

IX. Insurance

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Few, if any, of the cases during this survey period made significant changes in the body of Indiana insurance law. The cases that have been surveyed herein are the ones that, in this author's judgment, state a new holding or are noteworthy because they provide a practical example of how an insurance case should or should not be handled.¹

A. Arson Cases

During the 1982 survey period, the Indiana appellate courts decided three fire cases of significant interest. All three cases involved arson. Two of the three cases provide general guidelines that insurance companies may wish to observe in adjusting claims involving suspected arson, if they wish to avoid punitive damages in subsequent litigation over a denial of coverage. The third case deals with whether an in-

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¹There were other interesting insurance cases during the survey period that confirmed existing law. *See, e.g.*, *Siebert Oxidermo, Inc. v. Shields*, 430 N.E.2d 401 (Ind. Ct. App. 1982) (confirming general rule that the attorney retained by an insurance company to defend insured has the ethical duty to represent insured's interest only); *Wallace v. Indiana Ins. Co.*, 428 N.E.2d 1361 (Ind. Ct. App. 1981) (confirming rule that Indiana recognizes as valid those contract provisions that limit insured's time to sue the company on the policy); *Barmet of Indiana, Inc. v. Security Ins. Group*, 425 N.E.2d 201 (Ind. Ct. App. 1981) (confirming Indiana rules pertaining to construction to be given to ambiguous contract); *Protective Ins. Co. v. Coca-Cola Bottling Co.*, 423 N.E.2d 656 (Ind. Ct. App. 1981) (confirming and supplementing Indiana's rules pertaining to waiver and estoppel) (also contained an interesting discussion about a "Truckmen's Endorsement" to an automobile liability policy); *Town & County Mut. Ins. Co. v. Savage*, 421 N.E.2d 704 (Ind. Ct. App. 1981) (confirming rule that insurance agent has duty to use reasonable care in undertaking to supply insurance) (also established that an insured may get prejudgment interest from the company on disputed losses where the amount in dispute exceeds policy limits); *Aetna Casualty & Sur. Co. v. Dolson*, 421 N.E.2d 691 (Ind. Ct. App. 1981) (confirming rule that arbitration of an uninsured motorist claim can be waived by either party, if the party fails to request arbitration and litigates the matter before a court of competent jurisdiction); *Borgman v. Borgman*, 420 N.E.2d 1261 (Ind. Ct. App.), *reh'g granted*, June 24, 1981 (confirming life insurance rule that the insured can effectively change the beneficiary without completing every ministerial act involved if the insured did everything in his power to effect such change).

One additional case is of interest to insurance practitioners; however, it is discussed more extensively in the workers' compensation article. *See Baker v. American States Ins. Co.*, 428 N.E.2d 1342 (Ind. Ct. App. 1981) (stating that the exclusive remedy provision of the Indiana Workmen's Compensation Act did not bar an employee's lawsuit against the employer's insurance company where the insurer was sued for fraud and bad faith in negotiating the employee's compensation claim). *See also Coriden, Workers' Compensation, 1982 Survey of Recent Developments in Indiana Law*, 16 IND. L. REV. 433, 442 (1983).

sured can recover under a fire insurance policy when the fire damage has been caused by an act of arson committed by a fellow insured.

1. *Punitive Damages for Bad Faith Denial of Insured's Fire Claim.*—The two arson cases during the survey period that involved punitive damages were *Hoosier Insurance Co. v. Mangino*² and *Riverside Insurance Co. v. Pedigo*.³ In both cases, the appellate court noted that there was sufficient circumstantial evidence to support the company's denial of the insureds' fire claims on the basis of arson.⁴ However, in each case the jury had found for the insured. The two cases differ in that one company was assessed punitive damages, but the other was not.

In *Hoosier Insurance Co. v. Mangino*,⁵ the insurance company was confronted with a fire loss claim in which the circumstances surrounding the loss included several of the recognized indicators of arson.⁶ Among those indicators present were facts that suggested that the fire was of an incendiary origin, that the insureds had a meager income the year before the fire and the insured husband was unemployed at the time of the fire, that the significant personal property owned by the insureds had been paid for in cash, and that there were very few contents in the house at the time of the fire.

The fire in question occurred on December 22, 1976. By January 10, 1977, the insureds had provided Hoosier's adjuster with a signed and completed proof of loss statement wherein they sought recovery for the damage to the house, for the loss of personal property, and for the cost of living expenses. Hoosier responded on February 24, 1977, by denying liability and by declaring the policy of insurance void as to the Manginos.⁷ Hoosier based its denial of coverage upon a clause contained in the policy that provided:

"This entire policy shall be void if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto."⁸

²419 N.E.2d 978 (Ind. Ct. App. 1981).

³430 N.E.2d 796 (Ind. Ct. App. 1982).

⁴430 N.E.2d at 806-07; 419 N.E.2d at 987-88.

⁵419 N.E.2d 978 (Ind. Ct. App. 1981).

⁶For a general discussion regarding the type of evidence that may be admissible to prove arson in fire cases involving wilful destruction of property, see 19 G. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 79:561-:570 (2d ed. 1968 & Supp. 1981).

⁷419 N.E.2d at 980. In addition, Hoosier returned \$75 dollars of unearned premiums. *Id.*

⁸*Id.* at 990 (quoting Hoosier Insurance Company's Property Insurance Policy). The policy provision relied upon by Hoosier is one that is frequently relied upon by in-

Following Hoosier's denial of coverage, the Manginos filed suit for breach of contract; the Manginos sought, in addition to compensatory damages, punitive damages for Hoosier's alleged malicious denial of coverage. The jury awarded the Manginos both compensatory and punitive damages. On appeal, Hoosier sought only to overturn the punitive damages award.⁹ The Indiana Court of Appeals reversed the judgment awarding punitive damages because "[i]n view of all the evidence presented, the jury could not have reasonably concluded that elements of fraud, misrepresentation, malice, gross negligence, or oppression mingled in Hoosier's denial of Manginos' claim or in any other aspect of Hoosier's conduct."¹⁰

The plaintiffs had put forth several evidentiary facts in support of their contention that Hoosier's conduct was oppressive and therefore deserving of punishment.¹¹ None of this evidence was given any weight by the court. One piece of evidence, however, does deserve mention.

