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INSURANCE

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I Rates and Regulation

The survey year seems, as far as the law of Insurance in New Jersey is concerned, to have been more portentous than eventful. Across the river in New York, it has been decided that a company may be a partial subscriber to a rating bureau.[1] Now, another company is attempting, with at least partial success, to write certain types of fire insurance there at 20% less than the bureau rate.[2] These inroads on the bureau structure in New York will certainly have an effect throughout the country in the years to come. But what came to New York with a shout will probably come to New Jersey with a whisper. It is not in the nature of things for the same warriors to fight the same battle forty-eight times over with undiminished verve.[3]

The other big battle of this year is over the entry of the Federal Trade Commission into the field of insurance regulation with a full-dress investigation of misleading advertising in the accident and health business.[4] It does not seem likely that New Jersey will be directly affected; N.J. Rev. Stat. 17:29B seems to be as comprehensive a regulation as possible of misleading advertising, and of anything else that might invoke the jurisdiction of the FTC, including coercion, boycott, and intimidation. Since the McCarran Act eliminates the business of insurance from the operation of the acts enforced by the FTC to the extent the business is regulated by the states,[5] our regulation should be adequate to exclude the FTC. The McCarran Act preserves the ap-

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1. Cullen v. Bohlinger, 136 N.Y.S.2d 361 (App. Div. 1955) (affirming without opinion the order of the Superintendent of Insurance), *appeal dismissed* 308 N.Y. 886, 126 N.E.2d 564 (1955). An appeal is being taken to the United States Supreme Court. National Underwriter, June 9, 1955, p. 3. The appeal is evidently based on some theory that the data accumulated by the bureau are being confiscated, or being made the basis of unfair competition with bureau members. The contentions were not regarded by the Court of Appeal as of sufficient substance to support an appeal as of right. The Supreme Court will no doubt deal as summarily with them.

2. The latest on this is in the National Underwriter, July 7, 1955, p. 1, reporting that the New York Department has allowed only a 15% cut.

3. See the National Underwriter, June 23, 1955, p. 13, for maneuverings over a similar 20% rate cut by the same company in Washington.

4. National Underwriter, Jan. 6, 1955, pp. 1, 6; July 28, 1955, pp. 17, 22. The only previous federal intervention has been a few dragged-out anti-trust suits against local agency groups. National Underwriter, Jan. 27, 1955, p. 2; Feb. 10 1955, p. 12.

5. 59 Stat. 34 (1945); 61 Stat. 448 (1947); 15 U.S.C. § 1012(b) (1952).

plication of the Sherman Act to cases of coercion, boycott, and intimidation even though regulated by the states,[6] but since the FTC has no jurisdiction under the Sherman Act as such, and the operations of the Department of Justice in the realm of insurance have thus far been minor,[7] there would seem to be no immediate fear of federal intervention in the insurance picture in New Jersey. The chief danger to be apprehended is that the FTC investigations will turn up such significant failures in the regulatory patterns of other states that Congress will decide to scrap the McCarran Act as a failure. Furthermore, if the McCarran Act turns out to have failed to keep the federal government entirely out of the supervisory picture, the companies themselves may throw their weight behind full federal regulation, rather than attempt to operate under a dual system.[8]

If clouds are gathering for state regulation from the direction of the FTC, the United States Supreme Court has opened vast new horizons for it. While our local Supreme Court was deciding 4–3 that the liability policy of a deceased non-resident tortfeasor could not be used as a basis for granting administration of his estate in New Jersey,[9] the federal tribunal was holding that a state may make a non-resident's insurance company directly suable on an accident occurring within its borders.[10] The Louisiana Direct Action Statute thus upheld seems to be responsive to conditions that do not obtain except in Louisiana,[11] but it might be adopted elsewhere to provide a device for reaching the non-resident motorist that would have much to recommend it over the traditional substituted service scheme. It would not require the formality of making service on a public official, would not require the registered letter to the non-resident motorist, and, best of all, would eliminate a whole series of coy moves and countermoves directed at or against informing the jury that the burden of a judgment will rest on the insurance company.

If we are not to go to this extreme, rejecting the ingenious program offered by the plaintiff's lawyer in the *Roche* case would seem to have been an unfortunate move. Appointing an administrator to be sued and defended under the decedent motorist's insurance policy would be an admirable way to avoid the impact of the rule that the estate of a

6. 59 STAT. 34 (1945); 61 STAT. 448 (1947); 15 U.S.C. § 1013(b) (1952).

7. See note 4 *supra*.

8. For a typical expression by an insurance man of these areas of concern, see National Underwriter, March 24, 1955, p. 6.

9. *In re* Roche, 16 N.J. 579, 109 A.2d 655 (1954).

10. Watson v. Employers Liability Corp., 348 U.S. 66 (1954).

11. LA. REV. STAT. § 22.983 (1950). The appellate review of jury verdicts seems to be considerably broader in the Louisiana state courts than in the federal courts. Since most insurance companies are not incorporated in Louisiana, the direct action statute seems to provide the necessary diversity of citizenship to channel the bulk of Louisiana's personal injury litigation into the federal courts—much to the annoyance of the latter.

deceased motorist is immune from service under the Nonresident Motorists Act.[12] But as the case presented itself, only the accident was local. The victim was a New Yorker as well as the deceased tortfeasor. Perhaps the majority, by referring to the lack of local creditors as one reason for denying administration, has left the way open for a New Jersey plaintiff to fare better with the same device.

But the most portentous of all the portents of the survey year was the *Wilburn Boat* case,[13] in which the federal Supreme Court held that the states could regulate marine insurance as fully as other lines. Thus far, no state has seen fit to pick up the option. Since New Jersey has no general statute altering the effect of warranties in the manner of the Texas statute involved in *Wilburn Boat,* the case should have no effect in New Jersey unless the Legislature decides to act under it.

The problem of regulating marine insurance seems to be that it deals with two kinds of subject matter. The first is the traditional maritime venture, often world-wide in scope, almost always carried out under ancient customs and an international and esoteric legal system. In this venerable and cosmopolitan legal world, the prospect of state regulation is an anathema to all concerned.

On the other hand, more and more insurance is being written on vessels of an entirely different sort—pleasure craft, and craft used in small local businesses. The owners of these vessels are people who need the protection afforded them by state regulation in their insurance transactions, and have the right to expect it. Furthermore, a great deal of this coverage is being written not by marine companies, but by fire and casualty companies used to state regulation, and somewhat at a loss when asked to proceed without it.

