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MEDICAL PAYMENTS PROVISION OF THE AUTOMOBILE INSURANCE POLICY: AN ILLUSTRATION OF FIRST PARTY INSURANCE PROBLEMS

JAMES G. POUROS,* JOSEPH D. MELENDES** AND ROBERT G. CRAIG***

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I. INTRODUCTION

The medical payments provision of the automobile liability policy affords payment to certain persons, regardless of fault, for reasonable medical expenses incurred within one year. Medical payments coverage was first offered to the public in 1939 as an endorsement to automobile liability insurance policies.¹ In the 1930's there had been considerable agitation for some form of no-fault compensation for victims of auto-

mobile accidents. The insurance industry responded with the medical payments provision. The existence of guest statutes and intra-familial immunity were other reasons for the appearance of this first party insurance.

Thirty years after the introduction of medical payments coverage the automobile insurance industry and the tort system are again being attacked by no-fault advocates. The medical payments provision is viewed as the precursor of a much more encompassing automobile insurance plan which, if accepted, would have a profound effect on the very moral power of this nation. The authors of the best known of these plans, Professors Keeton and O'Connell, have said that their proposed system is: "[A] form of compulsory motor vehicle insurance closely comparable to the medical payments coverage of present automobile policies." This article was prepared partly because of the new importance being given to medical payments coverage, and because, after thirty years of experience, it is now possible to collect, collate and analyze the law interpreting the application of this short and seemingly simple provision. The analysis which follows demonstrates that first party coverage can give rise to numerous disputes and litigation. Therefore, advocates of expansion of these benefits and changes in the coverages must consider the legal precedent which has interpreted the medical payments provision for the past thirty years.

The object of this article is the examination of the meaning and scope of coverage in the medical payments provision of the Personal and Family Combination Automobile Insurance Policy. The discussion focuses on the coverage, exclusions, other insurance clause, limits of liability and policy conditions. Extended treatment is given to that language which is both peculiar to the medical payments provision and which has been the subject of litigation. Problems incident to the automobile policy in general are discussed summarily or not at all. Each significant clause of the policy is quoted either in the text or in a footnote as it is discussed. To give the reader an overview of the provision, Part II of a Personal and a Family Combination Policy has been reproduced in appendices at page 513.

II. COVERAGE

A. Introductory Paragraph of the Provision

The introductory paragraph of the medical payments provision will be discussed first. A standard wording has developed.

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2 See, e.g., the "Columbia Plan," the ancestor of almost all present day no-fault plans. Columbia University Council for Research in the Social Sciences, Report by the Committee to Study Compensation for Automobile Accidents 138 (1932).

3 R. Keeton & J. O'Connell, Basic Protection for the Traffic Victim 268 (1965). See also 273-4 and 7: "Basic protection coverage is a new form of automobile insurance; most of its features, however, are derived from types of insurance already in use, medical payments coverage of current policies
Coverage C - Medical Services. To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services: . . .

1. Incurred

The provision stipulates that the insurer must “pay all reasonable expenses incurred within one year from the date of accident.” The first word to be analyzed is “incurred.” Difficulty with this single word has arisen in two major areas: (1) claims involving servicemen; and (2) claims involving insureds who are also covered by hospital plans. The further concept of incurrence within one year will be discussed in the following section.

a. Servicemen. In Gordon v. Fidelity & Casualty Co. of New York, a career soldier was struck by an automobile while he was riding a motor scooter. He was hospitalized in the government hospital at Fort Jackson. The soldier brought an action against his automobile medical payments insurer for the reasonable cost of his hospitalization. The South Carolina Supreme Court, relying upon other cases which had construed the word “incurred” in other types of policies, held that there was no ambiguity and that: “There being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he ‘incurred’ no expense within the meaning of the provision of the policy of insurance issued by the appellant.”

A similar case is Irby v. Government Employees Insurance Co. The plaintiff, injured while on active duty with the Coast Guard, was not allowed to recover under the medical payments provision of his policy for the reasonable value of medical and hospital services which...
he had received at a government hospital. The court relied on the same cases that the Gordon court had cited but, curiously, did not mention the Gordon case itself. It was stressed that the word "incurred" emphasizes the idea of liability, and that: "[P]laintiff never was under any obligation to pay the medical and hospital expenses and therefore never 'incurred' the same; the defendant [therefore] cannot be forced to pay under its contract." 

*American Indemnity Co. v. Olesijuk,* is one of two other cases in which the serviceman did recover. A Navy physician was treated by non-governmental hospitals and doctors. He was then "reimbursed" under a federal statute applicable when such treatment is "not available from a Federal source." The plaintiff was allowed to recover under the medical payments provision because: "The fact that the insured has other arrangements for the reimbursement of his expenses does not operate to relieve appellant of its obligation as expressed in its contract in plain, certain and unambiguous language." The court was apparently impressed by the difference in the route the money took to get to the serviceman. In *Irby* the relevant federal statute spoke in terms of an "entitlement" to payment, rather than a reimbursement, but the statute was not there discussed. The court in *Olesijuk* distinguished cases like *Irby* as involving "free" service. *Walsh v. Grange Mutual Casualty Co.,* also involved a federal statute using the word "reimbursed." Relying heavily on *Olesijuk*, the court allowed the estate of the decedent serviceman to recover under the decedent's medical payments provision for funeral expenses which had been paid for in part by the government.

The exact wording of the applicable federal statute must be examined in order to predict the result of a case in which a serviceman has received medical treatment without cost and then attempts to recover under the medical payments provision. This language may be determinative. The legal question may be whether there has been "reimbursement" or whether the services have been "free" and the payment "direct."

Veterans may have similar difficulties with the proof of "incur-
"In State Farm Mutual Insurance Co. v. Fuller, a veteran was treated in a Veterans Administration Hospital, but only after verifying her inability to pay for such treatment. The insured-veteran later recovered against the tortfeasor. When a claim was made by the Veterans Administration, she paid for her treatment. The insurer argued that the expenses were not incurred. The court held for the insured for two reasons. One was that: "[J]ust as soon as Mrs. Fuller became able to pay her cost . . . she did so . . . and at this point the said medical expenses were, in fact, 'incurred' by appellee [Mrs. Fuller] . . .". The second basis, theoretical and closely tied to the language of the medical payments provision, was derived from Kopp v. Home Mutual Insurance Co. Kopp is the lead case on the word "incurred" as it applies to hospital plans. The policies often read: "To pay all reasonable expense incurred . . . To or for the named insured . . .". In the Fuller case the court held that the federal government incurred the hospital costs. There was incurrence for the insured. The court hinted that this treatment by the federal government was really part of the compensation to the veteran for serving in the armed forces and was not free. This argument was brought up in a later case and could be used for the insured in those cases in which the federal statute is phrased in terms of an entitlement.

b. Hospital Plans. The second area of contention involving the word "incurred" has arisen in cases in which the insured was protected by a hospital plan in addition to his medical payments coverage. In the lead case, Kopp v. Home Mutual Insurance Co., the plaintiff, who had medical payments coverage, was a subscriber to the Blue Cross Hospital Benefit Plan. He paid a quarterly premium. The plaintiff received hospital services free of charge at a so-called "affiliated" hospital. Blue Cross then reimbursed the affiliated hospital. The automobile insurance company defendant argued that had it been an "unaffiliated" hospital, (1) the plaintiff would have paid the bill and (2)
the plaintiff would have been reimbursed by Blue Cross and that this would have constituted an incurrence within the terms of the policy. It was argued that under the facts of the case (i.e., an “affiliated” hospital) there was no expense incurred by the plaintiff. The Supreme Court of Wisconsin held that such a distinction, which apparently is effective in the servicemen cases, “would lead to a highly absurd and socially undesirable result.” The court was impressed by the fact that in both cases the consideration given by the insured is the same, a premium. The court conceded that the plaintiff had incurred no debt.

However, a debt was incurred on the part of Blue Cross to pay such expense to Luther Hospital, and the plaintiff had paid quarterly premiums to Blue Cross as consideration for Blue Cross [sic] undertaking so to do. Thus expense was incurred for hospital services furnished “to or for” the plaintiff insured.

The . . . policy provisions do not state who is required to incur the expense in order for the insured to recover for medical or hospital services supplied to or for him.

Since the policy was found ambiguous, the court, following the well-known rule of construction, held for the plaintiff.

Three cases involving a plan similar to Blue Cross have all relied on the Kopp case and held for the insured. These cases have added very little to the rationale of the Wisconsin Supreme Court. They did suggest that there might be an opposite result if the medical payments provision was drafted in a manner similar to the typical Bodily Injury and Property Damage coverages. Those provisions obligate the insurer to pay on behalf of the insured sums which the insured shall become legally obligated to pay.

In summary, the distinction which prevails in the servicemen cases between free (direct) services and reimbursement has not been accepted by courts dealing with hospital plans. It should be mentioned, however, that none of the four hospital plan cases involved the reimbursement fact situation.

c. Incur Does Not Mean Pay For. In Collins v. Farmers Insurance Exchange, the plaintiff had doctor and hospital bills of $5,000. He compromised these debts for $2,250. The defendant insurer, which had denied the insured’s claim, argued that the insured had incurred expenses of $2,250 rather than $5,000. The Minnesota Supreme Court did not want to encourage insurers to deny meritorious insurance

28 Id. at 57, 94 N.W.2d at 226.
31 271 Minn. 239, 135 N.W.2d 503 (1965).
claims because of the insurer's hope that the insured would settle his liabilities. The court awarded the insured $5,000, stating: "The definition of incur is 'to become liable for,' as distinguished from actually 'pay for.'" 32 Although the word "incurred" can give rise to many legal difficulties, it is even more difficult to construe the meaning of the phrase "incurred within one year."

2. Incurred Within One Year

The medical payments provision encompasses payment for "all reasonable expenses incurred within one year from the date of accident . . . ." 33 It does not cover all expenses arising out of the accident. The "within one year" language is analogous to those policy limits which are expressed in dollars. 34 The difficulty with the phrase occurs when medical treatment cannot be fully performed within one year.

The lead case is Maryland Casualty Co. v. Thomas. 35 A nine year old boy had received serious damage to his teeth, necessitating a permanent bridge. At that age it was not possible to attach the bridge because the child still had baby teeth. The father solicited estimates of the cost of long range treatment from several doctors. Within one year from the date of the accident he accepted one of the estimates and paid it in full. The insurer argued that it was not liable because the repairs were not performed within one year from the date of the accident. The court accepted the argument of the plaintiff that: "[T]he language of the policy makes no requirement as to when the services for repairs must or may be performed . . . ." 36 All of the cases found have allowed the insurer to recover when he has prepaid. Clearly, if the insured is able, he should prepay, i.e., pay in advance within the one year period. 37

The fact situation in Thomas was substantially duplicated in Hoehner v. Western Casualty and Surety Co. 38 The court there suggested that the insurer could protect itself by requiring explicitly in the policy that the actual "treatment or services" must be performed within the one year period. 39 This case involved premises insurance with a medical payments provision very similar to that of the automobile liability policy. The court phrased its conclusion more broadly than the facts required. It held that the insured would prevail if he has: "[C]ontracted

32 135 N.W.2d at 507.
36 Id. at 654.
37 What if the work was done within the one year period, but the bill was not received by the insurance company until after that period? One source said, "I don't think that any company would quarrel over receipt of a bill shortly after the end of the period of one year . . . ." THE FORUM 27 (McCormick & Clapp eds. 1966).
39 155 N.W.2d at 236.
to pay a sum certain . . . within the year . . . although the services might be postponed beyond the year in the wisdom of the treating physician or dentist." Other cases have also held that prepayment constitutes expenses incurred within one year.

The real difficulty lies in determining how much less than actual prepayment will be sufficient. No cases were found in which a sum certain was decided upon but not paid in advance. Neither were any cases found in which the insured paid by note. In *Reliance Mutual Life Insurance Co. of Illinois v. Booher*, the plaintiff within one year engaged the services of a surgeon to perform reconstructive surgery. The fees of the surgeon were not agreed upon at that time. The court held, in effect, that the insured had not come close enough to payment in advance:

An expense is the same as a debt, and it has been incurred when liability for payment attaches. A contingent expense has been incurred when the contingency upon which the payment depends has occurred. . . . The plaintiff's engagement of the services of the surgeon for his future services constituted a contingent promise to pay for his services, and the expense was not incurred until the contingency occurred, which was the surgeon's performance of the services.

In the *Booher* case, the first of a series of operations had been performed within the requisite period. The insured was allowed those expenses. Two New York cases seem to indicate that the commencement of services within one year, even absent prepayment or a definite contract with the physician, is sufficient to make the insurer liable for all ensuing medical services, regardless of the date of performance. The reports of both cases are short and somewhat unclear. Nevertheless, they represent the most favorable interpretation of the medical payments coverage for the insured.

Finally, the case of *Czarnecki v. American Indemnity Co.*, pro-

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40 Id.
42 166 So. 2d 222, (Fla. Ct. App. 1964). The policy in this case read: "incurred within 52 weeks." The difference in language is not material.
vided two rather unsurprising insights. First, the North Carolina Supreme Court overruled the trial court which had held the "within one year" limitation invalid. The court held that there was no "statute in the exercise of the police power" which required it to hold that all expenses relate back to the time of the accident. Second, the court held that the expiration date of the policy does not terminate the liability of the insurer for medical expenses incurred within one year from the date of the accident. If the court had reached this second conclusion, problems would have arisen even among those who remain insured, since many automobile liability policies are renewable every six months.

In summary, the insured who will require medical services beyond the one year period can only recover his expenses by paying in advance. What, if anything, less than advance payment, will also bring the medical payments coverage into play may still be an open question.

3. Reasonable and Necessary

Medical expenses are recoverable as a part of the compensatory damages awarded the plaintiff in a personal injury action. Their recovery can also be provided for by contract, for example, through the medical payments provision. This coverage assumes only the obligation: "[T]o pay all reasonable expenses . . . for necessary medical, surgical, X-ray, and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services." Thus the insured, in order to recover his expenses under the insurance contract, must be prepared to prove that, (1) the services were necessary and, (2) that the amount charged was reasonable. This dual test is the same test that would be applied in any personal injury action seeking compensatory damages for medical expenses paid or incurred.

In attempting to prove reasonableness the insured may meet evidentiary problems. Often the amount charged is not allowed as evidence of reasonableness. The reasonableness of the expense is determined by the charges of the profession generally, not by the amount

46 131 S.E.2d at 348.
47 Id. at 349.
48 The most recent case is Hein v. American Family Mutual Insurance Co., 166 N.W.2d 363 (Iowa, 1969). The court said, at 368-69: "The unambiguous language of the policy provision here in question clearly required either the payment of the anticipated expenses within the one year period or the incurrence of a legal obligation within such period to pay such expenses in the future."
49 J. GHIARDI, PERSONAL INJURY DAMAGES IN WISCONSIN § 6.01, at 83 (1964).
52 Michalski v. Wagner, 9 Wis. 2d 22, 100 N.W.2d 354 (1960).
charged by a particular physician or surgeon. The attending doctor’s expert opinion of the reasonableness of the charge may be introduced into evidence to aid the jury in its determination of whether a particular expense is reasonable.

If the questioned expense has already been paid, this fact may in some instances be introduced on the issue of reasonableness. Some courts, however, hold that the mere fact of payment is of no evidentiary value on this issue. The plaintiff in American Central Insurance Co. v. Melton, owned a policy with a $1,000 medical payments provision. The plaintiff alleged that he had incurred medical expenses and demanded repayment under the contract. The insurer answered by a general denial. The case was heard by the jury. The plaintiff’s proof consisted only of his own testimony that he had incurred expenses as the result of necessary orthopedic and physiotherapeutic treatments, and that he had actually paid a stated amount. He was not allowed to testify as to the reasonableness of the expense. The jury gave the plaintiff a verdict of $800, but the defendant was awarded judgment notwithstanding the verdict. The Texas court held that the amount paid, by itself, was no evidence of reasonableness, and since no other competent evidence was submitted the insured must be denied recovery.

In Wisconsin, the amount paid or the liability incurred is evidence which can go to the jury to assist it in arriving at a reasonable award. But the medical bills are not conclusive on the issue of the amount that should reasonably be paid. The jury determines a reasonable award and is free to set a figure lower than the bills presented in evidence. Koczka v. Hardware Dealers Mutual Fire Insurance Co. involved a “whiplash” victim who underwent forty-five or more diathermy treatments to his spine and commenced suit to have this expense ($525) paid by his medical payments insurer. The insurer defended on the grounds that the treatments were unnecessary and that the charge for the treatments was unreasonable. The jury allowed no recovery and this determination was upheld on appeal. The court declared that if the jury should find the plaintiff guilty of bad faith in undergoing this series of treatments, then a verdict of no damages is correct, since the treatments were unnecessary.