Prior to the time the adjuster representing Hoosier adjusted the claim, he required the Manginos to sign a "Non-Waiver Agreement". The non-waiver agreement stated, in essence, that Hoosier Insurance Company would not be deemed to have waived any of its policy conditions simply by an act of investigating the claim.¹² The court accepted Hoosier's explanation that obtaining a non-waiver agreement was a routine matter in adjusting an insurance claim, and found that requiring the non-waiver agreement did not amount to misconduct.¹³

The main legal proposition to be gleaned from the *Hoosier* case is that insurance companies have a "right to disagree" with their insureds about the existence of coverage, as long as they are doing so in good faith.¹⁴ The court stated that, in the context of an insurance contract action, a company is acting in bad faith if it has no legitimate reason for denying the insured's claim but, nevertheless, does deny

insurance companies to deny fire claims in which arson is suspected. It is sometimes referred to as the "false swearing" provision. See 14 G. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 49:551-:563 (2d ed. 1965 & Supp. 1981). An insurance company may also deny coverage because of arson even if the policy does not contain a specific exclusion for arson. Fire insurance policies are said to contain an "implied exception" that prevents an insured from recovering for a loss he has intentionally or fraudulently caused. See R. KEETON, BASIC TEXT ON INSURANCE LAW § 5.3(a) (1971) *cited with approval in American Economy Ins. Co. v. Liggett*, 426 N.E.2d 136, 141 (Ind. Ct. App. 1981).

⁹419 N.E.2d at 980.

¹⁰*Id.* at 991.

¹¹*Id.* at 988-91.

¹²*Id.* at 988-89 & n.2.

¹³*Id.* at 989.

¹⁴*Id.* at 982-83 (citing *Vernon Fire & Casualty Ins. Co. v. Sharp*, 264 Ind. 599, 609-10, 349 N.E.2d 173, 181 (1976)).

the claim.¹⁵ Here, although Hoosier may have lost the disagreement with its insured, it was not penalized for disagreeing.

Lawyers representing insurance companies or aggrieved insureds may refer to the *Hoosier* case for guidelines on how an insurance company should adjust a claim for suspected arson. The *Hoosier* case may be particularly helpful when it is contrasted with the unsuccessful adjusting procedures followed in *Riverside Insurance Co. v. Pedigo*.¹⁶

The facts in *Riverside* pertaining to the question of arson are very similar to those in *Mangino*. In *Riverside*, there was evidence that the fire was incendiary in origin, that the closets in the house were empty, and that the insureds were experiencing financial difficulty at the time of the fire. As in *Mangino*, the appellate court found that there was sufficient evidence to support Riverside's arson defense had the jury chosen to accept it.¹⁷ However, the jury had not accepted it. The jury had returned a verdict against Riverside on the arson defense and had assessed a sizeable punitive damages award, which the appellate court did not reverse.

The key to the opposite results regarding punitive damages in *Mangino* and *Riverside* is the difference in which the two companies adjusted the fire loss claims. In *Mangino*, the loss was adjusted and the claim was denied in a period of approximately two months. The denial of coverage was firm and was based upon a policy condition. By contrast, in *Riverside*, although the insurance company began an arson investigation almost immediately after receiving the insureds' claim, the insureds were never notified of the company's arson suspicion. Instead, Riverside repeatedly turned down the insureds' claim because of alleged technical deficiencies with the proof of loss statements the insureds had submitted to the company. Six months after the fire, Riverside was still denying the claim because of technical problems.

In upholding the punitive damages award, the court of appeals found that Riverside had abused its "right to disagree."¹⁸ The court emphasized that the delay caused by Riverside's misrepresentations and concealment "arguably prejudiced [the insureds'] ability to prove their innocence."¹⁹ Riverside knew as soon as one month after the fire that it would deny the claim on the basis of arson.²⁰ The court found

¹⁵419 N.E.2d at 983 (citing *Rex Ins. Co. v. Baldwin*, 163 Ind. App. 308, 313-14, 323 N.E.2d 270, 274 (1975)).

¹⁶430 N.E.2d 796 (Ind. Ct. App. 1982).

¹⁷*Id.* at 806-07.

¹⁸*Id.* at 808 (citing *Vernon Fire & Casualty Ins. Co. v. Sharp*, 264 Ind. 599, 349 N.E.2d 173 (1976) and *Hoosier Ins. Co. v. Mangino*, 419 N.E.2d 978 (Ind. Ct. App. 1981)).

¹⁹430 N.E.2d at 808.

²⁰*Id.*

that the public interest would be served by allowing punitive damages because it might deter similar dilatory conduct in the future.²¹

It is apparent from a comparison of *Hoosier* and *Riverside* that if Indiana insurance companies wish to safely exercise their "right to disagree" in the case of a suspected arson claim, they must investigate as quickly as possible and they must be straightforward with their insureds. If a *thorough* early investigation points to arson, it would probably be best for the company to deny coverage on that basis and to bring the coverage question to a head without delay. Later, if the facts point away from arson, then the claim can be settled without the company's exposure to punitive damages. It is a company's unjustified delay in making its position known to the insured that exposes the company to punitive damages. When the delay is coupled with misrepresentation, then punitive damages are truly a threat, and the company's ability to prevail upon its arson defense is prejudiced by the loss of credibility that flows from the delay and misrepresentation.