Several solutions to the problem thus posed may be considered. The most obvious would be to draw some arbitrary line between the two types of insured—as by tonnage, value, area of operation, or something of the kind. Another alternative might be to leave the marine form unregulated, but develop a practice of insuring small marine risks under variants of traditional fire, casualty, and inland marine coverages, all of which are regulated in one way or another. Such a practice might well have competitive advantages against the marine form, particularly if the marine coverages could be combined in one policy form with nonmarine coverages. The advantage of this alternative is that it would tend to restrict the marine form—largely a seventeenth-century English translation of a fourteenth-century Italian document—to those who know how to use it, while the local agent could afford the coverage his clients need on forms that he can understand and can explain to his

12. Young v. Potter Title & Trust Co., 114 N.J.L. 561, 178 Atl. 177 (Sup. Ct. 1935), *aff'd,* 115 N.J.L. 518, 181 Atl. 44 (1935).

13. Wilburn Boat Co. v. Fireman's Ins. Co., 348 U.S. 310 (1955).

insured.[14] On the other hand, the drawing of a line between regulated and unregulated marine policy risks would enable the companies insuring small risks to take advantage of the marine form with its seagoing experience. Perhaps if the actual formulation of the line were left to an administrative agency there would be no great difficulty. Whatever is decided, the large shippers and their insurers, who are bargaining equals, will probably be able to work out an arrangement whereby they are not unduly burdened.

Meanwhile, the *Wilburn Boat* case should go a long way toward silencing those who had persisted in contending that insurance under the Longshoremen's and Harbor Workers' Compensation Act was not subject to state regulation. This, and several maritime employers' liability coverages, have long been written by endorsement on the policy used to afford insurance under the state workmen's compensation laws, and rates for them are included in the manuals put out by various rating agencies. Since the McCarran Act leaves in an equivocal position any system of bureau rates that is not subject to state regulation, the states, including New Jersey, that do not clearly regulate rates for these maritime coverages should take advantage of *Wilburn Boat* to enact legislation that will regularize the prevailing practices.

Another portent is the new statute that permits an insurer to combine in one form with the Standard Fire Policy any other coverages it can write.[15] How significant such a law will turn out to be depends, of course, on what coverages the companies decide to combine. Thus far, the big candidates for combining have been the various coverages, exclusive of automobile, needed by a typical member of the suburban middle class—fire, personal liability, and one or two types of crime lines or floater coverage on his personal effects. Policies issued in combinations of this sort become rather cumbersome looking, since they have to incorporate verbatim the language of the standard fire policy as required by statute,[16] and then have to add the several other coverages in language more or less conformable to that developed for the separate policy, each with its own set of exclusions and conditions. Until the draftsmen break loose from their old moorings, and until the legislatures let them break loose, we are apt to find that a really broad package policy contains so much print as to carry built-in sales resistance which the price advantages can only partly overcome. Even a man who would be enthusiastic about not having to buy five policies where one will do may feel that if he does have to buy five policies, there is no point in buying them all glued together.

The development of the unified insurance policy is somewhat analogous in its vicissitudes to the development of the unified civil action.

14. For an example of the kind of difficulty such an approach would go far toward solving, see p. 231 *infra*.

15. N.J. Laws 1954, c. 268, § 7; N.J. REV. STAT. 17:36–5.20 (1954).

16. N.J. Laws 1954, c. 268, § 6; N.J. REV. STAT. 17:36–5.20 (1954).

The business grew up in a set of statutory pigeonholes, responsive to some view that it is immoral to have the premiums paid for one kind of risk subjected to the payment of losses on another kind of risk. Gradually, companies were authorized to diversify their varieties of risks, until today in most states, including New Jersey, both fire and casualty companies have full multiple-line authority—can write all lines of insurance except life and title.[17] But for some reason it was often held by regulatory authorities that allowing a company to write several lines of insurance did not allow it to write several lines *on one policy*.[18] Hence the instant statute. There would now seem to be no legal obstacle to satisfactory combination policies in New Jersey except the standard fire policy law. But the practical obstacles and the psychological obstacles are manifold.[19] Every line of insurance has its own rating system, supported by its own set of statistics, and often promulgated by its own rating organization. Combining, for instance, into an indivisible premium the rate for a man's fire insurance, which varies with the type of construction of his house, with that for his automobile insurance, which varies with his age, is no mean feat. Meanwhile, when the rating data have been compiled over some years under a certain choice paragraph of policy language, companies display a natural reluctance to abandon it in favor of new language. Hence the verbiage on the combination policies. The homeowners' combination policies, inaugurated locally with the new statute, seem to have solved the rating obstacles to the satisfaction of the companies writing them, for they are written on an indivisible premium. Verbally, they leave a good deal to be desired, but would not be too bad if they did not have to incorporate the standard fire policy. These forms, however represent only a modicum of combination, and even as far as they go, have not commended themselves to all concerned. Further expansion, whether in the scope of coverage afforded, or in the volume of business done under the combination forms, will raise the same problems again. It is to be hoped that more favorable legislation, coupled with greater underwriting experience, will eventually bring the combination policy into its own. Meanwhile, the inland marine forms, which have been multiple peril coverages from the start, are being expanded—somewhat extra-legally—into more and more new areas.[20]

17. N.J. REV. STAT. 17:17–1 (1954).

18. See, *e.g.*, Weekly Underwriter [1952] Insurance Department Rulings, Connecticut 1.

19. The problems of gearing the bureau structure to multiple-line underwriting have been dealt with at some length in a recent report by the New York Insurance Department of their regular examination of the National Bureau. This aspect of the report is summarized at some length in the National Underwriter, March 24, 1955, p. 7.

20. *E.g.*, National Underwriter, Feb. 10, 1955, p. 12.

Another thing to watch in the coming year or so is the perennial problem of the uninsured motorist. The New Jersey Unsatisfied Judgment Fund has just begun paying off unsatisfied judgments. The system works rather like the Unsatisfied Judgment Insurance that is being written by a few companies elsewhere as an adjunct to conventional automobile insurance. The differences are that in New Jersey the coverage is written by a pool of insurers instead of by individual companies, the premium is hidden in the rates for other kinds of automobile insurance, and all insured motorists have to buy the coverage whether they want it or not. Why this is better than compulsory liability insurance is perhaps for the opponents of the latter to consider, rather than for this writer. Meanwhile, as the zero hour approached, the Legislature fidgeted nervously with the administration of the Unsatisfied Judgment Fund; [21] the advocates of compulsory insurance offered a plan that would make the uninsured motorist a disorderly person but would omit all objectionable administrative enforcement machinery,[22] and the Governor came out in favor of automobile accident compensation.

