XI. Insurance

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A. Issuance and Delivery

1. Conditional Receipt for Temporary Life Insurance.—During the survey period a new twist was added to the law of Indiana with respect to the duration of the interim life insurance coverage created by an insurer's giving of a conditional receipt.[1] In *Hornaday v. Sun Life Insurance Co. of America*,[2] the plaintiff was the beneficiary named on an application for life insurance which her husband had submitted to a salesman for the defendant insurance company. At the time of the application, the decedent had paid a small premium and had received a conditional receipt. Subsequently, the company approved the application and issued a policy. However, all efforts by company salesman to deliver the policy and to collect the full premium were rebuffed by the plaintiff's decedent and he died before delivery could be made.[3]

Plaintiff made a claim against the policy which was denied by Sun Life on the basis that no delivery had occurred, and that no premium had been tendered by plaintiff's decedent nor had any been collected by the company. In the breach of contract action brought by the plaintiff, the district court ruled that, although the conditional receipt had created life insurance coverage for the decedent, "it had expired by its own terms 60 days from the date of insurance application . . . , and was not in effect when Hornaday died . . . over 100 days after the insurance application date."[4]

On appeal, Mrs. Hornaday relied upon the Indiana cases of *Kaiser v. National Farmers Union Life Insurance Co.*[5] and *Monumental Life Insurance Co. v. Hakey*,[6] which stated "that a temporary insurance contract can be terminated in Indiana only upon (1)

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[1]Indiana follows the general rule that once an insurance company accepts a premium for life insurance and issues a receipt, a contract arises. Coverage may not be terminated unless the insurer notifies the applicant and returns the premium during the applicant's lifetime. *See generally* Monumental Life Ins. Co. v. Hakey, 354 N.E.2d 333 (Ind. Ct. App. 1976); Kaiser v. National Farmers Union Life Ins. Co., 167 Ind. App. 619, 339 N.E.2d 599 (1976).

[2]597 F.2d 90 (7th Cir. 1979).

[3]*Id.* at 91-92.

[4]*Id.* at 92.

[5]167 Ind. App. 619, 339 N.E.2d 599 (1976).

[6]354 N.E.2d 333 (Ind. Ct. App. 1976).

notice of such termination by the insurance company to the applicant, and (2) a return of the consideration paid."[7]

The appellant argued that there were strong social policy reasons for supporting the rules of *Kaiser* and *Monumental*, inasmuch as Indiana courts have sought to discourage insurance companies from retaining "unearned premiums yet refusing to provide coverage."[8] Further, Hornaday contended that the insurer's attempts to deliver the policy after the sixty days had expired constituted a waiver of the company's right to rely on the expiration of the conditional receipt.[9]

Although the court recognized and agreed with the policy reasons for supporting *Kaiser* and *Monumental*, it found precedent for permitting a conditional receipt to expire by its own terms.[10] Sun Life had presented the 100 year old Indiana case of *Barr v. Insurance Co. of North America*,[11] a fire insurance case, which had absolved an insurance company of liability where " '[t]he written contract of assurance expired by its own limitation, before the loss occurred . . . .' "[12] The court of appeals agreed with the district court that there was no cogent reason for distinguishing between fire insurance and life insurance because both were contracts.[13] In examining the language of the conditional receipt at issue,[14] the court adopted the district court's findings, and agreed that the terminology used was "unambiguous and obvious" and was "not a hidden phrase filled with legal technicalities buried within the small print of the contract."[15] The court's most compelling reason for re-

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[7]597 F.2d at 92 (citing Monumental Life Ins. Co. v. Hakey, 354 N.E.2d 333 (Ind. Ct. App. 1976); Kaiser v. National Farmers Union Life Ins. Co., 167 Ind. App. 619, 339 N.E.2d 599 (1976)). The company did send the plaintiff a check representing the amount of the temporary premium after receiving notice of the death. However, the plaintiff refused to accept it, and the court found it had no bearing upon the issue of the expiration of the conditional receipt. 597 F.2d at 92.

[8]597 F.2d at 94.

[9]*Id.*

[10]*Id.* at 92 (citing Barr v. Insurance Co. of N. America, 61 Ind. 488 (1878)).

[11]61 Ind. 488 (1878).

[12]597 F.2d at 92 (quoting 61 Ind. at 493).

[13]597 F.2d at 92 (quoting district court opinion).

[14]The pertinent language of the conditional receipt was as follows:

(A) . . . If the amount received was less than the full first premium, the insurance provided will be for (1) a period equal to such proportionate part of the first premium interval as the cash so paid bears to the full first premium or (2) a period of 60 days, whichever is longer. . . .

(C) Except as provided in this conditional receipt, any policy issued by the Company shall not take effect until it is delivered and the full first premium for it is paid during the lifetime and continued insurability, as stated in the agreement contained in the application, of the Proposed Insured.

597 F.2d at 91.

[15]*Id.* at 94.

jecting the appellant's application of the rules in *Kaiser* and *Monumental* was found in a suggestion by the district court:

> The application of plaintiff's interpretation of *Monumental* and *Kaiser* would effectively mean that once a conditional receipt is executed insurance coverage is in effect *ad infinitum*, regardless of the amount of the consideration tendered, unless notice of termination is given and the consideration returned. Hence, if the insured successfully avoids contact with the insurer, insurance coverage is in effect indefinitely regardless of the amount of the consideration paid. The result could be that in exchange for $12 or $15 an insured is effectively covered for as long a period as he can avoid contact with the insurer when an actual monthly premium would be much greater than the amount tendered if a regular insurance contract were issued.[16]

Finally, the court held that Sun Life did not waive the expiration of the interim insurance coverage by diligently continuing to attempt to deliver the policy after the sixty day limit.[17] It noted that such diligence would be expected of the insurance salesman. Besides, had the diligence paid off with delivery of the policy after the sixty day period, no harm would have resulted because coverage would have been immediately reinstated and would have been in force upon the insured's death.[18]

Under the facts of *Hornaday* the ruling seems entirely reasonable and the result not unjust. However, one could ask whether the court would have reached the same conclusion had the company been less diligent and the proposed insured less evasive. Insurance companies may now be expected to more frequently include automatic expiration clauses in their conditional receipts. Such theories as waiver and equitable estoppel will have to be employed by the courts to avoid unjust results where failure to deliver an insurance policy within the limited interim coverage period is attributable to the insurance company's lack of diligence and not the insured's.

2. The Relationship of the Insurance Broker to the Insurance Company.—It is not uncommon for a person seeking insurance to acquire coverage with a company through an intermediary agent known as a "broker." Because of the variety of coverage available and the prospective insured's relative lack of knowledge of the market, the insurance purchaser may rely largely on the broker's

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[16]*Id.* (quoting district court opinion).

[17]597 F.2d at 94.

[18]*Id.*

advice as to what coverage to obtain and which company to choose. If the adequacy of coverage is later questioned, the company's liability will often hinge upon whether the broker who procured the policy is deemed to be the agent of the company or the agent of the insured.[19]

In *Prestige Casualty Co. v. Mashburn*,[20] the court was called upon to determine whether an insurance broker was an agent of the company or an agent of the insured. Prior to the acts which were the subject of the lawsuit, the insured, Pearl Mashburn, had been issued an automobile liability policy by Prestige Casualty Company. The coverage for Mashburn's single automobile had been placed with the company by an independent insurance agent through an insurance broker, the Ott and Heying Insurance Agency.[21] At a later date Mashburn purchased a second car and wished to have it added to her existing policy. Unknown to Mashburn, her insurance agent instead requested a *transfer* of coverage. The agent submitted the request for transfer to Ott and Heying and they in turn wrote Prestige to secure the change. Prestige immediately returned the letter to Ott and Heying with an endorsement which signified approval of the transfer. However, before the endorsement was given to Mashburn she had an accident in her first automobile.[22]

When Mashburn made a claim under her policy for defense of a wrongful death action brought against her, Prestige denied coverage on the basis that the automobile was not covered because of the transfer.[23] In denying the insurer's request for a declaratory judgment, the trial court ruled that the negligence of the insurer's agents estopped the insurer from denying coverage.[24] The court of appeals affirmed the trial court holding but found entirely different reasons for doing so.[25]

Initially, the court looked to the terms of the policy to determine the conditions needed to effect a transfer of coverage. The court found that an effective modification required a written endorsement by the company (signifying approval) and issuance of such approval to the insured.[26] The word "issued" in the modification

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[19]For a discussion of the general liabilities of an insurance broker, see Annot., 29 A.L.R.2d 171 (1953).

[20]612 F.2d 1048 (7th Cir. 1980).

[21]*Id.* at 1049.

[22]*Id.*

[23]*Id.*

[24]*Id.* at 1048-49.

[25]*Id.* at 1049.

[26]*Id.* The specific policy language was as follows: "Changes: . . . nor shall the terms of this policy be waived or changed, except by endorsement issued to form a part of this policy." *Id.*

clause was determined to be the only unclear word and was accordingly defined as the "act of sending out, or causing to go forth; delivery."[27] Effective issuance was said to require "that the issuance be to the party not making the endorsement, that is, to the insured or the insured's agent."[28]

It was clear from the facts that the endorsement had not been "issued" to Mashburn personally. Therefore, the key issue to be decided was whether Ott and Heying, the broker, was an agent of the insured or an agent of the insurer "for the purpose of receiving delivery of the endorsement."[29]

Prestige urged the court to adopt the ruling of *Automobile Underwriters, Inc. v. Hitch.*[30] In *Hitch* the court had found that the agreement between the intermediate insurance agency and the company specified that the agency was an independent contractor.[31] Also, the agency in *Hitch* was shown to represent several insurance companies and was therefore defined as a "broker."[32] The *Hitch* court stated the general rule that

> [T]he negligence of a broker as opposed to an agent, is not imputed to the insurer. "An insurance broker can be considered an agent only for the purposes of delivering policies and collecting premiums thereon. The insurer would not be bound, ordinarily by the mistakes or negligence of a broker."[33]

The *Mashburn* court, finding the facts to be distinguishable, rejected Prestige's reliance upon *Hitch.* The court placed much weight upon the Agency Agreement between Prestige and Ott and Heying, the major part of which read as follows:

> [T]he Agency can solicit, receipt, and accept applications and proposals for insurance, endorsements, modifications, or other evidences of agreements of insurance; further the Agency can review, assess, and evaluate prospective risks, and where such risks are determined to be in the best interest of Prestige submit applications to Prestige Casualty

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[27]*Id.* (quoting WEBSTER'S NEW INT'L DICTIONARY OF THE ENGLISH LANGUAGE. (2d ed. Unabridged, 1948)).