2. *Validity of Claim by One Named Insured When Arson is Committed by Other Named Insured.*—In *American Economy Insurance Co. v. Liggett*,²² the Indiana Court of Appeals was faced with a case of first impression. The plaintiff and her late husband had been the named insureds on a homeowner's policy issued by American Economy. The insured property was damaged in a fire in which the plaintiff's husband died. The company conceded that the plaintiff was innocent of wrongdoing but alleged that the fire had been deliberately set by the husband.²³ The plaintiff's claim under the policy was denied because the company contended that her proof of loss statement violated the false swearing provision of the policy.²⁴

The true underlying issue in this case, however, was not whether the false swearing provision of the policy was applicable. The court immediately pointed out that the provision was not applicable, because the insurance company had stipulated that the plaintiff had neither participated in nor had any knowledge of the arson.²⁵ Rather, the true issue was whether Indiana would adopt the established general rule "that where one of two or more insureds intentionally caused the loss to the insured property, the remaining insureds, although entirely innocent of any wrongdoing, could not recover."²⁶

In discussing what Indiana would do in this situation, the court

²¹*Id.* at 804.

²²426 N.E.2d 136 (Ind. Ct. App. 1981).

²³*Id.* at 137-38.

²⁴*Id.* at 138. For an explanation of the false swearing provision, see *supra* note 8.

²⁵426 N.E.2d at 139.

²⁶*Id.* at 138.

began by pointing out that the established general rule had been seriously eroded.²⁷ Recent cases have taken the position that the rights of named insureds under a fire policy are several, not joint, and that the individual insured who is free of wrongdoing should reasonably expect that his coverage would not be jeopardized by a fellow insured's intentional acts, unless the policy specifically excluded coverage under those circumstances.²⁸

The court noted that in spite of the erosion in the general rule, some jurisdictions have continued to follow the rule when the insureds were husband and wife.²⁹ These courts gave either one or both of two reasons for following the rule. One reason given was that because married couples have long been regarded by many states as one legal entity, their rights and obligations under an insurance policy were considered to be joint and not several.³⁰ The second reason given was that the courts found it impossible to identify the interest of the innocent spouse and thus preferred to deny recovery completely.³¹ This second reason applied when the husband and wife held the insured property as tenants by the entireties.

The Indiana court in *American Economy* refused to apply the established rule to situations involving married couples, rejecting both of these reasons. The court discounted the "one legal entity" rationale by stating that:

Western civilization is based upon the premise of individual responsibility for wrongdoing. We do not impose vicarious liability for torts (including fraud) on our spouses just because of the marital relationship. More appropriately, since arson is a crime, we do not impose vicarious liability for criminal conduct upon those who are totally innocent whether they are married to the criminal or not.³²

²⁷*Id.* at 139 (citing *Hoyt v. New Hampshire Fire Ins. Co.*, 92 N.H. 242, 29 A.2d 121 (1942)).

²⁸426 N.E.2d at 139.

²⁹*Id.* See generally *Kosior v. Continental Ins. Co.*, 299 Mass. 601, 13 N.E.2d 423 (1938); *Matyuf v. Phoenix Ins. Co.*, 27 Pa. D.&C.2d 351 (1933); *Jones v. Fidelity & Guar. Ins. Corp.*, 250 S.W.2d 281 (Tex. Civ. App. 1952); *Cooperative Fire Ins. Assoc. v. Domina*, 137 Vt. 3, 399 A.2d 502 (1979); *Rockingham Mut. Ins. Co. v. Hummel*, 219 Va. 803, 250 S.E.2d 774 (1979); *Klemens v. Badger Mut. Ins. Co.*, 8 Wis. 2d 565, 99 N.W.2d 865 (1959); *Annot.*, 24 A.L.R.3d 450, 452-53 (1969).

³⁰426 N.E.2d at 139 (citing *Rockingham Mut. Ins. Co. v. Hummel*, 219 Va. 803, 806, 250 S.E.2d 774, 776 (1979)).

³¹426 N.E.2d at 139 (citing *Cooperative Fire Ins. Assoc. v. Domina*, 137 Vt. 3, 399 A.2d 502 (1979)). See also *Matyuf v. Phoenix Ins. Co.*, 27 Pa. D.& C.2d 351 (1933). *But see* *Morgan v. Cincinnati Ins. Co.*, 411 Mich. 267, 307 N.W.2d 531 (1981); *Lovell v. Rowan Mut. Fire Ins. Co.*, 302 N.C. 150, 274 S.E.2d 170 (1981).

³²426 N.E.2d at 140.

In rejecting the impossibility reasoning, the court noted that because entireties property is easily divisible in divorce and other similar situations, a trial court should have no difficulty in dividing marital property in situations like the one at bar.³³ The court also pointed out that the entireties distinction was meaningless in the present case, because, with the husband dead, the plaintiff owned all of the property as a survivor.³⁴

In rejecting the traditional reasons for denying coverage, the court referred to what it termed as the “right reasons” for possibly denying coverage in other cases. The court suggested that one reason to deny coverage would be to prevent a guilty person from profiting directly or indirectly from his wrongdoing.³⁵ To deny recovery for this reason, a court would have to conduct a case by case analysis of the facts to determine whether one guilty spouse would benefit if the other recovered.³⁶

A second reason for denying coverage in similar cases is to honor what the court referred to as the “implied exception” to coverage. In essence, the implied exception is that insurance policies do not insure against losses that are not fortuitous from the standpoint of the person who is to benefit from the coverage³⁷—usually the insured. If the loss is caused intentionally by the person who will benefit from it, then coverage will be denied, even if the policy is silent on the question of losses that are not fortuitous. This implied exception is based both upon the specific expectation the insured should have that his policy will not cover losses that are not fortuitous and upon public policies against fraud on insurance companies, profit from wrongdoing, and crime in general.³⁸

The court found that the implied exception did not apply in the present case because none of the policy considerations would be served by applying it.³⁹ Further, the fact that the loss in *American Economy* was allegedly caused by the plaintiff’s husband did not make the loss nonfortuitous as to the plaintiff.⁴⁰

³³*Id.*

³⁴*Id.*

³⁵*Id.*

³⁶*Id.* The court also noted that this reason did not apply in the present case because the guilty party was dead.

³⁷*Id.* at 141 (citing R. KEETON, BASIC TEXT ON INSURANCE LAW § 5.3(a) (1971)). As a legal matter, fortuitousness is to be viewed from the standpoint of the person making the claim. That person may be an insured or merely a beneficiary of the policy. 426 N.E.2d at 142.