The Legislature recessed until August without passing on the Prudential's proposed legislation that would permit the writing of the so-called variable annuity.[23] This annuity would entitle the annuitant to a certain number of "units" in a fund that would be invested in common stocks and other high-yield investments. The scheme works roughly in this fashion: The annuitant pays annually until the annuity matures a fixed number of dollars. He is credited with the number of units that number of dollars represents according to the most recent valuation of the fund (dollar value of holdings divided by number of units outstanding). When the annuity matures, he will be given the option of withdrawing X units immediately at the then dollar value of the unit, or of accepting Y units annually as long as he lives at the dollar value for each year of payment. X and Y will be stated in the contract as functions of the number of units credited to the annuitant through his annual payments. The number of units outstanding will be increased by the number paid in and decreased by the number paid out, so that the dollar value of the unit will reflect only the investment results of the fund, not the amounts paid in or out. If the value of these investments is responsive to the same economic factors as the cost of living, the annuitant should be able to provide himself with a hedge against increased living costs by foregoing the windfall that might be afforded by fixed annuity in case living costs went down.

21. N.J. Laws 1955 c. 1.

22. Assembly Bill No. 118 (1955), National Underwriter, Feb. 10, 1955, p. 15.

23. Assembly Bills Nos. 305–7 (1955). The Prudential's position is that the variable annuity is now legal, but that existing laws with respect to accounting and reserves make it impractical to write it. For the controversy these bills have provoked, see, *e.g.*, New York Herald Tribune, May 26, 1955, p. 29, col. 2.

This seems like a good plan, and the necessary legislation should be adopted. It has been argued that it will put the life companies in unwarranted competition with the investment trusts, and this is true in that both are candidates for the savings of the citizen. But it is pointed out that they differ markedly in that the company assumes the actuarial risk of the variable annuity just as it does with a fixed annuity, and that the cancellation of the variable annuity before maturity will be a sufficiently lengthy process to prevent its use for speculative purposes. Arguments and counter-arguments have also been advanced as to whether the variable annuity has unfair tax advantages over the other forms of savings. Whatever the merits of these arguments may be, they seem properly addressed to the framers of tax laws, rather than to those considering the appropriateness of the variable annuity as such. Unless someone can point out a way in which the proposed contract is detrimental to the public, the regulatory laws should not be so framed as to keep it from being written.

II New Forms

The three most important casualty forms in national use have been revised during the survey year. The major revisions are more of underwriting than of legal significance,[24] but a few points deserve the attention of lawyers. The most important of these is perhaps the articulation of the doctrine of severability, which has been productive of a spate of litigation in recent years. The doctrine calls for interpreting the word "insured" to mean only the person claiming coverage in the particular instance, and not any other person who may be within the definition of the word. It operates to afford coverage for instance, to an omnibus insured who injures an employee of the named insured, as against the contention that coverage is excluded by the clause that excludes injury to "any employee of the insured." This doctrine has always been in accordance with the intent of the framers and underwriters of the form, but enough cases have rejected it to make its specific inclusion desirable.[25] It appears in the new form in the words: "The term 'the insured' is used severally and not collectively. . . ."

Another important change in the automobile policy is to be found in the condition extending the coverage to comply with the Financial Responsibility Laws of the various states. Under the new form, this clause is only applicable where the policy is "certified as proof of

24. Such as the inclusion of the spouse of the named insured in the automobile policy as an insured, and as one whose permission to operate the car is effective under the omnibus clause, the exclusion of "dram shop" liability from the liability policy, the exclusion of war risk from contractual and emergency medical coverage under the liability policy, and from medical payments coverage under the automobile policy, and various broadenings of coverage under the workmen's compensation and employers' liability policy, particularly with respect to disease.

25. *E.g.*, Standard Surety & Cas. Co. v. Maryland Cas. Co., 281 App. Div. 446, 119 N.Y.S. 2d 795 (4th Dept. 1953).

financial responsibility for the future." This is evidently intended to avoid the result of *Atlantic Casualty Ins. Co.* v. *Bingham*,[26] in which it was held that a policy issued on the old form to a person of whom such proof should be required is conformed to the standards required by the law for policies certified as proof of financial responsibility for the future, even though the policy was not so certified, and the insured was never called on to file such proof. It is quite likely, however, that the result in *Bingham* was considered by the court to be dictated by the statute regardless of the wording of the policy.

The new language has also the disadvantage of not providing the insured with automatic protection against the severe inconveniences imposed by the typical Financial Responsibility Law on a motorist who, at the time of an accident, does not have in force a policy conforming to other standards, usually less rigorous than those required of the policy accepted as proof of financial responsibility for the future. In fact, the policy probably conforms to the standards of all the states for this type of coverage, but the omission of the automatic feature imposes a considerable responsibility on the draftsmen of the policy not to make a mistake in the coverage they afford.

The automobile policy has also been extended to afford coverage in the case, hitherto somewhat troublesome, in which someone operating the vehicle injures a private garage. Such cases have usually been regarded as within the exclusion of property owned by, transported by, rented to, or in charge of the insured. Garages rented to or in charge of the insured are now excepted from the operation of this exclusion.

The language of the old form excluding from the "drive other cars" coverage automobiles "owned by, hired as part of a frequent use of hired automobiles by, or furnished for regular use to the named insured or a member of his household" has been amended by the omission of the reference to hired automobiles, and by the addition of the word "either" before the words "the named insured." What is left of this exclusion should be enforceable according to its intent, superseding the *Pray* case[27] in the Sixth Circuit, which held that the old language did not exclude a car owned by a member of the household.

The revision of the Comprehensive General Liability Policy is marked by a splendid job of cleaning up the troublesome "products" definition. Cases like *McAllister*, discussed below, should no longer arise under it.[28] The application of this definition to concrete cases must

26. 10 N.J. 460, 92 A.2d 1 (1952).

27. Travelers Indemnity Co. v. Pray, 204 F.2d 821 (6th Cir. 1953).

28. See p. 237 *infra*. The only remaining difficulty is the title. The words "(Including Completed Operations)" appear with the term "Products" in the declarations page, but something of the kind should be added to the name of the hazard, as it appears in the body of the policy, and in the endorsement that will be added excluding it if the insured chooses not to buy it. "Products-Completed-Operations Hazard" is an inelegant term, but one which may save insurers a good deal of money.

always require a certain amount of judicial intervention, because the utility of drawing a line is more apparent than where it should be drawn. It seems, however, that the draftsmen have succeeded this time in framing a definition that will preserve intact the extensive body of case law applying the distinction under the old language, and, at the same time, make the underwriting intent apparent to the judiciary and to insureds in future cases.