[28]612 F.2d at 1049 (citing American Family Mut. Ins. Co. v. Bach, 471 S.W.2d 474, 479 (Mo. 1971)).

[29]612 F.2d at 1049.

[30]169 Ind. App. 453, 349 N.E.2d 271 (1976).

[31]*Id.* at 460, 349 N.E.2d at 276.

[32]*Id.* (citing 16 J. APPLEMAN, INSURANCE LAW & PRACTICE § 8730 (1968)).

[33]169 Ind. App. at 460, 349 N.E.2d at 276 (quoting 16 J. APPLEMAN, *supra* note 32, § 8730).

> Company for the purposes of the issuance of an insurance policy.
> [T]he Agency can collect, receive, and receipt for premiums on all policies solicited by the Agency.
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> [T]he Agency shall comply with Prestige Casualty Company's rules and regulations governing the Agency's operations, and the Agency must strictly comply with all instructions from Prestige, and further the Agency must use those instructions only in the interest of Prestige Casualty Company.
> [T]he Agency has binding authority with Prestige Casualty Company.[34]

The obvious authority to bind Prestige to contracts, the right to collect premiums, and the obligation to act "in the interest of Prestige," were all factors which led the court to conclude that Ott and Heying was the "general agent" of Prestige.[35]

Further, the court noted that the insurer had specified in the contract that delivery of an endorsement would be the "controlling event" necessary to complete a contract modification. Also, the company was responsible for the means chosen to deliver the endorsement.[36] Because Ott and Heying was the general agent of the insurer when the endorsement was received, the endorsement was never "issued" to the insured as specified by the contract. Thus, coverage on the first automobile had not been effectively transferred to the second automobile at the time of the accident.[37]

The result of *Mashburn* is that an insurance agency acting as a "broker" for several companies may be deemed an agent of the insured for one purpose and an agent of a company for another.[38] This rule will render each future case fact-sensitive, with heavy emphasis upon the terms of the agreement between the broker and the company.

3. Automatic Coverage for a Newly Acquired Automobile. — Frequently, a person having automobile insurance replaces a car or

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[34]612 F.2d at 1050.

[35]*Id.*

[36]*Id.*

[37]*Id.*

[38]The court in *Mashburn* made this observation when it distinguishd the rule in *Hitch* (that a broker is the agent of the insured): "It [*Hitch*] decided only that the insurance agency's negligence in failing to obtain sufficient liability insurance for the insured was not attributable, on an agency theory, to the insurer. It did not decide that the insurance agency is not an agent of the insurer for any purpose . . . ." 612 F.2d at 1050.

buys a new one during the term of an existing policy. To avoid a lapse of coverage between the time the vehicle is acquired and notification is given to the company, many standard automobile liability policies contain a provision for temporary automatic coverage.[39] Recently, the Indiana Court of Appeals had its first opportunity to construe a provision providing automatic coverage for a newly acquired automobile.[40]

In *Stockberger v. Meridian Mutual Insurance Co.*,[41] the court was called upon to construe the meaning of "newly acquired" as applied to an insurance policy provision which required that "notice of the acquisition [be] given to the Company within 30 days after [the car's] acquisition . . . ."[42]

The plaintiff in *Stockberger* had purchased a pair of inoperable unlicensed trucks in October of 1973. One was a 1960 one-ton pickup and the other was a 1952 pickup. In February of 1974, the plaintiff renewed coverage with the defendant, Meridian Mutual, for a 1963 pickup truck which he had owned prior to the October of 1973 acquisitions. The renewed coverage was to commence in April of 1974. Sometime during May of 1974, the plaintiff told his insurance agent that his 1960 pickup would soon be operable and that he desired to transfer his coverage from the 1963 pickup to the 1960 pickup. The conversation concerning the transfer took place during an informal gathering of businessmen for morning coffee. From that period on, the facts of the case were in conflict as to what actions were taken by the plaintiff and his insurance agent to accomplish the transfer.[43]

In August of 1974, the 1960 pickup was involved in an accident while being driven by the plaintiff's wife. When the plaintiff made a claim for coverage under his policy, Meridian Mutual denied coverage on the ground that no transfer had occurred and the plaintiff brought an unsuccessful lawsuit against his insurance agent and the company.[44]

The narrowly drawn issue in the action against the company was whether an automobile had to be *operable* when acquired in order to be "newly acquired" for the purpose of giving notice to the company.[45] The court found that there were two distinct lines of

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[39]*See* Stockberger v. Meridian Mut. Ins. Co., 395 N.E.2d 1272, 1276 (Ind. Ct. App. 1979) (quoting 12 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 45:184 (2d ed. 1964)).

[40]Stockberger v. Meridian Mut. Ins. Co., 395 N.E.2d 1272 (Ind. Ct. App. 1979).

[41]*Id.*

[42]*Id.* at 1275 (quoting policy language).

[43]*Id.* at 1274.

[44]*Id.* The plaintiff charged both the company and his insurance agent with breach of contract. In addition, he charged the agent with negligence. *Id. See* notes 58-68 *infra* and accompanying text for the discussion of the agent's liability.

[45]395 N.E.2d at 1276-78. The issue was raised by the plaintiff's claim that the

cases on the subject.[46] The first and "prevailing" line of cases was said to rule "that the test of when an automobile is 'newly acquired' for purposes of giving the requisite notice of acquisition is not when the vehicle is rendered operable but instead when it was acquired."[47] The basic rationale for the rule was that interpretation of an automobile policy as a whole will often indicate that coverage is intended for more than mere highway use.[48] Coverage often extends to such risks as fire, theft and collision, and to liability arising out of maintenance. Thus, coverage could reasonably include an inoperable automobile.[49]

The second line of cases held that the automatic coverage applied only to operable automobiles.[50] Those cases were based on the rationale that "traveling on highways exposes the vehicle's operator to liability, and that the risk for the insurance company is limited to one vehicle at a time, depending upon usage."[51]

In adopting the prevailing line of cases, the court found that the policy in question was intended to cover more than just use on the highway.[52] The policy covered liability arising out of ownership, maintenance, and use; losses for collision, fire and theft; and, losses for collision when the car was parked.[53] Thus, the fact that the plaintiff's pickup was inoperable when acquired, did not affect the duty of notifying the company.[54] On that basis, the plaintiff's alleged notification in May of 1974 was found to be not timely, and his claim was barred.[55]

The ruling in *Stockberger* is logical when one considers that standard automobile insurance is usually more than just liability

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automatic coverage provision was ambiguous. *Id.* at 1277. The court found that it was not. *Id.*

[46]*Id.* at 1276.

[47]*Id.* (citing Reciprocal Exch. v. Noland, 542 F.2d 462 (8th Cir. 1976); Allstate Ins. Co. v. Stevens, 445 F.2d 845 (9th Cir. 1971); Williams v. Standard Accident Ins. Co., 158 Cal. App. 2d 506, 322 P.2d 1026 (1958); Illinois Nat. Ins. Co. v. Trainer, 1 Ill. App. 3d 34, 272 N.E.2d 58 (1971); Brown v. State Farm Mut. Auto. Ins. Co., 306 S.W.2d 836 (Ky. App. 1957); Mahaffey v. State Farm Mut. Auto. Ins. Co., 175 So. 2d 905 (La. App. 1965); Collard v. Globe Indem. Co., 50 So. 2d 838 (La. App. 1951); Providence Wash. Ins. Co. v. Hawkins, 340 S.W.2d 874 (Tex. Civ. App. 1960)).

[48]395 N.E.2d at 1276 (citing Wisbey v. Nationwide Mut. Ins. Co., 264 Or. 600, 507 P.2d 17 (1973)).

[49]395 N.E.2d at 1276.

[50]*Id.* at 1276-77 (citing Luke v. American Family Mut. Ins. Co., 476 F.2d 1015 (8th Cir.), *cert. denied*, 414 U.S. 856 (1973); Glen Falls Ins. Co. v. Gray, 386 F.2d 520 (5th Cir. 1967)).

[51]395 N.E.2d at 1277.

[52]*Id.* at 1278.

[53]*Id.* at 1277-78.

[54]*Id.* at 1278.

[55]*Id.*

coverage. However, most if not all of the cases involving automatic coverage have been ones in which the car owner was seeking insurance coverage for liability to a third party.[56] The contractual notice requirement seems calculated only to give the insurer the opportunity to collect an additional premium when necessary. Is it realistic to require the owner of an inoperable vehicle to give notice, when the notice will require a high premium for liability coverage while his vehicle is inoperable? The immediate answer would be to have the owner give notice but not require him to pay a premium for liability coverage during the inoperable period. This answer, however, does no more than to require the owner to give a second notice when the vehicle becomes operable.

The court in *Stockberger* stated that "an automobile is an automobile."[57] In the contemplation of most car owners, however, it may be more realistic to say that an automobile is only an automobile when it can be used for its designated purpose—to be driven. Surely, few people feel a need for insurance until a car becomes operable and the potential of personal liability arises. So far as *liability* coverage is concerned, a liability insurer is really not on the risk until the car is operable. It would seem more reasonable to require notice for a newly acquired *replacement* vehicle only when actual "replacement" occurs.