The Koczka case is the only recent medical payments insurance case dealing with the issue of necessity. The issue has, however, been pre-

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55 Annot., supra note 53, at 1392.
56 Id. at 1376.
57 Id. at 1370.
59 Gerbing v. McDonald, 201 Wis. 214, 229 N.W. 860 (1930).
61 Seitz v. Seitz, 35 Wis. 2d 282, 151 N.W.2d 85 (1967).
62 29 Wis. 2d 395, 138 N.W.2d 737 (1966).
sented in tort cases which clearly indicate that the plaintiff must meet his burden of proof regarding the necessity of treatment. The plaintiff is denied recovery when he presents bills for medical expenses, but offers no proof of the type of treatments or of their necessity. He has the burden of proving the propriety of medical expenses incurred. A simple presentation of an unsegregated statement of total cost does not satisfy this burden. In two recent Wisconsin tort cases, the plaintiffs were not allowed any recovery for medical expenses. In Smee v. Checker Cab Co., the plaintiff had already been enroute to see his doctor because of abdominal pains. The taxi he was riding in was involved in a collision which caused him to incur a brain concussion. Another taxi conveyed him to his doctor who had him hospitalized immediately. The plaintiff was originally awarded $275 for medical and hospital expenses. This award was reversed on appeal because the plaintiff had not produced evidence that the amount awarded was for expenses incurred as a result of the accident. The plaintiff's doctor testified to the effect that his bill was for treatment primarily of the abdominal problem. No effort had been made to differentiate between services rendered in connection with the pre-existing abdominal condition and those made necessary as a result of the concussion suffered in the accident. To like effect is Michalski v. Wagner. The plaintiff suffered a "whiplash" injury, and underwent a number of tests at the Mayo Clinic. Although the bill from the clinic totaled $460, the plaintiff was not able to recover any of this amount, since the bill failed to segregate those charges which were for necessary treatment of the "whiplash." Testimony was taken that some portion of the total bill was for services rendered merely for the sake of giving the plaintiff a complete physical examination. Since the bill failed to differentiate expenses, the entire bill was excluded.

While Smee and Michalski did not involve the medical payments insurance provision, they would probably be followed in cases concerning insurance payments. The policy only pays expenses to one who had bodily injury caused by accident while occupying an automobile or through being struck by an automobile. Thus the plaintiff has the burden of proving that his expenses resulted from bodily injury suffered in the accident. Seitz v. Seitz, another tort case, might be persuasive authority in a medical payments insurance dispute. The plaintiff had medical bills totalling $2,689 admitted into evidence, but the jury awarded only $1,800. The verdict was affirmed on appeal. The court noted that not

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62 1 Wis. 2d 202, 83 N.W.2d 492 (1957).
64 9 Wis. 2d 22, 100 N.W.2d 354 (1960).
66 35 Wis. 2d 282, 151 N.W.2d 86 (1967).
all of the bills presented were supported by proof that they were necessary expenses incurred as a result of the accident.

4. Categories of Expenses Covered

To be recoverable, the expenses must not only be reasonable and necessary, but must also fall within one or more of the categories specified in the policy language.

The first category of expense for which payment will be made is "medical" expense. Fees charged by doctors usually are included here if made for treatments necessitated by the injury. Expenses incurred for rental of a vibrator and heater have been allowed. A doctor's fee of $35 for preparing a medical report according to the insurer's request has also been allowed. This fee for preparing a medical report would appear to be a legal rather than a medical fee since it is not related to the treatment of the patient. Nevertheless, it was allowed as an item of medical services expense.

Surgical expense is provided for and includes expense of reconstructive surgery if deemed necessary.

X-ray and dental expenses have not been the subject of litigation, at least not under a policy which specifically includes X-ray and dental coverage. Dental expense has been recovered under a policy which did not provide specifically for "dental" expense but did provide for medical and surgical expense. In *Gasul v. Michigan Mutual Liability Co.*, the insured's dental bridge was damaged in an accident. That court had little difficulty in determining that dentistry is a subdivision of surgery and hence covered by the policy.

If the bodily injury necessitates the use of a prosthetic device, the policy specifically covers this item. An attempt was made in *Trachtenberg v. Home Indemnity Co.*, to collect the expense incurred by the insured in replacing his damaged dental bridge. The insured had the bridge in his shirt pocket at the time of the accident. Contact with the steering wheel smashed the dental bridge. The insured contended that the expense was covered, since caused by accident and since prosthetic devices were specifically covered by the policy. The court denied recovery because the injured had not suffered bodily injury to his face or mouth. The decision indicated that recovery would have

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70 345 Ill. App. 607, 104 N.E.2d 122 (1952). One source has raised the question of whether dentures are covered for full repair or replacement cost or whether possible depreciation should be considered. The former was indicated. *The Forum* 27 (McCormick & Clapp eds. 1966).
been allowed if the bridge was damaged while in the insured's mouth. Thus a replacement would be covered only if the original prosthetic device was in use at the time of the accident. The court reasoned that if the device were being used, it became part of the body, and hence any damage to it would be a bodily injury and therefore a recoverable expense.

Hospital service expenses are also specifically provided by the typical provision. The reasonable and necessary expense of items incidental to the hospital stay have been included as compensable damages in tort actions. In an action based on a medical payments provision, the court included the cost of a telephone plus the extra expense incurred for guest trays and a cot used by the patient's guest. The patient was in traction during the hospital stay and the court found it necessary for someone to stay with him.

The policy states that reasonable expenses for necessary hospital services will be paid. It does not limit payment to services rendered in any particular type of institution nor is it limited to services while confined in a hospital. In Morris v. Fireman's Fund Insurance Co., the insured recovered over $1,200 for hospital services rendered to her by her son-in-law while she stayed in his home during her post-operative period. During this period she was undergoing required outpatient treatment at the hospital. The bill for the son-in-law's services included itemized amounts for meals, room, laundry, personal care and mileage for conveying the insured to the hospital for treatment. While the court held these expenses to be for hospital services, it would appear they were actually expenses for nursing services. If they had been deemed nursing expenses, they would not have been recoverable under the policy, since the services were not rendered by a professional nurse. The court did note that the insured could have elected to stay in the hospital instead of being treated as an outpatient, in which case the actual hospital expense would have been much higher than the amount sought for the son-in-law's services.

Nursing service is a part of the compensatory damages awarded in a personal injury tort case and there is no requirement that it be rendered by a professional. Under the medical payments provision, however, payment is limited to professional nursing services. Thus, the insurer is not required to pay for services rendered by a wife to her husband or for domestic help needed in the home, unless, of course, these services are performed by a professional nurse and

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it is necessary that a professional nurse perform them. The term "professional" nurse encompasses the licensed practical nurse as well as the registered nurse.  

Funeral services are also covered by the medical payments provision. They too must meet the requirements of being reasonable and necessary. One would not expect the necessity of a funeral to be placed in issue. However, the reasonableness of the amount charged for the funeral could be a disputed issue. *Pan American Fire & Casualty Co. v. Trammell* 77 was just such a case. An elderly couple was killed in an automobile accident. During their lifetime they had very few worldly possessions, but at their death each was covered by a $2,000 medical payments provision. Their daughter ordered a $1,500 funeral for each, including burial in $1,000 copper caskets. The insurer tendered only $150 per funeral. The case was remanded for a new trial at which time the jury was to examine each of the itemized services constituting the funeral and then determine the necessity of that item. Thus, in effect, the jury was to determine whether it was necessary that a poor man be buried in a copper casket. If the casket was determined to be necessary, then the jury was to determine a reasonable charge. However, the victim's lack of wealth was not to be considered, just as it was not considered in establishing the premium he paid for his insurance.

Often expenses incidental to death and burial are not recoverable as funeral expenses. The expenses incurred for a grave, a cantor and a rabbi have been allowed as necessary, but the expense incurred for perpetual care of the grave was not recovered. 78 The expense for a burial vault, where not usually furnished as a part of the funeral, has been deemed not necessary and therefore not recoverable. 79

**B. DIVISION ONE: PAYMENTS TO NAMED INSUREDS AND RELATIVES**

In order to distinguish between the coverage afforded the named insureds (and their relatives) and other persons, the medical payments provision is separated into Divisions One and Two. The former defines the coverage for the named insureds and each relative, and the latter for certain other persons. Division One generally reads as follows:

Division 1. To or for the named insured and each relative who sustains bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury," caused by accident,

(a) while occupying the owned automobile,

(b) while occupying a non-owned automobile, but only if such person has, or reasonably believes he has, the permission

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of the owner to use the automobile and the use is within the scope of such permission, or
(c) through being struck by an automobile or by a trailer of any type.\textsuperscript{80}

1. \textit{Caused by Accident}

Division One allows payment of "all reasonable expenses incurred within one year from the date of accident."\textsuperscript{81} Both Division One and Division Two cover only bodily injury "caused by accident."\textsuperscript{82} Apparently the word "accident," by itself, has created little difficulty in construing the medical payments provision. One case involving the medical payments provision defined the word accident as "an undesigned; sudden and unexpected event."\textsuperscript{83} This definition differs little from that found in cases not involving the medical payments provision,\textsuperscript{84} or even from that used in Workmen's Compensation law.\textsuperscript{85} One authority has listed the wording of the definitions to illustrate that they differ only in form.\textsuperscript{86} The rule seems to be that: '[T]he word 'accident' has never acquired any technical signification in law, and when used in insurance contracts, it is to be construed and considered according to the ordinary understanding and common usage of people generally.'\textsuperscript{87}

There has been more difficulty, however, with the entire phrase "caused by accident," as used in the medical payments provision. It is very difficult, perhaps impossible, to segregate those cases dealing with "accident" from those dealing with "caused by accident"—no such attempt has been made. In some cases the question has been whether the injury was caused by a prior condition, rather than by the accident. In \textit{Allstate Insurance Co. v. Miller},\textsuperscript{88} a wife had been hospitalized, at least partially due to a beating given to her by her husband. She also

\textsuperscript{80} Northwestern Nat'l Ins. Co. Policy, Coverage C—Medical Payments, Division 1.
\textsuperscript{81} Milwaukee Mut. Ins. Co. Policy, Coverage C—Medical Services; Northwestern Nat'l Ins. Co. Policy, Coverage C—Medical Payments.
\textsuperscript{82} Milwaukee Mut. Ins. Co. Policy, Divisions 1 and 2; Northwestern Nat'l Ins. Co. Policy, Divisions 1 and 2.
\textsuperscript{83} Collins v. Farmers Ins. Exch., 271 Minn. 239, 135 N.W.2d 503 (1965). The case held, not surprisingly, that turning too quickly in freezing rain thereby causing a skid into a utility pole was an accident within the meaning of the policy.
\textsuperscript{84} Koehring Co. v. American Auto. Ins. Co., 353 F.2d 993 (7th Cir. 1965) (involving breakdown of cement mixers caused by failure to install adequately designed cylinders); Watson v. Western Cas. Sur. Co., 72 N.M. 382 F.2d 723 (1963) (general liability insurer); Clark v. London & Lancashire Indem. Co. of Am., 21 Wis. 2d 268, 124 N.W.2d 29 (1963) (insurance against bodily injury caused by accident and arising out of the plaintiff's operation of a gravel pit; actually construed phrase "caused by accident"); Schneider v. Provident Life Ins. Co., 24 Wis. 28, 29-30 (1869) (policy insuring against death by accident covered the negligent and disastrous attempt of insured to board a moving train).
\textsuperscript{85} Yellow Cab Co. v. Industrial Comm., 210 Wis. 460, 246 N.W. 689 (1933); Vennen v. New Dells Lumber Co., 161 Wis. 370, 154 N.W. 640 (1915).
\textsuperscript{86} 10 G. COUCH, Cyclopedia of Insurance Law § 4:16, at 28 (1962).
\textsuperscript{88} 152 Colo. 249, 381 P.2d 255 (1963).
had a history of serious back trouble. The day after her release from the hospital she was involved in an automobile accident which caused an alleged injury to her back. The court held that it was a jury question whether the injuries were "caused by accident," and pointed out that the jury, which held for the plaintiff, probably had heeded the plaintiff's doctor who testified that: "Something happened between the two dates . . . ."\(^8\)

A similar case is *Minsky v. Hardware Mutual Casualty Co.*\(^9\) The plaintiff had suffered from cancer since 1954. The accident occurred in 1959. Within a year of the accident the plaintiff died, after being hospitalized almost that entire year. The medical testimony was convincing that the hospitalization was, with some minor exceptions, solely due to cancer. The failure of the plaintiff to segregate the expenses resulted in the nonrecovery of even that small portion of the expenses which were caused by the accident.\(^9\)

The proposition that medical testimony is of extreme importance in cases involving prior cause is further shown by *Zeringne v. Hartford Accident & Indemnity Co.*\(^9\) The plaintiff, claimed that an abortion was caused by "emotional disturbance" over an accident which had occurred thirty-five days earlier. Throughout her life the plaintiff had had a history of abortions for health reasons. In an action on the medical payments provision in plaintiff's automobile liability policy, the court held for the insurer, relying upon medical testimony as to the difficulty of causing an abortion. It said:

This was and is obviously a medical question on which we must be guided almost entirely by the opinion of the only doctor who treated Mrs. Zeringne. He, in great detail, outlined various evidences of impending abortion and discussed some of the causes thereof, and finally concluded that, in his opinion, while it was possible that the episode on the railroad track might have caused the abortion, he felt that that had not been the cause.\(^9\)

A slightly different type of causation question arises when the defense argues that the causal connection between accident and injury is too remote to allow recovery. In *Wagner v. Nationwide Mutual Insurance Co.*,\(^9\) an eighty-five year old plaintiff received lacerations and fractured ribs in an automobile accident. He soon developed three

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\(^8\) 381 P.2d at 258.
\(^1\) Id. at 669. The court speaks in the tort terminology of "proximate causation."

The question should be posed whether the entire literature of proximate causation in tort should be injected into the medical payments provision. There probably is no alternative.

\(^2\) 185 So. 2d 100 (La. Ct. App. 1966).
\(^3\) Id. at 101; see Hudak v. Nationwide Mut. Ins. Co., 112 Ohio App. 306, 167 N.E.2d 666, 670 (1960) (poor reasoning in that the causal connection must be between the injury and accident, not the expenses and accident).

\(^4\) 235 N.E.2d 741 (Ohio C.P., Montgomery County, 1968) (Family Compensation Insurance Endorsement 479D-3, quite similar to medical payments provision, was being litigated).
complications—uremia, encephalopathy and acute urinary retention. The court allowed him to recover for the complications since they were “not necessarily uncommon following trauma to a man of his advanced age.”95 The fourth day after the accident, “[H]e became restless and confused and despite restraints would get out of bed and walk at various intervals.”96 On the eighth day after the accident the plaintiff was discovered lying on the floor of his room and was found to have a fractured femur. As to the medical and hospital expenses necessitated by treatment of the fracture, the court held for the insurer:

There is no causal connection between the automobile accident and the fall in the hospital. The fall was an independent accident and the medical and hospital expenses incurred in the care and treatment of the resulting fractured femur may have been caused by the failure to properly restrain the plaintiff.97

The court quoted the Latin maxim that the direct cause, rather than the remote cause, is to be considered.98

The concept of an independent accident, or more accurately, intervening cause, was also argued by the insurer in American Family Life Insurance Co. v. Robinson.99 A parked automobile rolled backward, knocking the plaintiff-pedestrian to the ground and causing a gun, which he was carrying, to discharge. The plaintiff brought an action on his medical payments provision seeking recovery for injuries caused by the discharge. The accidental discharge of the gun was held to be “directly caused by the automobile striking the insured.”100

Because the words “caused by accident” have not been construed often by the courts, one court decided that those cases construing the phrase “accidental means” can be “guiding beacons” in a case involving a “caused by accident” issue.101 The plaintiff had twisted his back by stepping directly into a pickup truck instead of using the running board. The court reasoned that the injury was the only fortuity, since the insured purposefully took the higher step. Had the plaintiff claimed that he had missed the running board or slipped, he apparently would have recovered.102 Surely, such fine distinctions should be confined only to those policies which still actually bear the burden of the words “accidental means.”

95 235 N.E.2d at 744.
96 Id. at 742.
97 Id. at 745.
88 Id. (“causa proxima non remota spectatur”).
99 115 Ga. App. 526, 154 S.E.2d 763 (1967). This case involved a personal accident policy, the operative words of which read: “provided such bodily injuries are caused solely by reason of an automobile . . . accident.”
100 Id.
102 Id. at 62.
The defense in *Columbia Casualty Co. v. Abel* made a similar argument. In that case a young man attempted to assault his date. She was preparing to jump from the moving automobile when the man swerved the automobile and accelerated. She fell out, striking her head on the pavement. The insurer argued that she intentionally jumped from the automobile and that she could not recover from the man's insurer because her injuries were not "caused by accident." The court gave two reasons for allowing recovery. First, and directly opposed to the *Robinson* case, she could recover because she intended to land on her feet and did not anticipate the actual result. The *Robinson* court would presumably have ruled for the insurance company on such an issue. The second basis for the reasoning in *Abel* highlights an important factual distinction between the two cases. In *Robinson* there was one cause, the intentional stepping directly into the truck, whereas in *Abel* there were two causes: the swerving of the automobile by the driver and the intentional jump by his date. The court in *Abel* reasoned that:

[The policy] did not restrict or limit the obligation of the company in those respects to instances where bodily injury was caused *solely and exclusively of all other causes by accident* arising out of the ownership, maintenance, or use of the automobile. And where accidental injury is proximately caused by two or more concurrent causes only one of which is within the coverage of a policy of this kind, the company is liable even though other causes contribute to the accident.

This case shows, among other things, the importance of the exact wording of the policy. Had the policy read "injury caused solely by accident," the plaintiff would not have recovered.

In *Abel* the court dodged the question of whether recovery should be prevented because the "accident" involved was closely related to an assault and battery. The court probably so reasoned because the plaintiff could not have recovered by the specific terms of the policy, if an assault or battery had been "committed by the insured or at his direction." Assaults not committed by the insured or at his direction were deemed accidents by the policy. The issue of whether an assault and battery can be termed an accident within the medical payments provision was raised in *Goetz v. General Fire & Life Assurance Corp.*

The plaintiff's automobile was stopped by three robbers who forced him out of the car and stabbed him. The court denied recovery, stressing that the assault "was not connected in any way with the automobile other than the incidental fact that the driver was operating it at the

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103 171 F.2d 215 (10th Cir. 1948).
104 Id. at 218.
105 Id. at 218-19 (emphasis added).
106 Id. at 216.
time.” A dissenting opinion, in addition to discussing the “occupying” argument which was held determinative by the majority, said, “[I]f the assault be without provocation by the person assaulted, it should be regarded as an accident within the meaning of any insurance policy including the instant one for medical expense, unless the policy specifically excludes an injury caused by an assault.”