Less commendable is the amendment of the definition of "insured" whereby, if the insured is a partnership, a partner is covered "only with respect to his liability as such," instead of the former "while acting within the scope of his duties as such." The old term has been judicially construed to include what is covered under the new, so the only effect of the amendment would seem to be to exclude coverage to a partner individually for negligent torts committed by him personally in the course of the partnership business.[29] Why he ought to be worse off in this respect than the executive officer of a corporation, who is still covered while acting within the scope of his duties as such, is hard to see.

Another change in this definition is the addition of the words "and any organization or proprietor with respect to real estate management for the named insured." The purpose of this language is evidently to enable a managing agency to be insured on the owner's policy, but it is so drawn that there is apt to be trouble if the companies have it in mind to distinguish between an "organization or proprietor" and a mere janitor or superintendent.

The affording of coverage for liability under scheduled contracts not automatically included has been made the subject of a new endorsement which should go far toward clarifying just what is and is not covered. Among other things, the problem of liability imposed in arbitration proceedings is addressed. If the arbitration agreement permits the company to exercise the insured's rights in the choice of arbitrators and the conduct of arbitration proceedings, the company will defend the proceedings and pay the award up to the policy limits; otherwise, it will do neither. If, however, the company schedules on such an endorsement a contract containing an arbitration clause in which it cannot exercise the insured's rights, it is still in danger of being held to have waived these restrictions on its liability for arbitration awards.[30] Indeed, many of the exclusions contained in this endorsement might not stand up if a contract was scheduled which subjected

29. The writer has been informed that the underwriting intent was not to work such an exclusion, but to negative the possibility of the company's being held to a liability unconnected with the partnership business. This danger seems illusory under the old language.

30. See Madawick Contracting Co. v. Travelers Ins. Co., 307 N.Y. 111, 120 N.E.2d 520 (1954) (scheduling a contract for contractual coverage makes insurer liable to pay award made pursuant to arbitration clause in contract).

the insured for the most part to liabilities excluded from the coverage afforded. The way out for the company would seem to be either to read each contract carefully before covering it, or to schedule contracts in general terms, rather than referring to specific contracts.

In this endorsement, as well as in the policy itself with respect to contracts automatically covered, there appears a new exclusion of "any obligation for which the insured may be held liable in an action on a contract or an agreement by a person not a party thereto." The application of this clause is somewhat speculative, but most of the possibilities are not apt to commend themselves to the courts. The language is perhaps designed to reach the situation in which the insured undertakes a contractual duty the breach of which may cause harm to third persons. Under such circumstances it is possible that the insured would be liable even though the other party to the contract were not liable. It is by no means certain, however, that this liability will be regarded as contractual at all. Even though the underlying duty is raised by a contract, the breach of that duty gives rise to an action that sounds in tort,[31] and may not be excluded either by the new language or by the exclusion which applies with certain listed exceptions to any "liability assumed by the insured under any contract or agreement." [32] The draftsmanship with respect to contracts, then, still leaves a good deal to be desired. Fortunately, however, the new policy, by dealing with warranties separately from contracts generally, prevents products cases from being exposed to most of the difficulties of contractual coverage.

The most extensive revision was that of the Workmen's Compensation and Employers' Liability Policy. The new form embodies most of the provisions included on the old by endorsement, assimilates the language as much as possible to that developed for the other third-party liability forms, and standardizes the endorsements affording voluntary compensation, maritime coverage, and "all states" coverage. Coverage no longer depends on the reporting of payroll for premium purposes, as it did under the old form; if the policy applies in a state at all, it covers all employees and operations [33] in that state not expressly excluded by endorsement. The possibility of an uninsured liability for a disease that is neither an accident nor an occupational disease, which troubled some lawyers under the old form, has been met by making the employers' liability coverage applicable to all disease. These coverages have not been very litigious for many years, and the new policy is

31. Milford v. Bangor Ry. & Elec. Co., 104 Me.233, 71 Atl. 759 (1908).

32. See Larsen v. General Cas. Co., 99 F. Supp. 300 (D. Minn. 1951). A case that has troubled claims departments for years, and is still up in the air, is this: Insured agrees to keep *A* supplied with oil for his furnace all winter. *A* runs out of oil, and his pipes freeze and burst. Insured is sued for the damage.

33. Except farm and domestic employment, which is not covered unless described in the declarations.

broad enough so there will not be too much likelihood of litigation in the future. It remains to be seen what loopholes will develop.

III Cases

With all these thought-provoking factors elsewhere, the judicial developments in the law of insurance proper during the survey year seem fairly dry. Of some interest however is the holding that a reimbursement clause on a policy issued to comply with the federal Motor Carrier Act entitles the company to reimbursement for a settlement made without any participation by the insured.[34] The court seems to have left room for relieving the insured in case of bad faith or negligence on the part of the company in settling the case, but leaves the burden of showing such bad faith or negligence on the insured. The case seems to involve no earth-shaking policy decisions. The company had sent the insured a disclaimer of coverage before the settlement negotiations were entered into, and the insured could have assumed the handling of the case itself at that time, had it chosen to do so. It is unlikely that the insured will be subjected to a similar reimbursement suit where the company has sent no disclaimer letter, since in the absence of a disclaimer the assumption by the insurer of the defense and settlement of the case would operate as a waiver of these policy defenses that can be waived, and, if carried through to conclusion, as an estoppel to deny coverage. Since the reimbursement clause is made operative by a loss that the company would not have had to pay except for its extension of coverage to comply with the Motor Carrier Act, anything that would indicate a waiver or estoppel binding the insurer even in the absence of such an extension of coverage would seem to be available to the insured to defeat a claim for reimbursement.

Other decisions involve chiefly points of policy interpretation. How much work a man dying of cancer can do and still be disabled,[35] or whether money stolen from a corporate officer at a party was being conveyed by a messenger,[36] are questions of interest only to those who must answer the same questions another time, and West indexes them admirably. More interesting to us are the methods used by the courts in handling questions of policy interpretation.

Of the various canons of interpretation current in our courts, one which has proved particularly dangerous is that which requires the policy to be taken as a whole. Now, insurance policy forms, as everyone knows who has concocted them, are things of shreds and patches.