4. Liability of an Insurance Agent for Failure to Procure Coverage.—In addition to considering the question of automatic insurance coverage, the court in *Stockberger v. Meridian Mutual Insurance Co.*[58] discussed the liability of an insurance agent for failure to procure coverage. The plaintiff in *Stockberger* claimed that his insurance agent had breached an implied contract to insure plaintiff's truck. Further, the plaintiff claimed that his agent had been negligent in failing to procure coverage once a request had been made.[59]

The factual setting for the issue raised is fairly simple. The plaintiff and his insurance agent discussed the question of insurance for the plaintiff's truck while having coffee one morning with a group of businessmen. The plaintiff claimed that he made a request for a transfer of coverage from one vehicle to another under an existing policy. However, the plaintiff gave his agent no specific information about the truck in question. The agent testified that no request for transfer was made, and that the parties only discussed

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[56]*See* cases cited notes 47 & 50, *supra*.

[57]395 N.E.2d at 1276.

[58]395 N.E.2d 1272 (Ind. Ct. App. 1979).

[59]*Id.* at 1278.

generally the need to insure the vehicle once it was put in use.[60] Although the substance of the conversation was in conflict, it was clear that no further effort was made by either party to consummate the transfer of coverage.

In dealing with the question of implied contract, the court found initially that Indiana law requires agreement on five essential elements in order for a contract of insurance to exist. Those elements were, "(1) the subject of the insurance; (2) the risk or peril insured against; (3) the amount of coverage; (4) the limit and duration of the risk; and (5) the amount of the premium to be paid."[61] On the basis of these five elements the court found that no "meeting of the minds" could have occurred and thus, that no contract could exist.[62]

In arriving at its holding, the court noted that past dealing between the parties could create an implied contract to procure insurance.[63] The evidence showed that the plaintiff had relied to some extent on his agent in the past.[64] However, the court ruled that even though an agent may have authority to perform most of the essential tasks to creating the contract, there was "a corresponding duty on the part of the insured to provide the agent or broker with the information necessary to implement the policy. An agent or broker is not liable when the insured's loss is due to the insured's own act or omission."[65] In this case, the evidence showed that the plaintiff had been aware through past dealing with his agent of his duty to provide information for the policy change.[66] Because no information had been provided, no contract existed.[67] Further, the court determined that the plaintiff had not met his burden of proving the existence of an implied contract arising from an established past practice.[68]

After *Stockberger*, it is apparent that a contract to procure insurance will not be easily established. The intent of the parties to enter into a contract will have to be clearly proven.[69] It is arguable, however, that less proof will be required in a situation where a

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[60]*Id.*

[61]*Id.* at 1279 (citing Farmers Mut. Ins. Co. v. Wolfe, 142 Ind. App. 206, 233 N.E.2d 690 (1968)).

[62]395 N.E.2d at 1279-80.

[63]*Id.* at 1279 (citing Hamacher v. Tumy, 222 Or. 341, 352 P.2d 493 (1960), and citing for comparison Western Assur. Co. v. McAlpin, 23 Ind. App. 220, 55 N.E. 119 (1899)).

[64]395 N.E.2d at 1278-79.

[65]*Id.* at 1279 (citing 3 G. COUCH, *supra* note 39, § 25:60 and Annot., 72 A.L.R.3d 747 (1976)).

[66]395 N.E.2d at 1279.

[67]*Id.* at 1279-80.

[68]*Id.* at 1280.

[69]*Id.*

modification of existing coverage is proposed; the amount of information needed to change a policy may be less than that needed to create a new policy.

B. Misrepresentation

1. Rescission of the Policy. a. Requirement of tender of premiums.—When an insured misrepresents matters in an application for insurance, the insurer may, as a general rule, rescind the policy.[70] The purpose of rescission is to restore the parties to their pre-contract positions.[71] Therefore, to rescind an insurance policy, the insurer must return any premiums paid by the insured.[72] In *American Standard Insurance Co. v. Durham*,[73] however, the Indiana Court of Appeals held that a tender back of premiums paid is not required to rescind a policy if the company has previously paid claims under the policy in excess of the premiums paid by the insured.[74] American Standard issued a policy of automobile insurance to Durham covering a 1973 Corvette. On the application it was stated that Durham had been convicted of bank robbery. Actually, Durham's criminal record was somewhat longer, including convictions for larceny, robbery and leaving the scene of an accident. Durham maintained that he told American Standard's agent about his entire criminal record. Despite this knowledge, the agent had prepared the application form listing only the bank robbery conviction. A single premium of $180 was paid on the policy. A few months later Durham was involved in a one-car accident. American Standard paid a claim of $2300 for the damages. Soon thereafter the car was stolen. The theft was reported to the police and Durham's insurance agent. American Standard investigated the theft but refused to pay anything.[75] Durham sued American Standard for breach of contract seeking compensatory and punitive damages. American Standard set up the affirmative defense of misrepresentation in the application and sought to rescind the policy. A jury awarded Durham $16,900.[76] American Standard appealed, claiming error in a jury instruction to the effect that an insurer must tender premiums paid to rescind a

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[70]*See* Prentiss v. Mutual Ben. Health & Accident Ass'n, 109 F.2d 1 (7th Cir.), *cert. denied*, 310 U.S. 636 (1940); 45 C.J.S. *Insurance* § 470 (1946).

[71]Prudential Ins. Co. v. Smith, 231 Ind. 403, 108 N.E.2d 61 (1952).

[72]Smeekends v. Bertrand, 262 Ind. 50, 311 N.E.2d 431 (1974); Blaising v. Mills, 374 N.E.2d 1166 (Ind. Ct. App. 1978); Berry-Jefferson Corp. v. Gross, 358 N.E.2d 757 (Ind. Ct. App. 1977).

[73]403 N.E.2d 879 (Ind. Ct. App. 1980).

[74]*Id.* at 881.

[75]*Id.* at 880.

[76]*Id.*

policy. It was American Standard's contention that a tender back of premiums was unnecessary because American Standard had already paid a claim which exceeded the amount of premium paid in.[77]

The court of appeals reversed and remanded the case for a new trial.[78] The court recognized an exception in Indiana to the rule requiring prompt tender of premiums; when the insurer has paid a claim which is greater in amount than the premiums, the insurer need not tender the premiums before rescinding the policy.[79] There remains a problem, however, which the court neither dealt with nor apparently recognized. While an insured is bound by *his own* misrepresentations, when an agent, in filling out an application, makes mistakes or misrepresentations, the insured is not bound unless the insured participates in making the misrepresentations.[80] Instead, the insurer is bound by the agent's misrepresentations.[81] In the present case, Durham told the agent about his criminal record, but the agent omitted parts of it on the application. The court apparently accepted the assertion as true, but it did not hold the insurer liable for the agent's mistake. American Standard, not Durham, should be bound by these omissions. The insured should not lose the protection purchased merely because the agent failed to convey what he had been told.

b. When tender is timely.—In *Gary National Bank v. Crown Life Insurance Co.*,[82] the court dealt with another problem concerning when premiums must be tendered. Warren Pike obtained a $50,000 insurance policy on his own life from Crown Life. Gary National Bank was made trust beneficiary of the proceeds. When Pike died five months later, it became apparent that he had made misrepresentations on the application with respect to his medical history. Gary National Bank filed for the death benefits on July 17, 1974. On September 6, 1974 Crown Life refused to pay based on the misrepresentations, and sent a check for the premiums to Gary National Bank. The bank, while still in possession of the check, filed suit on January 28, 1975. The check was returned to Crown Life on June 17, 1975. On May 25, 1976, less than a month before trial, Crown Life tendered a check for the premiums into court.[83] The trial court held for Crown Life.[84] On appeal, the only issue decided was whether

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[77]*Id.* at 880-81.

[78]*Id.* at 882.

[79]*Id.* at 881. *See* Great E. Cas. Co. v. Collins, 73 Ind. App. 207, 126 N.E. 86 (1920).

[80]17 J. APPLEMAN, *supra* note 32, § 9409; G. COUCH, *supra* note 39, § 26:170.

[81]17 J. APPLEMAN, *supra* note 32, § 9409; G. COUCH, *supra* note 39, § 26:170.

[82]392 N.E.2d 1180 (Ind. Ct. App. 1979).

[83]*Id.* at 1180-81.

[84]*Id.* at 1181.

Crown Life's tender of the premiums into court was timely.[85]

The court of appeals found that the tender was timely and affirmed.[86] When the beneficiary refuses a tender of premiums, the insurer must pay the money into court or the fraud upon which the rescission is based is waived.[87] When the check was returned to Crown Life on June 17, 1975, Crown Life had a duty to tender the premiums into court. The purpose of paying the money into court is to determine who is entitled to it.[88] By the time Crown Life finally paid the premiums into the court, neither party claimed any right to it. The court noted that both parties could have been more diligent in tendering the premium check, but as long as the court was in possession of the funds before a trial on the merits, Crown Life's tender was timely.[89] In *Prudential Insurance Co. of America v. Smith*,[90] a case factually similar to the present case, the Indiana Supreme Court held that failure of the insurance company to tender premiums into court after the beneficiary had refused them constituted a waiver of a fraud defense on the policy.[91] In that case the insurer never paid the premiums into court, whereas Crown Life tendered the premium just prior to trial. The court did not decide exactly when a tender of premiums to a beneficiary would have to be made to be timely. The decision does indicate, however, that once a beneficiary refuses the tender of premiums, an insurance company can wait until just prior to trial to pay the premiums into court. Not only does the insurance company not have to pay any proceeds on the policy, but it has use of the premiums until trial.

c. Duty of insurer to investigate application.—The extent to which an insurer must make inquiry into representations on an application was decided in *State Farm Mutual Automobile Insurance Co. v. Price*.[92] On the application for an automobile liability insurance policy John Price answered "no" to the question whether the applicant or any member of his household had been convicted of or forfeited bail for any traffic violation. Price's son, John Ray Price, however, had been convicted of three traffic offenses.[93] State Farm did not investigate the driving records of Price or his family but relied on the answers on the application. John Ray was involved in an accident while driving an insured automobile. State Farm

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[85]*Id.*

[86]*Id.* at 1182.

