TOP TEN ACCIDENT BENEFITS CASES 2008-2009

By Jennifer Griffiths, Zarek Taylor Grossman Hanrahan LLP

Over the past twelve months, there have been a number of decisions in the realm of statutory accident benefits that should affect the way we approach and analyse our files, whether from the perspective of the insurer or of the accident benefit claimant. Although the trend from previous years continues in that insurers still tend to be on the losing end of procedural disputes and cases involving the scope of catastrophic coverage, some recent authority from the Court of Appeal suggests that the tests pertaining to benefit entitlement under the *Statutory Accident Benefits Schedule* may be interpreted more stringently than we had previously understood.

1. *Burtch v. Aviva Insurance Company of Canada*, 2009 ONCA 479

This case involved an appeal by Aviva of the trial judge's finding that Mr. Burtch met the post 104 week test for weekly income replacement benefits pursuant to section 5(2)(b) of the *Schedule*, on the grounds that he was completely unable to engage in any employment for which he was suited by education, training and experience.

The fact situation in the *Burtch* case was exceedingly common. Mr. Burtch was 29 years old at the time of the accident. He had a grade 11 education and worked as a general labourer with heavy physical demands at the time of the accident. He had only ever done heavy to very heavy physical work. He suffered back and shoulder injuries as a result of the accident, which prevented him from performing the heavy physical components of his pre-accident work, and he therefore qualified for weekly disability benefits within 104 weeks of the accident on the grounds that he suffered a substantial inability to perform the essential tasks of his employment. It was also alleged that he had suffered some degree of cognitive impairment, although there was also some question as to whether this impairment pre-dated the accident. The cognitive impairment and possible underlying depression was considered significant by a first DAC assessment which concluded that Mr. Burtch was disabled from his own occupation within 104 weeks post-accident.

A Post-104 week DAC however, concluded that Mr. Burtch did not meet the stricter test of disability required at the 104 week mark, even though he was not yet "job-ready". This DAC committee found the evidence of cognitive compromise unpersuasive. The DAC committee reached the conclusion that Mr. Burtch "might be" capable of returning to a job involving light to medium physical demands. Three specific recommendations were made to assist Mr. Burtch to become job-ready:

1. Mr. Burtch needed vocational assistance to get a job due to his intellectual limitations and poor academics;

2. Mr. Burtch hadn't worked in two years and therefore needed help to overcome physical deconditioning; and

3. Mr. Burtch needed counseling to help him overcome the belief that he had suffered neurocognitive impairments, which belief was not supported by testing.

A vocational counselor was thereafter retained to work with Mr. Burtch. As a result of this intervention, the occupation of long haul truck driver was identified as the "greatest potential for future employment" for Mr. Burtch. However, in order to obtain work in this field, Mr. Burtch was required to take a truck driving course at a cost of $4250 and to obtain an i94 waiver card allowing him to cross the border. Mr. Burtch testified that he was willing to give this occupation a try.

The Court of Appeal ruling does not go into details as to whether Mr. Burtch was offered funding to take his driving course, or whether he was offered support to obtain the i94 waiver card, and in fact stated that such considerations were irrelevant in that entitlement to a weekly benefit post 104 weeks was the sole issue at trial; specifically, there was no claim for vocational rehabilitation services required but not funded. Similarly, the appeal court did not consider the Appellant's argument that the insured was required by sections 55 and 56 of the *Schedule* to participate in rehabilitation and to make best efforts to obtain work.

Simmons, J.A., writing for the majority stated that these arguments were not relevant as the only issue raised by Mr. Burtch in his Statement of Claim was his entitlement to post 104 week income replacement benefits. It was his position that no suitable employment alternative existed for him.

The Court of Appeal rejected Mr. Burtch's position and the trial judge's analysis. On the facts as found by the trial judge, the appeal court found that the job of long haul trucker was employment that was reasonably suitable for Mr. Burtch even though he required a modest amount of training, in that:

> *The trial judge earlier found as a fact that the respondent did not require substantial upgrading or retraining to engage in long haul trucking. He also found the job opportunities were available in the field; it paid similar remuneration as the respondent's past employment; and while an i94 waiver was required to permit cross-border trucking, the trial judge observed that there were trucking jobs in Canada. Most importantly, the medical and vocational evidence indicated that the respondent could perform the duties of the job.*

It is very interesting that the Court of Appeal did not address the question of funding for training, which was perceived by the trial judge to be central to the question of whether or not long-haul trucking was an appropriate employment option for the insured at the time of trial. Clearly, it was very significant that steps had been taken further to the post-104 week DAC to provide more specific evidence regarding potential employment options for Mr. Burtch and to identify the additional steps that would have to be taken to make him job-ready. It also appeared to be significant that Mr. Burtch indicated his willingness to consider this type of job. However, the failure to ensure that Mr. Burtch was completely job-ready in terms of training or upgrading was not visited upon Aviva. The test was met simply because the job identified was a job for which Mr. Burtch was reasonably suited by education, training or experience, even though modest further training would be required.