34. Bankers Indemnity Ins. Co. v. A.E.A. Co., 32 N.J. Super. 471, 108 A.2d 464 (App. Div. 1954).

35. Fannick v. Metropolitan Life Ins. Co., 34 N.J. Super. 556, 113 A.2d 28 (App. Div. 1955). See p. 240 *infra*.

36. Trad Television Corp. v. Hartford Acc. & Ins. Co., 35 N.J. Super. 36, 113 A.2d 47 (App. Div. 1955) (it wasn't).

Underlying the form is basic language that was drafted by a group of men who are now dead, meeting in a hotel that has been torn down, considering a situation that no longer obtains. Succeeding generations have cut and pasted, changing a phrase to cover a new situation, adding an exclusion to cover a situation that they were unable to persuade some court was already excluded, providing for a situation that was not foreseen when the first draft was done, leaving alone what has proven serviceable in the past. Today, when an insurance man wishes to draw up a new policy, he gets out one of the printed forms in his company's file drawers, a pair of scissors, and a jar of mucilage, and sets to work, just as those who have gone before him have done. In addition to changes in the printed form itself, there may be amendments to adapt the printed form to other circumstances. These will be embodied in slips of paper of varying shapes and sizes, to be pasted, pinned, or clipped onto the printed form as the occasion demands. Occasionally, instead, they are made up in the form of rubber stamps to use on any white area the printed form may present. Under the circumstances, the policy may be a functional whole, but it is hardly a literary whole. Two cases—fortunately not from our appellate courts—decided since this subject was last surveyed have failed, alas, to make this important distinction.

The first[37] is this: It seems that in March of 1884 a pump on a ship named the Inchmaree was damaged by being run with a valve closed that should have been opened. The insurer resisted payment under its policy on the ground that the loss was not caused by any of the perils assumed under the following language:

> And touching the adventures and perils which [are covered] they are, of the seas, men-of-war, fire, enemies, pirates, rovers, thieves, jettisons, letters of mart and countermart, surprisals, takings at sea, arrests, restraints and detainments of all kings, princes, and people of what nation, condition, or quality soever, barratry of the master and mariners, and of all other perils, losses, and misfortunes that have or shall come to the hurt, detriment, or damage of the aforesaid subject-matter of this insurance, or any part thereof.

The House of Lords, reversing the Court of Appeal, held that this particular mishap was neither caused by any peril expressly listed nor covered by the "all other perils" clause—which had to be interpreted in the light of the doctrine of ejusdem generis.[38]

To meet this decision, the trade adopted language, called the Inchmaree clause, covering:

> . . . loss of and/or damage to hull or machinery through the negligence of master, mariners, engineer or pilots or through explosions, bursting

37. American Shops, Inc. v. Reliance Ins. Co. of Phila., 26 N.J. Super. 145, 97 A.2d 513 (Essex Co. Ct., Law Div. 1953).

38 Thames and Mersey Marine Ins. Co. v. Hamilton, Fraser & Co., L.R. 12 A.C. 484 (H.L. 1887).

> of boilers, breakages of shafts, or through any latent defect in the machinery or hull, provided such loss or damage has not resulted from want of due diligence by the owners of the vessel, or any of them, or by the manager.

On the printed form involved in the case now under consideration (denominated a "yacht policy" and issued on a 25′ Chris Craft), this clause appeared as quoted above. In addition to the printed matter, the following language was placed on the policy with a rubber stamp:

> Not liable for loss or damage to the rudder, propellor, shaft or machinery, unless caused by stranding, sinking, burning, or collision with another vessel.

The policy thus printed and stamped was held to cover damage to the engine of this Chris Craft due to a latent defect, against the contention of the company that the stamped language was to prevail over the written language. Having insisted that the policy was to be read as a whole, meaning a *literary* whole, the court thought it necessary to search for a way of reading the stamped language as not inconsistent with the Inchmaree clause. It found such a way by holding that the stamped language, in virtue of the doctrine of ejusdem generis, applied only to *underwater* machinery. In addition, it found that the two clauses, if inconsistent after all, set up an ambiguity, which, of course, must be resolved in favor of the insured.

Besides the other objections to which this process is open, it does not accomplish its avowed purpose of reading the policy so as to make a literary whole. For one thing, it is difficult to see what underwater machinery a 25′ Chris Craft may have besides her rudder, propellor, or shaft; for another, there are no boilers to burst; there are no sails, spars, or tackle like that described in the list of subjects of insurance. Furthermore, while the list of perils assumed is not quoted in the opinion, it is doubtless rather like that quoted above—the traditional marine policy language, peopling the waters of Lake Hopatcong with an improbable assortment of men-of-war, enemies, pirates, rovers, and bearers of letters of mart and countermart. What really happened here was that the insurer, when it decided to sell insurance to yacht owners, took the venerable language of the marine policy, which has afforded satisfactory insurance to generations of mariners, but which has been subject to so long a process of judicial construction that no man is wise enough to change it, and amended it with such overriding provisions as it thought appropriate to the circumstances it was covering.

The policy read as an organic, and not a literary whole, is not too difficult to see in these terms. The traditional marine coverage, expressed in the traditional language, is amended in certain specific respects in which the foresight of the underwriter observes that it is unfit for use on small pleasure craft. The relation to be considered is

not merely one between two seemingly inconsistent clauses of the same document, but between printed language obviously intended to apply to a large vessel and language stamped on the form, presumably by someone who knew it was going to be issued on a small craft. Even disregarding any extrinsic knowledge we may have of the practice of insurers of amending printed language by rubber stamps, it should be fairly clear that that is what was done here. And indeed, there is no more reason why a person should be able to insure the engine of a 25′ Chris Craft against mechanical breakdown than there is why he should be able to insure the engine of his car against mechanical breakdown. If items of this sort go before their time, the purchaser looks to the manufacturer or dealer; if they go at the end of their expectable life span, he should have no complaint.

The other recent case giving an unfortunate application to this doctrine of taking the policy as a whole is the *Gunther* case.[39] It involved a Comprehensive Personal Liability Policy, a form meant basically to afford coverage as to non-business tort liability exclusive of automobile liability. The language involved deals with the relation between this policy and workmen's compensation coverage. The policy excluded:

> . . . bodily injury to or sickness, disease or death of (1) any employee of the insured while engaged in the employment of the insured, if benefits therefor are either payable or required to be provided under any workmen's compensation law; or (2) any residence employee of the insured while engaged in the employment of the insured if the insured has in effect on the date of the occurrence a policy providing workmen's compensation benefits for such employee.

In *Gunther,* the court held that since (2) was a special provision for residence employees, the insurer cannot have meant (1) to apply to them. Thus, the insurer had to pay a workmen's compensation award against the insured in favor of a residence employee, because the insured had no policy in effect providing such benefits. The court was unable to find any other interpretation of (1) that would give (2) any reason for being in the policy.

