing to take a realistic view toward the problems of insurers and their insureds, and will not accept every wild argument advanced by claimants' counsel. This, of course, is befitting a Court that has rejected so many technical defenses advanced on behalf of insurers in recent years.

C. Premiums—Recitals as to Payment

It has been said that hard cases make bad law. It might also be observed that hard decisions sometimes spur legislators to change the law.¹⁹

18. 48 Cal.2d 31, 307 P.2d 359 (1957).

19. Last year in this article (Seligson, *INSURANCE, Cal Law—Trends and Developments 1969*, p. 493, we noted legislative action following reviewing court decisions in *Abbott v. Interinsurance Exchange*, 260 Cal. App.2d 528, 67 Cal. Rptr. 220 (1968) and *Lopez v. State Farm Fire and Casualty Company*, 250 Cal. App.2d 210, 58 Cal. Rptr. 243 (1967). In each case, there was a clear disagreement between the

court and the Legislature over the proper public policy for the state. *Abbott* dealt with an exclusion in an automobile liability policy of a person designated by name (which the court held to be invalid and the Legislature revalidated) and *Lopez* involved an exclusion to uninsured motorist coverage of a relative who owned an automobile but did not take out coverage to protect either himself or the public (the court could find no statutory authorization for the exclusion, and so the Legislature provided it).

During 1969, the most striking example of action and reaction by the State Supreme Court and the Legislature arose out of a decision by the Supreme Court involving a recital of payment of the premium in an insurance policy, where the insured had not in fact paid the premium. In *Sawyer v. State Farm Fire and Casualty Company*,²⁰ the Court held that a clause in an automobile liability policy delivered unconditionally to the insured, stating that the policy was "in consideration of the premium paid," constituted an "acknowledgment" within the meaning of Insurance Code section 484 that the premium had been paid and that under the statute the acknowledgment was, in the absence of fraud, conclusive evidence of its payment and precluded the insurer not only from claiming that the policy had not gone into effect at all, on the ground of nonpayment, but also from cancelling the policy on the same ground at any time during the premium period. The Court further held that the company was estopped from claiming that it had canceled the policy prior to the accident for nonpayment of the premium. The trial court had properly refused to receive evidence of such attempted cancellation, where, although the insured had failed to comply with the terms of an extension of limited personal credit for such payment, the policy had been unconditionally delivered to him and contained an "acknowledgment" of the payment within the meaning of the statute.

Justices McComb and Burke dissented, primarily on the basis that the insurer had a right, on proper notice before a loss, to exercise the cancellation right reserved to it in the policy. Justice McComb stated his view of the proper interpretation of Insurance Code section 484, as follows:

Rather, it appears to me from the clear language of the statute, that the Legislature intended to provide that if the receipt of premium is acknowledged in the policy, a binding insurance contract has come into existence even though (1) the policy provides that it shall not be binding until the premium is actually paid, and (2) the

20. 69 Cal.2d 801, 73 Cal. Rptr. 232, 447 P.2d 344 (1968).

premium has not been paid. The section does not in any way indicate that such binding contract of insurance is immune from cancellation, when the right of cancellation has been reserved to the insurer in the policy.¹

Justice McComb's dissenting interpretation of the statute was promptly codified by the Legislature, which amended section 484, to provide:

An acknowledgment in a policy of the receipt of premium is conclusive evidence of its payment so far as to make the policy binding. Notwithstanding such acknowledgment, a policy may be canceled effective at such times as otherwise permitted by law for nonpayment of all or any portion of the premium which is actually unpaid if such cancellation right is reserved to the insurer in the policy.

D. *Uninsured Motorist Coverage*

Insurance Code section 11580.2, provides that no policy of motor vehicle liability insurance shall be issued or delivered in California to the owner or operator of a motor vehicle, or shall be issued or delivered by any insurer licensed in California upon any motor vehicle then principally used or principally garaged in California without the uninsured motorist coverage required by the statute, unless the insurer and named insured have agreed in writing to delete such coverage. In *Modglin v. State Farm Mutual Automobile Insurance Company*,² the court held that this provision applied not only to new policies but also to renewals of existing policies. Thus, where a policy was renewed on a motor vehicle "then principally used or principally garaged" in California, the statute provided uninsured motorist coverage as a matter of law unless the coverage had been waived by the named insured by an agreement in writing. The court felt that the limitation of the statute only to new policies would permit insurance carriers to circumvent

1. 69 Cal.2d 801, 812, 73 Cal. Rptr. 232, 239, 447 P.2d 344, 351. See 1969 amendment, Stats. 1969, Ch. 536.