Finally, one case has held that an escaping felon, who wrecks his automobile while he is the subject of hot pursuit, can recover for his injuries under the medical payments provision. The Michigan Supreme Court rejected the public policy arguments of the lower courts that the allowance of recovery would encourage crime. As happens so often in this area of “caused by accident,” the insurer was chastised for not writing a more specific contract exempting “injuries sustained as the result of violation of law.”

The words “caused by accident” in the medical payments provision have been the subject of litigation as to prior cause, remote cause, intervening cause, concurrent causes and accidental means. They have been the focus of litigation involving highly unusual fact situations. It does not seem rash to predict that such cases will continue to arise.

2. Relative

The medical payments provisions often allow payments “to or for the named insured and each relative who sustains bodily injury.” The word “relative” is commonly defined in the Definitions section of the policy as “a person related to the named insured who is a resident of the same household.” This word has caused some problems. In cases involving the provision there has been little litigation concerning the words “related to.” One case seemed to involve both consanguinity and affinity, but really only held that a granddaughter was related to “the named insured.” Another medical payments case has held that a stepdaughter is a relative. The children of the named insured were passengers in an automobile owned by his stepdaughter. The named insured was denied coverage under the medical payment provisions of his automobile family combination policy for the injuries of his children because the stepdaughter came within an exclusion for automobiles

108 Id. at 70, 262 N.Y.S.2d at 308.
109 Id. at 70, 262 N.Y.S.2d at 309 (dissenting opinion).
111 96 N.W.2d at 763.
owned by relatives. After pointing out that it was clumsy for the insurer to attempt to define the word "relative" in its policy by using the word to be defined, the court said:

When "relative" is considered along with the limiting phrase "resident of the same household," the policy intent to deny coverage to other cars readily available to covered persons within the same household is noted, and the close affinity, although not consanguinity, present in the stepdaughter-stepfather relationship is recognized, it is our opinion that [the named insured's stepdaughter] was a "relative" under the policy giving that term its plain, ordinary meaning as understood by the average man...116

This case is distinguishable from others construing the words "related to" or "who is a resident of the same household" because it involved an atypical exclusionary clause.

The primary difficulty is with the words "who is a resident of the same household." In Arellano v. Maryland Casualty Co.,117 the named insured husband, due to an argument with his wife, moved out of the house about one and one-half years before the accident in question. He owned the house where his wife and daughter continued to live and he sometimes paid for the utilities. When the named insured's daughter was injured in an automobile accident it was held that she was not a "relative" of her father, under the medical payments provision, because she was not living "under the same roof" as the insured at the time of the accident.118 The house that the father maintained for them was not "the same household" in which he lived.

In one case the question arose, due to the peculiar wording of the policy, whether the household had to be a household headed by the named insured.119 The policy offered coverage to those related to the named insured "while residents of his household."120 The named insured was an adult bachelor who lived at home with his parents. The plaintiff was his brother, also a bachelor living at home. The court held that it was ambiguous whether "household" meant one headed by the named insured or "the household of which insured is a member."121 The policy, of course, was construed in favor of coverage. It appears that if "household" does not mean a household headed by the named insured under this policy, it surely could not have that meaning under the typical policy, which does not include the word "his."

Having two houses to live in does not prevent coverage if the plaintiff and the named insured are residents of the same household "at

116 300 N.Y.S.2d at 976-77.
118 Id. at 702.
120 Id. at 875.
121 Id. at 876.
the time the casualty occurred."\(^{122}\) Even if the plaintiff lived with her grandmother only while the plaintiff's brothers were away at college, she could recover if the accident occurred while she was living there.\(^{123}\)

A temporary absence from home does not deny one medical payments coverage. A high school girl spent her summer vacation working long hours as a waitress at a resort twenty-five miles from home.\(^{124}\) It was most convenient for her to stay overnight, as all the girls did in rooms provided for them. There was no question that she planned to return home to finish high school in the autumn. The court held that: "[A]n established residence is not lost by temporary absence therefrom, either on business or on pleasure, with no intention to abandon that residence or acquire another."\(^{125}\)

The key question in these cases is whether there has been manifested an intention to abandon the former actual residence.\(^{126}\)

3. Automobile; Owned Automobile; Non-Owned Automobile

Division One of the medical payments provision, the coverage for the named insured and relatives, is divided into three subsections, all of which employ the word "automobile."\(^{127}\) The word does not appear to have a meaning in the medical payments provision any different from that used in automobile insurance law generally.\(^{128}\) The word "automobile" is not ambiguous and is given its common meaning. A motorcycle is not an automobile within the medical payments provision.\(^{129}\) It almost goes without saying that a motor scooter is not an automobile.\(^{130}\)


\(^{123}\) Id.


\(^{125}\) Id. at 14. The case is made even stronger by the fact that the policy read: "who is a resident of and actually living in the same household as the named insured." It was held that "actual" means permanent rather than physical. Id.

\(^{126}\) Goodsell v. State Auto. & Cas. Underwriters, 153 N.W.2d 458 (Iowa 1967). The dissent in this case raised the close question that there is a distinction between an intention to return and a non-intention to stay where one is. The close case is where the plaintiff "was going to take up permanent residence elsewhere but did not know where." Id. at 464 (dissenting opinion).


\(^{128}\) Milwaukee Mut. Ins. Co. Policy, Coverage C—Medical Services, Division 1; Northwestern Nat'l Ins. Co. Policy, Coverage C—Medical Payments, Division 1.


\(^{130}\) Labracio v. Northern Ins. Co. of N.Y., 66 N.J. Super. 216, 168 A.2d 682, 683 (1961) ("A motor scooter has been held to be nothing more than a motorcycle"); Texas Cas. Ins. Co. v. Wyble, 333 S.W.2d 668, 669 (Tex. Civ. App. 1960) ("[A] scooter is even farther removed from the term 'automobile' than is a motor cycle.").
The difficulty arises with hybrid vehicles such as the Post Office Department's "mailsters." This vehicle has two wheels in the rear and one in the front and weighs about 800 pounds. One court meticulously compared the mailster's characteristics to those of both an automobile and a motorcycle. The court held that it was in "every essential respect" an automobile, not a motorcycle, and that the medical payments coverage was applicable. Other more specialized problems with the meaning of the word "automobile" occur as to the third section of Division One, "through being struck by an automobile." These problems will be discussed in another part of this article.

Some difficulty has also occurred as to "owned automobile" and "non-owned automobile." If "owned automobile" is defined in the policy as that automobile specifically described in the policy, obviously there is no coverage for an automobile not so described. On the other hand, one case has held that the absence of this specific definition will not limit the coverage only to described automobiles, even if there is a blank in the policy for "Description of owned automobile."

The term "non-owned automobile" is commonly defined in the automobile liability policy to mean: "[A]n automobile or trailer not owned by or furnished for the regular use of either the named insured or any relative, other than a temporary substituted automobile." This language has been the subject of several medical payments cases, a typical example of which is Bringle v. Economy Fire & Casualty Co. The plaintiff was a carpet layer. His employer owned five trucks which were used to carry material and personnel to installation sites. The plaintiff was injured while in one of these trucks. He brought an action unsuccessfully on his medical payments provision, claiming that the vehicle was not furnished for his regular use because he had the use of the vehicle only for business purposes. The court held that the trucks were furnished for his regular use. It relied on five "signposts" that had been devised in another case.

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132 110 S.E.2d at 466. The court considered the following factors: (1) Does it stand upright when not in operation? (2) How exposed is the rider? (3) Does a driver or passenger ride in or on it?
133 Id.
134 See the section of this article, "Through Being Struck by an Automobile," p. 475; Milwaukee Mut. Ins. Co. Policy, Division 1 (c); Northwestern Nat'l Ins. Co. Policy, Division 1 (c).
136 American Indem. Co. v. Garcia, 398 S.W.2d 146 (Tex. Civ. App. 1966). No cases were found dealing specifically with "non-owned automobile" within the context of a medical payments provision problem.
138 169 N.W.2d 879 (Iowa 1969).
1. Was the use of the car in question made available most of the time to the insured? [Answered Yes.]
2. Did the insured make more than mere occasional use of the car? [Yes.]
3. Did the insured need to obtain permission to use the car or had that been granted by blanket authority? [Blanket authority.]
4. Was there a purpose for the use of the car in the permission granted or by the blanket authority and was it being used for such purpose? [Yes.]
5. Was it being used in the area where it would be expected to be used? [Yes.] 140

Other courts have similarly construed the definition of “non-owned automobile.” 141 No cases were found dealing with the question of temporary substitute automobile within the context of the medical payments provision.

4. Occupying

An insured who sustains bodily injury while occupying an automobile may recover his attendant medical expenses within the limits of the medical payments provision. It is the purpose of this section to determine the coverage afforded by the term “occupying.” “Occupying” is defined under Coverage C as “in or upon or entering into or alighting from” an automobile. 142 The coverage extended to an injured party under this definition is broad, yet each component term is limited in its application. Therefore, the coverage afforded while “occupying” an automobile may best be understood by illustrating how each term has been construed by the courts.

In construing the terms “in,” “upon,” “entering into,” and “alighting from,” the courts have uniformly found some ambiguity and, under insurance contract rules of interpretation, have interpreted the language in favor of the insured.

a. In. The term “in” is the easiest to understand. Because of the common view that the component terms of the definition of “occupying” are not synonymous, the coverage that “in” affords is quite limited. 143 The terms “upon,” “entering into,” and “alighting from” are expansions of the basic coverage afforded by the term “in.” It appears that the term “in” has a limited practical application to injuries sustained

140 169 N.W.2d at 892.
by one while actually within the passenger compartment of an automobile.

The rule is different as to accident policies which provide coverage for injury only while in an automobile: "One does not have to be actually sitting in the place ordinarily provided for the accommodation of passengers in an automobile in order to come within the coverage of a provision in a policy indemnifying against injuries sustained while "in" an automobile." In Independence Insurance Co. v. Jeffries' Adm'r, an action was brought on an accident policy providing benefits for accidental death or disability sustained by the wrecking of any automobile "in which the insured is riding." The insured was riding on the running board outside the car. The car swerved abruptly and the insured was thrown off the automobile, struck his head and later died as a result of the injuries. The insurer argued that the decedent was not riding in the car as provided in the policy. The court rejected this argument, stating that the policy language was ambiguous and would be construed most strongly against the insurer. The court ruled that the word "in" is ordinarily accepted and used as an equivalent to the word "on" and that the insured was in the automobile under such an interpretation. The court indicated that the result might have been different if the words "within" or "actually in" had been used to show an intent to limit the coverage to the space set apart for the use of passengers.

Since the terms "in" and "on" are not synonymous, those cases which interpret "in" as equivalent to "on" are rendered superfluous when the definition of occupying includes both "in" and "on." Therefore, the coverage afforded by the term "in" in the medical payments provision is properly limited to injury sustained by one while in the passenger compartment.

b. Upon. Two theories or rules have developed with regard to the construction of the term "upon." The first of these is the physical contact theory which has been stated as follows:

In some cases where the injury sustained was determined to be within the coverage of a clause in a policy providing for indemnity for injuries sustained while . . . "upon," an automobile, the injured person, although not sitting in the place provided for the seating of passengers, was in some sort of physical contact with the automobile.

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145 294 Ky. 680, 172 S.W.2d 566 (1943).
146 For cases with similar fact situations reaching the same result, see Stewart v. North Am. Acc. Ins. Co., 33 S.W.2d 1005 (Mo. Ct. App. 1931) and Inter Ocean Ins. Co. v. Norris, 205 Tenn. 217, 326 S.W.2d 437 (1959).
147 Annot., supra note 144, at 956.
McAbee v. Nationwide Mutual Insurance Co.\footnote{249 S.C. 96, 152 S.E.2d 731 (1967).} applied the physical contact theory. The action was on a policy which provided indemnity in case of bodily injury or death while in or upon, entering or alighting from, a described motor vehicle. The insured sustained fatal injuries when he was crushed against the rear of a stationary vehicle by a tractor rolling down a slope. The sole question was whether the insured, while standing with his back against the vehicle and his arms out in an effort to keep the tractor from rolling against him, was “upon” the vehicle within the meaning of the policy. The court, in allowing recovery, stated:

[W]e do not think that the meaning of the word “upon” is restricted to “on top of,” as when the weight of a person's body is resting upon or supported by the vehicle . . . .

One of the common and ordinary meanings of the word “upon” is that of “contact with” . . . . Since the policy contains no restrictions as to how or in what manner the insured was to be upon the vehicle, we think it reasonable to conclude that the parties contemplated a construction of the word that would include actual physical contact with the vehicle the insured was using.\footnote{Id. at 732-33.}

The second rule of construction formulated in interpreting “upon” is the “use” rule. According to this rule, as long as the insured is injured as a direct result of the risk insured against (the use of the automobile) he is covered. An illustrative case is Madden v. Farm Bureau Mutual Automobile Insurance Co.\footnote{82 Ohio App. 111, 79 N.E.2d 586 (1948).} This was an action on a medical payments provision covering injury while occupying an automobile. The insured had stopped to change a flat tire; after he had changed the tire and while in the act of placing the removed tire in his trunk, he was struck by an approaching automobile and wedged between the automobiles. While placing the removed tire in the trunk, the insured was standing behind the automobile and almost touching it, and was leaning forward with the upper part of his body and arms in the trunk. The insurer argued that the insured was not “in” or “upon” or “entering” or “alighting from” the automobile at the time he was injured. The court answered this argument:

However, he was using the automobile and was in such relation to it as to subject himself to the hazard insured against and was injured as a direct result of that risk . . . . It seems to us that it was the intent of the insurer, by the language used, to provide for coverage in every case in which the owner was using the automobile and in such a position in relation thereto as to be injured in its use. In reaching a conclusion on this subject, not
only the act in which the insured was engaged at the time, but
also his purpose and intent must be considered.\textsuperscript{151}

The court accordingly held that the policy covered the plaintiff's in-
juries.

Another case in which the "use" rule was applied is Pennsylvania
National Mutual Casualty Insurance Co. v. Bristow;\textsuperscript{152} an action under
an uninsured motorist endorsement which provided coverage while
"occupying" the insured automobile. The plaintiff had raised the hood of
the car and was leaning over the motor to check some of the wiring. His
legs were touching the bumper and his stomach may have been touching
the automobile. At that moment, the disabled automobile was struck by
an automobile driven by an uninsured motorist and the plaintiff was in-
jured. The issue was whether the plaintiff was covered by the policy
of the driver of the disabled vehicle. More precisely, was the plaintiff
"upon" the automobile at the time of the accident? The court rejected
the "physical contact" or "touching" theory and accepted the "use"
theory by declaring:

The word "upon" must be viewed with relation to the word
in the policy which it defines, that is, the word "occupying." . . . When the disputed word is so viewed and read, it is clear
that to be "upon" an insured vehicle is to have some connection
with "occupying" it . . . .

Within the purposes contemplated here, a person may be
said to be "upon" a vehicle when he is in a status where he is
not actually "in," or is not in the act of "entering into or alight-
ing from," the vehicle, but whose connection . . . relates to his
"occupying" it.\textsuperscript{154}

Since the plaintiff had not used the automobile in relation to the risk
insured against, he was denied coverage.

It would appear that the "use" rule is the better way to construe the
word "upon." Although "upon" is clearly meant to cover a class of
situations not necessarily included in the other component terms, mere
physical contact by a person with an automobile should not subject an
insurer to liability for medical expenses.

c. Entering. The words "entering into" constitute a simple phrase
and would appear at first to present no problem. Such is not the case.
The problem of the courts is the ascertainment of the moment when
the act of entering begins. Once it is ascertained that entrance into the
automobile had started, then coverage will be allowed. Any point short
of that moment will be termed an "approach" and, even though car-
rried out with intent to enter, will fall short of the required action on

\textsuperscript{151} 79 N.E.2d at 588.
\textsuperscript{152} 207 Va. 381, 150 S.E.2d 125 (1966).
\textsuperscript{153} 150 S.E.2d at 128.
the part of the injured person. Two cases will amply illustrate this distinction.

In *New Amsterdam Casualty Co. v. Fromer*, the plaintiff had stopped to investigate a possible collision between his car and another car. He was struck by a third automobile while about six feet from his car. He was returning to his car for the purpose of entering it. The plaintiff sought recovery of his medical expenses under his policy coverage for injury while entering an automobile. The court referred to the Webster’s definition of “entering” and found it to be the equivalent to “going into; passing into the interior of.” The court then concluded:

Applying these word meanings to the present situation . . . plaintiff was plainly not “entering” his automobile when his injury occurred. . . . True [plaintiff] says he was in the act of walking toward his automobile “to enter same.” But the most that can be said for this activity is that he was approaching the vehicle for the prospective purpose of “entering.” We cannot agree that an intent to enter converts an act of approaching into an act of “entering.”

Judgment was entered for the defendant-insurer.

*Goodwin v. Lumbermens Mutual Casualty Co.* also involved the meaning of the term “entering.” The plaintiffs, who had attended a wedding, started back to their automobile in order to return home. One of them had unlocked and opened the right front door and was reaching to unlock the rear door; another was holding the front door; a third was standing beside it; and a fourth had hold of the handle of the rear door. At that moment an oncoming vehicle collided with the plaintiffs, causing injuries to each of them. In allowing coverage under the “entering” term of the medical expenses provision, the court said: “They had all completed their approach to the car, they were not coming up to it with the purpose of entering it, they had reached it, and they were actually engaged in the process of getting in. That is what Coverage D [medical expenses] intended by ‘entering’.”