³⁸426 N.E.2d at 141 (citing R. KEETON, BASIC TEXT ON INSURANCE LAW § 5.3(a) (1971)).

³⁹426 N.E.2d at 141.

⁴⁰*Id.* at 142.

The court went much further than it needed to in deciding this case.⁴¹ The fact that the alleged wrongdoer died makes the final result much easier to reach and probably limits the holding to the facts of the case.⁴² When the wrongdoer spouse survives, the court will have to review the situation to determine whether any of the "right reasons" for denying coverage exist.

Interestingly, the court provided a means by which insurance companies may, in the future, avoid a controversy as occurred in *American Economy*. The court suggested that the companies could make the policy clear and unambiguous by placing the following legend across the front of the policy in red ink:

IF YOU OR ANY PERSON INSURED BY THIS POLICY
DELIBERATELY CAUSES A LOSS TO PROPERTY
INSURED THEN THIS POLICY IS VOID AND WE WILL
NOT REIMBURSE YOU OR ANYONE ELSE FOR THAT
LOSS.⁴³

To predict whether such a clause would be binding in the face of the standard challenge that insurance policies are adhesion contracts would be speculative. However, insurance companies may wish to incorporate such a clause in their policies if they have not done so already. The use of such a clause would certainly make a denial of coverage by a company much clearer than a denial under existing false swearing clauses.

B. Automobile Cases

1. *Cancellation vs. Nonrenewal—Duty of Insurer to Give Notice to Insured.*—In *American Family Mutual Insurance Co. v. Ramsey*,⁴⁴ the court of appeals was called upon to distinguish between the cancellation of an insurance policy and the nonrenewal of a policy for the purpose of determining whether notice to the insured was required under the circumstances.

⁴¹See *id.* at 145 (Staton, J., concurring).

⁴²The court noted that only one other reported case, *Howell v. Ohio Casualty Ins. Co.*, 124 N.J. Super. 414, 307 A.2d 142 (Law Div. 1973), *modified*, 130 N.J. Super. 350, 327 A.2d 240 (App. Div. 1974), is "on all fours" with the present case. 426 N.E.2d at 143. The court also extensively cited less similar cases involving husbands and wives as fellow insureds. See *Hosey v. Seibels Bruce Group, S.C. Ins. Co.*, 363 So. 2d 751 (Ala. 1978); *Steigler v. Insurance Co. of N. Am.*, 384 A.2d 398 (Del. 1978); *Auto Owners Ins. Co. v. Edinger*, 366 So. 2d 123 (Fla. Dist. Ct. App. 1979); *Economy Fire & Casualty Co. v. Warren*, 71 Ill. App. 3d 625, 390 N.E.2d 361 (1979); *Hildebrand v. Holyoke Mut. Fire Ins. Co.*, 386 A.2d 329 (Me. 1978); *Simon v. Security Ins. Co.*, 390 Mich. 72, 210 N.W.2d 322 (1973); *Winter v. Aetna Casualty & Sur. Co.*, 96 Misc. 2d 497, 409 N.Y.S.2d 85 (1978).

⁴³426 N.E.2d at 141.

⁴⁴425 N.E.2d 243 (Ind. Ct. App. 1981).

The plaintiff originally procured an automobile policy with American Family on December 4, 1976. The policy contained the following language with respect to renewal: “[T]he renewal of this policy may be refused by the named insured by refusing to pay the renewal premium when due; in which event the policy shall terminate at the end of the last policy period for which premium was paid.”⁴⁵ The policy also stated that no notice of nonrenewal would be required “if the named insured fails to discharge when due any of his obligation in connection with the payment of the renewal premium.”⁴⁶

The last policy period for the insured’s policy ended on June 4, 1979. Sometime in May 1979, the company sent the insured a premium notice indicating that the premium was due “on or before June 4, 1979” in order for the insurance to continue. The notice also declared that payment would be considered to have been made when it was received by the company and not when it was mailed. Prior to this time, the insured had regularly renewed the policy. This time, however, the insured failed to pay his premium.

Approximately two weeks after the last policy period ended, Ramsey was in an automobile accident. When Ramsey submitted a claim to the company, the company denied coverage and Ramsey filed suit for breach of contract. The issue raised was whether the company had an obligation to give notice that the policy had not continued in effect after the June 4, 1979 date.⁴⁷

The court first looked to the Indiana statutes that pertain to the notice required to be given by an insurer to the insured, if a policy is cancelled or not renewed.⁴⁸ The court pointed out that although the term “renewal” is defined in the statutes, the term “cancellation” is not.⁴⁹ “Renewal” is defined as

“the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer insuring the same insured, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term”⁵⁰

Relying upon the statutory definition for renewal, the court distinguished the term “cancellation” from the term “nonrenewal” by saying that “the term ‘cancellation’ refers to the termination of a policy prior to the end of the policy period, whereas a ‘non-renewal’ is the

⁴⁵*Id.* at 243 (quoting insurance policy).

⁴⁶*Id.* (quoting insurance policy).

⁴⁷*Id.* at 244.

⁴⁸*Id.* (citing IND. CODE §§ 27-7-6-1 to -6 (1976)).

⁴⁹425 N.E.2d at 244.

⁵⁰*Id.* (quoting IND. CODE § 27-7-6-3 (1976)).

nonissuance or nondelivery of a new policy at the end of the previous policy period."⁵¹

The court found that the occurrence at issue was a nonrenewal not a cancellation and, thus, the cancellation notice statute did not apply.⁵² In fact, the court pointed out that the cancellation statute specifically states that "[t]his section shall not apply to non-renewals."⁵³ The court then went on to review the renewal notice statute, which provides:

"No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least twenty [20] days' advance notice of its intention not to renew. In the event such policy was procured by an agent duly licensed by the state of Indiana notice of intent not to renew shall be mailed or delivered to such agent at least ten [10] days prior to such mailing or delivery to the named insured unless such notice of intent is or has been waived in writing by such agent.