[87]Prudential Ins. Co. v. Smith, 231 Ind. 403, 108 N.E.2d 61 (1952).

[88]392 N.E.2d at 1182.

[89]*Id.*

[90]231 Ind. 403, 108 N.E.2d 61 (1952).

[91]*Id.* at 413-14, 108 N.E.2d at 65.

[92]396 N.E.2d 134 (Ind. Ct. App. 1979).

[93]*Id.* at 135-36.

discovered the misrepresentations in the application and filed an action to rescind the policy.[94]

The trial court found that Price had materially misrepresented the driving records of Price and his son and that State Farm had relied on these statements. Although State Farm was not put on notice of any misrepresentations, the trial court determined that State Farm had a duty to investigate an applicant's insurability within a short time after issuance of the policy; State Farm had failed to conduct an investigation and therefore had waived its right to rescind the policy.[95]

The court of appeals reversed the trial court's decision.[96] The court noted that, as a general rule, an insurance company may rely on matters asserted in a policy application.[97] When an insurance company is placed on "inquiry notice" it has a duty to investigate and failure to do so waives the company's right to rescind the policy. Such notice arises when the company or its agent has knowledge that would lead a prudent man to inquire about the matter;[98] but when the company has no reason to doubt a statement in an application, it may rely on that statement without inquiry.[99] The trial court found State Farm had no notice of the misrepresentations of John Ray Price's driving record; therefore no duty to investigate arose, and State Farm was not precluded from rescinding the policy.[100]

2. Misrepresentation by the Insurer's Agent.—In *AAA Wrecking Co. v. Barton, Curle & McLaren, Inc.*,[101] the court of appeals held that where "a party with knowledge of the facts, makes a representation of a material fact with the knowledge . . . that another party will rely upon it, and where the representation does induce reliance by the other party, the party making such representation will be estopped from denying its truth . . . ."[102] AAA Wrecking entered a contract to destroy a building in downtown Indianapolis owned by Thomas. Thomas requested that AAA carry collapse insurance. Thomas agreed to adjust the contract price upwards to reflect the cost of this insurance. It was also agreed that the cost of this extra insurance would be worked out between the insurance agent, Bar-

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[94]*Id.* at 136.
[95]*Id.*
[96]*Id.* at 137.
[97]*Id.*
[98]*Id.*
[99]*Id.*
[100]*Id.*
[101]395 N.E.2d 343 (Ind. Ct. App. 1979).
[102]*Id.* at 346-47.

ton, Curle and McLaren (BC & M), and Thomas.[103] An agreement was reached and BC & M did provide the extra coverage. BC & M requested that AAA pay $4,198 as the premium for the additional coverage. AAA maintained, however, that the figure given to Thomas was only $1,871 and that since this was the figure by which the contract price was adjusted, AAA had relied to its detriment on the representation of BC & M. Therefore, AAA argued that BC & M was estopped to recover the excess premium.[104]

The trial court held that AAA had not carried its burden of proof on the issue of whether the lesser figure was supplied in such a way as to amount to an equitable estoppel. The court of appeals, however, reversed the trial court's decision as contrary to the evidence.[105] Testimony indicated that BC & M had quoted the $1,871 figure to Thomas and that this figure had been incorporated into the contract. BC & M did not contradict this testimony. The court of appeals found that BC & M knew or should have known that AAA would rely on the figure to its detriment.[106] Therefore BC & M was estopped to recover any more than $1,871 as premium for providing the requested coverage.[107]

C. Uninsured Motorist Coverage

1. Stacking of Benefits.—Recently, the court of appeals addressed the subject of intra-policy stacking of benefits under uninsured motorist coverage in Indiana. *Liddy v. Companion Insurance Co.*[108] and *Indiana Insurance Co. v. Ivers*[109] dealt with very similar fact settings and virtually identical issues.[110] *Ivers*, the most recent of the two cases, will be the focus of discussion in this section.

In *Ivers*, the plaintiffs' decedents were killed when the automobile in which they were riding collided with a vehicle driven by an uninsured motorist.[111] At the time of the collision there was an insurance policy in effect through the defendant, Indiana Insurance Company, which extended to the plaintiffs' decedents.[112] The policy

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[103]*Id.* at 344.

[104]*Id.*

[105]*Id.* at 347.

[106]*Id.* at 346.

[107]*Id.*

[108]390 N.E.2d 1022 (Ind. Ct. App. 1979).

[109]395 N.E.2d 820 (Ind. Ct. App. 1979).

[110]Besides the question of stacking, *Liddy* also dealt with the issue of what constitutes a proper subject of arbitration. *See* text accompanying notes 219-24 *supra.*

[111]395 N.E.2d at 821. The negligence of the uninsured driver was stipulated to be the proximate cause of the accident. *Id.*

[112]The plaintiffs were the administrators of the decedents' estates. One plaintiff,

in question covered three automobiles and required individual premiums for each automobile. A separate premium for uninsured motorist coverage was also required on each automobile. The limits of liability stated for uninsured motorist coverage were $15,000 for each person and $30,000 for two or more persons for injuries arising out of one accident.[113]

The plaintiff's claim for wrongful death against the company was $90,000. This amount represented the combined maximum uninsured motorist coverage for each of the three automobiles. The plaintiffs reasoned that they should be able to "stack" the maximum benefits of $30,000 for each automobile because the policy listed each automobile separately and because a separate uninsured motorist premium was assigned and collected for each vehicle.[114] The crux of the plaintiffs' position was that the "limits of liability" provision[115] of the policy conflicted with the "separability clause" of the policy,[116] thereby creating an ambiguity which the plaintiffs argued had to be construed against the company and in favor of extended coverage.[117] The plaintiffs also asserted that the company's collection of a separate uninsured motorist premium for each automobile raised an implication that a separate contract existed for each automobile.[118]

The precedent for the plaintiffs' ambiguity argument came from the 1974 Indiana Court of Appeals decision in *Jeffries v. Stewart*.[119] In *Jeffries*, the court had compared a limits of liability clause and a separability clause much like the ones facing the *Ivers* court. In ad-

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Bobby W. Ivers, was the owner of the vehicle involved in the accident and the named insured on the automobile insurance policy. *Id.*

[113]*Id.* at 822. The limits of liability were identical to the minimum amounts required by IND. CODE §§ 27-7-5-1, 9-2-1-15 (1976). 395 N.E.2d at 822.

[114]395 N.E.2d at 822.

[115]The "Limits of Liability" provision read as follows:

> The limit of liability for family protection coverage [uninsured motorist coverage] stated in the declarations as applicable to "each person" is the limit of the company's liability for all damages, including damages for care or loss of services, because of bodily injuries sustained by one person as a result of any one accident and, subject to the above provision respecting each person, the limit of liability stated in the declarations as applicable to "each accident" is the total limit of the company's liability for all damages, including damages for care or loss of services, because of bodily injuries sustained by two or more persons as a result of any one accident.

Id.

[116]The "separability clause" stated: "4. Two or more automobiles—Parts I, II, and III. When two or more automobiles are insured hereunder, the terms of this policy shall apply separately to each . . . ." *Id.*

[117]*Id.* at 823.

[118]*Id.* at 822.

[119]159 Ind. App. 701, 309 N.E.2d 448 (1974).

dressing the issue of ambiguity, the court in *Jeffries* had stated:

> Ambiguity arises because of conflict between the "two or more automobiles" clause and the "limits of liability" clause. The "two or more automobiles" clause, or separability clause as it is also known, effectuates a contract of insurance separately as to each car insured, and binds each policy with all of the provisions and conditions of the single policy. Each of the three policies then contains a promise to pay the insured damages . . . .[120]

The *Jeffries* court then found that the separability clause expressly applied to the uninsured motorist provision and held that a separate contract of insurance existed for each of the three automobiles.[121] Stacking of benefits was therefore allowed.[122]

The *Ivers* court found *Jeffries* to be distinguishable because the separability clause in the Indiana Insurance Co. policy did not apply to the uninsured motorist provision.[123] Thus, no ambiguity was found to exist and the court refused to allow stacking of benefits.[124]

To fully dispose of the question of stacking, the *Ivers* court lastly addressed the plaintiffs' argument that the separate uninsured motorist premiums charged obligated the insurer to provide multiple coverage.[125] The court rejected the argument, stating, "We find that the insurer gave consideration in the form of accepting increased risk for the extra premium charged per automobile; therefore, we do not find that the separate premiums require 'stacking.'"[126] This holding was based on the premise that the company would have more than one risk of loss if all the insured vehicles were on the highway at one time.[127]

After *Ivers*, it is probable that the issue of stacking may not be raised again in Indiana. As one author remarked following *Jeffries*, the ambiguity issue raised in stacking cases can be avoided by "proper

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[120] *Id.* at 707, 309 N.E.2d at 452.

[121] *Id.*

[122] *Id.* at 709, 309 N.E.2d at 453.

[123] 395 N.E.2d at 823.

[124] *Id.* The *Ivers* court found its ruling to be consistent with other Indiana cases having similar facts. *Id.* (citing Trinity Universal Ins. Co. v. Capps, 506 F.2d 16 (7th Cir. 1974) (wherein the separability clause did not include uninsured motorist coverage); Miller v. Hartford Accident & Indem. Co., 506 F.2d 11 (7th Cir. 1974) (wherein the insurance policy contained no separability clause); & Liddy v. Companion Ins. Co., 390 N.E.2d 1022 (Ind. Ct. App. 1979) (wherein the separability clause exempted uninsured motorist coverage)).

[125] 395 N.E.2d at 823-24.

[126] *Id.* at 824.

[127] *Id.* The holding was found to be consistent with numerous other authorities. *See* cases cited, *id.* at 824-25.

draftsmanship."[128] The contract language in Indiana stacking cases since *Jeffries*[129] has avoided any problematic ambiguity, leading to the suggestion that insurance contract drafters may have taken heed of the *Jeffries* lesson.