Where a disability assessment suggests that an insured should be capable of employment, it is essential for an insurer to obtain the additional evidence that Aviva was able to present in the *Burtch* case, supporting the suitability of one or more than one potential employment option. An insured who passively refuses or fails to take steps to attempt vocational reintegration runs considerable risks as demonstrated in this case.

2. *Heath v. Economical Mutual Insurance Company* 2009 ONCA (CanLii)

Mr. Heath was involved in a minor rear end motor vehicle collision on March 10, 1998. He had not worked regularly for a number of years, and therefore applied for non-earner benefits, a claim which Economical denied. Together with prosecuting his tort claim, Mr. Heath sued Economical for the disputed non-earner benefits, acting on his own behalf at trial. Although he was successful at trial, the trial judge's ruling was set aside on appeal, and Mr. Heath's claim was dismissed. From the reasons of the Court of Appeal, it is evident that Mr. Heath simply failed to lead any evidence on key points. These evidentiary gaps coupled with the trial judge's misapprehension of the relevant test for non-earner benefits resulted in the dismissal of Mr. Heath's action.

Mr. Heath testified that he sustained various significant injuries as a result of his accident, including several stable spinal fractures, subluxations and slipped discs, leg length discrepancy, myopia, cracking in his neck and ankles, tingling sensations and body pain. The evidence supporting any kind of injury in the immediate aftermath of the accident was very limited and included reports from Mr. Heath's family doctor to ODSP in late 1998, reflecting modified independence in a few areas (pain, sustained occupational activity, transportation). A treating orthopedic surgeon commented that there may have been some mild mechanical and postural neck pain based on minimal degenerative changes. There was no reason to consider surgery or narcotic analgesics. There was no reason Mr. Heath could not perform light duties, according to his orthopedic surgeon. The only limiting factor physically was deconditioning.

Seven years after the accident, a medicolegal referral was made by Mr. Heath's then-counsel to a physiatrist, Dr. Sequeira. Dr. Sequeira felt that Mr. Heath had developed a chronic pain syndrome as a result of the accident over the course of several years, with altered body mechanics then accounting for some of the ongoing pain over time. He noted that Mr. Heath was "subjectively significantly disabled." His perception that he had suffered severe injuries was itself a barrier to recovery. Dr. Sequeira also noted that Mr. Heath had not worked for several years (and had in the interim been approved for ODSP), and his current prognosis for return to any kind of work was poor. Dr. Sequeira did not think it likely that Mr. Heath had sustained a spinal wedge fracture as he believed.

The trial judge accepted Dr. Sequeira's explanation of Mr. Heath's presentation, concluding that Mr. Heath did meet the test for non-earner benefits.

In arriving at this conclusion, the trial judge grossly misstated the test for non-earner benefits as set out in the 1996 *Statutory Accident Benefits Schedule*. Instead, he cited the OMPP era test of a "partial inability to carry on a normal life" for 156 weeks post-accident, and a "complete inability" thereafter. He also misstated the test for a "complete inability to carry on a normal life" as, "a complete inability to engage in substantially all of the activities in which he or she

would ordinarily engage." Rather, the test requires the person to sustain "an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident."

In addition to misstating the test, the trial judge misapplied it. The trial judge's finding of disability had been based upon the development of chronic pain. He dismissed the early reports of Mr. Heath's treating practitioners as out of date, in contrast to the 2005 report of Dr. Sequeira, even though Dr. Sequeira had never seen Mr. Heath during the 104 week window relevant to determination of initial entitlement to a non-earner benefit. The trial judge did not make any finding as to when Mr. Heath's disability arose.

Both the evidence led by Mr. Heath and the trial judge's approach to this case focused on the period of time leading up to the trial. Additionally, Mr. Heath led very little evidence regarding his level of activity prior to the accident. As such, there was insufficient evidence in this case sufficient to satisfy the test once properly articulated and the claim was dismissed.

The Court of Appeal articulated the following principles as setting out a proper approach to interpreting section

- *Generally speaking, the starting point for the analysis of whether a claimant suffers from a complete inability to carry on a normal life will be to compare the claimant's activities and life circumstances before the accident to his or her activities after the accident. This follows from the language of the section as well as a review of the predecessor provisions. That said, there may be some circumstances in which a comparison, or at least a detailed comparison, of the claimant's pre-accident and post-accident activities and circumstances is unnecessary, having regard to the nature of the claimant's post-accident condition.*

- *Consideration of a claimant's activities and life circumstances prior to the accident requires more than taking a snap-shot of a claimant's life in the time frame immediately preceding the accident. It involves an assessment of the Appellant's activities and circumstances over a reasonable period prior to the accident, the duration of which will depend on the facts of the case.*

- *In order to determine whether the claimant's ability to continue engaging in "substantially all" of his or her pre-accident activities has been affected to the required degree, all of the pre-accident activities in which the claimant ordinarily engaged should be considered. However, in deciding whether the necessary threshold has been satisfied, greater weight may be assigned to those activities which the claimant identifies as being important to his/her pre-accident life.*