These cases illustrate the importance of determining the time at which approach has ended and the point at which the act of entering the automobile has begun.

d. *Alighting.* Litigation regarding the construction of the “alighting from” aspect of the definition of occupying has arisen due to a failure of the insurance contract to define when the act of alighting is completed. Accordingly, the courts have construed the term most favorably to the insured. However, the courts have differed as to when

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155 Id. at 648.
156 199 Md. 121, 85 A.2d 759 (1952).
157 85 A.2d at 764.
one has reached the point of no-return, that is, when one has completed the act of "alighting" so as to cut off the coverage provided by that term.

A New York court, in *Katz v. Ocean Accident & Guaranty Corp.*, has applied a "naturally and consequentially related" test in defining the coverage afforded by the term "alighting." The plaintiff's wife, after getting out of the driver's seat, was locking the automobile with her hand upon the door. Suddenly seeing an oncoming vehicle bearing down on her she ran behind her automobile to protect herself. The oncoming automobile struck her car and pushed it back, crushing her between her car and one that had been parked behind it. The insurer refused payment on the ground that she was not alighting from the automobile—that the injured party must have some physical contact with some part of the automobile at the time of the accident. The court rejected this narrow interpretation and held that she was covered by the policy. It concluded:

> [I]t would appear that plaintiff's wife was still in the act of alighting from the car because the ordinary individual reading the terms of the policy in the instant case would naturally conclude that locking the door of a car is a natural and consequential act related to the actual alighting from the car and securing same properly.

The Mississippi Supreme Court used a "continuity of movement" test in construing "alighting" in *St. Paul-Mercury Indemnity Co. v. Broyles.* The plaintiff had parked her automobile in a garage located at the top of a sloping drive, pulled on the hand brake, stepped out of the automobile, closed the door and walked to the rear of the car with the intent to enter her house. The automobile's brakes slipped while the plaintiff was behind the rear bumper and the automobile ran over the plaintiff while she was running to avoid it. Defendant-insurer denied coverage since plaintiff had already lighted from the automobile and was finished with it for the time. The court rejected this argument. It reasoned:

> [The medical payments provision] applies to injuries . . . "while" alighting from the automobile. This means "during the time that" or "as long as." . . . The word "while" connotes some continuity of actions by the injured person.

> . . . "Alighting" from the automobile literally means to remove a burden from it, to get down or descend.

> Considering these terms together, the entire provision, and the context of its purpose in such a policy, we think that it extends to and covers the injuries . . . There was a continuity of

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\(^{160}\) 112 N.Y.S.2d at 739.

\(^{160}\) 230 Miss. 45, 92 So. 2d 252 (1957).
movement, and . . . there was no interruption in [plaintiff's]
actions involved in the act of alighting from the car and leaving
it.

Coverage C should not be disassociated . . . so as to limit the
meaning of the word "alighting" to simply the physical act of
stepping out of the car and on the ground.\textsuperscript{161}

Perhaps the most reasonable interpretation of "alighting" is found
in the case of \textit{Carta v. Providence Washington Indemnity Co.}\textsuperscript{162} There
the Connecticut Supreme Court adopted a "naturally related" test but
with the added refinement of an "independent course of conduct" limi-
tation. The facts in this case are amazingly similar to those of the \textit{Broyles}
case.\textsuperscript{163} Here the plaintiff was injured when the automobile she had
alighted from ran over her as she attempted to pass in front of it to
enter a cafe. The court held that the policy left uncertain the point at
which the act of alighting is complete and that such ambiguity would
forbid a narrow construction of the term. The court laid down the
test as follows:

The purpose of the coverage was to pay the bills incurred by a
person injured as the result of an accident occurring while he
was engaged in the variety of actions normally performed by
one getting out of an automobile . . . . Some reasonable length
of time must be allowed a person, after getting out, for the com-
pletion of acts which can reasonably be expected from those in
similar situations.\textsuperscript{164}

The following limitation was put on the foregoing rather indefinite
test: "A person is not in the process of alighting if, at the time, he
has completed all acts normally performed by the average person in
going out of an automobile under similar conditions and if he has
embarked upon a course of conduct entirely distinct from acts reason-
ably necessary to make an exit from the car."\textsuperscript{165} Applying this test,
the court ruled that the plaintiff was not alighting from the automobile
when injured, and recovery was denied.

The "independent course of conduct" limitation, as enunciated by
the court in \textit{Carta}, appears, for three reasons, to be the best definition
of when one is "alighting from" an automobile. First, it affords the
finder of fact an ascertainable cutoff point in construing the term
"alighting." Second, it resolves the ambiguity in favor of the insured
without extending the coverage beyond the plain meaning of the words.
Third, it comes closest to arriving at the intent of the parties.\textsuperscript{166}

\begin{itemize}
  \item \textsuperscript{161} 92 So. 2d at 254.
  \item \textsuperscript{162} 143 Conn. 372, 122 A.2d 734 (1956).
  \item \textsuperscript{163} 230 Miss. 45, 92 So. 2d 252 (1957).
  \item \textsuperscript{164} 122 A.2d at 736.
  \item \textsuperscript{165} \textit{Id.} at 737.
  \item \textsuperscript{166} Perhaps the ultimate attempt to expand the definitional content of the term
      "occupying" occurred in \textit{Hollingsworth v. American Guarantee & Liability
      Ins. Co.}, 254 A.2d 438 (R.I. 1969). The plaintiff pedestrian in that case,
5. Through Being Struck by an Automobile

One of the major areas of contention over the medical payments provision is the definitional content of subsection (c) of Division One (the coverage division for named insureds and their relatives), which allows coverage to one who is injured "through being struck by an automobile." The phrase is espoused by plaintiffs who are, most often, named insureds and not qualified under the other sections of the medical payments provision. The most obvious example is a pedestrian who is run over by an automobile. He is occupying neither an owned nor non-owned automobile and must rely on subsection (c). The problem also arises when a plaintiff without medical payments coverage attempts to benefit from such coverage held by the defendant tortfeasor. Most of the cases to be discussed and cited involve a medical payments provision. Some cases involve precursors of such coverage which had substantially similar language (for example, accident policies for pedestrians). (Such differences as exist will be footnoted.) The courts have often ignored the fact that a policy in a precedential case did not involve a medical payments provision and have instead focused on the actual words "through being struck by an automobile." Schematic diagrams are included in the hope that they might possibly aid the reader in understanding the total problem as well as each fact grouping.

a. No Physical Touching With Plaintiff

Figure 1.

"S," enclosed in a rectangle in this figure, and in those to follow, is the striking vehicle. The arrow indicates the striking. The encircled "P" indicates the person of the plaintiff. When enclosed in a rectangle, the plaintiff is an automobile. In such a case there is no physical touching between the striking vehicle and the person of the plaintiff.

According to the literal language of the policy, the plaintiff has not been struck by an automobile. Rather, his automobile has been struck by another automobile. The plaintiff, in these cases, has been actually touched by his own automobile or by some object outside of his vehicle, attempting to recover under the medical payments provision of the insurance of the driver who struck him, unsuccessfully argued that the ultimate impact with the injuring vehicle was itself sufficient to constitute "occupying."
such as the road. The question of whether this plaintiff has been injured "through being struck by an automobile" continues to be asked, probably because of the influence of two 1945 cases which both held for the defendant-insurer.  

In one of those cases the plaintiff argued that he had been struck by his own automobile. The court answered that there was no "personal contact," that the concern was not with proximate cause and that the phrase: "means to be struck by an automobile other than one in which one has the activity status of being a driver of an excluded vehicle." In the other case the court also stressed that this was not a question of proximate cause but rather of simple unambiguous policy language. The court succinctly reasoned: "It never touched him." With the exception of one unusual Texas case the trend has clearly been away from this literal reasoning.

The cases which hold for the insured simply state that the phrase must be given its common, usual, reasonable and ordinary meaning.

Two cases have drawn an analogy to the tort of battery in which "striking an object identified with the plaintiff" has the same juridical effect as actually striking the plaintiff. Finally, one case expresses the common argument that the insurer could have explicitly limited

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168 Johnston v. Maryland Cas. Co., 22 Wash. 2d 305, 155 P.2d 806 (1945) (an automobile accident policy which read, "struck or run over by an automobile"); Metropolitan Cas. Ins. Co. of N.Y. v. Curry, 24 So. 2d 316 (Fla. 1945) (limited accident policy).


170 155 P.2d at 808. There was a very brief dissent at 808.

171 Metropolitan Cas. Ins. Co. of N.Y. v. Curry, 24 So. 2d 316 (Fla. 1945) (The policy read, "struck by an automobile which is in motion under its usual motive power." Id. at 317).

172 Id. at 318.

173 In Vaughn v. Atlantic Ins. Co., 397 S.W.2d 874, 875 (Tex. Civ. App. 1965), the policy contained an exclusion for bodily injury, "sustained by the named insured or a relative (1) while occupying an automobile owned by or furnished for the regular use of either the named insured or any relative, other than an automobile defined as an 'owned automobile.'" The plaintiff came squarely within this exclusion. The court refused to accept the plaintiff's argument that the "through being struck by an automobile" provision meant that the exclusion only applied to one-car wrecks. The policy was held not to be ambiguous. Compare Vaughn with Hale v. Allstate Ins. Co., 162 Tex. 65, 344 S.W.2d 430 (1961), and Cockrum v. Travelers Indem. Co., 420 S.W.2d 230 (Tex. Civ. App. 1967).


recovery to actual physical contact.\textsuperscript{170} It seems predictable that insureds will win cases in this category despite the actual wording of the policy.

\begin{itemize}
\item[b.] \textit{Separated Part of Automobile Hits Plaintiff}
\end{itemize}

\begin{figure}
\centering
\includegraphics[width=0.5\textwidth]{figure2.png}
\caption{Figure 2.}
\end{figure}

In this situation the plaintiff was struck not by what can be loosely termed the “entire” automobile, but rather by a separated part $S_1$. In a sense this problem involves again the definition of the term “automobile.” Is $S_1$ an automobile? If the plaintiff had been struck by $S$, absent $S_1$, would this constitute being struck? What if $S$ and $S_1$ were somehow miraculously the same size? Where is the line to be drawn?

Fortunately the cases have been neither numerous nor complex. There are two old cases with very scanty reasoning. One involved a nut flying off a wheel;\textsuperscript{177} the other involved an exploding tire, with the tube and rim hitting the plaintiff.\textsuperscript{178} Both cases held for the defendant insurer. A fuller consideration of this issue was given in a more recent case, \textit{Beagle v. Automobile Club Insurance Co.}\textsuperscript{179} The plaintiffs in that case while spectators at a race track, were injured when a wheel came loose from one of the racers. The plaintiffs recovered. The court said:

Certainly if the remainder of the automobile with only three wheels had run off the track and injured some one, the Court feels it would still be an automobile even though it had only

\begin{itemize}
\item[\textsuperscript{170}] Labracio v. Northern Ins. Co. of N.Y., 66 N.J. Super. 216, 168 A.2d 682, 685 (1961). Analogously, the phrase “physical contact,” as between automobiles, has been used in uninsured motorist endorsements as a protection against fraud involving the hit and run situation. Even this terminology has created problems when there has been a chain accident, which has not yet arisen in conjunction with the phrase “through being struck by an automobile.” \textit{See}, \textit{e.g.}, Inter-Insurance Exch. of the Auto Club of S. Cal. v. Lopez, 238 Cal. App. 2d 441, 47 Cal. Rptr. 834, 836 (1966); Motor Vehicle Acc. Indemnification Corp. v. Eisenberg, 18 N.Y.2d 1, 218 N.E.2d 524, 271 N.Y.S.2d 641 (1966); Johnson v. State Farm Mut. Auto. Ins. Co., 70 Wash. 2d 587, 424 P. 2d 648, 649 (1967).
\item[\textsuperscript{177}] Harley v. Life & Cas. Ins. Co. of Tenn., 40 Ga. App. 171, 149 S.E. 76 (1929); “A nut, flying off of an automobile, is not an automobile or a substantial portion thereof.” 149 S.E.2d at 76. The court seemed sure that if the nut was lying in the street, the plaintiff surely could not win. The fact that there was grave doubt whether the plaintiff could prove the nut came off the car probably hurt his case. The plaintiff was the only witness. The case involved a pedestrian policy with no important language differences.
\item[\textsuperscript{178}] Enyon v. Continental Life Ins. Co. of Mo., 252 Mich. 279, 233 N.W. 228 (1930) (also involving a pedestrian policy).
\item[\textsuperscript{179}] 86 Ohio L. Abs. 67, 176 N.E.2d 542 (C.P. 1960).
\end{itemize}
three wheels. The Court can see no difference in principle between such a situation and the situation that we have in this case.180

The plaintiff-insured actually lost the case because the court held that the entire vehicle, a racing car, was not covered by the insurance policy. It would seem that another argument that a plaintiff could make in such a case is that a person is always struck by only a part of a vehicle, such as the left front bumper or the four wheels. The only real difficulty is that in these cases there is a detachment before the striking.

Two other old cases which are somewhat analogous will be discussed under this category. In one,181 a pedestrian was struck in the eye by a wire which was wound around some pipes being transported by a truck. The wire was not attached to the truck in any way, but only to the load. The ultimate question was whether being struck by the load was equivalent to being struck by the vehicle itself. The court, holding for the insurer, said:

The load is that which is deposited when the destination is reached. The vehicle is what comes back. It is not conceivable that a load of watermelons or chickens could, except by a most strained construction, be regarded as a part of the truck itself. If one having purchased a truck, upon going to get it, found it loaded with brick, would it ever occur to him that the brick were included in the purchase? If a driver was told to ascertain the weight of a vehicle, would any, but an imbecile, drive the loaded truck upon the scale?182

It must be emphasized that this is a 1933 case by an intermediate appellate court dealing merely with a precursor of the medical payments provision.183 It is discussed because it illustrates the problems which could arise under the medical payments provision. It poses the question whether one would be able to recover his medical expenses under the medical payments provision of his automobile liability policy if a watermelon flew off a passing truck and struck him in the head.

A second old case, Gilbert v. Life & Casualty Co. of Tennessee,184 involved a cable. Unlike the wire in the previous case, however, the

180 176 N.E.2d at 543-44.
182 Id. at 335.
183 The case involved an “Industrial Travel and Pedestrian Policy” which read (Id. at 333): “If insured shall be struck by actually coming in physical contact with a vehicle itself, and not by coming in contact with some object struck and propelled against the person by said vehicle.” The fact that the premiums on these policies were very low may have influenced the court. Id.
184 185 Ark. 256, 46 S.W.2d 807 (1932). This case also involved a pedestrian policy which read: “If the insured shall be struck by a vehicle . . . .” Id. at 808. The case hinted that there would be recovery regardless of what was attached to the vehicle and whether it served some functional purpose. Id.
cable was attached to the vehicle as a device for pulling out tree stumps. The court held that being struck by the cable was no different from being run over by the vehicle. What a modern court would do with these wire cases or with the cases in which a part of the automobile actually becomes separated is speculative. What is an "automobile" is the surface issue.

c. Object Hits Plaintiff.

![Figure 3](image)

In this situation there are actually two strikings. After S comes in physical contact with the object, the object comes in physical contact with the plaintiff. This could be, for instance, a chain accident in which the object is not an "automobile" within the policy as, for example, a motorcycle. Has the plaintiff been struck by S?

The insured has been successful in those cases which use the typical policy language. Since the insurer could make the provision clearer it is construed against him. One case which the insurer did win, Patin v. Life & Casualty Insurance Co. of Tennessee, involved a policy which was written by a scrivener who was clearly aware of the problems in the area. The policy read, in part: "If the injured shall be struck by actually coming in physical contact with the vehicle itself and not coming in contact with (1) some object loaded on or (2) attached thereto, or (3) some object struck and propelled against the person by said vehicle . . . . This language was an attempt to anticipate cases relating to the previous category (dealing with a separated part of the automobile), this category (automobile knocks down object), and the next category (automobile causes object to fly).

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188 Id. at 220 (emphasis added).
189 In addition to having a strictly drafted policy (an industrial and pedestrian policy), the case had, from the plaintiff's viewpoint, weak facts. The insured was killed when a ditch in which he was working caved in due to vibration of the ground caused by a passing automobile.
d. Flying Object Hits Plaintiff.

The only difference between these facts and Figure 3 is that the first of the two strikings causes the object to fly before it strikes the plaintiff. They are generically the same fact situation.

As in the previous category there is no actual physical touching between the striking vehicle and the plaintiff. In three cases the flying object was a plank placed under the vehicle to provide traction. Both cases which held for the insurer simply stated that the plaintiff was struck by a board, not an automobile, and that the policy was not ambiguous.\footnote{Gant v. Provident Life & Acc. Ins. Co. of Chattanooga, 197 N.C. 122, 147 S.E. 740 (1929) (This case involved an accident policy with a schedule of payments like workmen's compensation. It read, "struck, run down or run over by a moving automobile." Id.); Quinn v. State Farm Mut. Auto. Ins. Co., 238 S.C. 301, 120 S.E.2d 15, 17 (1961) (relied heavily on Gant).}

The third traction plank case, which held for the insured, ignored the literal language of the policy and delved into the world of tort causation.\footnote{State Farm Mut. Auto. Ins. Co. v. Johnson, 242 Miss. 38, 133 So. 2d 288 (1961).} The court held:

The blow inflicted upon the insured as a result of his being struck by the piece of timber hurled at him was the efficient and proximate cause of his injury and death; and the fact that he was struck by the piece of timber hurled at him by the moving car instead of by some part of the moving vehicle seems immaterial.