This section shall not apply: (a) if the insurer has manifested its willingness to renew nor (b) *in case of nonpayment of premium:* Provided, That, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies."⁵⁴

The court found that because the insured had failed to pay his premium, his policy had lapsed at the time of the accident and the company was not required to give notice to the insured that coverage had terminated.⁵⁵

Now that the court of appeals has defined the term "cancellation" and distinguished it from the term "nonrenewal," controversies of this nature should not arise in the future because any existing ambiguity has been cleared up.

2. *Duty to Defend Insured—Notice of Suit to Company.*—In *F & F Construction Co. v. Royal Globe Insurance Co.*,⁵⁶ the insured sued Royal Globe, its insurance company, for breach of the insurance company's duty to defend. Royal Globe contended that it had not received notice of the lawsuit against the insured, and the court agreed.⁵⁷

⁵¹425 N.E.2d at 244.

⁵²*Id.*

⁵³*Id.* at 244 n.2 (quoting IND. CODE § 27-7-6-5 (1976)).

⁵⁴425 N.E.2d at 244 (quoting IND. CODE § 27-7-6-6 (1976)) (emphasis added by court).

⁵⁵425 N.E.2d at 244.

⁵⁶423 N.E.2d 654 (Ind. Ct. App. 1981). For a discussion of the evidentiary aspects of this case, see Karlson, *Evidence, 1982 Survey of Recent Developments in Indiana Law*, 16 IND. L. REV. 191, 199 (1983).

⁵⁷423 N.E.2d at 656.

The case arose when an employee of F & F Construction was involved in an automobile accident with a third party. Before any suit was filed, an attorney representing the third party apparently contacted F & F Construction. Through F & F Construction, Royal Globe became involved in the case, at least to the extent of discussing the claim with the third party's attorney. Thereafter, suit was filed against F & F Construction and the proper papers were served upon F & F Construction's company president. The president turned the papers over to his office manager and asked that they be forwarded to the insurance company. Following that event, the route taken by the papers is uncertain; however, Royal Globe did not receive the papers and a default judgment was entered against F & F Construction. In the suit by F & F Construction against Royal Globe for failure to defend, Royal Globe defended itself on the basis that F & F Construction had failed to meet a condition precedent that required F & F Construction to " 'immediately forward to the company every demand, notice, summons or other process received by [it].' " ⁵⁸

There are two points of interest to be gleaned from this case. First, the court described the quantum of proof necessary for an insured to prove that a summons has been forwarded to the company. The court said that "[n]ormal office procedure in preparing and dispatching outgoing mail is not sufficient to prove mailing, instead, proof consisting of testimony from one with direct and actual knowledge of the particular message in question is required to establish proof of mailing." ⁵⁹

The second, and most significant point of the case is that the court held that the notice Royal Globe had received of the third party's claim was not sufficient actual or constructive notice of the pending litigation. ⁶⁰ The court's holding on this point may imply that the court does not recognize any continuing duty on the part of an insurance company to monitor the progress of a claim against an insured, even though the company has notice of the claim's existence. The result certainly would have been different if the attorney representing the third party had informed the insurer of the suit being filed. Almost any notice to the company of the commencement of litigation, be it oral or written, would probably have been enough here to implicate the company's duty to defend. ⁶¹

⁵⁸*Id.* (quoting insurance policy).

⁵⁹*Id.* at 656 (citing *United Farm Bureau Mut. Ins. Co. v. Adams*, 145 Ind. App. 516, 251 N.E.2d 696 (1969)).

⁶⁰*See* 423 N.E.2d at 656.

⁶¹If a company receives notice of litigation from a source other than its insured, it may be hard pressed to rely on the breach of a contractual provision to avoid coverage. For example, in order for a company to avoid coverage because of its insured's failure to cooperate, the company must show that it was actually prejudiced

Arguably, however, unless a claim has been turned over to an insurance company prior to the commencement of litigation, an insurer may not have a duty to immediately defend the insured merely because it has learned of the existence of litigation against the insured. The insured has a right not to invoke his insurance coverage, if he so chooses. As a practical matter though, few insured persons ignore the coverage for which they have paid.

3. *Waiver and Estoppel—Waiver of Insurer's Right to Subrogation.*—In *National Mutual Insurance Co. v. Fincher*,⁶² the insured was permitted to recover under the medical expense coverage of his automobile policy, notwithstanding the fact that he had previously destroyed the insurer's subrogation rights by settling with the third-party tortfeasor. The court found that the insurance company, National, had either waived its subrogation rights or was estopped from asserting them because the company had failed to pay the insured's legitimate claim for over a year, had induced the insured to settle with the third party for less than the full value of his claim, and had arbitrarily denied a portion of the insured's claim without justification.⁶³

This case arose when the insured was involved in an accident with an uninsured motorist. At the time of the collision, the insured had coverage for medical expenses, loss of income, and uninsured motorist coverage.⁶⁴ The insured initially brought suit against the uninsured motorist. While that suit was pending, the insured filed a claim with National for medical expenses and lost wages. When National failed to pay the claim, the insured joined National as an additional defendant in the lawsuit. Subsequently, the insured received an offer to settle with the third party for less than the full value of his claim. When National was informed of the settlement offer, its attorney advised the insured to accept the settlement. In addition, National's attorney advised the insured of the company's subrogation rights and informed the insured that acceptance of the settlement would constitute a waiver of the insured's medical expense claim under the policy.⁶⁵ The insured accepted the settlement and gave the third party a covenant

in conducting a defense. *Motorists Mut. Ins. Co. v. Johnson*, 139 Ind. App. 622, 631, 218 N.E.2d 712, 717 (1966). In the context of the insured's failure to give notice, actual prejudice to the company need not be shown. *Muncie Banking Co. v. American Sur. Co.*, 200 F.2d 115, 118-20 (7th Cir. 1952). The emphasis is on providing the company with adequate time to protect its interests. *Id.* Thus, if the company has notice of litigation from another source, it can protect its interest and should not be permitted to deny coverage if the insured's failure to give notice is excusable.