2. 273 Cal. App. 2d —, 78 Cal. Rptr. 355 (1969).

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the statute by the mere expedient of renewing their policies instead of issuing new ones.

The Legislature also acted in the same area by amending the statute so as to provide that the written agreement deleting uninsured motorist coverage could be made either "prior to or subsequent to the issuance or renewal of a policy." In the past, some companies required the insured to sign a waiver with each renewal of the policy. Under the statutory change, it would seem that that is no longer necessary. Presumably, however, a waiver can be withdrawn by the insured with respect to subsequent renewals, so as to prevent renewal of the policy automatically carrying forward an earlier waiver.

Several other statutory changes of significance were made in this field. Under the prior statute, a company could reduce payments made under uninsured motorist coverage by amounts paid or payable under automobile medical payments insurance. As of January 1, 1971, however, an insurer may deduct medical payments only from the damages which the insured is entitled to recover under the uninsured motorist coverage. Thus, if the insured's damages are \$50,000 and his uninsured motorist coverage is \$15,000, the insurer will not get the benefit of the reduction for medical payments coverage after the effective date of the statute. As can be seen, this statutory change will be significant only in cases where the damages exceed the policy limits. This seems fair, since the theory against double recovery has no application in such cases.

Under Insurance Code section 11580.5, no award made in an uninsured motorist arbitration proceeding shall be deemed to be *res judicata* or collateral estoppel in any court action which may be pending or brought by the insured against the owner or operator of an uninsured motor vehicle. In 1969, the Legislature adopted a conforming amendment to Insurance Code section 11580.2 (f), so that an award or a judgment confirming an award shall not be conclusive on any party in any action or proceeding between (1) the insured, his insurer, his legal representative, or his heirs and (2) the uninsured motorist.

The statute of limitations for uninsured motorist proceedings has been a trap for the unwary. Under Insurance Code section 11580.2(i), an insured who has an uninsured motorist claim has one year from the date of accident to either file suit for bodily injury against the uninsured motorist, or reach an agreement as to the amount due under the policy with the insurer, or formally institute arbitration proceedings. Many attorneys, representing minors, were not aware of the fact that the one-year limitation applied to all claimants, including minors; and this writer suspects that more than one legal malpractice claim has arisen because of this problem. In 1969, an effort was made to conform the statute of limitations for uninsured motorist claims to the regular rule set forth in the Code of Civil Procedure for injury actions, including the exception of time during which a person is under disability as provided in section 352. This attempt did not succeed. However, the Legislature did adopt Insurance Code section 11580.2(j), which provides that an uninsured motorist carrier whose insured has made a claim under the coverage, which is still pending, shall, at least 30 days before the expiration of the applicable statute of limitations, notify its insured in writing of the applicable statute. Failure of the insurer to provide this written notice operates to toll any applicable statute of limitation or other time limitation for a period of 30 days from the date the written notice is actually given. Certainly, this is not a satisfactory solution to the problem. However, it does afford protection that did not previously exist.

E. *Loading and Unloading*

The courts in recent years have given increasing scope to the "loading and unloading" coverage contained in automobile liability insurance policies. This trend continued during 1969. In *Brunswick Wholesale Druggist v. Travelers Insurance Company*,³ a garbage truck driver, who was in the process of collecting trash from Brunswick's waste well, was injured by the negligence of Brunswick's employee, who lost control of

3. 273 Cal. App. 2d 11, 77 Cal. Rptr. 859 (1969).

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a metal cart while attempting to empty the cart into the opening of the chute to the waste well. At the time of the accident, the driver was about twenty feet from the point where the truck was parked. Although the driver was not injured by anything used in loading the truck, the court held that the accident came within the "loading and unloading" coverage of defendant's truck policy. The court justified this on the basis that the duties of Brunswig's employee included the dumping of trash down the chute into the waste well; and that this was part of the "continuous process" by which the trash would be loaded from the well onto the truck.