The agency which inflicted the blow was the moving vehicle, against blows from which he had contracted for indemnity.\footnote{133 So. 2d at 290; see also the dissent in Quinn v. State Farm Mut. Auto. Ins. Co., 238 S.C. 301, 120 S.E.2d 15, 20 (1961).}

This appears to be a broadening of the literal language but at least the court is helpful enough to state its reasoning rather than merely finding ambiguity and construing against the insurer.

Two other old cases were found in which objects smaller than planks were hurled. One is the Harley case,\footnote{Harley v. Life & Cas. Ins. Co. of Tenn., 40 Ga. App. 171, 149 S.E. 76 (1929); see 10 U.S.C. § 6203 (1964).} discussed in the category dealing with a separated part of the automobile striking the plaintiff. Harley indicated that there could be no recovery for injuries caused by a nut propelled off the ground by an automobile. The other
case, *Maness v. Life & Casualty Co. of Tennessee*, specifically rejected *Harley*. The object was a rock. The reasoning was quite similar to that in the third traction plank case, *State Farm Mutual Automobile Insurance Co. v. Johnson*, which had relied on *Maness* heavily. It was held that "the agency which inflicted the blow" was the automobile. Although *Maness* is a 1930 case not dealing with the medical payments provision, which did not then exist, it was still very influential thirty-one years later.

**e. Must Plaintiff be Struck by Automobile?**

![Figure 5](image)

In both cases found by the authors there was no question that there was a striking; the issue of physical touch did not arise. The problem is that what has been termed in these diagrams the "striking" vehicle was not the striker. The arrows point in the opposite direction.

The key word would appear to be "by" rather than "struck." In *Foundation Reserve Insurance Co. v. McCarthy*, a motorcycle ran into a moving automobile. The court relied on Webster to supply the law.

"by"] has various meanings depending upon the intention and purpose of its use. Webster's Dictionary, [Third New International] among other definitions gives the meaning as: "through", "through the medium of", "through the means of", "in consequence of." We think that the phrase is . . . ambiguous. Whenever a court finds an ambiguity in the insurance contract the insured recovers. This case was no exception.

In the only other case directly considering this issue a bicycle ran into a parked vehicle. This case, holding for the insurer, probably construed the policy more in line with its ordinary meaning. The in-

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194 *161 Tenn. 41, 28 S.W.2d 339 (1930)* (accident insurance policy, same insurer as in *Harley*).

195 *242 Miss. 38, 133 So. 2d 288 (1961)*.

196 *Maness v. Life & Cas. Ins. Co. of Tenn., 161 Tenn. 41, 28 S.W.2d 339, 340 (1930)*.

197 *77 N.M. 118, 419 P.2d 963 (1966)*.

198 *419 P.2d at 964; see also* the dissent in *Quinn v. State Farm Mut. Auto Ins. Co., 238 S.C. 301, 120 S.E.2d 15, 20 (1961)*.

sured did not recover because the automobile was not the "striking force," or the "causation force," but rather merely a "passive vehicle." 200

f. Must Automobile be Propelled by Its Own Motive Power?

In Dean v. American Fire & Casualty Co., 201 a jack collapsed while the plaintiff was attempting to remove it from under an automobile. The automobile fell, injuring the plaintiff. Was he struck by an automobile within the meaning of the medical payments provision of the automobile liability policy? The defense argued, taking a hint from old-fashioned "pedestrian" policies, that the policy contemplated "forward or backward movement while being propelled under its own motive power." 202 The court did not agree.

The word "struck" is the past tense of the word "strike" which in its plain, ordinary and popular sense means "to hit with some force"; "to come in collision with"; "to give a blow to"; "to come into contact forcibly". . . Here, the falling automobile with the causitive force bringing about the appellant's injury. 203 The court, purporting to adhere to the ordinary meaning of the word, held for the insured.

Two cases in this category, spanning over thirty years, each involved an exploding tire. The insured lost in both cases. 204 In the more recent case the plaintiff was changing a wheel. While he was replacing a missing bolt the tire exploded, causing the tire and part of the wheel to strike the plaintiff. The plaintiff brought action against his medical payments insurer. The court, as did the court in the Dean case, purported to discern the common meaning of the policy:

[W]e conclude that the parties to the insurance contract intended that plaintiff was to be insured against the usual injuries from an automobile (or trailer in this case) resulting from being struck, run into or run down by the vehicle, and that there was no intent to provide coverage for the unusual type of accident which occurred here, where the trailer did not in any way participate in causing the blow. 205

There was a dissent in which the judge would not have exculpated the insurer unless his policy had read "struck by an entire automobile in motion." 206

In the above three cases there was some movement by the automo-

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200 339 S.W.2d at 893.
202 152 S.E.2d at 248.
203 Id. at 248-49.
205 152 So. 2d at 71.
206 Id.
In *Houston Fire & Casualty Insurance Co. v. Kahn*, previously discussed in conjunction with the word "by," a bicycle ran into a parked automobile. There was no movement at all on the part of the unoccupied automobile. The court held for the insurer since the "movement and propulsion" of the automobile was not a factor in the collision.

In summary, the words "through being struck by an automobile" have caused a variety of close cases. The only way to predict a result is to classify the case in question with other similar fact situations, keeping carefully in mind the danger involved in each word.

6. Permission

The medical payments provision of the automobile liability policy commonly covers bodily injury to the named insured and each relative: "[W]hile occupying a non-owned automobile, but only if such a person has the permission of the owner to *use* the automobile and the *use* is within the scope of such permission." The difficulty with this wording is the meaning of "permission." Generally speaking, some courts have given a liberal and others a strict interpretation of the term. All of the cases found deal with the so-called "second permittee problem."

The liberal view is illustrated by *Loffler v. Boston Insurance Co.*, where a father permitted his son to use the car for a date, specifically instructing not to let anyone else drive. The boy let his date drive. She was the so-called second permittee. The court held that:

> [T]he car was being *used* by the insured's son for the very purpose for which permission had been granted. He did not, by the mere act of turning the wheel over to his companion, convert the automobile to a different *use*. He did not become a mere piece of supine cargo: he was still *using* it for "dating" purposes, only the driver being changed. While it is true that a car cannot be operated without being *used*, the converse is not true. We must decline to hold the automobile was not in a permitted *use* at the time of the tragic accident.

The girl was also allowed to recover. The court relied on cases which, while not involving the medical payments provision, discussed the word "permission" in other insurance contexts. The concept is not peculiar to the medical payments provision. The court advised the insurer that

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208 359 S.W.2d at 893.

209 Milwaukee Mut. Ins. Co., Coverage C—Medical Services, Division 1 (b); Northwestern Nat'l Ins. Co. Policy, Coverage C—Medical Payments, Division 1 (b) (emphasis added).


211 Id. at 693 (emphasis added).
it would not have such difficulties if it would insert the verb "operate" for "use" in the provision.\textsuperscript{212}

Not all cases on permission and the medical payments provisions have been so generous to second permittees. For example, in \textit{Schultz v. Tennessee Farmers Mutual Insurance Co.},\textsuperscript{213} a mother lent her automobile to her son for him to use at college. She had no knowledge that any person other than her son had used the car. The son allowed a college friend to drive the automobile. The plaintiff in the case was a passenger in the car while the college friend was driving. The court held for the insurer, following cases construing the permission concept in non-medical payments insurance cases. A second permittee was not covered unless there was some express or implied permission given by named insured to the second permittee. An example of implied permission would be the permission given to a garage repairman.\textsuperscript{214} In order to predict the result in these cases one must determine whether the concept of permission has been viewed liberally or strictly in the jurisdiction. One must also discover what specific instructions were given to the first permittee.

C. \textsc{Division Two: Payments to Other Persons}

"Division Two" is that language of the medical payments provision which affords coverage to certain other persons who are neither named insureds nor relatives of named insureds. The analysis of Division Two coverage will be limited to a comparison of the coverage provided "all other persons" and the coverage provided to the named insured and relatives in Division One. No cases have been discovered which deal with the particular problems posed by the language used in this portion of the provision. Generally speaking, the language of Division One is the same in most policies. Because the language of Division Two differs from policy to policy two examples of this division will be given. The significant differences in the two policies are noted by italics.

In both of the examples coverage is extended to "all other persons" but is in fact qualified by the requirement that they be occupying an automobile. If injury occurred in an "owned automobile," recovery is predicated on use of the automobile at the time of the accident by the named insured or any other person having the permission of the named insured. Additionally, Example A affords coverage to a person

\textsuperscript{212} \textit{Id.}; Butterfield \textit{v.} Western Cas. \& Sur. Co., 83 Idaho 79, 357 P.2d 994 (1960), is a similar case except there was no special restriction, \textit{i.e.}, there was \textit{general} permission. \textit{See also} American Fire \& Cas. \textit{v.} Glanton, 182 So. 2d 36 (Fla. Ct. App. 1966), which also gives the hint to the insurer that the verb "operation" should be put in the place of "use."

\textsuperscript{213} 218 Tenn. 465, 404 S.W.2d 480 (1966).

\textsuperscript{214} 404 S.W.2d at 480; \textit{see also} Rakestraw \textit{v.} Allstate Ins. Co., 238 S.C. 217, 119 S.E.2d 746 (1961), for another case involving the strict rule.
Example A.
Division 2. To or for any other person who sustains bodily injury, caused by accident, while occupying
(a) the owned automobile, while insured, by any resident of the same household or by any other person with the permission of named insured, or
(b) a non-owned automobile, if the bodily injury results from
(1) its operation or occupancy by the named insured or its operation on his behalf by his private chauffeur or domestic servant, or
(2) its operation or occupancy by a relative provided it is a private passenger automobile or trailer,
but only if such operator or occupant has, or reasonably believes he has the permission of the owner to use the automobile and the use is within the scope of such permission.\(^{215}\)

Example B.
Division 2. To or for any other person who sustains bodily injury, caused by accident, while occupying
(a) the owned automobile, while being used by the named insured or by any other person with the permission of the named insured; or
(b) a non-owned automobile, if the bodily injury results from its operation or occupancy by the named insured or its operation on his behalf by his private chauffeur or domestic servant but only if such operator or occupant has the permission of the owner to use the automobile and the use is within the scope of such permission.\(^ {215}\)

injured by an owned automobile while being used by any resident of the named insured’s household, regardless of whether the resident has permission to use the vehicle. It is important to remember that negligence plays no part in the recovery.

The coverage for one operating a “non-owned automobile” is more narrow. When occupying a non-owned automobile one must also be prepared to prove the injury results from the operation or occupancy of the automobile by the named insured or by its operation on his behalf by his private chauffeur or domestic servant. Again negligence plays no part in recovery. The words “result from” indicate only that the insured’s conduct relates to the injury. As in the case of “owned automobiles” the coverage under Example A is broader than that under B. A also affords coverage when the injury results from the operation or occupancy of a non-owned automobile by a relative.

The major distinction between Division Two and Division One is that under the former the injured party must be an occupant of an automobile (owned or non-owned) whereas there is coverage under Division One even if the injured party is not an occupant but is merely “struck by an automobile.” Any further comment on Division One and its relationship to Division Two must await court interpretation.


\(^{216}\) Milwaukee Mut. Ins. Co. Policy, Coverage C—Medical Services, Division 2.
D. Set-Off of Medical Payments Against Liability of Tortfeasor-Insured

This section investigates the question of whether sums disbursed under the medical payments provision, providing coverage regardless of fault, may be deducted by a tortfeasor-host or his insurer from the amount awarded an injured passenger in an action based on the host's negligence. At its inception, the medical payments provision was intended to be a credit to the named insured in the event he was liable in tort to a passenger, that is, any payments made to a passenger should accordingly reduce the liability of the insured for such injury. However, such intent was not initially expressly incorporated into the insurance contract. Early decisions interpreting the medical payments provision allowed a guest to recover his medical expenses twice—once under the medical payments provision of his host's policy and again under the liability coverage in a tort action based on the host's negligence.

Faced with the prospect of double recovery, some insurers incorporated provisions into their policies to the effect that any amount payable under the liability coverage of the policy will be reduced by payments made to such person under the medical payments provision. As will be illustrated, this obviates the problem of double payment

217 For another treatment of the same topic, see Annot., 11 A.L.R.3d 1115 (1967).
220 A typical example of such a provision, taken from the Milwaukee Mut. Ins. Co. Policy, reads: [P]rovided that no such payment shall be made under Division 1 or Division 2 unless the person to or for whom such payment is made shall have executed a written agreement that the amount of such payment shall be applied toward the settlement of any claim, or the satisfaction of any judgment for damages entered in his favor, against any insured because of bodily injury arising out of any accident to which the liability coverage applies.

The exact language of these provisions is very important. Financial responsibility acts have been utilized by some courts recently to invalidate "other insurance" provisions of uninsured motorist indorsements. For example, see Sellers v. United States Fid. & Guar. Co., 185 So. 2d 689 (Fla. 1965). See also Pouros, Multiple Uninsured Motorist Coverage Under More Than One Policy, Defense Memo, 10 For The Defense No. 8 (Oct. 1969). If the medical payments set-off provisions are not carefully worded they may suffer a similar fate. It is necessary that the provision does not reduce the statutorily mandatory bodily injury coverage, but rather reduces only the non-mandatory medical payments coverage. An example of a provision which has successfully withstood this public policy attack is found in Caballero v. Farmers Ins. Group, CCH Auto Ins. L. ¶ 6324, 9041-2 Ariz. App. June 20, 1969.

"(1) Expenses Actually Incurred. 'Expenses actually incurred' means expenses for medical services . . . in excess of those paid or payable to or on behalf of any person . . . (b) as damages under Part I [the Bodily Injury Liability coverage] . . . and all payments made to or on behalf of any person under this Part III [Medical Payments Provision] shall be deemed to have been advanced under the coverage afforded by Part I . . . . (Emphasis by the Court.)"
and alleviates the increased costs for both the insurer and the insured. Such a provision also obviates the problems which face the courts in arriving at a disposition of cases in which double recovery is sought under policies lacking such a provision.

In the few cases in which double recovery has been sought under a policy containing a set-off provision, the courts have given effect to the provision, finding an intent not to duplicate benefits. In the Louisiana case of Bowers v. Hardware Mutual Casualty Co.,\footnote{110 So. 2d 671 (La. Ct. App. 1960).} the plaintiff had been paid the amount of her medical expenses by the defendant-insurer. Notwithstanding this fact, the plaintiff contended she was entitled to recover an identical amount under the general liability provisions of the policy. The court, relying on the set-off provision contained in the policy, refused to allow any medical expenses to be included in the recovery of damages under the liability coverage.

Likewise, in Gunter v. Lord,\footnote{242 La. 943, 140 So. 2d 11 (1962).} the court held that the plaintiffs, who had recovered their medical expenses under the medical payments provision of their host’s policy, were not entitled to recover the same expenses in an action brought under the liability coverage of such policy. The court analyzed the policy coverage carefully, noting the condition relating to medical payments coverage that payments made “shall reduce the amount payable hereunder for such injury.” The court denied a double recovery of the guest’s medical expenses, concluding:

\begin{quote}
We think the parties to the contract clearly intended coverage C [medical expenses] to provide medical payments in all cases, up to the stated limit, but, in the event of tortious conduct on the part of the insured, that such payments would satisfy the claim for damages normally awarded for those expenditures.\footnote{140 So. 2d at 16 (emphasis added).}
\end{quote}

Absent such a provision relating to set-off against liability, the courts have arrived at divergent conclusions as to whether an injured guest may recover his medical expenses twice. The crucial elements in the cases are the insurance contract of the tortfeasor and the intent of the parties. Three cases illustrate this particularly well.

The lead case is Severson v. Milwaukee Automobile Insurance Co.,\footnote{245 Wis. 488, 61 N.W.2d 872 (1953).} a direct action against an automobile liability insurer to recover under a medical expenses provision for damages previously recovered in a tort action. The court held that where an automobile liability policy contained a clause providing for payment of medical expenses of any passenger in the insured’s automobile who is accidentally injured and where a separate premium was paid for such coverage, that the clause constituted a separate agreement to pay under any circumstances. The fact that the insurer had previously paid a judgment recovered by the
plaintiff in a tort action arising out of the negligent operation of the automobile did not relieve the insurer of its liability to the plaintiff under the medical payments provision. The insurer had argued that it was not the intention of the parties to the policy that medical expenses be paid twice to any injured person. The court answered: 
"[The medical expenses provision] is an absolute agreement to assume or pay the medical payments. Had the defendant intended to exclude medical payments under coverage K if the same were paid or required to be paid under Coverage A [liability], it could easily have so provided."

In *Moorman v. Nationwide Mutual Insurance Co.*, the issue was whether the plaintiff was entitled to a recovery of her medical expenses under the medical payments provision. She had already received payment for her damages in a tort action against the operator of the insured automobile. The court resolved this issue in the affirmative, noting that where there are separate coverages in an automobile liability policy, with separate premiums for each coverage, a separate and specific claim could arise under each coverage. The court continued: "We do not base our decision on the theory of one claim sounding in tort and the other in contract. Our decision is based on the provisions of the insurance policy before us."

In *Beschnett v. Farmers Equitable Insurance Co.*, the Minnesota Supreme Court was faced with a release of a tortfeasor and a satisfaction by the insurer, pursuant to the terms of a liability policy. The issue was whether a verdict which included medical expenses would bar the plaintiff from again recovering those expenses in a separate action against the insurer under the medical payments provision of the same policy. The court held that where the insurer is neither named in the release nor otherwise expressly relieved of further obligation by it, a party is not thereby barred from bringing a subsequent action to recover medical payments provided by the policy. The court, in allowing double recovery, repeated the following argument from an opinion it cited with approval:

"This question leads to another equitable problem: is the insurer obtaining a double benefit? . . . Two distinctive forms of protection have been supplied for two fees, and yet one payment here will relieve both obligations. This possibility of double charge-single payment is even more unwarranted than what this plaintiff might receive as a possible no charge-double recovery bonanza."