⁶²428 N.E.2d 1386 (Ind. Ct. App. 1981).

⁶³*Id.* at 1391.

⁶⁴*Id.* at 1387.

⁶⁵*Id.* at 1388.

not to sue. The insured continued to pursue his action for medical expenses and lost wages against National and ultimately received a judgment for medical expenses.⁶⁶

On appeal, National urged the court to reverse the judgment on the theory that the insured could not collect against the company once the insured had recovered from a third party and had given the third party a covenant not to sue. National argued that the insured had compromised the company's subrogation rights and, therefore, had breached the policy requirement that "[i]n the event of any payment under this insurance . . . [the insured] shall do nothing after loss to prejudice such [subrogation] rights."⁶⁷

In response to National's position, the court acknowledged the general rule that if an insured settles with a wrongdoer, he is barred from any action on the insurance policy.⁶⁸ The rationale behind this rule is that the release of the tortfeasor destroys the insurance company's subrogation rights under the policy, because the company's rights against the wrongdoer are identical to those of the insured.⁶⁹ In spite of the above-mentioned rule, however, the court found that National was prevented from asserting the rule's application because National had induced the insured to settle with the third party.⁷⁰

The court recognized three situations in which an insurer may be held to have waived its subrogation rights or is estopped to assert them: "[W]aiver or estoppel by the insurer in this regard may consist of a direct suggestion of settlement, an unreasonable delay in satisfying its obligation under the policy, or an arbitrary denial of a claim."⁷¹ In the present case, the court found that the insurer had done all three.⁷² Thus, a waiver or estoppel was an appropriate conclusion.

This case is indicative of the confusion that exists among laymen, attorneys, and insurance companies about the nature of subrogation. Many laymen would prefer to recover a small loss directly from a wrongdoer because they fear a rise in their insurance rates if they make a claim with their insurance company. However, collection directly from the wrongdoer is less certain and frequently takes longer to accomplish. Thus, the insured is put in a position in which he makes claims in both directions, as in the present case. In this situation, the insured or his attorney would be well advised to consult the insurance

⁶⁶*Id.*

⁶⁷*Id.* at 1389 n.6 (quoting insurance policy).

⁶⁸*Id.* at 1389 (citing *Hockelberg v. Farm Bureau Ins. Co.*, 407 N.E.2d 1160 (Ind. Ct. App. 1980)).

⁶⁹428 N.E.2d at 1389.

⁷⁰*Id.* at 1391.

⁷¹*Id.* at 1390 (citing numerous other jurisdictions).

⁷²*Id.* at 1391.

company and determine exactly what the company's position will be. The insured may discover that it would be cheaper for him to get his money from the company and let the company bear the expense of pursuing the wrongdoer. Obviously, a person should not carry collision, comprehensive, medical expense, or loss of income insurance if his fear of increased premiums is going to deter him from making a claim.

C. *General Liability Cases*

1. *Homeowner's Insurance—Business Pursuits Exception.*—In *Economy Fire & Casualty Co. v. Beeman*,⁷³ the insured was an electrician who was called to a fast food restaurant to repair an electrical appliance. While the insured was at the restaurant, he picked up or moved an employee of the restaurant who was standing in front of the appliance to be repaired. As an alleged result of the contact made by the insured, the employee was injured. This case presented to the Court of Appeals for the Seventh Circuit the issue whether the insured's conduct was covered by the personal liability coverage of an insured's homeowner's insurance policy issued by Economy.⁷⁴

The personal liability coverage of the policy in question contained an exclusion that denied coverage for losses "arising out of business pursuits of any Insured except activities therein which are ordinarily incident to non-business pursuits."⁷⁵ The injured employee argued that the insured's act of moving her was an act ordinarily incident to non-business pursuits. She contended that the court should analyze the insured's conduct by determining whether the conduct at the moment of the injury was "necessary to the business pursuit."⁷⁶

The court rejected the employee's analysis stating that "[t]o the contrary, numerous cases have held activities resulting in injury to be incident to business pursuits, even though the actions in question were not strictly necessary, and in most events, were counterproductive to carrying out the business activities."⁷⁷ The court affirmed the trial court's finding that no coverage existed because the injury was caused while the insured was engaged in a business pursuit.⁷⁸

Unfortunately, the court gave no standard by which to analyze future cases. The ruling is based upon comparisons that the court made with similar holdings in other jurisdictions.⁷⁹ The lack of analytical

⁷³656 F.2d 269 (7th Cir. 1981).

⁷⁴*Id.* at 270.

⁷⁵*Id.* (quoting insurance policy).

⁷⁶*Id.* at 271.

⁷⁷*Id.*

⁷⁸*Id.* at 272.

⁷⁹*Id.* at 271 (citing *Stanley v. American Fire & Casualty Co.*, 361 So. 2d 1030 (Ala. 1978); *Neil v. Celina Mut. Ins. Co.*, 522 S.W.2d 179 (Ky. Ct. App. 1975); *Pitre v. Penn-*

framework is particularly distressing in view of the court's comment earlier in the case that "[e]xclusionary clauses for business pursuits in homeowners' policies have spawned frequent litigation over the precise issue disputed here—whether a particular momentary act occurring within an overall business context is incident to the business pursuit or ordinarily incident to a nonbusiness pursuit."⁸⁰ The question presented by this case is probably not susceptible to easy analysis, yet *Economy* does not give any guidelines for the trier of fact to follow in such future cases, unless the factual setting is on all fours with prior precedent.