2. The Effect Upon Uninsured Motorist Coverage of Prior Settlement with Tortfeasor.—In *Spears v. Jackson*[130] the court of appeals upheld an insurance policy provision which voided uninsured motorist coverage if the insured entered into settlement with a tortfeasor without the consent of the company.[131]

The plaintiff in *Spears* was injured in a three car collision. Of the two tortfeasors, one was insured and the other was not. Without the permission of the insurance company, Spears settled with the insured tortfeasor. Spears' subsequent claim for uninsured motorist coverage was denied for violation of the aforementioned provision.[132]

In upholding the validity of the provision, the court found that the consent-to-settle requirement did not contravene public policy as an improper restriction on a person's right to redress injuries in a court of law.[133] Further, the court rejected the plaintiff's argument "that the provision was intended to void coverage *only* in the context of settlements with uninsured motorists."[134] The policy language was found to be clear and unambiguous; the court therefore refused to strictly construe the contract against the insurer.[135]

The most important aspect of *Spears* was the court's express rejection of the Michigan rule of insurance policy construction which always gives "a construction which is most favorable to the insured."[136] The court stated that Indiana law allows such a construction only where the policy language is ambiguous.[137] Otherwise,

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[128]Frandsen, *Insurance, 1974 Survey of Recent Developments in Indiana Law*, 8 IND. L. REV. 217, 224 (1974).

[129]*See* cases cited note 124 *supra*.

[130]398 N.E.2d 718 (Ind. Ct. App. 1980).

[131]The relevant provision in the Prestige Casualty policy was as follows:

> This [uninsured motorist] endorsement does not apply:
>
> a) to bodily injury to an insured with respect to which such insured, his legal representative or any person entitled to payment under this endorsement shall, without written consent of the company, make any settlement with any person or organization who may be legally liable therefor.

Id. at 719.

[132]*Id.*

[133]*Id.*

[134]*Id.*

[135]*Id.* at 720.

[136]*Id.* at 719 (rejecting Michigan Mut. Liab. Co. v. Karsten, 13 Mich. App. 46, 163 N.W.2d 670 (1968)).

[137]398 N.E.2d at 719.

"[w]here the policy language is clear and unambiguous, it must be taken in its plain, ordinary and popular sense."[138]

D. Subrogation—Builder's Risk Insurance

During the previous survey period, the decision in *Morsches Lumber, Inc. v. Probst*[139] introduced into the law of Indiana the concept that "an agreement to provide insurance constitutes an agreement to limit the recourse of the party acquiring the policy solely to its proceeds even though the loss may be caused by the negligence of the other party to the agreement."[140] In the recent survey period the rule of *Morsches* was firmly entrenched in Indiana in *South Tippecanoe School Building Corp. v. Shambaugh & Son, Inc.*[141] While *Morsches* dealt only with a simple owner-contractor construction relationship, *Shambaugh* involved a complex construction contract with an owner, a general contractor, and several subcontractors.

The lawsuit in *Shambaugh* was a subrogation action brought by the builder's risk insurer, Hartford Insurance Company, in the name of the property owner, South Tippecanoe. Hartford had paid South Tippecanoe for property damage to a high school building under construction which allegedly resulted from negligence by the contractor, subcontractors, and architects on the project. The various defendants were awarded a summary judgment in the trial court on the basis that the existing contracts foreclosed an action for the injuries alleged.[142]

In order to ascertain the intent of the parties to the construction contracts the court laid out the relevant provisions of the general contract (Contract for Construction) and the relevant provisions of the builder's risk insurance policy. The paragraph of the general contract entitled *Property Insurance* set forth three obligations with respect to the procurement of builder's risk insurance. First, the owner was required to maintain insurance on the entire project which would protect and include the interest of all the parties for fire and other property damage hazards.[143] Second, proceeds

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[138]*Id.* (citing Vernon Fire & Cas. Ins. Co. v. American Underwriters' Inc., 356 N.E.2d 693 (Ind. Ct. App. 1976)).

[139]388 N.E.2d 284 (Ind. Ct. App. 1979).

[140]*Id.* at 285. For a general discussion of *Morsches*, *see* Mortensen, *Insurance, 1979 Survey of Recent Developments in Indiana Law*, 13 IND. L. REV. 279, 289-91 (1980).

[141]395 N.E.2d 320 (Ind. Ct. App. 1979).

[142]*Id.* at 322.

[143]*Id.* at 323. The provision stated:

> 11.3.1 Unless otherwise provided, the Owner shall purchase and maintain property insurance upon the entire Work at the site to the full insurable value thereof. This insurance shall include the interest of the Owner, the Contractor, Subcontractors and Sub-subcontractors in the Work and shall in-

payable for any loss were to be paid to the owner as "trustee" for all insureds.[144] Third, the owner and general contractor were to "waive all rights against each other" for insured perils and the contractor was required to procure similar waivers from all subcontractors.[145]

The key provision of the insurance policy was the subrogation clause which allowed the company to be subrogated to the insured's rights. However, the clause permitted the insured to waive its rights against subcontractors and other entities performing work without invalidating the insurance coverage.[146]

On the basis of the foregoing contractual limitation the court found that the contract "evinces an intent to place any risk of loss on the Work on insurance; the Defendants are intended 'insured' under the builder's risk policy; and, the waiver provisions are fully applicable here."[147] The court went on to conclude that "a builder's risk insurer is not entitled to subrogate against one whose interests are insured even though the party's negligence may have occasioned the loss, in the absence of design or fraud."[148]

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sure against the peril of Fire, Extended Coverage, Vandalism and Malicious Mischief. [Subparagraph]

Id. (footnotes omitted).

[144]*Id.* The provision stated: "11.3.3 Any insured loss is to be adjusted with the Owner and made payable to the Owner as trustee for the insureds, as their interests may appear, . . . [Subparagraph]." *Id.*

[145]*Id.* The provision stated:

> 11.3.6 The Owner and Contractor waive all rights against each other for damages caused by fire or other perils to the extent covered by insurance provided under this Paragraph 11.3, except such rights as they may have to the proceeds of such insurance held by the Owner as trustee. The Contractor shall require similar waivers by Subcontractors and Sub-subcontractors in accordance with Clause 5.3.1.5. In waiving rights of recovery under terms of this paragraph, the term "Owner" shall be deemed to include his employees and the Architect and his employees as the Owner's representative as provided for in the Contract Document. [Subparagraph]

Id.

[146]*Id.* at 324. The clause stated:

> In the event of any payment under this policy, the Company shall be subrogated to all of the Insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Insured shall do nothing after loss to prejudice such rights.
>
> This insurance, however, shall not be invalidated should the Insured waive in writing prior to a loss to the described property any or all right of recovery against any entity for whom work is being performed, or against any subcontractor working on the job insured hereunder.

Id.

[147]*Id.* at 326.

[148]*Id.* at 328.

The *Shambaugh* case is a well written and soundly reasoned opinion. The rule will aid in solving the problem of apportioning risks in the context of construction contracts and should help to reduce litigation arising out of construction loss disputes.

E. Insurer's Duty to Settle

One of the realities to be faced by a plaintiff in modern tort litigation is that defense of a lawsuit is likely to be managed, negotiated, and tried or settled by the defendant's liability insurer.[149] As a result, a plaintiff who has been met with less than good faith bargaining on the part of a defendant's insurance company may justifiably desire to see the insurer taken to task. During the survey period the Indiana Court of Appeals made a definite statement with respect to the insurer's duty to use good faith in negotiating with a tort claimant on behalf of its insured tortfeasor.

In *Winchell v. Aetna Life & Casualty Insurance Co.*,[150] the plaintiff brought a lawsuit against the University of Evansville for alleged injuries to her minor son. While her first lawsuit was pending, the plaintiff initiated a second lawsuit against the University's liability insurer, Aetna Life and Casualty, wherein she sought damages for economic and emotional injuries allegedly caused by the insurer's failure to settle in good faith.[151] A key fact relied on by the plaintiff in her second action was that she was also insured by Aetna through coverage provided by her employer.[152] This fact, she alleged, created a fiduciary duty on the part of the insurance company toward her, and made the company liable for its unwillingness to accept her settlement offers.[153] The trial court granted the insurance company's motion to dismiss for failure to state a claim upon which relief could be granted.[154]

In addressing the issue of the insurer's duty to "make a reasonable effort to compromise the plaintiff's claim against the defendant-insured,"[155] the court of appeals relied principally upon the 1972 Indiana case of *Bennett v. Slater*.[156] In *Bennett*, the tort claimant had recovered a judgment in excess of policy limits against the

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[149]*See* Annot., 50 A.L.R.2d 458 (1956); Annot., 49 A.L.R.2d 694 (1956); Annot., 41 A.L.R.2d 434 (1955).

[150]394 N.E.2d 1114 (Ind. Ct. App. 1979).

[151]*Id.* at 1115.

[152]*Id.*

[153]*Id.* The plaintiff also sought punitive damages for alleged willful and intentional acts by the insurer to deprive her of her rights. *Id.*

[154]*Id.*

[155]*Id.* at 1116.

[156]154 Ind. App. 67, 289 N.E.2d 144 (1972).

defendant-insured. Prior to trial, Bennett had offered to settle for the policy limits but Slater's insurer had declined. When Slater, the insured-judgment debtor, refused to bring his own action against his insurer, Bennett sued the company directly to recover his excess judgment. The dismissal of Bennett's direct action was upheld because the court of appeals found that the company had no duty to Bennett to accept Bennett's settlement offer.[157] The *Bennett* court had concluded that "[t]he duty of an insurance company to protect its insured against liability cannot consistently be extended to include protection to one who is seeking to hold the insured liable."[158]

In applying the *Bennett* rule, the *Winchell* court noted that its own factual setting was distinguishable.[159] However, the court found the *Bennett* rule to be particularly significant because the appellant was suing the insurer *prior* to termination of her suit against the insured: "If a party with a claim against the insured cannot maintain an action against the insurer even when the insured refuses to sue, then surely the claimant cannot maintain such an action before the insured indicates that it will not sue its insurer."[160]

The court made short shrift of the appellants' fiduciary duty argument. There were no matters pleaded from which the court could find reason to make a connection between Winchell's own insurance contract with Aetna and her claim for negligence against the University.[161] The court concluded:

> Common sense indicates that such a leap in reasoning is imprudent. It stretches the concept of a fiduciary relationship too far to say that a fiduciary relationship established between an insurance company and its insured extends to a lawsuit by that insured against another person insured by the same insurance company.[162]

Thus, it is clear in Indiana that an insurance company has no duty to use good faith in negotiating with a tort claimant on behalf of an insured defendant. Moreover, no special fiduciary duty arises on the part of the company where it turns out that the claimant and the tortfeasor are both insured by the same carrier.