It seems that we are fast approaching the point where any injury to a delivery man or a truck driver will be covered under the truck policy. Under *Brunswig*, if you leave milk bottles in such a position that the milkman trips over them and is injured, you would be covered under the milk company's truck policy. Query: What if your child leaves a skate in the same place and the milkman is injured? While that may not be part of the "continuous process" of loading or unloading, will a different result apply or will some court hold that the landowner's duty to keep the pathway free from objects is a "step necessary to accomplish the purpose for which the truck was being used"⁴ so as to come within the truck policy?

It may be that the answer to the above question was given in *Shippers Development Co. v. General Insurance Co. of America*.⁵ In that case, a produce dealer's truck driver, who had come onto the premises of the plaintiff supplier for the purpose of icing the produce in his employer's truck and trailer, was injured when he fell off the end of the supplier's dock after he got out of the truck but before he could open the trailer door for the purpose of icing the truck. The court held that his case came within the "complete operations"⁶ doctrine, and that the failure of a consignor or consignee, who is

4. 273 Cal. App.2d 11, 15, 77 Cal. Rptr. 859, 862; see also *American Auto. Ins. Co. v. American Fidelity and Casualty Co.*, 106 Cal. App.2d 630, 638, 235 P.2d 645, 649 (1951).

5. 274 Cal. App. —, 79 Cal. Rptr. 388 (1969).

6. See *Entz v. Fidelity and Casualty Company*, 64 Cal.2d 379, 50 Cal. Rptr. 190, 412 P.2d 382 (1966).

using a vehicle for loading or unloading, to maintain a safe place for that activity is an act or omission which has a causal relationship to the use of the vehicle so as to come within the terms of the truck policy. It looks more and more as though there is coverage for the homeowner whose child leaves a skate in the path of the milkman.

II. Life Insurance

A. *Application Misrepresentation—Incontestable Clauses*

The furnishing of a copy of the application to the insured or to his beneficiary is not required by statute in California. In *Metzinger v. Manhattan Life Insurance Company*,⁷ however, the insurer chose to enlarge the incontestable provisions required by Insurance Code section 10206, by providing, in a group life insurance policy and a certificate of individual insurance issued thereunder, that no statement made by the insured relating to his insurability shall be used in contesting the validity of the insurance unless a copy of the application had been furnished to the insured or to his beneficiary. The Court properly ruled that the insurer could not escape the application of that provision most beneficial to the insured. The purpose of such a provision is to provide an opportunity to review the application while the insured is still alive, and to correct misstatements that might have appeared therein. The language of the provision, the Court opined, was calculated to lead an insured to believe that if a copy of the application concerning his statements had not been furnished during his lifetime, such statements might not be relied on by the insurer after his death.

B. *Effective Date of Coverage—Accidental Death*

In *Slobojan v. Western Traveler's Life Insurance Company*,⁸ the State Supreme Court was faced with a situation

7. 71 Cal.2d 423, 78 Cal. Rptr. 463, 455 P.2d 391 (1969).

8. 70 Cal.2d 432, 74 Cal. Rptr. 895, 450 P.2d 271 (1969).

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where an individual died after signing an application for life insurance but before accepting delivery of the policy. As might be expected, the insurer, confronted with the realization that the risk was not as desirable as it had first seemed, chose to contest the claim by asserting that the policy had not gone into effect. This effort to evade coverage was summarily rejected on motion for summary judgment granted in favor of the claimant. The Supreme Court affirmed.

Plaintiff's decedent signed defendant's application for life insurance in the amount of \$25,000, with double indemnity covering accidental death with respect to the first \$5,000. He paid the first month's premium of \$16.14 by check, which defendant deposited in its account. Defendant's agent explained to him that the insurance would not take effect until the application was accepted by the company and a policy issued and accepted by him and that he would be required to take a physical examination. The decedent took the physical examination at defendant's request; and on the same date, defendant issued the policy and forwarded it to its agent. The agent thereupon notified decedent that the policy was ready to be delivered but that the premium for double indemnity would be \$.44 per month higher, since he was a police officer who made arrests. Decedent told the agent that he had been inquiring about other policies and would let her know whether or not he wished to accept defendant's policy. Five days later he died. On the reverse side of a "conditional receipt" given to the decedent for his first premium was language indicating that payment of the first month's premium on date of application would put the policy into effect on either the date of application or date of medical examination, whichever was later. The Court gave effect to the language in the "conditional receipt," and held that the contract of insurance arose on the insurer's receipt of the completed application and the first premium payment. In so holding, the Court followed its opinion in *Ransom v. Penn Mutual Life Insurance Company*,⁹ where the Court stated:

⁹ 43 Cal.2d 420, 274 P.2d 633 (1954).