2. *Professional Liability Policy.*—In *Drake Insurance Co. v. Carroll County Sheriff's Department*,⁸¹ the insurance company sought a declaratory judgment to determine the extent of its duty to defend under a professional liability policy held by the county sheriff's department. In an earlier action, the administratrix and widow of a former prisoner had filed suit against the sheriff's department, alleging negligent supervision of the prisoner who had committed suicide while incarcerated in the Carroll County jail.⁸²

At the time of the prisoner's death, the sheriff's department had a professional liability insurance policy through Drake. The policy contained specific coverage for "Personal Injury" and separate coverage for "Bodily Injury."⁸³ Under both coverages, the insurance company had the right and the duty to defend the insured. The policy stated specifically that it did not apply "to bodily injury to any person occurring while such person is in the custody of the insured or any municipal, state or federal authority."⁸⁴ The company utilized this exclusion to deny coverage and brought the present case as a declaratory judgment action to determine whether it had a duty to defend.

The Indiana Court of Appeals found that coverage did exist. In arriving at its ruling, the court analyzed the definitions contained in the policy for the term "Bodily Injury" and the term "Personal Injury." "Bodily Injury" was restricted to injuries that occurred during the course of an arrest.⁸⁵ "Personal Injury," on the other hand, referred

sylvania Millers Mut. Ins. Co., 236 So. 2d 920 (La. Ct. App. 1970); *Berry v. Aetna Casualty & Sur. Co.*, 221 So. 2d 272 (La. Ct. App. 1969); *Dieckman v. Moran*, 414 S.W.2d 320 (Mo. 1967); *North River Ins. Co. v. Poos*, 553 S.W.2d 500 (Mo. Ct. App. 1977); *Martinelli v. Security Ins. Co.*, 490 S.W.2d 427 (Mo. Ct. App. 1972); *Wiley v. Travelers Ins. Co.*, 534 P.2d 1293 (Okla. 1974); *Davis v. Frederick's, Inc.*, 30 Utah 2d 321, 517 P.2d 1014 (1973).

⁸⁰656 F.2d at 271.

⁸¹427 N.E.2d 1153 (Ind. Ct. App. 1981).

⁸²*Id.* at 1154.

⁸³*Id.*

⁸⁴*Id.*

⁸⁵*Id.* at 1155.

to such intrusions as "false arrest, erroneous service of civil papers, false imprisonment, malicious prosecution, libel, slander, defamation of character, [and] violation of property rights" ⁸⁶

The court found that the "Bodily Injury" coverage was not involved because the suicide occurred a day after the decedent was arrested.⁸⁷ The exclusion provision would also result in no coverage.⁸⁸ The court next looked to determine whether coverage could fall within the "Personal Injury" coverage. The only possible application could be for "violation of property rights." In order for the court to find coverage under the property rights concept, it had to look to Indiana's Wrongful Death Act.⁸⁹

In reviewing the Wrongful Death Act, the court pointed out that the Act provides recovery to the decedent's estate for the pecuniary loss caused by the death.⁹⁰ The court also noted that "[t]he right to sue emanates from the tortious act causing death, rather than from the person of the deceased."⁹¹ Thus, the suit by the administratrix against the sheriff's department was in the nature of protection of a property interest. The court found such a holding to be consistent with other Indiana cases, which had held wrongful death cases to be partly based on injury to property.⁹² However, the court held that coverage was owed only for the pecuniary loss occasioned by the death and not for those losses associated with the injury to the body of the decedent, such as medical expenses, funeral bills, etc.⁹³

The *Drake* court's legal reasoning is sound; however, the scope of coverage defined by the court is probably broader than originally intended by either party to the contract. The insurance company's attempt in the policy to exclude jailhouse injuries was obviously inadequate, but the attempted exclusion does demonstrate the company's intent not to cover such a loss. It is also doubtful that the sheriff's department had actual reasonable expectations that this type of loss would be covered, in light of the language of the exclusion provision. The court avoided the temptation to find the policy in question to

⁸⁶*Id.* (quoting from insurance policy) (emphasis added by court).

⁸⁷*Id.* at 1155.

⁸⁸*Id.*

⁸⁹*Id.* at 1155 n.1 (citing IND. CODE § 34-1-1-2 (1976)).

⁹⁰427 N.E.2d at 1155-56.

⁹¹*Id.* at 1156 (citing *In re Estate of Pickens*, 255 Ind. 119, 127, 263 N.E.2d 151, 156 (1970)).

⁹²427 N.E.2d at 1156 (citing *Graf v. City Transit Co.*, 220 Ind. 249, 41 N.E.2d 941 (1942); *Thompson v. Town of Fort Branch*, 204 Ind. 152, 178 N.E. 440 (1931); *Rush v. Leiter*, 149 Ind. App. 274, 271 N.E.2d 505 (1971); *Hahn v. Moore*, 127 Ind. App. 149, 133 N.E.2d 900 (1956); *Merritt v. Economy Dep't Store*, 125 Ind. App. 560, 128 N.E.2d 279 (1955)).

⁹³427 N.E.2d at 1156.

be ambiguous;⁹⁴ however, the court would have been justified in finding the policy to be confusing and misleading.

D. Life Insurance Cases

In *Cook v. Equitable Life Assurance Society of the United States*,⁹⁵ the plaintiffs' decedent bought a life insurance policy in 1953 that named his wife at the time as beneficiary. By 1965, the decedent had divorced his first wife and remarried. After the divorce, the decedent stopped paying on the policy and it was converted from whole life to a paid-up term policy with coverage through 1986.⁹⁶ In 1976, the decedent made a holographic will in which he bequeathed the life insurance policy to his second wife and to a son by his second marriage. After the decedent died in 1979, the second wife made a claim for the benefits of the policy. The insurance company brought an interpleader action in the estate proceedings to determine who should receive the benefits of the policy.⁹⁷

The policy in question required that a change of beneficiary could only be made "by written notice to the Society" before the death of the insured.⁹⁸ Because the beneficiary had not been changed as required by the policy, the court of appeals held that the proceeds of the policy should go to the first wife who had been named as beneficiary.⁹⁹

The general rule that a change of beneficiary can only be effected through strict compliance with the policy requirements was established in Indiana by the 1887 case of *Holland v. Taylor*.¹⁰⁰ The court in *Cook* noted, however, that Indiana has recognized three exceptions to the general rule.¹⁰¹ First, strict compliance may not be necessary if the company has waived its own requirements. Second, strict compliance may not be required if it is beyond the insured's power to comply with the policy requirements. Finally, a change of beneficiary may be allowed without strict compliance if the insured has done everything within his power to accomplish the change but has been thwarted by death before the change was complete.¹⁰²

The court pointed out that all parties concerned benefit from the

⁹⁴See *id.* at 1155.