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[157] *Id.* at 73-74, 289 N.E.2d at 148 (quoting Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1176 (1954)).

[158] 154 Ind. App. at 73, 289 N.E.2d at 148 (quoting Seguros Tepeyac, S.A., Compania Mexicana v. Bostrom, 347 F.2d 168 (5th Cir. 1965)).

[159] 394 N.E.2d at 1117.

[160] *Id.* The court further commented that Winchell's premature lawsuit "could have the effect of determining the insured's liability prior to its own trial, because the question of the insurer's good faith regarding settlement may be related to the relative strength of the plaintiff's case against the insured." *Id.*

[161] *Id.* at 1117-18.

[162] *Id.* at 1118.

The question which remains after *Winchell* and its reliance upon *Bennett*, is who will be responsible for holding the insurance company accountable for occasional misconduct in defending lawsuits. The obvious person would seem to be the insured. In *Bennett v. Slater*,[163] however, the insurance company exposed its insured to an excess judgment, forced the plaintiff into litigation, and then escaped unscathed when the insured refused to exercise his own chose in action for bad faith.[164] The question of insurance company accountability is one that should not be overlooked when the courts have occasion to rule in the future on the issue of the insurer's duty to use good faith in settling lawsuits.

F. Waiver and Estoppel

Forfeitures of insurance proceeds are not favored in Indiana law. Nevertheless, failure to pay a premium may result in a forfeiture unless waived by the insurer or unless the insurer does something which causes the insured to fail to pay a premium on time. Failure to timely pay a premium was the subject of two cases decided during the survey period.

In *Hargis v. United Farm Bureau Mutual Insurance Co.*,[165] Farm Bureau had issued a general liability policy to the Hargises to cover a recreational facility which they operated. The policy was to run for a year beginning June 25. An estimated premium was paid in advance and was then adjusted at the end of the year to the actual amount of the premium which depended on the number of people using the recreational facility. If any premium was unearned, it was to be returned to the insured. On May 14, 1974, a combination billing statement/cancellation notice was sent to the Hargises. The amount

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[163]154 Ind. App. 67, 289 N.E.2d 144 (1972).

[164]*Id.* Numerous problems arise in relying upon the insured to hold the insurer accountable. In practice, the insured may have no idea of the wrong which has been done to him by the insurer's bad faith refusal to settle. *See, e.g.*, Simpson v. Motorists Mut. Ins. Co., 494 F.2d 850 (7th Cir.), *cert. denied*, 419 U.S. 901 (1974) (wherein the insurance company negotiated with the claimant and rejected his settlement offers without notifying the insured); Jones v. National Emblem Ins. Co., 436 F. Supp. 1119 (E.D. Mich. 1977) (wherein the insurer conducted negotiation and settlement while misrepresenting to its insureds the chances of successful defense and potential exposure); Rutter v. King, 57 Mich. App. 152, 226 N.W.2d 79 (1974) (wherein the attorney for the insurance company (who had represented the insured in the personal injury action) helped the insured to file his bankruptcy papers in order to discharge an excess judgment). The reality is that though the insured may be the one positioned to hold the insurer accountable, such alternatives as bankruptcy or flight (as in the *Bennett* case) may appear preferable to hiring a new attorney and bearing the cost of further litigation while one's credit is impaired and one's property is subject to execution.

[165]388 N.E.2d 1175 (Ind. Ct. App. 1979).

due was $221, and if it was not paid by July 8, 1974, the policy was to be cancelled. Normally a copy of this statement was also sent to the local agent; in this case, however, none was sent. The Hargises did not pay the premium although they acknowledged that they had received the notice.[166]

On July 26, 1974, a minor, Ronald Gibbs, was injured on the premises of the recreational facility. The Hargises notified the local agent of Farm Bureau and an investigation and processing of the claim commenced. Farm Bureau paid Patricia Koch, Gibbs' mother, for some of Gibbs' medical bills. Koch was also told to buy some medical equipment in expectation of reimbursement.[167] It is unclear who told Koch to purchase the equipment, but it can be inferred that it was either the local agent or the adjuster. Neither the agent nor the adjuster was informed that the last premium had not been paid.[168] The regional adjuster discovered the failure to pay the premium in January of 1975, at which time a letter was sent to the Hargises which stated that the company had not waived the premium requirement.[169] Gibbs and Koch filed suit in tort against the Hargises and subsequently, Farm Bureau brought this action against the Hargises, Gibbs, and Koch for a declaratory judgment that it had no obligation to defend the Hargises.[170]

The trial court found that no insurance policy was in force on the date of the accident and that there was no waiver or estoppel by Farm Bureau that would give effect to the policy.[171] The Hargises, Gibbs, and Koch appealed.

Four issues were raised on appeal:[172] (1) Did the trial court abuse its discretion in denying a motion by Gibbs and Koch for leave to amend their answer to include the affirmative defenses of estoppel and waiver? (2) Was Farm Bureau estopped to assert the unpaid premium by virtue of the actions of itself and its agents? (3) Did Farm Bureau impliedly waive the payment of the premium as a condition to recover on the policy? and (4) Should the past unused premiums apply toward the premium due for the term in question?[173]

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[166]*Id.* at 1177.

[167]*Id.* at 1177-78.

[168]*Id.*

[169]*Id.* at 1178.

[170]*Id.*

[171]*Id.*

[172]The court said three issues were raised on appeal, but it dealt with estoppel and waiver as if they were a single issue. *Id.* at 1179.

[173]*Id.* at 1178-80. There was no evidence presented in regard to the existence or amount of any unused premiums. The court of appeals refused to consider this fourth issue. *Id.* at 1180.

The court found no abuse of discretion as to the first issue.[174] Leave to amend is a matter of discretion with the trial court. The trial court had permitted the Hargises to amend their answer to include estoppel and waiver as affirmative defenses.[175] Gibbs and Koch were not permitted to amend because the action was for declaratory judgment on a contract to which they were not parties. Any recovery inuring to Gibbs and Koch would depend on the existence of a contractual relation between Hargis and Farm Bureau.[176]

Because Gibbs and Koch were not permitted to amend, resolution of the other three issues did not apply directly to them but to the Hargises. Resolution of issues (2) and (3) gave the court an opportunity to explain the difference between estoppel and waiver.[177] Waiver is distinguised from estoppel in that waiver includes an intent to surrender a known right while intent is immaterial for estoppel. An implied waiver may be shown when a party by his actions indicates an intention to waive his rights inducing the other party to act upon the belief that there has been a waiver. Estoppel requires a deception by which the other party is induced to rely on the acts or statements to his detriment.[178] Obviously, the distinction between implied waiver and estoppel is difficult to discern.

The court found that estoppel did not apply because there had been no detrimental reliance.[179] The Hargises did not change their position or give up any defense because of the acts of the company's agents.[180] The Hargises claimed an estoppel based upon the insurer's payment of medical bills and its promise to reimburse Mrs. Koch for her purchase of medical equipment. A further estoppel was claimed because the policy had been treated as in force for six months. The court reasoned that the Hargises could not be "lulled by a false sense of security to not acquire insurance elsewhere to cover an accident which had already occurred."[181]

There are two possible problems with this reasoning: First, while the Hargises did nothing after the accident, Koch did rely on the acts of the agents of Farm Bureau in telling her to purchase medical equipment. To the extent that the Hargises would be relieved

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[174]*Id.* at 1178.

[175]*Id.*

[176]"[P]arties who are strangers to the contract and not named therein as the insured have been held not entitled to claim waiver or estoppel against the company so as to extend the coverage of the policy to include their interest in the insured property." 45 C.J.S. *Insurance* § 677, at 622 (1946).

[177]388 N.E.2d at 1178-79.

[178]BLACK'S LAW DICTIONARY 1417 (5th ed. 1979).

[179]388 N.E.2d at 1178.

[180]*Id.* at 1179.

[181]*Id.*

of liability for this cost by Farm Bureau's promise to pay, their position was changed in reliance on the acts of Farm Bureau's agents. Second, while the Hargises would not have purchased insurance from another insurer after the accident, they might have done so had they been informed of the cancellation prior to the accident. Ordinarily, an insurance policy cannot be cancelled without notice to the insured.[182] It is unclear whether the billing statement was sufficient notice to cancel. If the premium was not paid because the statement was lost or mislaid or because of oversight, obviously the notice of cancellation would be lost, mislaid or overlooked, too. In addition, no notice was sent to the insured's local agent, which might have been construed as additional notice to the insured.