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225 265 Wis. at 493, 61 N.W.2d at 875.
227 148 S.E.2d at 876.
228 275 Minn. 328, 146 N.W.2d 861 (1966).
229 146 N.W.2d at 865.
In these three cases, Severson, Moorman and Beschnett, the plaintiff recovered from the tortfeasor and then brought an action against the host's insurer under the medical payments provision. The courts have turned to the policy language and have uniformly allowed a double recovery by gleaning intent from an analysis of the provisions.

A second situation occurs when the injured guest is paid his medical expenses under his host's medical payments provision and then seeks to recover them again in a negligence action against his host. A good deal of confusion has arisen in these cases from the notion that the answer to the question of set-off is to be found in the collateral source rule. An analysis of the cases in this area will bear this out.

The cases which have denied a double recovery have done so on the theory that payments from a tortfeasor, or from a fund created by him (in these instances, his medical payments coverage) may be shown to mitigate recovery. To hold otherwise would be an offense to the collateral source rule and to equity. Thus, in Yarrington v. Thorneburg, the court held that the tortfeasor was entitled to a credit, in reduction of damages, for medical payments made to an injured guest under the tortfeasor's policy. Speaking of the collateral source rule, the court said: "The doctrine, however, does permit the tortfeasor to obtain the advantage of payments made by himself or from a fund created by him; in such an instance the payments come, not from a collateral source, but from the defendant himself."231

In Dodds v. Bucknum, an injured passenger was denied recovery of her medical and hospital expenses in a tort action against her host. The court noted that they had already been paid for under the medical payments provision of the host's policy. In allowing the credit, the court noted that it made no difference that the payment did not come out of the host's own pocket or from insurance purchased by him since it would be unjust to penalize a tortfeasor who had enough foresight to provide such a fund through insurance. The court concluded: "It should therefore logically follow that if a wrongdoer provides a source or fund out of which the injured party's special damages are paid prior to trial the recovery of plaintiff is diminished to that extent."233

A New York court in Moore v. Leggette, held that the collateral source rule has no application where the tortfeasor himself had procured insurance for the benefit of the injured party. It concluded that there should be a "reduction in damages to the extent that these have already been defrayed by such policy . . . ."235

230 205 A.2d 1 (Del. 1964).
231 Id. at 2.
233 20 Cal. Rptr. at 397.
235 264 N.Y.S.2d at 767.
In each of these three cases denying double recovery, the court did not examine the provisions of the policy, but relied on the fact that the tortfeasor created the insurance fund. It is worthy of note that in both Yarrington and Dodds, the courts sought to distinguish Severson, the lead case for double recovery, on the basis that in Severson the action was directly against the insurer, thus intimating that direct interpretation of the policy involved was the determining factor in that case. But should not interpretation of the policy also be determinative in an action against the tortfeasor?

In only one case did the court purportedly interpret the intent of the parties to the contract and arrive at the conclusion that there could not be a double recovery under both the liability and medical payments provisions. But in that case, Tart v. Register, the court stated that neither the insurance policy nor its provisions were before it. The court admitted: "If double recovery can be had when [the tortfeasor] is insured, it is not by reason of one claim sounding in tort and the other in contract, as suggested, but solely by reason of the provisions of the insurance contract." Yet in the next breath the court, in the absence of the policy, said that: "In our opinion it was not within the contemplation of the contracting parties that there should be a double recovery of medical expenses." On the other hand, some courts have allowed the plaintiff to recover in a tort action against his host after receiving identical medical damages from the host's insurer. Each of these courts reached this conclusion after an examination of the policy involved.

In Long v. Landy, the plaintiff had collected her medical expenses under her husband's policy and sought the same damages in tort from his estate. The plaintiff argued that the estate should receive credit for the insurance fund since the tortfeasor had paid the premiums. The court replied that under the policy the plaintiff was a direct contractual beneficiary. It concluded: "The contractual right is separate and distinct from any right [the plaintiff] may have to recover for the quantum of damages sustained by her from the independent tortious act of her husband. The two should not be confused." In Edmonson v. Keller, the plaintiff was awarded damages in a tort action for medical and hospital expenses which had already been paid under the medical expenses provision of the defendant's policy.

236 205 A.2d 1, 3 (Del. 1964).
238 265 Wis. 488, 61 N.W.2d 872 (1953).
239 257 N.C. 161, 125 S.E.2d 754 (1962).
240 125 S.E.2d at 764 (emphasis added).
241 Id.
243 171 A.2d at 7.
On appeal, the defendant contended that payment for such expenses under the liability provision of the contract was excused. The court rejected this argument and also the application of the collateral source rule, citing the Severson case as authority. The court accordingly denied a credit for medical expenses payments.

In Blocker v. Sterling, the plaintiffs recovered an award against their host which included their medical expenses. These expenses had previously been paid by the host's insurer under his medical expenses coverage. The defendant-host argued that the collateral source rule should not apply since defendant had created the insurance fund and that the parties had not intended that there be a double recovery of medical expenses. The court, relying heavily on Moorman v. Nationwide Mutual Insurance Co., held that since there were two separate premiums and two separate coverages, there could be recovery under each separate undertaking. The court noted that the insurer "provided no... exclusion to indicate that the payments under the medical expenses coverage should not be in addition to payments under liability coverage."248

In summary, double recovery has been denied in, (1) those cases in which a set-off clause is involved and, (2) in some of the cases in which no set-off clause is involved and the plaintiff has first recovered from the insurer and then brings an action against the tortfeasor. On the other hand some of the cases in situation (2) have allowed double recovery, as have cases in which the plaintiff has recovered from the tortfeasor-host and then brings an action against the tortfeasor's insurer.

One source in attempting to resolve the question of whether double recovery should be allowed where a set-off clause is lacking, cogently stated what appears to be the preferable approach:

In this connection, however, the apparent right of the tortfeasor and his insurer to contract for such coverage as they see fit must not be overlooked. Since the law in most states requires no medical payments coverage at all, it is evident that the claimant's rights must be measured to a large extent by the particular language of the individual policy, and while some courts properly approach the question as one calling for construction of the policy language, others seem to erroneously have assumed that they were free to adopt one view or another regardless of the contract.249

245 265 Wis. 488, 61 N.W.2d 872 (1953).
246 251 Md. 55, 246 A.2d 226 (1968).
248 246 A.2d at 230.
249 Annot., supra note 217, at 1117: Another area where insurers have attempted to prevent double recovery involves uninsured motorist coverage as well as medical payments provision. The "Limits of Liability" condition of the 1963 Countrywide Uninsured Motorist Endorsement contains the following subsection which did not appear in the 1956 endorsement:
III. EXCLUSIONS

Relatively few cases were found on the exclusions to the medical payments coverage. Rather than discuss all of the exclusions, which would necessitate a mere recitation of some of the policy language, only those terms which have been litigated in the appellate courts will be discussed.

A. PUBLIC OR LIVERY CONVEYANCE

The first exclusion commonly stated that the policy does not apply to bodily injury sustained while occupying "an owned automobile while used as a public or livery conveyance." In *Spears v. Phoenix Insurance Co.*, a station wagon was transformed into a funeral home ambulance. The court held that the medical payments provision applied.

"[T]he meaning of the phrase 'public or livery conveyance' means the indiscriminate holding out of a vehicle for public use and that in its broadest sense is intended to cover such vehicles as taxicabs and buses which are used ordinarily for the purpose of public conveyances, but it is likewise the opinion of the Court that [it] is not limited to taxicabs or buses, but . . . includes the using of any other vehicle where the operator uses the vehicle as a means of conveying members of the public, usually for a price, but without discrimination as to the persons within the class of persons to be transported, but indiscriminately for any who may call for such service."

The court relied on cases which discussed the exclusion as to non-medical payments insurance.

Another case with a similar holding is *McDaniel v. Glens Falls Indemnity Co.* The plaintiff purchased an automobile and was going
to take a long trip to sell the vehicle. In response to an advertisement soliciting people who were willing to transport others, she took three paying passengers. The plaintiff, who was injured while so driving the automobile, was allowed to recover. The exclusion did not apply. The automobile was not used indiscriminately in conveying the public, but was instead limited to this special occasion.

B. **Farm Type Tractor and Public Roads**

Another exclusion is: "(b) . . . bodily injury sustained by the named insured or a relative while occupying or through being struck by (1) a farm type tractor . . . while not upon public roads . . . ."\(^{255}\)

The case of *Leski v. State Farm Mutual Automobile Insurance Co.*,\(^{256}\) which primarily involved a dispute as to whether an accident site was a public road, explained the public policy behind this exclusion:

> [T]he manifest underwriting intent was to exclude from coverage . . . the risks normally attending the operation of a farm tractor in its ordinary place of usage . . . . A description of the ordinary place of usage would be in and about the fields and premises of a farm . . . . It seems clear that it intended to extend the coverage to operation of a farm tractor in other than its ordinary place of usage; in other words, in a type of operation in which the tractor would be used on the road going to and from farms or when used on the road for hauling.\(^{257}\)

In *Leski*, although a road was not yet officially opened to public travel, people were often using it to reach a specific destination. It was held that a "reasonable understanding . . . by a layman" would include this route as a public road.\(^{258}\) "Public roads" may mean more than some insurers anticipated.

C. **Other Equipment Designed for Use Off Public Roads**

In addition to the "farm type tractor," there is also an exclusion for injury to a named insured or relative while occupying or through being struck by: "other equipment designed for use principally off public roads, while not upon public roads . . . ."\(^{259}\) Two cases have held that other equipment does not mean only other farm equipment.\(^{260}\)

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\(^{255}\) Milwaukee Mut. Ins. Co. Policy, Coverage C—Medical Services, Exclusion (b); Northwestern Nat'l Ins. Co Policy, Coverage C—Medical Payments, Exclusion (b) (1); Wright v. Beacon Mut. Indem. Co., 87 Ohio L. Abs. 178, 179 N.E.2d 547 (C.P. 1961) (a tractor driven on a public road is clearly not excluded).


\(^{257}\) 116 N.W.2d at 721.

\(^{258}\) Id.

\(^{259}\) Milwaukee Mut. Ins. Co. Policy, Coverage C—Medical Service, Exclusion (b) (1); Northwestern Nat'l Ins. Co. Policy, Coverage C—Medical Payments, Exclusion (b) (1).

comprehends, moreover, not only accessories, but entire vehicles.\textsuperscript{261} Furthermore, the \textit{original} design of the vehicle is not determinative. An automobile manufactured for normal use but later modified for racing purposes is "designed for use principally off public roads."\textsuperscript{262}

With the exception of the "other insurance" exclusion, which will be treated in the next section, these are the only exclusions found which have been specifically construed in medical payments provision cases. Some general terms which are integral to the medical payments exclusions, for example, "automobile business," have been defined in other automobile insurance contexts and there is little doubt that such case law would carry over into medical payments coverage.\textsuperscript{263}

D. \textbf{The "Other Insurance" Exclusion}

Some insurers, in order to eliminate duplication and to attain low rate packages for their policyholders, have incorporated an "other insurance" exclusion in their medical payments provision. Such exclusion generally applies:

\begin{quote}
"[T]o that amount of any expense for medical services which is paid or payable to or for the injured person under the provisions of any (1) premises insurance affording benefits for medical expenses, (2) individual, blanket or group accident, disability or hospitalization insurance, (3) medical, surgical, hospital or funeral service, benefit or reimbursement plan or, (4) workmen's compensation or disability benefits law or any similar law."\textsuperscript{264}
\end{quote}

This exclusion is aimed at cases like \textit{Kopp v. Home Mutual Insurance Co.},\textsuperscript{265} in which the plaintiff had a hospitalization plan. The hospitalization insurer reimbursed the hospital directly for services rendered to the plaintiff. When the plaintiff sought to recover these expenses under his medical payments provision, the insurer refused, claiming the plaintiff had incurred no expense. The court allowed recovery. Had the automobile policy contained an exclusion such as that quoted above, this duplication of benefits would have been avoided.


\textsuperscript{262} Id.; see also Beeler v. Pennslyvania Threshermen & Farmers Ins. Co., 48 Tenn. App. 370, 346 S.W.2d 457, 461 (1960).


\textsuperscript{265} 6 Wis. 2d 53, 94 N.W.2d 224 (1959).
More than twenty years ago, when the "other insurance" clause was new, one author expressed the view that: "[I]t is not necessary for the person to collect such benefits in order to be excluded from the coverage." Subsequent court decisions have established the rule that the other benefits need only be payable in order for the exclusion to operate.

In State Farm Mutual Automobile Insurance Co. v. Rice, a suit was brought for medical payments benefits against an automobile liability insurer by one who was struck by an insured automobile. At the time of the accident, the plaintiff was employed and entitled to receive workmen's compensation benefits. These benefits were refused for unstated reasons. The medical payments provision held that the policy did not apply: "if benefits therefore are in whole or in part either payable or required to be provided under any workmen's compensation law." The court held that where medical payments coverage was thus expressly excluded, one who was injured by the insured automobile and was also entitled to recover workmen's compensation for those injuries could recover no benefits under the medical payments provision. This was true even though he received no workmen's compensation for his injuries, and irrespective of whether his failure to receive benefits was due to his refusal to accept them or due to the refusal of his employer or the insurer to provide them.

In order for this exclusion to operate, the available benefits must cover the same risk. That is to say: "[T]he exclusion has no application to other forms of insurance providing benefits that are not measured in terms of incurred medical expense, such as a weekly disability benefit or specific indemnity for loss of life or limb." In point is Northland Insurance Co. v. Miles, where the plaintiff-driver of a non-owned automobile sued the insurer of the owner of the automobile under the owner's medical payments provision. The insurer claimed coverage was excluded by the "other insurance" exclusion. The policies of the plaintiff related to indemnity for loss of life, limb, or sight, and for the loss of time due to accident injury. The court held:

It is clear beyond doubt that the policy sued on is a policy for medical expense; and no coverage is excluded under [the "other insurance" clause] except "medical expense" payments.

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267 205 Tenn. 344, 326 S.W.2d 490 (1959).
268 326 S.W.2d at 491.
270 Katz, supra note 218, at 279.
271 446 P.2d 160 (Wyo. 1968).
made under certain enumerated kinds of insurance. Other insurance benefits (aside from medical expense payments), such as disability benefits, death benefits, annuity payments, or payments to cover loss of earnings, may not be deducted by appellant-insurance company in the settlement of its liability for medical expense loss.\textsuperscript{272}

The court based its conclusion on the following reasoning:

There is no difference in principle between the excluding of liability and the limiting of liability. The authorities are legion that for a proportionate recovery clause to operate in the insurer's favor . . . there must be identity of risk . . . .

It follows from this that the exclusion we are dealing with can be operative only as to insurance of a type and kind referred to in the phraseology of the exclusion.\textsuperscript{273}

The court accordingly held the "other insurance' 'exclusion inapplicable.

IV. LIMIT OF LIABILITY

Medical services coverage is secured by the payment of a separate premium. The size of that premium, of course, determines the amount of coverage to which the insured is entitled. The amount of coverage is typically referred to as the insurer's limit of liability, the insurer's maximum exposure for any one injury. A medical payments provision limit of liability clause generally reads: "The limit of liability for medical services stated in the declaration as applicable to 'each person' is the limit of the company's liability for all expenses incurred by or on behalf of each person who sustains bodily injury as the result of any one accident."\textsuperscript{275} Since limits of liability are contained in all parts of the automobile liability policy, the problems presented by such clause are not unusual. Therefore, this aspect of the medical payments provision will not be treated in depth.

However, one problem arises more than infrequently and demands some detailed attention. Where more than one automobile is covered under one policy and medical expenses coverage has been purchased for each automobile, the question arises as to the amount of coverage available. Most automobile policies state: "When two or more automobiles are insured hereunder, the terms of this policy shall apply separately to each . . . ."\textsuperscript{276} What is the effect of this condition on the limits of liability clause?

\textsuperscript{272} Id. at 161.
\textsuperscript{273} Id. at 161-62.
\textsuperscript{274} For other cases sustaining the view that the available benefits must cover the same risk, see Pitts v. Glen Falls Indem. Co., 222 S.C. 133, 72 S.E.2d 174 (1952); Fogelmark v. Western Cas. & Sur. Co., 11 Ill. App. 2d 551, 137 N.E.2d 879 (1956).
\textsuperscript{275} Milwaukee Mut. Ins. Co. Policy, Limit of Liability.
\textsuperscript{276} Milwaukee Mut. Ins. Co. Policy, Condition 4.
The majority rule is that the amount of medical payments available for each person injured is the coverage purchased multiplied by the number of automobiles insured.277

The lead case supporting the majority rule is *Southwestern Fire & Casualty Co. v. Atkins*.278 An insured under the defendant-insurer's medical payments provision was injured when struck by an automobile other than the two named in the policy. The stated limit of liability was $500. The issue was whether under the terms of the policy $500 was the limit of recovery although the policy provided coverage on two automobiles with premiums allocated to each separately. The court noted that the limit would have been $1,000 had there been two separate policies. It concluded:

[If he can collect only $500, he is no better off for having taken out medical payments on both cars than on one car, since he could recover the same amount had he taken out medical payments on only the one car.]