The insurer offered an affidavit as to what it intended by (2). In eleven states, it said, domestic servants can be brought under the workmen's compensation laws by the act of buying a workmen's compensation policy covering them. In these states, (1) might be regarded by a court as inapplicable, since workmen's compensation benefits are not required to be provided, and are only payable by virtue of the existence of a policy voluntarily purchased by the insured. The court quite rightly pointed out that the legal reasoning supporting this misgiving as to possible liability despite (1) is farfetched. But arguments of this

39. Gunther v. Metropolitan Cas. Ins. Co., 33 N.J. Super. 101, 109 A.2d 485 (Law Div. 1954).

sort loom larger at forms committee meetings than they do in court, and paper is cheap enough so that the draftsmen often end up by putting in almost superfluous clauses to set their minds at rest on just such far-fetched points. At any rate, such by affidavit was the intent of the insurer. The court, however, far from disbelieving it, did not regard it as putting in issue a material fact; it rendered summary judgment for the insured. Instead of the actual intent of the insurer in using the language under consideration, there was to be substituted a hypothetical intent, based on the impression left by the language on a "reasonable and disinterested third person"—in this case, a third person oblivious of the situation in any state other than New Jersey, and possessed of a singular confidence in the skill and determination with which the draftsmen of the National Bureau of Casualty Underwriters (whose form this is) avoid superfluity in the preparation of their policies. These are strange draftsmen, who strain at a gnat of superfluity, but who do not scruple to omit a major exception from the express language of another clause.[40]

Here again, if we look at the policy as an organic whole, it should give us no trouble. What we have is a catch-all kind of policy—one which affords insurance for a very few dollars for a miscellany of sources of liability, carefully excluding those which are the subjects of well-established and far more expensive coverages. The policy is not only cheap, it is very rough-and-ready actuarially. Unless the insured maintains two residences or has an elevator, he will pay neither more nor less than $10.00 for this policy regardless of his circumstances. The reason why this lack of actuarial subtlety is possible is that the policy covers a multitude of sources of liability all of which are of rather rare occurrence. Were it to cover an insured's business, his car, or his airplane, it would have to operate on far more refined premium bases. Otherwise, the man who has no car would have to pay a disproportionate premium to reach a flat rate adequate to cover automobile liability. In this context, the underwriting judgment that assimilates a servant entitled to recover for any injury sustained on the job to the disproportionate risks like automobiles, but leaves a servant who can recover only for negligence of the master, subject to the common-law defenses, in a class with golf and roller skates left on the sidewalk, should be quite understandable.

This is not to say that the draftsman should have the benefit of the

40. The National Bureau has amended the quoted language, so that it now excludes:

> . . . bodily injury to or sickness, disease or death of any employee of the insured arising out of and in the course of his employment by the insured, if benefits therefore are in whole or in part either payable or required to be provided under any workmen's compensation law, or if the insured has in effect on the date of such occurrence a policy providing workmen's compensation benefits for such employee.

policy as an organic whole to escape from the predicament in which he is placed by his failures in drafting the policy provisions. He is certainly responsible for the purport of his individual dispostions. But, if those dispositions are to be altered by their juxtaposition with other dispositions, it would seem that the alterations should be accomplished in the light of the policy as an organic whole. The case of *Prather* v. *American Motorists Ins. Co.*,[41] relied on in both the cases under consideration as establishing the doctrine that the policy must be read as a whole, seems to support the foregoing reasoning at least as well as it does the results reached in these two cases. This is the case: It seems that the insured bought an automobile policy on a two-company form, the Casualty Company making itself liable on the liability coverages, the Fire Company on the physical damage coverages. Of the latter, the insured bought only "comprehensive" (most losses except by collision) at the inception date of the policy in April, 1946. But two months later, he bought $50 deductible collision coverage, to expire October 1, 1946, although the rest of the policy was to run until April, 1947. This coverage was added by an endorsement, duly executed by both companies, that listed, after its statement of the added coverage, all the coverages then in force. On this list, after the words "$50 ded. collision" appeared the parenthetical notation "(until October 1, 1946)." In August, the insured got rid of his car and got another. An endorsement was issued changing the coverage from the old to the new car, and listing again the coverages in force. This endorsement lacked the parenthetical notation limiting the time of the collision coverage. This August endorsement was, inadvertently, it seems, executed only by the Casualty Company. In September, a new endorsement was added reading the same as the August endorsement, but executed by both companies. It was made retroactive to the August date. All three endorsements were typed on a printed form that recited that it would terminate with the policy. The question was whether collision coverage existed after October 1. Our Supreme Court held, with one dissent, that it did not.

In arriving at this result, the court has, to be sure, read the policy as a whole, but in a very different way from the courts in the two cases just discussed. To any honest man reading the policy with these three endorsements attached, it is evident that a hideous mistake has been made. The notation "(until October 1, 1946)" that appeared on the first endorsement has been left off of the last. Whether that mistake can be rectified, and the policy applied as if the omitted words had been present, depends on familiar principles which need not be taken up here. It need only be said that the decision does not depend on whether the third endorsement can be given a different *meaning* in the light of

41. 2 N.J. 496, 67 A.2d 135 (1949).

the first two from what it would have standing alone. It is clear that the person who typed up the third endorsement was under the impression that the insured had bought and paid for a full term of collision coverage, and that such was not the case. The language of the court about adopting a construction that gives effect to all the endorsements cannot properly be read except in the light of these principles. It was the endorsements as organic units, not their language, that was being given effect. Thus, *Prather* should not be used to support the two cases under consideration.

But behind this attempt to read the policy as a literary whole lies, perhaps, a very real concern. Some of the foregoing discussion may indicate what verbal hash the marine policy has become under the hands of so many generations of scissors-and-pastepot draftsmen. The comparatively few years our casualty forms have been in existence have not sufficed to do quite the same, but the trend is discernible. The reading given the policies in the two cases under consideration is probably responsive to that trend, but does nothing to reverse it; in fact it robs the forms of what little ready comprehensibility they had. In each case, the clause actually involved was understandable by itself, and became unclear only by its connection with other clauses. If a layman is at sea reading the policy clause by clause, he is far more so attempting the subtle process engaged in by the court in these two cases. Furthermore, this type of reasoning is productive of the very kind of draftsmanship at which it is directed. The atmosphere in which insurance policy drafting is carried on is one of mistrust of the judiciary. Superfluous clauses like the one involved in *Gunther* are multiplied through apprehensiveness based on inability to predict what the courts will do. If clarity is a desideratum, the approach adopted in these cases will not serve it.

One panel of judges in the Appellate Division suggested an alternative, which is to leave the whole question of policy interpretation in the hands of the jury.[42] The particular question was whether a clause in a burglary policy excluding loss "contributed to by any change in the condition of the risk" referred to any change in the premises, or only to such changes as made burglary materially more likely. The mandate of the Appellate Division reversing a directed verdict for the insured, seems to require that that question be left to the jury with no kind of standards to guide them. In all probability, no direct evidence of intent will be allowed to influence the decision. The idea that the language means what a reasonable man would understand it to mean furnishes some argument for employing the jury as our system's traditional embodiment of the reasonable man. But the disadvantages of this method far outweigh any logical consistency there may be in it.