⁹⁵428 N.E.2d 110 (Ind. Ct. App. 1981).

⁹⁶*Id.* at 111-12.

⁹⁷*Id.* at 112.

⁹⁸*Id.* at 111.

⁹⁹*Id.* at 113.

¹⁰⁰111 Ind. 121, 12 N.E. 116 (1887).

¹⁰¹428 N.E.2d at 114 (citing *Heinzman v. Whiteman*, 81 Ind. App. 29, 139 N.E. 329 (1923); *Modern Bhd. v. Matkovich*, 56 Ind. App. 8, 104 N.E. 795 (1914)).

¹⁰²428 N.E.2d at 114.

rule requiring strict compliance with policy terms.¹⁰³ Obviously, the company benefits from having a certain beneficiary because the company is free to pay the policy proceeds without later being subjected to claims of which it had no prior notice or knowledge.¹⁰⁴ The insured benefits because he can rely upon having the proceeds of the insurance paid to the person he has designated.¹⁰⁵ Further, the beneficiary benefits because the payments will be more prompt if the insurance company does not have to wait until the decedent's will has been probated before it can safely make the payments.¹⁰⁶

Although the result of this case is harsh, the court's reasoning is sound. The court itself pointed out that bad law is made when courts try to use their equitable powers to achieve a good result despite applicable settled law.¹⁰⁷ The result may have been harsh under the circumstances, but it does allow for certainty and predictability in one area of Indiana law.

E. Statutory Developments

1. *Financial Responsibility of Motor Vehicle Owners and Operators.*—During the 102d Indiana General Assembly's term, the legislature made several changes that are of interest to insurance companies and insurance practitioners.¹⁰⁸ The most important addition to the financial responsibility laws was the new requirement that proof of financial responsibility must be shown at the time an application for registration of a motor vehicle is made.¹⁰⁹ A second important financial responsibility amendment came in the area of enforcement. As of January 1, 1983, persons who fail to prove financial responsibility will be committing a Class C misdemeanor.¹¹⁰ A third amendment increased the minimum limits of financial responsibility from \$15,000/\$30,000 to \$25,000/\$50,000 as of June 1, 1983.¹¹¹

¹⁰³*Id.* The majority of jurisdictions have ruled under similar circumstances that attempts by a will to change a life insurance beneficiary will not, without more, be sufficient to effect a change. For a listing of these jurisdictions, see 2A J. APPLEMAN, INSURANCE LAW AND PRACTICE § 1078 (1966) and Annot., 25 A.L.R.2d 999 (1952).

¹⁰⁴428 N.E.2d at 115.

¹⁰⁵*Id.* at 114 (citing *Stover v. Stover*, 137 Ind. App. 578, 204 N.E.2d 374 (1965)).

¹⁰⁶428 N.E.2d at 115.

¹⁰⁷*Id.* at 116.

¹⁰⁸See generally Act of Feb. 25, 1982, Pub. L. No. 83, 1982 Ind. Acts 799 (codified at IND. CODE §§ 9-1-4-3.5, -2-1-11, -4-1-53.5 (1982)).

¹⁰⁹Act of Feb. 25, 1982, Pub. L. No. 83, 1982 Ind. Acts 799, 799 (codified at IND. CODE § 9-1-4-3.5 (1982)). At the time of the writing of this Article, the manner in which the proof is to be shown had not yet been determined.

¹¹⁰Act of Feb. 25, 1982, Pub. L. No. 83, 1982 Ind. Acts 799, 800 (codified at IND. CODE § 9-4-1-53.5 (1982)).

¹¹¹Act of Feb. 24, 1982, Pub. L. No. 84, 1982 Ind. Acts 804, 804-05 (codified at IND. CODE § 9-2-1-15 (1982)).

There is some skepticism among members of the insurance industry about the usefulness of these amendments. The first amendment may be useful in forcing more drivers to obtain insurance initially. However, nothing in the amendment prevents them from cancelling their insurance or letting it lapse once the registration is obtained. Although the Insurance Commissioner could arguably require companies to give notice to the Bureau of Motor Vehicles when an insured cancels or a policy lapses, such a requirement would be unworkable. The companies could not bear the expense of giving notice and the Bureau would probably be overburdened with the problems of enforcement.

The other two amendments may be no more effective. The second amendment will only be useful if police agencies and prosecutors are willing to prosecute. The third amendment to the financial responsibility laws will give only a small measure of added protection to drivers.

2. *Uninsured Motorist Coverage.*—The uninsured motorist coverage provision of Indiana statutory law¹¹² was completely repealed and rewritten during the 102d Indiana General Assembly's term.¹¹³ The revision does not significantly change the old statute,¹¹⁴ except that the law is now easier to read. The only major change is that the legislature has now included an option that allows for uninsured motorist *property* damage insurance.¹¹⁵ The new property coverage will apply only to damage to the automobile and personal property in it. The new coverage will not include loss of use of damaged or destroyed property.¹¹⁶ Also, there will be coverage only if the at-fault operator is identified.¹¹⁷

¹¹²IND. CODE § 27-7-5-1 (1976).

¹¹³Act of Feb. 24, 1982, Pub. L. No. 166, 1982 Ind. Acts 1237 (codified at IND. CODE §§ 27-7-5-2 to -6 (1982)).

¹¹⁴See IND. CODE § 27-7-5-1 (1976).

¹¹⁵See Act of Feb. 24, 1982, Pub. L. No. 166, 1982 Ind. Acts 1237, 1238-39 (codified at IND. CODE § 27-7-5 (1982)).

¹¹⁶IND. CODE § 27-7-5-3(b) (1982).

¹¹⁷*Id.* § 27-7-5-3(c).