In the present case we think [the limit of liability] provision applies to each car separately and independently as provided in the policy, and means that for each car the limit is $500, or a total of $1,000 for the two cars. If the insurance company intended to limit the medical payments to the amount of $500 which a policy on only one car would provide, it should have so stipulated in no uncertain language, and it should not have charged a premium on each car separately.279

This construction creates a separate contract of insurance as to each insured automobile and permits recovery rather than a forfeiture of a benefit for which the insured had paid.280

A California court reached the opposite conclusion in *Sullivan v. Royal Exchange Assurance*,281 perhaps the earliest case on this specific question. The plaintiff brought an action for declaratory relief to determine his rights under a policy of insurance. Two automobiles owned by the plaintiff were covered by a policy issued to him by the defendant-insurer. Medical expenses coverage in the amount of $2,000 existed on each of two automobiles owned by the insured, a separate premium having been assessed on each. While the policy was in effect, the plain-

279 Id. at 894-95.
280 For other cases following the majority rule, see *Kansas City F. & M. Ins. Co. v. Epperson*, 234 Ark. 1100, 356 S.W.2d 613 (1962) (holding the policy to be ambiguous and therefore to be construed against the insurer); *Central Sur. & Ins. Co. v. Elder*, 204 Va. 192, 129 S.E.2d 651 (1963) (since the continuation contract was given two interpretations, the court held for the insured, saying: "It is reasonable to think that the additional premium charged for the inclusion of a second car was intended to afford some corresponding benefit to the insured." 356 S.W.2d at 614).
tiff's son was struck by an automobile not covered by the policy and sustained damages in excess of $4,000. The court rejected the plaintiff's argument that the limit of $2,000 should be applied separately and individually to each automobile insured. The court reasoned that the condition regarding two automobiles and the limit of liability clause were complementary and that the specific limitation provision regarding liability would prevail over the general condition regarding two automobiles which applies to all parts of the policy. It should be noted that in the Atkins and Sullivan cases the insured was injured in an automobile other than one of those named in the policy.

Contrasting with the Atkins and Sullivan cases is Guillory v. Grain Dealers Mutual Insurance Co.,282 where the plaintiff was injured while occupying one of the two automobiles insured in the policy. The defendant-insurer paid its policy limits for medical expenses upon proof of loss. When a supplemental proof for $370 was put in, liability was denied, on the basis that the insurer's maximum exposure under the circumstances had been paid. The court denied the plaintiff's claim for a recovery on each automobile stating:

Had the plaintiff been involved in an accident while driving one of his own vehicles upon which no medical payment clause had been taken, then he would not have been entitled to recover under the medical payments clause reserved on another his own vehicles because neither condition would have been presented, i. e., he would not have been in an owned vehicle . . . and he would not have been driving a non-owned vehicle. Thus, the argument of the plaintiff that he would be paying double premiums for no good reason must fall.283

This case illustrates what appears to be the better rule where the insured is injured in one of the named automobiles.284

V. OTHER INSURANCE

The "other insurance" clause of the medical payments provision of an automobile policy is not distinctive.285 Since it creates no problems

283 Id. at 764. See also Odom v. American Ins. Co., 213 2d 359 (La. Ct. App. 1968) (six different vehicles were listed under the schedule of automobiles; same circuit and same holding).
284 There are two cases which, unlike Guillory, have allowed double recovery even though the injury was sustained while in a vehicle named in the policy. Government Employees Ins. Co. v. Sweet, 186 So. 2d 95 (Fla. Ct. App. 1966) and Travelers Indem. Co. v. Watson, 140 S.E.2d 505 (Ga App. 1965). Both of these cases are distinguishable because the policies involved do not contain the standard language that Guillory does.

Also, it should be noted that the possible interaction of the other insurance clause with the various provisions discussed in these double coverage cases has not yet been explored by the courts.
285 The Northwest Nat'l Ins. Co. Policy's "other insurance" clause provides:

If there is other automobile medical payments insurance against a loss covered by Part II of this policy the company shall not be liable under this policy for a greater proportion of such loss than the applica-
unusual to medical payments coverage, it will not be discussed at length. Two cases will be used to illustrate the typical problems presented when two medical payments provisions are applicable to the same injuries.

In *Vallaire v. Employers Liability Assurance Corp.*, the plaintiff was injured while occupying a non-owned automobile. The host's liability insurer paid its limits under its medical payments provision. The plaintiff sought to recover the full amount of liability under his mother's medical payments provision. The court held that the defendant-insurer was entitled to a credit for the plaintiff's medical expenses received under the host's policy. In other words, the defendant's policy constituted surplus insurance. The excess clause of the other insurance provision functioned to produce this result.

In *Harkavy v. Phoenix Insurance Co.*, the plaintiff was injured in an automobile accident while a passenger of a host who had medical payments coverage of $5,000. The plaintiff had $2,500 of medical expenses. Ignoring her host's insurance, she settled with a third party tortfeasor for $8,500 and then brought an action on her own medical payments provision for the limits of $2,000. The insurer-defendant denied coverage, relying on the "other insurance" clause. Her action was dismissed because there was other valid and collectible automobile medical expenses insurance on the automobile in which she was a passenger. It afforded primary coverage. Her policy afforded only excess coverage. Of course, not all of the cases have come to the same result as these two.

VI. CONDITIONS

A. GENERALLY

All of the coverages contained in the standard automobile liability policy are affected by the conditions which form a part of the insuring agreement. The application of some of these conditions is exactly the same whether recovery is being sought under the liability provisions, the medical payments provision, or any other part. Those conditions which determine whether the insurance policy was in force at

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286 For a discussion of the "other insurance" clause, see generally Watson, *The Other Insurance Dilemma*, 16 Federation Ins. Counsel Q. 47 (Summer 1966) and T. Ford, *Concurrent Coverage Controversies*, in AUTOMOBILE INSURANCE PROBLEMS 59 (1968).


the time of the accident fall in this category. While they apply to the medical payments provision their application poses no unique problem within the scope of this article. It is sufficient to note that if the policy itself has expired, has been cancelled, or has not been renewed, then there can be no recovery under any part of the policy. Accordingly, only those conditions which have particular application to the medical payments claimant will be discussed.

B. NOTICE

The "notice" condition requires that the insurer be given written notice of the particulars of the accident, including the names of the injured and of available witnesses. The policies variously require this notice be given "as soon as practicable," or "as soon as reasonably possible," or "within 20 days." There is no requirement that the notice be submitted by the named insured or by any particular individual; any person may give notice of the accident.

The notice condition most often becomes the subject of a medical payments provision dispute because notice has been given late. General Accident Fire & Life Assurance Corp. v. Margolis involved a motion to consolidate two trials. One was an action by a passenger seeking recovery under the medical payments provision of his host's automobile insurance. The other was a declaratory judgment action by the same insurer seeking a judgment of no coverage with the host driver as defendant. The basis of the insurer's action was that no notice of the accident was given until six months after the accident. The motion to consolidate was granted, indicating that the six month delay could also defeat the passenger's action for medical expenses.

In Henderson v. Hawkeye-Security Insurance Co., there had been a thirteen month delay in giving notice of the accident. The court held that the delay was unreasonable and that it was to be presumed prejudicial to the insurer. It was acknowledged that the presumption was rebuttable but that the plaintiff seeking medical expenses had not rebutted it under the facts present in the case.

A twenty month delay was the subject of litigation in Merchants Mutual Casualty Co. v. Izor. The passenger of the insured had slipped while alighting from the insured's automobile. At the time both parties had treated the incident as a trivial mishap and neither party saw fit to give the insurer notice of the accident. The insured did give notice to the insurer just as soon as the passenger commenced

292 Id.
293 116 N.Y.S.2d 209 (Special T. 1952).
294 252 Iowa 97, 106 N.W.2d 86 (1960).
suit by service of summons upon the insured. Upon trial the insurer raised the defense of late notice but the trial court felt this breach should not affect the medical payments coverage. Upon appeal the court held the breach of the notice requirement vitiated all coverages, not just the liability portion of the policy. From these decisions it appears that one seeking recovery under the medical payments provision should make certain that timely notice is given to the insurer.

Under the terms of the policy, notice must be given in writing, in addition to being made as soon as practicable.\textsuperscript{298} An oral notice to an insurance agent is not sufficient. In \textit{Aetna Insurance Co. v. Durbin},\textsuperscript{297} the claimant had been in touch with her agent by telephone and in person. She had furnished all the information the agent requested but she did not promptly notify the insurance company in writing as the policy required. The first written notice was made four months later by her attorney. Aetna disclaimed coverage because of late notice, and the claimant countered maintaining written notice was waived by the agent who had been satisfied with her furnishing the necessary information by telephone. The court, in allowing Aetna to disclaim, held that that the agent's actions did not constitute a waiver by the company of its requirement of written notice. While the agent could not waive the written notice requirement, the condition could have been waived by conduct of the company itself.\textsuperscript{298}

In addition to making a timely written notice of the accident, the condition also requires certain information about the accident, if reasonably obtainable, such as the names and addresses of those injured. In \textit{Caruso v. Western Casualty & Surety Co.},\textsuperscript{299} medical payments were denied because the notice, made the day after the accident, made no mention of the insured suffering any injury in the accident.

In conclusion, the notice condition requires written notice as soon as practicable. The requirement is that this notice be “given by or for insured.” Thus, if the insured is not going to give notice, for whatever reason, the burden of supplying the notice falls upon whomsoever might expect to benefit by the coverages provided.

C. Medical Reports: Proof and Payment of Claims

This condition\textsuperscript{300} applies especially to those seeking recovery under the medical payments provision. In a sense it is a grouping of three conditions, (1) Medical Reports, (2) Proof of Claim, and (3) Pay-

\textsuperscript{298} Policies, \textit{supra} notes 290 and 291.
\textsuperscript{297} 417 S.W.2d 485 (Tex. Civ. App. 1967).
\textsuperscript{298} See McCown v. Safeco Ins. Co. of Am., 116 Ga App. 655, 158 S.E.2d 486 (1967), for an example of waiver of notice condition by insurer's actions.
\textsuperscript{299} 397 S.W.2d 711 (Mo. Ct. App. 1965).
ment of Claim. While "notice" provides the insurer with timely information about the accident, this condition also makes available to the insurer timely information about the injuries which will be the basis for medical payments.

1. Medical Reports

The medical reports must be submitted "as soon as practicable." In *Allen v. Western Alliance Insurance Co.*, 107 days was held not to be as soon as practicable. The insured had arrived at a settlement with the other driver before making his claim for injury. The same result was reached when no claim was made until nine months after the claimant had fallen in a supermarket. The supermarket case dealt with medical payments under a general liability policy.

Another "as soon as practicable" case involved an insured who first settled his liability claim with his own insurer, who also was the insurer of the other vehicle involved in the accident. The facts in *Gordon v. London & Lancashire Indemnity Co. of America* indicate that prompt notice of the accident had been made. In the process of presenting his case for recovery under the liability policy of the other driver, the insured had furnished his insurer with all medical reports. He did not, however, notify the insurer that his policy contained a medical payments provision until he won his verdict in the liability case. The fact that Gordon had not advised his insurer of the medical payments provision was held not to be prejudicial and recovery was allowed.

2. Proof of Claim

The condition requires "written proof of claim, under oath if required." This means more than simply an oral discussion with an adjuster and letters demanding settlement. On the other hand, where the claimant had requested a formal claims form which was never sent, the insurer was held liable. The court concluded that the insurer had been furnished enough information upon which to base a settlement. The policy gives the insurer the right to demand that claims be stated under oath, but where the insurer fails to assert this right, the requirement is dispensed with.

The condition requiring proof of claim obliges the insured to execute authorizations to obtain medical reports and records. It also requires the insured to submit to physical examination. In *Collins* 162 Tex. 572, 349 S.W.2d 590 (1961).
v. Farmers Insurance Exchange, the claimant was allowed to recover without executing all necessary authorizations. He had never refused to execute them and the insurer had disclaimed on the basis that the bodily injury had not been due to accident. By the time the insurer made a request (at trial), there had not been time to sign all the authorizations.

3. Payment of Claim; Admission of Liability

The language of the condition permits the insurer to pay the injured person or any person or organization rendering services. If someone other than the injured person is paid, this will lower the amount recovered by the injured person. While this gives the insurer the option of whom it is going to pay, it is questionable whether a person rendering services has an enforceable right under the policy. Although an injured person may assign whatever rights he has to the person or institution that has cared for him, the consent of the insurer might be required to make the assignment binding.

The payments made under the medical payments provision are independent of liability coverage. The policy states that a payment made under the Medical Expenses Provision shall not constitute an admission of liability. This severance of coverages was demonstrated in Cox v. Santoro where the payment made by the insurer for medical expenses was held not to estop the insurer from denying coverage under the liability portion of the policy. Mayflower Insurance Co. v. Osborne was another case in which the insurer was able to disclaim liability (due to breach of the cooperation clause) for the accident even though it had paid medical expenses arising out of the same accident.

D. Two or More Automobiles

This condition simply states that when two or more automobiles are insured, the terms of the policy shall apply separately to each. The effect of this language can be seen by examining the following two fact situations.

held that an insurer was entitled to only one physical examination and that submission of proof of claim in connection with liability claim was enough to satisfy an insurer's requirements regarding medical payments claim.

308 271 Minn. 239, 135 N.W.2d 503 (1965).

309 See Milwaukee Mut. Auto. Ins. Co. Policy, Condition 15; Northwestern Nat'l Auto. Ins. Co. Policy, Condition 15; Dallas County Hosp. Dist. v. Pioneer Cas. Co., 402 S.W.2d 287 (Tex. Civ. App. 1966), held an assignment of rights under the policy not to be binding on the insurer where no consent to the assignment was given and where the insurer had already paid the insured.


311 326 F.2d 461 (4th Cir. 1964).

In *Hansen v. Liberty Mutual Fire Insurance Co.*,\(^{313}\) the insured had three automobiles insured and had medical payments coverage on each. Only one recovery was allowed, even though three automobiles were insured. In *Cockrum v. Travelers Indemnity Co.*,\(^{314}\) there were again three automobiles insured, but medical payments coverage was purchased for only one. It was held that the coverage on the insured automobile extended coverage to family members while driving the other two automobiles. This conclusion was reached because Division One covers the named insured and his relatives while occupying the owned automobile or any non-owned automobile. If the definitions of "owned" automobile and "non-owned" automobile (found in the liability part of the policy) are read, it is difficult to determine on which the court could grant recovery. The automobiles without medical payments coverage could not be deemed "owned" since no premium charge was made with respect to medical payments coverage. On the other hand, the automobiles could not be deemed "non-owned," since they were actually owned and regularly used by the named insured and his relatives. If the automobile in which the accident occurred was neither "owned" nor "non-owned" with respect to medical payments coverage, then no recovery should have been allowed.

Additional cases bearing on the effect of having two or more automobiles insured have been previously discussed in conjunction with the limits of liability clause, the interpretation of which is greatly influenced by this condition.\(^{315}\)

E. Action Against Company

The policy, as a condition precedent to any legal action against the insurer, demands full compliance with all the terms of the policy. With regard to medical payments claimants, this means the claimant must have complied. Thus, no action will lie against the insurer for medical expenses until a formal claim for medical payments has been made and the insurer has refused to pay the claim.\(^{316}\)

The condition does not demand, as a condition precedent to the claimant's action, that the insured must have made full compliance. In a case where the insured had breached the cooperation clause, enabling the insurer to avoid liability coverage, the medical payments claimant still had the right to an action for medical payments coverage.\(^{317}\)

F. Subrogation

Under the medical payments provision, the insurer agrees to

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\(^{315}\) See cases cited in the section of this article, "Limit of Liability," p. 496.


MEDICAL PAYMENTS PROVISION

indemnify the insured for all reasonable medical and related expenses within the stated limits. Some insurers have incorporated a subrogation provision into their medical services coverage. Such provision generally requires that in cases where the insurer pays the expenses of a person injured due to the negligence of a third party, the insurer shall be subrogated to the injured party's right of recovery for such expenses against the tortfeasor. Specifically, a typical subrogation clause provides:

In the event of any payment under this policy, the company shall be subrogated to all the rights of recovery therefore which the injured person or anyone receiving such payment may have against any person or organization and such person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. Such person shall do nothing after loss to prejudice such rights.

The validity of such subrogation provisions has been challenged in a number of cases, resulting in a split in authority regarding an insurer's right to subrogation. The purpose of this section is to

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318 That medical services coverage is indemnity insurance has not gone unquestioned. See e.g., C. BRAINARD, AUTOMOBILE INSURANCE 244 (1st ed. 1961). But cf. Katz, supra note 218, at 270; Kircher, Set-Off And Subrogation In Automobile Medical Payments Coverage, Defense Memo, 7 For The Defense No. 10 (Dec. 1966).


One jurisdiction has enacted a statute expressly forbidding the incorporation of a subrogation provision in medical expenses coverage: VA. CODE ANN. § 38.1-38.12 (1968).
review these decisions, in order to ascertain the better reasoned rule regarding the validity of such provisions.\textsuperscript{321}

The question as to an insurer's subrogation rights under a medical payments subrogation clause in an automobile policy may arise in a number of ways.\textsuperscript{322}

(1) An insurer who has made medical payments pursuant to the policy may attempt to recover them directly from the tortfeasor;\textsuperscript{323}

(2) An insurer claiming the right to reimbursement may attempt to recover the amount paid from the insured after the latter has settled with or recovered a judgment against the tortfeasor;\textsuperscript{324}

(3) An insured may attempt to recover medical payments from an insurer which refuses to pay them unless and until the insured executes a formal agreement subrogating the insurer to the proceeds of any recovery which the insured may obtain;\textsuperscript{325}

(4) An insured may bring an action to recover medical payments from an Insurer which flatly refuses to make them because the insured has already settled with and released the tortfeasor and has thereby prejudiced the insured's subrogation rights;\textsuperscript{326}

(5) One insurer claiming a right to subrogation may attempt to recover the medical payments made to its insured from the insurer of the tortfeasor after the first insurer has given the tortfeasor's insurer notice of its subrogation rights and the tortfeasor's insurer thereafter makes settlement with the insured of the first insurer;\textsuperscript{327}

(6) The insured may commence an action seeking a declaration that the subrogation clause is void as against public policy.\textsuperscript{328}

\textsuperscript{321} See Annot., 19 A.L.R.3d 1054 (1968), for a discussion of the same topic.