42. Clark-McCaffrey Co. v. Nat. Fire Ins. Co., 32 N.J. Super. 138, 108 A.2d 32 (App. Div. 1954).

An insurance policy is underwritten with at least a certain amount of precision. If the draftsman is to hope eventually to accomplish concomitant precision in his form, he is at least entitled to believe that the words he uses will be interpreted the same way in every case. The thrust of the statutory policy that forbids an insurer to play favorites is in the same direction. Accordingly, a canon of interpretation that takes the job from the court and leaves it to a jury, whose determinations have, of course, no precedent value, is open to strenuous objection.

To attempt to discern a better alternative, let us consider what the ends are that should be achieved in the judicial consideration of insurance policies. First, the policy should be recognized for what it is, and not dealt with under rules developed for the resolution of controversies arising between citizens who have dickered over a horse at the county fair. A policy form is printed, and sold on a take-it-or-leave-it basis, rather as a vacuum cleaner is sold. The product, the sales talk runs, will do certain things; with appropriate attachments it will do other things; still others it will not do. Except in the case of large insureds whose cases seldom reach the courts, there is no negotiation as to language. Second, insurance itself should be recognized for what it is—a social function of vital importance in our society. It is in form a private business, but it is one of the most heavily regulated private businesses in our system, and the regulation is in great part concerned with the content of the very documents that the courts are called on to interpret. These range all the way from the fire policy, whose exact language is fixed by statute, to the accident and health forms, which, at least as to coverage, are little regulated. In between are the marine form, whose meager and arcane language is governed by a body of decisional law as venerable and almost as voluminous as that governing the Statute of Frauds, and the casualty forms, which are subject to regulation in most states, and, as a matter of practice, are submitted to all state regulatory bodies before they are used. The trend toward drafting policies on a bureau, rather than a company, level is growing, and the responsiveness of the insurance business to social considerations is growing with the centralization of the business in organizations concerned with the survival and growth of the business as a whole, rather than with competition between companies. These factors would seem to point to a need for the handling of the insurance policy as a social, rather than as a business document.

Finally, clarity of draftsmanship should be encouraged. For one thing, it is entirely posssible for a policy form to get so complicated that the judge will be unable to understand it even when it is explained to him. For another thing, if insurance is really to be responsive to social requirements it is necessary that it be generally known what insurance is being afforded. It is not necessary that every insured be

aware of every limitation on his coverage, but the general scope of the customary coverages should be generally known. The application of any document in common use must depend in some part on reported judicial constructions of its terms, but the general outlines should be discernible from the text. This kind of clarity can best be achieved by a fairly long-term dialogue between the draftsman and the judge, carried out in an atmosphere of stability.

To achieve these standards, considerations dehors the policy language should be brought in. It should not be enough, for instance, to ask ourselves what a policy means, we should ask how clearly it means it, and what it ought to mean. In other words, we must take the policy in its social and underwriting contexts—as an organic whole. Let us consider how this works. First, since the terms of the policy are not the subjects of negotiation between insurer and insured, there is no reason why it should be required that the insured fully understand the policy. Insurance is sold in packages, and if the insured is given to understand which of the available packages he is buying, and its general purport, the exact content of the package can safely be left to the judiciary, the rating bureaus, and the state regulatory authorities. Thus, terms like "caused by accident" and "perils of the sea" and those appearing in the products definition are left to judicial interpretation, without any particular effort being made to apprise an insured of their exact limitations.

On the other hand, the requirement that the insured be acquainted with the general scope of the coverage he is buying calls for a more exacting standard of clarity in dealing with terms inconsistent with the general purport or apparent general purport of the policy. While terms not inconsistent with that general purport can be left to the intepretation the courts will put on them after a careful reading in the light of precedent and other relevant factors, inconsistent terms should be given no effect at all against the insured unless they are clearly adverted to in the policy—even if the judge can understand them. This is the thrust of the *McAllister* case, decided by the Appellate Division in 1953, and affirmed by the Supreme Court on Judge Bigelow's opinion.[43] It involves a schedule liability policy which lists certain "hazards" and affords coverage with respect to such of them as are indicated by typed entries on the declarations page of the policy. One of the distinctions in this schedule is that between the "premises-operations" hazard and the "products" hazard. The breakdown is motivated by the fact that the danger in the operation whereby a certain result is produced is in no way a function of the danger in the result itself. Thus, a cleaner and presser who uses steam boilers and naphtha will present a great risk of liability arising out of the way he does his job, and little risk of

43. McAllister v. Century Indemnity Co. Hartford, 24 N.J. Super. 289, 94 A.2d 345 (App. Div. 1953), *aff'd*, 12 N.J. 395, 97 A.2d 160 (1953).

liability arising out of his finished product, whereas a person who wraps egg salad sandwiches may cost his insurer many thousands of dollars in ptomaine cases before the process of sandwich wrapping claims a single victim. Accordingly, the manuals by which liability insurance is rated contain for each class of business rates for the premises-operations hazard based on the size of the plant or the number of employees, and rates for the products hazard based on the dollar volume of business. The two hazards are kept separate on the policy by an exclusion to the effect that nothing is covered under premises-operations that could be covered under products. In the policy involved in this case the products hazard is defined as follows:

> Division 3. Products. The handling or use of or the existence of any condition in goods or products manufactured, sold, handled or distributed by the Named Insured, if the accident occurs after the Insured has relinquished possession thereof to others and away from premises owned, rented or controlled by the Insured; and operations covered under Divisions 1 and 6 of the Definition of Hazards (other than pick-up and delivery and the existence of tools, uninstalled equipment and abandoned or unused materials), if the accident occurs after such operations have been completed or abandoned at the place of occurrence thereof and away from such premises.[44]

It will be noted that the part of the foregoing after the semicolon is concerned not with the product of one who deals in goods, but with the operation of one who deals in services. Anyone who has followed the discussion thus far will perhaps accept with fairly good grace the logic that assimilates the dichotomy between an operation going on and an operation completed or abandoned to that between the making of a product and the product itself. He may even see the validity of the exceptions contained in the parentheses in the quoted language. He may, however, be less than sympathetic with the choice of words, or with the label "products."