The Hargises also argued that the premium requirement was impliedly waived by the acts of the agents in treating the policy as in effect for six months after the accident.[183] The court refused to impute the knowledge of cancellation by the home office to the local agent.[184] Because the intent to waive rights is necessary for a waiver, an agent who was not aware of failure to pay a premium could not intend to waive the failure as a condition of recovery. The court gave four reasons for this: (1) Failure to pay the premium and the cancellation notice were never discussed by the agent and the Hargises; (2) the Hargises never paid the premium and nothing was discussed as to using previous excess premium towards the premium due; (3) "most, if not all, insureds know that if they fail to pay the premiums they are no longer insured;"[185] and (4) the Hargises were not injured by the length of the period during which the policy was treated as in force.[186]

There are numerous problems with this reasoning. First, there are strong policy reasons for imputing the knowledge of the home office to the agent. Farm Bureau knew that no premium had been received and that it had cancelled the policy on July 8, 1974. It would seem that Farm Bureau should have a duty to inform its agents and adjusters that the policy had been cancelled within a reasonable time rather than let them treat the policy as in force for six months. Because the agents were not notified, Farm Bureau should be bound by the representations of the agents. Second, it

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[182]Hoosier Ins. Co. v. Ogle, 150 Ind. App. 590, 276 N.E.2d 876 (1971); LaSalle Cas. Ins. Co. v. American Underwriters, Inc., 148 Ind. App. 675, 269 N.E.2d 563 (1971); Allstate Ins. Co. v. Morrison, 146 Ind. App. 497, 256 N.E.2d 918 (1970); United Farm Bureau Mut. Ins. Co. v. Adams, 145 Ind. App. 516, 251 N.E.2d 696 (1969).

[183]388 N.E.2d at 1179.

[184]*Id.*

[185]*Id.*

[186]*Id.*

makes no difference that the agent and the Hargises never discussed the premium, because implied waiver, by definition, is usually discerned from actions rather than express statements.[187] Third, even if the agent had no authority to bind Farm Bureau, the adjuster did. An adjuster is regarded as the representative of the company.[188] "[A]cts performed by him within the usual scope of business entrusted to him are binding on the company in the absence of notice of any limitations to the insured or fraud."[189] There is authority to support an implied waiver when the adjuster treats the policy as valid and effective, even when there is a defense known to the insurer.[190]

Finally, the facts do not indicate whether the Hargises were injured by the delay before refusal to honor the policy. Presumably, they were operating without insurance during this period and could have been liable for other accidents. It is also unclear whether they changed their position in any way as a result of the belief that they were covered for the accident.

Brand v. Monumental Life Insurance Co.[191] raises the issue of whether there is a forfeiture of the proceeds of a life insurance policy for failure to pay a premium within a 31-day grace period when the established company policy was to accept payments within sixty days after the grace period.[192] An agent of Monumental visited Bruce and Dorothy Brand at their home on July 9, 1975 for the purpose of collecting an overdue premium on a $10,000 insurance policy on the life of Bruce Brand. Bruce died five days later without having paid the premium. Dorothy tendered the overdue premium on July 22, 1975, but the tender was refused by Monumental's agents. Monumental admitted that it normally accepted premiums for sixty days after the end of the grace period provided that the insured was alive and in apparent good health and that Monumental would have accepted the premium had Bruce Brand been alive and apparently well.[193] From a trial court decision for Monumental, Brand appealed.[194] In reversing the trial court,[195] the court of appeals af-

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[187]*See* note 142, *supra*.

[188]16A J. APPLEMAN, *supra* note 32, § 9369.

[189]*Id.*

[190]*See* Travelers Ins. Co. v. Eviston, 110 Ind. App. 143, 37 N.E.2d 310 (1941) (a general agent of insurance company, in the absence of the insured's knowledge of limitation on his authority, has authority to bind the company by his acts to the extent of modifying terms and conditions of the policy); Penn Mut. Life Ins. Co. v. Senhenn, 40 Ind. App. 85, 81 N.E. 87 (1907) (payment of premium may be waived).

[191]396 N.E.2d 417 (Ind. Ct. App. 1979).

[192]*Id.* at 419.

[193]*Id.*

[194]*Id.* at 418.

[195]*Id.* at 422.

firmed its long-standing rule in *Odd Fellows' Mutual Aid Association v. Sweetser*[196] that the insurance company will be estopped to insist on a forfeiture when, by an agreement, the insured is led to believe that the premiums will be accepted after the date specified as the end of the period.[197] This agreement does not have to be express; it can be implied from statements or established by a mere course of conduct.[198] Monumental's practice was to accept the premium only if the insured was alive and seemed to be in good health. Such a practice conditions liability on having no risk during the extension period. This was prohibited in *Michigan Mutual Life Insurance Co. v. Custer*,[199] because it "enable[s] the company, under a show of leniency, to receive all the benefits of the extension, and yet remain in a condition to repudiate all liability during the same time."[200] Recovery for a loss occurring before payment should not be disallowed when the company has extended the time for payment beyond the date of loss. Indiana agrees with the majority of jurisdictions in this rule,[201] which is consistent with the general disfavor which forfeitures face.[202]

G. Arbitration

Arbitration is a means of dispute settlement common to insurance contracts. While arbitration clauses are usually enforced if applicable, the court of appeals found on two recent occasions that an arbitration was not applicable to the situation before it.

During the survey period, the court of appeals decided an arbitration clause case which it considered to be one of first impression. In *McNall v. Farmers Insurance Group*[203] David McNall was severely injured when the motorcycle on which he was riding was struck by a motorcycle driven by Rick Waterson. Waterson was uninsured and did not have an operator's license. David's father, Ralph McNall, held three policies of insurance issued by Farmers Insurance Group, all of which contained uninsured motorist coverage. Farmers denied that it was liable under the policies because the motorcycle on which David had been riding was not an insured vehi-

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[196]117 Ind. 97, 19 N.E. 722 (1889).

[197]*Id.* at 101, 19 N.E. at 723.

[198]*Id.*

[199]128 Ind. 25, 27 N.E. 124 (1891).

[200]*Id.* at 30-31, 27 N.E. at 126.

[201]*See* 15 J. APPLEMAN, *supra* note 32, § 8404; G. COUCH, *supra* note 39, § 32:135.

[202]Union Ins. Exch., Inc. v. Gaul, 393 F.2d 151 (1968); Guardian Life Ins. Co. of America v. Brackett, 108 Ind. App. 442, 27 N.E.2d 103 (1940); Painter v. Massachusetts Mut. Life Ins. Co., 77 Ind. App. 34, 133 N.E. 20 (1921).

[203]392 N.E.2d 520 (Ind. Ct. App. 1979).

cle under any of the policies. Farmers also claimed that David had been contributorily negligent.[204]

Each of the three policies contained the following arbitration clause:

> 4. Arbitration: If any insured making claim hereunder and the Company do not agree that such insured is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle because of bodily injury to the insured, or do not agree as to the amount payable hereunder, then either party, on written demand of the other, shall institute arbitration proceedings by serving upon the other a formal demand for arbitration.[205]

Farmers demanded that the claims be submitted to arbitration. The McNalls filed suit instead to establish four things: (1) the existence of coverage; (2) Waterson was an uninsured motorist; (3) Waterson's liability; and (4) the amount of damages.[206] Farmers moved to dismiss and to order the McNalls to go to arbitration. The trial court granted summary judgment in favor of the McNalls on the issue of the existence of coverage and determined that Waterson was an uninsured motorist. The liability of Waterson and the amount of damages were tried to a jury. The senior McNall was awarded $6,000 damages, but David was awarded nothing.[207] David and Farmers appealed. The court addressed and resolved six issues.[208] Only one of these will be considered here: whether the trial court erred in denying Farmers' motion to require arbitration.

The court of appeals found that arbitration was required on three issues only: (1) the existence of an uninsured motorist; (2) the liability of that uninsured motorist to the insured; and (3) the amount of damages.[209] Because the question of whether the policies covered David was not one of these issues, arbitration was not required and the issue could be determined by a court of law.[210] The court of appeals also found that the trial court properly retained jurisdiction over the dispute after deciding the issue of coverage.[211] The court stated that Indiana had never dealt with the issue of whether denial of coverage was a waiver of an arbitration provision,[212] but

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[204] *Id.* at 521.

[205] *Id.* at 522.

[206] *Id.* at 521.

[207] *Id.* at 521-22.

[208] *Id.* at 522.

[209] *Id.*

[210] *Id.*

[211] *Id.* at 524.

[212] G. COUCH, *supra* note 39, § 50.108, cites two Indiana cases, Orient Ins. Co. v. Kaptur, 176 Ind. 308, 95 N.E. 230 (1911) and Milwaukee Mechanics' Ins. Co. v. Stewart,

that Indiana had "followed the general rule that denial of liability under an insurance policy is a waiver of the right to demand performance of conditions precedent."[213] In fact, the Indiana Supreme Court held in *Orient Insurance Co. v. Kaptur*[214] that where an insurer, after being given notice of the loss, denied all liability, the insured was relieved of an obligation to submit to arbitration before bringing suit.[215] The facts in *Kaptur* are not sufficiently clear to determine whether the issue was precisely the same as in *McNall*, but it is clear that Indiana has always followed the general rule that a denial of liability is a waiver of obligations under the contract.[216] If Indiana has never considered the precise issue in *McNall* before, the rule here is only a logical extension of previous cases.

Clearly some of the issues decided by the trial court in *McNall* were issues which the parties had agreed to submit to arbitration under the policies.[217] To the extent that the trial court decided these issues, the reasons behind arbitration are usurped. Those reasons include utilization of a less expensive means of dispute settlement and relief of crowded court dockets. Had the court held that the McNalls, after having brought suit to establish coverage, must stop that proceeding and begin a new one before an arbitrator, these policy reasons would be disserved.[218] Additionally, the amount of time necessary to settle the dispute would be increased.

In *Liddy v. Companion Insurance Co.*,[219] the court of appeals held an arbitrator did not have jurisdiction to interpret an insurance contract.[220] The insured, who owned two cars insured under one policy, sought arbitration on whether the insurer was required to pay the

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13 Ind. App. 640, 42 N.E. 290 (1895), for the proposition that the insurer's denial of liability on an insurance policy estops the insurer from insisting on arbitration when the insured brings an action on the policy.

[213]392 N.E.2d at 523 (footnote omitted). *See* Ohio Farmers Ins. Co. v. Vogel, 166 Ind. 239, 76 N.E. 977 (1906) (proof of loss); Globe Life Ins. Co. v. Miller, 94 Ind. App. 289, 180 N.E. 689 (1932) (proof of death); United States Health & Accident Ins. Co. v. Clark, 41 Ind. App. 345, 83 N.E. 760 (1908) (written notice of loss).