\textsuperscript{322} Id. at 1055.


\textsuperscript{328} Miller v. Liberty Mut. Fire Ins. Co., 48 Misc. 2d 102, 264 N.Y.S.2d 319
The minority of courts which deny effect to medical payments subrogation have based their decisions on arguments that such provisions are void because they either: (1) attempt an assignment of a cause of action for personal injuries; or (2) constitute the splitting of an indivisible cause of action in tort.

In *Peller v. Liberty Mutual Fire Insurance Co.*, the plaintiffs were injured and incurred medical expenses. The defendant-insurer refused to pay unless and until each plaintiff assigned to the defendant his right of recovery to the extent of such payments, pursuant to the insurer's subrogation provision. In an action for declaratory relief, the plaintiffs alleged that the subrogation provision was invalid, illegal and against public policy. The court noted that the result of the provision was to transfer the insured's cause of action against a third-party tortfeasor to the insurer. Since the state legislature had codified the common law rule against assignability of causes of action arising out of personal injuries, the court was compelled to hold the subrogation clause invalid. The court suggested that such a common law rule should not apply to subrogation for medical expenses, but decided that any change must be made by the legislature.

In *Travelers Indemnity Co. v. Chumbley*, the insured was injured in an automobile accident. The resulting medical expenses were paid by the plaintiff-insurer, who then notified a third party tortfeasor of its payment and right to subrogation. Subsequently, the insured settled all claims with the tortfeasor, in violation of the subrogation provision. The insurer then sued to recover the payment from its insured, or in the alternative, to recover from the tortfeasor the amount that the insurer had paid to the insured. The insurer argued that medical expenses are a special damage, separate and apart from bodily injury claim and thus subject to subrogation. The court conceded that such damages were special, but noted that they were nonetheless an integral element of a personal tort. The court consequently held the provision invalid as a prohibited assignment of a claim arising out of personal injury. The court further reasoned that to...
allow subrogation would invite multiple subrogation claims and promote suits and interpleaders, all contrary to the policy of the law.\textsuperscript{334}

Lowder v. Oklahoma Farm Bureau Mutual Insurance Co.,\textsuperscript{335} was an action by an insurer to recover from a tortfeasor for medical expenses paid to its insured. The court noted that in Oklahoma a single tort to a single person gives rise to but a single action, however numerous the resulting items of damage may be. Thus a separate action by an insurer to recover only medical expenses controverted the rule against splitting a cause of action and was barred. The court reasoned that the prevention of a multiplicity of suits and of vexatious litigation outweighed the arguments for subrogation.

The majority of courts have found the medical payments subrogation provision valid and enforceable for one or more of the following reasons:

(1) A claim for personal injuries may be assigned;\textsuperscript{336} (2) Medical payments subrogation merely impresses a lien in favor of the insurer (to the extent of its payment upon the proceeds of any recovery obtained by the insured from the tortfeasor);\textsuperscript{337} (3) Such right is based on contract, is not unfair or overreaching, and is accompanied by an appropriately reduced premium;\textsuperscript{338} (4) Such provision is not contrary to public policy in the absence of action by the insurance department, which is vested by the legislature with duties concerning the form of insurance policies;\textsuperscript{339} and (5) The provision merely provides for conventional subrogation and does not constitute an assignment.\textsuperscript{340}

\textsuperscript{334} See also Harleysville Mut. Ins Co. v. Lea, 2 Ariz. App. 538, 410 P.2d 495 (1966).
\textsuperscript{335} 436 P.2d 654 (Okla. 1967).
In Hospital Services Corp. v. Pennsylvania Insurance Co., a subscriber to a Blue Cross hospitalization policy was injured as a result of the negligence of a third party. Blue Cross paid her hospital bills pursuant to its contract and then notified the tortfeasor and her insurer. Thereafter the tortfeasor and her insurer entered into a settlement with the injured party of all her claims. The demand of Blue Cross was not honored. It commenced an action joining the tortfeasor, her insurer, and the injured subscriber as defendants. The court held that Blue Cross was entitled to subrogation under its contract. It concluded that the clause differed from an assignment. The court further stated that such a contract tends to reduce premiums and fosters a type of coverage that provides protection for the insured without creating a windfall.

In Davenport v. State Farm Mutual Automobile Insurance Co., State Farm brought an action against Allstate and its insured to recover a sum paid out under its medical payments provision. State Farm had given Allstate, the tortfeasor's insurer, notice of its payment and subrogation rights. Thereafter Allstate settled with State Farm's insured for all claims. The court upheld the plaintiff's action for subrogation. It held that the assignability of the right to sue in tort for personal injuries was governed by the test of survivorship. That is, if the right of action survived the death of the injured person, the right was assignable. Since a right to sue in tort survives in Nevada, subrogation to proceeds of a personal injury recovery was permissible.

In Bernardini v. Home & Automobile Insurance Co., the plaintiff-insured was involved in an automobile accident and incurred medical expenses as a result. The defendant-insurer's policy contained a subrogation clause. The plaintiff effected a settlement with the tortfeasor's insurer and executed a release in its favor. The defendant refused to pay the plaintiff's medical bills, claiming that the plaintiff had prejudiced its subrogation rights. The plaintiff contended the subrogation clause was an assignment of a personal injury claim and therefore void. The court held that there was no attempted assignment, since subrogation operates only to secure contribution and indemnity, whereas an assignment transfers the whole claim. The

842 For other cases decided under group medical and hospitalization policies and upholding the validity of subrogation, see Michigan Medical Service v. Sharpe, 339 Mich. 574, 64 N.W.2d 713 (1954); Metropolitan Life Ins. Co. v. Ritz, 70 Wash. 2d 317, 422 P.2d 780 (1967); Associated Hosp. Service, Inc. v. Milwaukee Auto. Mut. Ins. Co., 33 Wis. 2d 170, 147 N.W.2d 225 (1967).
court concluded that a medical payments subrogation clause merely impresses a lien in favor of the insurer to the extent of its payment upon any recovery obtained from the tortfeasor.\textsuperscript{346}

In \textit{DeCespedes v. Prudence Mutual Casualty Co.},\textsuperscript{347} the issue was whether an insured was entitled to a recovery under the medical payments provision of an automobile policy containing a subrogation clause. He had settled his claim against a third party tortfeasor and executed a full release. The court, in denying recovery and upholding the insurer's right to subrogation, stated:

Under the doctrine of subrogation the insurer is \textit{substituted}, by operation of law, to the rights of the insured . . . . It is not available to a volunteer, only to one under a duty to pay. Furthermore, it is not available to an extent greater than the amount paid by the insurer, and then only after the insured has been fully indemnified. By contrast, an assignment generally refers to or connotes a voluntary act of \textit{transferring} an interest . . . .

Subrogation serves to limit the chance of double recovery or windfall to the insured, and, when exercised, tends to place the primary liability upon the tortfeasor, where it belongs . . . . So long as subrogation, as applied to this medical pay provision serves to bar double recovery, it should be upheld.\textsuperscript{346}

The court thus distinguished subrogation of medical payments from assignment of a tort action.\textsuperscript{349}

It is apparent after a review of decisions bearing on the subject, that subrogation provisions in medical payments coverage should be recognized as valid contractual agreements. It is no defense to such a provision that it amounts to an assignment of a claim for personal injuries:

Subrogation, however, differs materially from an assignment. Subrogation is the act of the law, depending . . . upon the principles of equity, while assignment . . . depends generally on intention. So also subrogation presupposes an actual payment and satisfaction of the debt or claim to which the party is sub-

\textsuperscript{346}This view was also expressed in: National Union Fire Ins. Co. v. Grimes, 278 Minn. 45, 153 N.W.2d 152 (1967); Miller v. Liberty Mut. Fire Ins. Co., 48 Misc. 2d 102, 264 N.Y.S.2d 319 (Special T. 1965); and Metropolitan Life Ins. Co. v. Ritz, 70 Wash. 2d 317, 422 P.2d 780 (1967). But note that in \textit{Grimes} the court upheld the provision only as between the insurer and its insured, reserving ruling on the validity of such a clause if asserted against a third party tortfeasor.

\textsuperscript{347}193 So. 2d 224 (Fla. Ct. App. 1966).

\textsuperscript{348}Id. at 227 (citations omitted).

rogated, although the remedy is kept alive in equity for the benefit of the one who made the payment under circumstances entitling him to contribution or indemnity, while assignment necessarily contemplates the continued existence of the debt or claim assigned. Subrogation operates only to secure contribution and indemnity, where as assignment transfers the whole claim.350

The validity of such a provision should be based on the rudimentary concept of subrogation:

[S]ubrogation is a creature of equity having for its purpose the working out of an equitable adjustment between the parties by securing the ultimate discharge of the debt by the person who in equity and good conscience ought to pay it.351

[A] wrongdoer who is legally responsible for the harm should not receive the windfall of being absolved from liability because the insured had had the foresight to obtain, and had paid the expense of procuring, insurance for his protection; since the insured has already been paid for his harm, the liability of the third person should now inure for the benefit of the insurer.352

It should be noted that although a court recognizes the validity of a medical payments subrogation provision, it may declare the insurer estopped from asserting it against its insured. In Silinsky v. State-Wide Insurance Co.,353 the court held that an insured under an automobile liability policy was entitled to reimbursement of her medical expenses, although she had given a general release to the tortfeasor and although there was a subrogation provision in the policy. The insurer's delay of ten months in paying plaintiff combined with its failure to ascertain the facts of her settlement prevented the insurer from asserting any defenses.

In at least one state in which direct action against a third party tortfeasor by means of subrogation is denied, a reimbursement agreement in an automobile policy with respect to medical payments coverage has been upheld, despite a statutory prohibition against assignment of a claim for personal injuries.354 Under such an agreement, the insurer obligates itself to advance medical payments within policy limits. However, its ultimate liability for the loss becomes fixed only in the event that the injured insured is unable to recover such expenditures from the third party tortfeasor. In Tryper v. Meritplan Insurance Co.,355 the court held:

350 6 C.J.S. Assignments § 2(b), at 1051 (1937).
352 Id.
355 Id.
With the growth of insurance coverage and the increasing cost of automobile insurance . . . possibilities of double recovery . . . may constitute inequities against good conscience to which this court should not shut its eyes.

We see no good reason why an insured desiring to obtain and an insurer desiring to sell (both in good faith) insurance upon as low a premium as possible, may not enter into a contract that permits [reimbursement].

One ought to seek to be made whole, but not enriched through an automobile accident which happens too frequently in the milieu of modern life.

The considerations mentioned by the court point up the equities attendant upon an insurer's right to subrogation when a third party tortfeasor has caused injury to its insured.

VII. CONCLUSION

This article has attempted to analyze all of the litigated points of dispute that have developed from the medical payments provision of the automobile liability policy since that provision's emergence thirty years ago. The coverage over these years has been gradually expanded. A much more spectacular expansion in the use of first party medical pay and first party coverage is being proposed today. This will include all areas of economic loss but any expansion must be viewed in light of the considerable judicial experience with first-party insurance.

Some questions which have arisen have not been easily solved; some still appear very difficult; others appear insoluble. The difficulties of yesterday may predict the obstacles of tomorrow. Medical payments coverage can be complicated and change must contemplate the legal problem which this coverage has presented to countless claimants. Therefore the collection and analysis of this judicial precedent should be helpful in the interpretation and solution of issues created by the current medical payments coverage but most importantly will serve as a guide for charting expanding first-party economic loss coverage in the future.
Coverage C—Medical Services. To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services:

Division 1. To or for the named insured and each relative who sustains bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury", caused by accident,
(a) while occupying the owned automobile,
(b) while occupying a non-owned automobile, but only if such person has the permission of the owner to use the automobile and the use is within the scope of such permission, or
(c) through being struck by an automobile,

Division 2. To or for any other person who sustains bodily injury, caused by accident, while occupying
(a) the owned automobile, while being used by the named insured or by any other person with the permission of the named insured; or
(b) a non-owned automobile, if the bodily injury results from its operation or occupancy by the named insured or its operation on his behalf by his private chauffeur or domestic servant but only if such operator or occupant has the permission of the owner to use the automobile and the use is within the scope of such permission;

provided that no such payment shall be made under Division 1 or Division 2 unless the person to or for whom such payment is made shall have executed a written agreement that the amount of such payment shall be applied toward the settlement of any claim, or the satisfaction of any judgment for damages entered in his favor, against any insured because of bodily injury arising out of any accident to which the Liability Coverage applies.

Definitions. The definitions under Part I apply to Part II, and under Part II:
“occupying” means in or upon or entering into or alighting from;
“an automobile” includes a trailer of any type.

Exclusions. This policy does not apply under Part II:
(a) to bodily injury sustained while occupying (1) an owned automobile while used as a public or livery conveyance, or (2) any vehicle while located for use as a residence or premises;
(b) to bodily injury sustained by the named insured or a relative while occupying or through being struck by (1) a farm type tractor or other equipment designed for use principally off public roads, while not upon public roads, or (2) a vehicle operated on rails or crawler-treads;
(c) to bodily injury sustained by any person other than the named insured or a relative, (1) while such person is occupying a non-owned automobile while used as a public or livery conveyance, or (2) resulting from the maintenance or use of a non-owned automobile by such person while employed or otherwise engaged in the automobile business, or (3) resulting from the maintenance or use of a non-owned automobile by such person while employed or otherwise engaged in any other business or occupation, unless the bodily injury results from the operation or occupancy of a private passenger automobile by the named insured or by his private chauffeur or domestic servant, or of a trailer used therewith or with an owned automobile;
(d) to bodily injury sustained by any person who is employed in the automobile business, if the accident arises out of the operation thereof and if benefits therefor are in whole or in part either payable or required to be provided under any workmen’s compensation law;
(e) to bodily injury due to war;

(f) to bodily injury sustained while occupying any vehicle which is designed or equipped for so-called “hot rod” or “stock car” racing either while so operated or while being tested, repaired or serviced; or while occupying any vehicle in an organized race or contest;

(g) to that amount of any expense for medical services which is paid or payable to or for the injured person under the provisions of any (1) premises insurance affording benefits for medical expenses, (2) individual, blanket or group accident, disability or hospitalization insurance, (3) medical, surgical, hospital or funeral service, benefit or reimbursement plan or (4) workmen’s compensation or disability benefits law or any similar law.

Limit of Liability. The limit of liability for medical services stated in the declarations as applicable to “each person” is the limit of the company’s liability for all expenses incurred by or on behalf of each person who sustains bodily injury as the result of any one accident.

Other Insurance. If the insured has other automobile insurance affording the benefits for medical expenses against a loss covered by Part II of this policy the company shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability stated in the declarations bears to the total applicable limit of liability of all valid and collectible automobile medical services insurance; provided, however, the insurance with respect to a temporary substitute automobile or non-owned automobile shall be excess insurance over any other valid and collectible automobile medical services insurance.
SAMPLE POLICY B
Northwestern National Insurance Company
Family Combination Automobile Policy

PART II — EXPENSES FOR MEDICAL SERVICES

Coverage C — Medical Payments: To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services:

Division 1. To or for the named insured and each relative who sustains bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury", caused by accident,
   (a) while occupying the owned automobile,
   (b) while occupying a non-owned automobile, but only if such person has, or reasonably believes he has, the permission of the owner to use the automobile and the use is within the scope of such permission, or
   (c) through being struck by an automobile or by a trailer of any type;

Division 2. To or for any other person who sustains bodily injury, caused by accident, while occupying
   (a) the owned automobile, while being used by the named insured, by any resident of the same household or by any other person with the permission of the named insured; or
   (b) a non-owned automobile, if the bodily injury results from
      (1) its operation or occupancy by the named insured or its operation on his behalf by his private chauffeur or domestic servant, or
      (2) its operation or occupancy by a relative, provided it is a private passenger automobile or trailer,
      but only if such operator or occupant has, or reasonably believes he has, the permission of the owner to use the automobile and the use is within the scope of such permission.

Definitions: The definitions under Part I apply to Part II, and under Part II:
"occupying" means in or upon or entering into or alighting from;

Exclusions: This policy does not apply under Part I to bodily injury,
   (a) sustained while occupying (1) an owned automobile while used as a public or livery conveyance, or (2) any vehicle while located for use as a residence or premises;
   (b) sustained by the named insured or a relative while occupying or through being struck by
      (1) a farm type tractor or other equipment designed for use principally off public roads, while not upon public roads, or (2) a vehicle operated on rails or crawler-treads;
   (c) sustained by any person other than the named insured or a relative,
      (1) resulting from the maintenance or use of a non-owned automobile by such person while employed or otherwise engaged in the automobile business, or
      (2) resulting from the maintenance or use of a non-owned automobile by such person while employed or otherwise engaged in any other business or occupation, unless the bodily injury results from the operation or occupancy of a private passenger automobile by the named insured or by his private chauffeur or domestic servant, or of a trailer used therewith or with an owned automobile;
   (d) sustained by any person who is employed in the automobile business, if the accident arises out of the operation thereof and if benefits therefor are in whole or in part either payable or required to be provided under any workmen's compensation law;
   (e) due to war.

Limit of Liability: The limit of liability for medical payments stated in the declarations as applicable to "each person" is the limit of the company's liability for all expenses incurred by or on behalf of each person who sustains bodily injury as the result of any one accident.

Other Insurance: If there is other automobile medical payments insurance against a loss covered by Part II of this policy the company shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability stated in the declarations bears to the total applicable limit of liability of all valid and collectible automobile medical payments insurance; provided, however, the insurance with respect to a temporary substitute automobile or non-owned automobile shall be excess insurance over any other valid and collectible automobile medical payments insurance.