At any rate, a policy in this form was issued to an excavator who did not buy coverage for the "products hazard" but did buy coverage for the "premises-operations hazard." He dug a hole, and filled it in, so negligently, it was complained against him, that long after he had done his work a person tripped in the depression he had left in the sidewalk. The insured successfully defended his case after the company had disclaimed, and he now seeks to recover his counsel fees. The insurer contends that this is a products case, and, as such, excluded from the premises-operations coverage the insured has bought. Judge Bigelow in the Appellate Division makes short work of this contention:

> A careful and repeated reading of the [exclusion and the quoted language] only emphasizes the vagueness and ambiguity of the policy. We are satisfied, however, that an excavator's liability insurance is not offered under the heading "Products." [45]

44. 24 N.J. Super. at 293, 94 A.2d at 347.
45. *Id.* at 294, 94 A.2d at 347.

Then, after alluding to the necessity of construing strongly against the insurer, he goes on to say:

> The obvious object of the plaintiff in procuring this policy was indemnity against liability on tort claims growing from his operations as an excavator. The company seems, in general, to have intended by the policy to afford him such indemnity for a limited period, the policy year. Except as particular provisions of the policy so curtail its scope that an ordinarily intelligent man would understand that the policy does not cover certain risks which come within its general scope—with that exception, the policy should be construed to cover all liability for accidents arising from plaintiff's operations, whether the accidents happened before or after the excavation job was finished. We agree with the trial court that the company is liable on its policy in respect to the claim that was asserted against plaintiff.[46]

As Justice Brennan quite rightly points out in his dissent[47] from the affirmance by the Supreme Court on Judge Bigelow's opinion, there is no ambiguity in this language. Language is ambiguous when it may mean either of two or more things. This language, if it means anything at all, means what the company contends it means. The question that Judge Bigelow was really answering adversely to the company was whether it is to mean anything at all. The quotation from Judge Bigelow's opinion tells us why we have asked this question and answered it in this way. The policy purports to be a general liability policy, and the company is contending that a broad area of general liability is excluded from the coverage. Under these circumstances, it is not enough that the company point to language that excludes it. The company must point to language that makes it clear that it is excluded. This case illustrates very well the principle just set forth. Taking the policy as an organic whole, the reasons for splitting coverage for operations completed from coverage for operations going on are worthy of sympathetic consideration. The quoted language defining what is completed operations coverage, and thus excluded from operations-going-on coverage, is abstruse, but would probably have been given effect, except for one thing. Nowhere was it made clear that completed operations were not covered. Had the policy said in large print: "Completed Operations are not Covered," the court would probably have applied the quoted langauge just as it was written. This language under a catchline "products" has no different meaning from what it would have under a catchline "completed operations." But the effect to be given it is quite different.

These principles are perhaps given further application in the recent agency cases, *Heake* v. *Atlantic Casualty Co.*[48] in which the policy was so prolix and so finely printed that the insured was allowed to

46. *Ibid.*
47. 12 N.J. at 395, 97 A.2d at 160.
48. 29 N.J. Super. 242, 102 A.2d 385 (App. Div. 1954), *aff'd*, 15 N.J. 475, 105 A.2d 526 (1954).

reform it to conform to his understanding with the agent, even though he had been remiss in not reading it, and *Yannuzzi* v. *United States Cas. Co.*,[49] in which the agent through whom the insured had dealt with the company was regarded as a proper person to receive notice called for in the policy regardless of his actual authority. In each case, the company's disclaimer was based on standards inconsistent with the ostensible scope of the package of insurance the insured thought he was buying. The same is true of *Mattia* v. *Northern Ins. Co. of New York*,[50] where the insured had automobile theft insurance under a certificate, and was held not bound by a provision in the master policy, incorporated by reference in the certificate, which would have excluded all coverage while the automobile was subject to a conditional sale agreement. Again, the exclusion is not consistent with the general scope of the coverage to be expected.

So much for considerations based on the manner in which policies are sold and the encouragement of good draftsmanship. There remains the standard of social context as a factor in the application of insurance policies. This is well illustrated by the *Fannick* case,[51] decided during the survey year, in which it is held that a man can be "wholly prevented . . . from engaging in any and every business or occupation and from performing any work for compensation or profit . . ." where he ought not to work, even if he does work. The decision is an extension of a much earlier case where the insured attempted manfully to attend to his duties, but was all but worthless in them. Here, the insured took a job at which he performed quite satisfactorily for some weeks, but the court still held that whether the requisite disability existed was for the jury.

If this case were socially neutral, there would be little to be said for the result reached by the court. In fact, however, the court is, with a good deal of justification, assimilating what the policy provides to what it should provide. The policy was a group life contract issued at the insured's place of employment, to terminate with the employment. If, however, death came within a year of termination of the employment, and during the intervening time the insured was disabled under the above-quoted language defining that word, the insurance would persist. The insured left his job on account of a cancer that had begun to manifest itself; three months later he was dead. Meanwhile, he had worked four weeks in a different occupation. Although he seems to have put in a satisfactory day's work each day, he was in a far advanced stage of his last illness all the while. The case

49. 32 N.J. Super. 373, 108 A.2d 489 (App. Div. 1954), *rev'd*, — N.J. —, — A.2d — (1955).

50. 35 N.J. Super. 503, 114 A.2d 582 (App. Div. 1955).

51. Fannick v. Metropolitan Life Ins. Co., 34 N.J. Super. 556, 113 A.2d 28 (App. Div. 1955).

presents the figure of a man who should be allowed the advantage of the group life insurance at the place of employment he left on account of the onset of his fatal illness. Few are surprised at the result of the case, and few of those who are surprised are unhappy. Insurance policies, then, are to be interpreted in the light of their social function. This standard was to some extent articulated in *Fannick,* to a larger extent in *Booth,*[52] its 1925 predecessor. It would seem to justify dealing more freely with the words of a policy than does the principle that ambiguities should be resolved in favor of the insured.

Our cases, then, offer alternatives to the process of achieving just results from wrestling with the concept of a policy as a literary whole —a process whose fruitlessness is illustrated by the two cases discussed above in which it was used. These alternatives are to be found in the concept implicit in Judge Bigelow's reference to the coverage the company "seems, in general, to have intended to afford"—what has here been referred to as the policy read as an organic whole. That concept is drawn from the logic of the underwriter's profession, considered either in itself, or in its social context. The ills that may befall mankind have been broken down by either custom or logic or both into separate categories, separately rated and separately insured. The general thrust of an insurance policy will be to cover one or another of these categories. When a provision is unexpected in this context, it is not enough that it be stated; fair warning of it must be given. This is the impact of *McAllister* and *Heake.* To this *Fannick* adds that when a provision is harsh or inappropriate it will be softened or rendered appropriate by construction. These criteria are as yet incipient in our law, but they may well develop into highly serviceable tools for making proper use of insurance policies as social instruments.

52. Booth v. United State Fidelity & Guaranty Co., 3 N.J. Misc. 735, 130 Atl. 131 (Sup. Ct. 1925).