[214]176 Ind. 308, 95 N.E. 230 (1911).

[215]*Id.* at 311, 95 N.E. at 231.

[216]In Ohio Farmers Ins. Co. v. Vogel, 166 Ind. 239, 243, 76 N.E. 977, 978 (1906), the court said:

> The principle is old and thoroughly established that when a party repudiates a contract and denies liability under it, the performance of conditions precedent, such as notice, demand, tender and the like, are waived on the ground that the law will not require a thing to be done which the party entitled has excused, or given notice that it will be unavailing. This principle applies to insurance as well as other contracts.

[217]*See* text accompanying notes 205-06 & 210, *supra*.

[218]392 N.E.2d at 524.

[219]390 N.E.2d 1022 (Ind. Ct. App. 1979).

[220]*Id.* at 1029.

uninsured motorist coverage limits on each car,[221] presumably to avoid Indiana's rule against stacking.[222] The court held that the arbitration clause in the policy provided for arbitration of two issues only: "(1) whether . . . the insured . . . [was] legally entitled to recover damages *from the . . . operator of an uninsured automobile*; and (2) if so, the amount of damages . . . ."[223] It did not include the amount the insurance company would have to pay the insured.[224] Presumably, that amount would be the policy limits, but because the policy limit was the issue, an interpretation of the policy would be required. Interpretation of contracts involves questions of law, which the arbitrator did not have jurisdiction to decide.

H. Financial Responsibility Act

1. Effect of the Act.—The Indiana Court of Appeals, in *Grimes v. Government Employees Insurance Co.*,[225] reiterated that the Indiana Financial Responsibility Act[226] was not meant to be a compulsory insurance statute. Grimes was involved in an accident with Roberts, an Illinois resident. Grimes recovered a judgment against Roberts' estate for $275,000. Government Employees Insurance Company (GEICO), Roberts' insurer, paid to Grimes $20,000, which was the limit of liability for bodily injury sustained in a single accident. The policy contained a provision[227] under which GEICO obligated itself to pay an amount which an out-of-state motorist would be required to maintain under an applicable financial responsibility law. The minimum amount stated in the Indiana Financial

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[221] *Id.* at 1024.

[222] *See* text accompanying notes 108-27 *supra*. The "separability clause" in *Liddy* did not apply to the uninsured motorist coverage. 390 N.E.2d at 1033.

[223] 390 N.E.2d at 1028.

[224] *Id.*

[225] 402 N.E.2d 50 (Ind. Ct. App. 1980).

[226] IND. CODE §§ 9-2-1-1 to -45 (1976 & Supp. 1980).

[227] The policy provision read:

> It is agreed that, subject to all the provisions of our policy except where modified herein, the following provision is added:
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> If, under the provision of the motor vehicle financial responsibility law of any state or province, a non-resident is required to maintain insurance with respect to the operation or use of a motor vehicle in such state or province and such insurance requirements are greater than the insurance provided by the policy, the limits of the company's liability and the kinds of coverage afforded by the policy shall be set forth in such law, in lieu of the insurance otherwise provided by the policy, but only to the extent required by such law and only with respect to the operation or use of a motor vehicle in such state or province . . . .

402 N.E.2d at 51.

Responsibility Act was $30,000.[228] Grimes brought an action to compel GEICO to pay an additional $10,000, the difference between the $30,000 required by the Act and $20,000 already collected.[229] The trial court held for GEICO.[230]

In affirming the trial court,[231] the court of appeals quoted extensively from *Green v. State Farm Mutual Automobile Insurance Co.*[232] and *Hill v. Standard Mutual Casualty Co.*[233] In *Green*, one Whitaker obtained insurance from State Farm while in Mississippi, and then moved to Indiana where he was involved in an accident with Green. Green sued Whitaker and State Farm defended. State Farm then filed an action to determine the limit of its liability. The policy limit was $5,000 less than the amount required by the Financial Responsibility Act in force at the time.[234] The court of appeals refused to require an additional $5,000 recovery because it found that the Act was not compulsory insurance law.[235] Proof of financial responsibility was defined in the Act as "proof of ability to respond in damages for liability *thereafter incurred*, arising out of the ownership, maintenance or use of a motor vehicle."[236] The court reasoned that no proof of responsibility is required until after the first accident and no recovery on that required insurance could be obtained until the driver was involved in a second accident. Therefore, Green could not recover.[237]

In *Hill*, the Seventh Circuit Court of Appeals held that a policy was not rendered ambiguous as to whether a guest in an automobile could recover from the insurer, by a provision protecting the insured from liability imposed by a state's financial responsibility act.[238] The court said:

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[228]IND. CODE § 9-2-1-15 (1976), in effect at the time of the accident, read:
Proof of financial responsibility shall mean proof of ability to respond in damages for liability thereafter incurred, arising out of the ownership, maintenance or use of a motor vehicle, in the amount of fifteen thousand dollars [$15,000] because of bodily injury to or death of any one [1] person . . . in the amount of thirty thousand dollars [$30,000] because of bodily injury to or death of two [2] or more persons in any one [1] accident, and in the amount of ten thousand dollars [$10,000] because of injury to or destruction of property in any one [1] accident. Proof in the amounts required by this section shall be furnished for each motor vehicle registered by such person.

[229]402 N.E.2d at 51.

[230]*Id.*

[231]*Id.* at 54.

[232]168 Ind. App. 434, 343 N.E.2d 828 (1976).

[233]110 F.2d 1001 (7th Cir. 1940).

[234]168 Ind. App. at 435-37, 343 N.E.2d at 829-30.

[235]*Id.* at 438, 343 N.E.2d at 831.

[236]IND. CODE § 9-2-1-15 (1976) (emphasis added).

[237]168 Ind. App. at 439, 343 N.E.2d at 831.

[238]110 F.2d at 1006.

> In our opinion this particular law seeks to increase public protection in respect to motor vehicle operation. But the Indiana Law is not a general compulsory insurance law. It merely guarantees the ability of a selected group of drivers or owners to respond in damages for future accidents. In other words, the Indiana Financial Responsibility Law protects the victim against the automobile operator's second accident, and in this case it was the operator's first accident.[239]

In *Grimes* the Indiana Court of Appeals held that at the time of the accident Roberts was not required to maintain insurance to drive his car in Indiana and therefore State Farm did not have to pay the amount required under the Financial Responsibility Act.[240] The court went on to justify the holding on the basis that the Act was intended to operate in futuro.[241]

The interpretation in *Green*, as followed in *Grimes*, of the Indiana Financial Responsibility Act is probably correct. Financial responsibility laws are intended to require liability insurance as a condition of using the highways but only after the driver has been involved in an accident.[242] The purpose of these laws, though, is to protect the public and to provide a fund from which persons injured by negligent operation of automobiles may recover.[243] To the extent that victims of accidents with out-of-state motorists cannot be assured of this fund unless the driver has previously had an accident in Indiana, this purpose may possibly be thwarted.

2. "No Action" Clause.—In *American Underwriters Inc. v. Curtis*,[244] Curtis and other claimants were involved in an accident with Johnson. Johnson was insured by American Underwriters (AUI) under a policy issued pursuant to the Indiana Financial Responsibility Act.[245] The claimants sued and obtained a default judgment against Johnson in excess of $50,000. Proceedings supplemental were then brought against AUI to recover on the insurance policy.[246] The trial court held AUI liable for the $30,000 policy limit.[247] AUI appealed, raising two issues: (1) Is suit by the claimants against AUI

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[239] *Id.*
[240] 402 N.E.2d at 53.
[241] *Id.* at 54.
[242] 7 AM. JUR. 2d *Automobile Insurance* § 20 (1980).
[243] *Id.* § 22.
[244] 392 N.E.2d 516 (Ind. Ct. App. 1979).
[245] IND. CODE §§ 9-2-1-1 to -45 (1976 & Supp. 1980).
[246] 392 N.E.2d at 517-18.
[247] *Id.* at 518.

barred under the "no action" clause of the Financial Responsibility Act, because there was no final judgment after an actual trial? and (2) Is the action barred because of a failure to give notice to AUI of the suit against the insured?[248]

The "no action" clause of the Indiana Financial Responsibility Act states: "No action shall lie against the insurance carrier by or on behalf of any claimant under the policy until after final judgment has been obtained after *actual trial* by or on behalf of any claimant under the policy."[249] AUI contended that a default judgment falls short of an actual trial and that the claimants could not recover on the policy until they had established Johnson's liability in a contested trial. The court found the reasoning logical but was not convinced that the Act required a claimant to force the insured to answer a complaint and contest the action.[250] In any case, AUI failed to specifically plead this defense in its answer to the claimants' action or at a hearing on the matter. Because the matter was neither raised nor tried by implied consent, the issue was waived by AUI.[251] The court indicated its reluctance to permit an insurance company to wait until an adverse judgment was obtained before raising its defense.[252]

AUI also claimed that the act "impliedly required"[253] the claimants to give notice to AUI of their suit against Johnson. The court held, however, that "notice is neither contemplated nor required under the Financial Responsibility Act."[254] Liability becomes absolute whenever loss or damage covered by a policy occurs. The court refused to insert a notice requirement that was not intended by the legislature.[255]

The question remains whether the court would have set aside the default judgment and permitted the insurance company to defend on behalf of the insured in an actual trial against the plaintiff, had the company raised the lack of notice at the earliest possible moment. In all fairness, an insurance company should have the opportunity to raise policy defenses before becoming bound by a judgment. A requirement that the third party give notice to the insurance company when it brings suit against a party whom it knows to be insured would assure the company of every opportunity to defend.

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[248] *Id.*

[249] IND. CODE § 9-2-1-5(c) (Supp. 1980) (emphasis added).

[250] 392 N.E.2d at 518 n.2.

[251] *Id.* at 519.

[252] *Id.* at 519 n.4.

[253] *Id.* at 519.

[254] *Id.*

[255] *Id.*