The understanding of an ordinary person is the standard which must be used in construing the contract, and such a person upon reading the application would believe that he would secure the benefit of immediate coverage by paying the premium in advance of delivery of the policy. There is an obvious advantage to the company in obtaining payment of the premium when the application is made, and it would be unconscionable to permit the company, after using language to induce payment of the premium at that time, to escape the obligation which an ordinary applicant would reasonably believe had been undertaken by the insurer. Moreover, defendant drafted the clause, and had it wished to make clear that its satisfaction was a condition precedent to a contract, it could easily have done so by using unequivocal terms.¹⁰

The company's effort to avoid the double-indemnity accidental death provision likewise met with failure. On the date Mr. Slobojan died, he was on regular duty as a deputy sheriff and started a chase on foot after a crime suspect. The chase involved running and fence climbing, and while so engaged, he tripped and fell. An autopsy disclosed a pre-existing mild atherosclerosis, but that such condition was non-manifest and nondisabling. The trial court found that the chase created an unusual physical stress and strain on the decedent's entire body, which was involuntary, reasonably unexpected and unanticipated by him, and resulted in injury, accidental in origin. The accidental death provision stated that the death must result "directly and independently of all other causes from bodily injuries caused by accident" and must not have resulted from "disease" or "bodily or mental infirmity." The Court affirmed the holding of "accidental death," restating the rule in *Brooks v. Metropolitan Life Ins. Co.*,¹¹ that:

The correct rule is that the presence of preexisting

¹⁰. 43 Cal.2d 420, 425, 274 P.2d 633, 636.

¹¹. 27 Cal.2d 305, 163 P.2d 689 (1945).

disease or infirmity will not relieve the insurer from liability if the accident is the proximate cause of death; and that recovery may be had even though a diseased or infirm condition appears to actually contribute to cause the death if the accident sets in progress the chain of events leading directly to death, or if it is the prime or moving cause.¹²

III. Insurance and the Adhesion Contract Doctrine

As indicated earlier in this article, the doctrine of adhesion contract has been utilized by the State Supreme Court in determining the reasonable application of language contained in insurance policies. It is likewise interesting to note the application of the doctrine by the Courts of Appeal in dealing with cases where an insurer is attempting to defeat the reasonable expectation of its insured through technical language buried in the policy. Running through these cases appears to be the element of fairness, which the courts utilize in reaching a result that comports with the reasonable expectation of the insured.

In *Schmidt v. Pacific Mutual Life Insurance Company*,¹³ the insurer attempted to limit its monthly disability benefits, in an accident and disability insurance policy, to disabilities "commencing . . . within twenty days after the date of the accident." The insured's disability did not start until 75 days after his accident; and under rules of strict application of contract language, his claim would be denied. Indeed, that was the ruling of the trial court. However, the Court of Appeal reversed judgment with directions to enter judgment for the insured. It did so on the basis that the limitation unexpectedly and inharmoniously appeared as a subsidiary clause in a sea of print, preceded and followed by the policy's emphasis on the insurer's major promises as to the benefits to be paid in the event of total disability. In refusing to apply the buried language, the court stated:

¹². 27 Cal.2d 305, 309-310, 163 P.2d 689, 691.

¹³. 268 Cal. App.2d 735, 74 Cal. Rptr. 367 (1969).

We do not dispute respondent's right to insert in its contracts of insurance a provision that will limit a buyer's right to recover benefits to those cases where total disability is caused ' . . . within twenty days after the date of the accident.' We merely say that where, as here, such an exclusionary provision disappoints the reasonable expectations of the buyer, and fails to pass the ' . . . conspicuous, plain and clear . . . ' test prescribed by our Supreme Court, it cannot operate to defeat the buyer's rights.¹⁴

Another illustration of this principle may be found in *Oil Base, Inc. v. Continental Casualty Company*,¹⁵ where an insurer attempted to limit its general comprehensive liability insurance policy to "accidents which occur during the policy period within the United States of America, its territories or possessions, or Canada." The insured, during the policy period, sold some bags of its drilling mud to a South American company; and while the mud was stored in a warehouse belonging to the purchaser in Venezuela, it caught fire from spontaneous combustion. The company attempted to avoid coverage on the basis that the accident had occurred in Venezuela. Here too, the trial court ruled in favor of the insurer; and once again, judgment was reversed on appeal. The reviewing court found an ambiguity in the word "accident" and, more significantly, applied the doctrine of adhesion contract in finding in favor of the insured. In doing so, the court noted that the insured was charged and paid premiums on its gross business, foreign and domestic, and did not know that the exclusion clause was in the contract. Under such circumstances, although the court was sensitive to the fact that the exclusion clause was not in fine print, it was still persuaded that the principles set forth in *Gray v. Zurich Insurance Company*¹⁶ applied; and it held that the insurer had wrongfully refused to defend its insured.

14. 268 Cal. App.2d 735, 740, 74 Cal. Rptr. 367, 370.

15. 271 Cal. App.2d 378, 76 Cal. Rptr. 594 (1969).

16. 65 Cal.2d 263, 54 Cal. Rptr. 104, 419 P.2d 168 (1966).

Insurance

Finally, of particular interest in view of the Supreme Court's decision in *Slobojan v. Western Travelers' Life Insurance Company*,¹⁷ is the case of *Young v. Metropolitan Life Insurance Company*,¹⁸ which also dealt with the question of a conditional receipt given by a life insurance agent to an applicant after payment of the premium but before issuance of the policy. In *Young*, the court found that the language of the conditional receipt was not ambiguous and misleading, where it emphatically stated that the policy applied for would become effective "if and only if" all conditions "precedent" thereafter enumerated in the same paragraph had been complied with, and then made it reasonably clear that the only coverage provided to the applicant during the interim was an accidental death benefit. The court stated that it could not be said that the applicant, presumably a person of ordinary intelligence, would have been misled into believing that he was immediately covered by the insurance policy applied for if he had been aware of the pertinent clause contained in the application and if he had carefully read the conditional receipt. Nevertheless, the court reversed judgment in favor of the insurer on the ground that there was no evidence (nor a court finding) that the limited interim coverage contained in the conditional receipt was ever called to the insured's attention. There was evidence that the agent of the company had filled out the part of the application containing the clause on the deceased's behalf and then secured his signature. There was also evidence that the deceased first mistakenly signed the application under the medical part, thus indicating that he had not read it; and also that after he signed the proper part of the application, he immediately paid the premium and was handed the conditional receipt by the agent, apparently without comment. In ruling in favor of the beneficiary to the policy, the court stated:

It is now firmly settled that insurance contracts are contracts of adhesion between parties not equally situated. (citations) Consequently, the insurer, as the dominant

¹⁷ 70 Cal.2d 432, 74 Cal. Rptr. 895, 450 P.2d 271 (1969), discussed supra.

¹⁸ 272 Cal. App.2d 453, 77 Cal. Rptr. 382, 78 Cal. Rptr. 568 (1969).

and expert party in the field, must not only draft such contracts in unambiguous terms but must bring to the attention of the insured all provisions and condition which create exceptions or limitations on the coverage. (citations) Manifestly, it should have even a greater duty to call attention to such provisions or conditions when they are contained in receipts given to an applicant after he has paid the premium in advance, because the very acceptance of an advance premium by the carrier tends naturally toward an understanding of immediate coverage though it be temporary and terminable. (citation) In short, to the ordinary layman, payment of the insurance premium constitutes payment for immediate protection, and it is unlikely that he would carefully read the fine print contained in a receipt unless he was given the incentive to do so by the carrier's agent.¹⁹

This writer believes that the approach taken by the courts in the above cases is salutary and to be commended. He likewise hopes that these principles are applied with equal force in other areas of adhesion contracts, where the consumer needs just as much protection. All too often, the individual who has borrowed money discovers the existence of a "due-on-sale" clause or a pre-payment penalty which it would be unconscionable to apply. Yet, the courts have given effect to such provisions contained in adhesion contracts, notwithstanding the punitive effect of the clause and the fact that the clause was not called to the attention of the borrower at the time the contract was entered into. If the doctrine of adhesion contract is to receive its full flower, it cannot and should not be limited to the insurance field.

¹⁹. 272 Cal. App.2d 453, 460-461, 77 Cal. Rptr. 382, 387, 78 Cal. Rptr. 568.

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