  Although this approach differs somewhat from the approach taken in Walker v. Richie, 2003 Can Lii 17106 (ON. S.C.), 2003 Can Lii 17106 (Ont. S.C.), *in which the trial judge focused on those activities that were "most important" to the claimant before the accident, in my opinion, it better reflects the high threshold created by the language of the section and at the same time allows a claimant focused inquiry.*

- *It is not sufficient for a claimant to demonstrate that there were changes in his or her post-accident life. Rather, it is incumbent on a claimant to establish that those changes amounted to him or her being continuously prevented from engaging in substantially all of his pre-accident activities. The phrase "continuously prevents" means that a claimant must prove "disability or incapacity of the requisite nature, extent or degree which is and remains uninterrupted."*

- *The phrase "engaging in" should be interpreted from a qualitative perspective and as meaning more than isolated post-accident attempts to perform activities that a claimant was able to perform before the accident. The activity must be viewed as a whole, and a claimant who merely goes through the motions cannot be said to be "engaging in" an activity. Moreover, the manner in which an activity is performed and the quality of performance post-accident must also be considered. If the degree to which a claimant can perform an activity is sufficiently restricted, it cannot be said that he or she is truly "engaging in" the activity.*

- *In cases where pain is a primary factor that allegedly prevents the insured from engaging in his or her former activities, the question is not whether the insured can physically do these activities, but whether the degree of pain experienced, either at the time, or subsequent to the activity, is such that the individual is practically prevented from engaging in those activities.*

3. *Liu v. 1226071 Ontario Inc* 2009 ONCA 571

In this case, the Appellant, Liu, appealed the trial judge's finding that he had not suffered a catastrophic impairment as a result of an April 9, 1999 pedestrian/motor vehicle accident. This appeal took place in the context of a tort proceeding. The jury had awarded $865,000 for future care, in the event that the catastrophic definition was met.

In this instance, the Catastrophic DAC had been conducted by Dr. Becker and Dr. Salmon. They concluded that the catastrophic definition had been met on the basis that a Glasgow Coma Scale reading of 9 or less had been obtained according to a test administered within a reasonable period of time by a person trained for that purpose.

The evidence established that the plaintiff had sustained a brain injury. There were no confounding factors. A GCS reading of 3 and then 8 was obtained by the paramedics, before a reading of 12 was obtained approximately 40 minutes after the accident.

The trial judge's ruling on the catastrophic issue was sparsely written and vulnerable to appeal. It did not address whether the first two readings were invalid on the grounds that they were not obtained within a reasonable period of time after the accident or on other grounds. Rather, the trial judge appeared to look to the outcome in Mr. Liu's case, and concluded that his ability to look after his own clothing, hygiene, shelter, safety and independent travel was inconsistent with a "catastrophic impairment."

Without directly addressing the question of what constitutes a "reasonable period of time" and whether a transient reduction in consciousness would be sufficient to result in a catastrophic

designation, the Court of Appeal rejected the trial judge's approach to this case and substituted a finding of catastrophic status and entitlement to related damages as assessed by the jury.

The ruling in this case underscores that criterion e(i) of the catastrophic designation is meant to be applied on an immediate basis and is not contingent upon the ultimate medical outcome, stating:

> *Any notion of catastrophic injury, other than the specific meaning ascribed to that term by the legislation must be discarded when considering whether a claimant meets the statutory test. The statutory scheme creates a bright line rule which is relatively easy to apply. This enhances the ability of those looking to the definition to know what injuries will and will not be considered catastrophic. Having the same definition for both no fault and third party liability claims avoids inconsistency. The ease with which the rule can be applied adds an element of predictability which will facilitate the settlement of claims.*

4. *Pastore and Aviva*, Arbitrator Liz Nastasi FSCO AO4-002496

The FSCO arbitral decision in *Pastore and Aviva*, addressing the catastrophic threshold, further develops our understanding of how the catastrophic threshold is being approached by decision makers. In this case, Arbitrator Nastasi followed the *Desbiens v. Mordini /Arts v. State Farm* approach to combining physical and psychological impairments to reach the 55% catastrophic whole person impairment threshold and endorsed this approach as correct.

In addition to addressing the combining of physical and psychological impairments, the *Pastore* decision also deals with the definition of catastrophic impairment using Chapter 14 of the *AMA Guides to the Evaluation of Permanent Impairment, 4th Edition*, for the purpose of determining whether a class 4 "marked" or class 5 "extreme" impairment had been sustained due to mental or behavioural disorders.

Ms. Pastore was a 66 year old woman who had suffered orthopaedic injuries to her ankle, requiring surgical repair. She also went on to undergo a knee replacement post-accident. The impairment rating attributable to her ankle injury was between 2 and 12% WPI. The Arbitrator ultimately accepted that the 2% WPI was correct. There was divergence in the medical opinions as to whether the knee impairment was attributable to the accident or the result of a pre-existing degenerative condition. It would appear that where the majority of the physical medicine opinions on this point were to the effect that the knee impairment was not rateable due to the accident, the arbitrator accepted that it was, and ascribed a 20% whole person impairment rating for the knee. The balance of the physical complaints did not translate into a rateable injury.

From a psychological perspective, Ms. Pastore was diagnosed with an Adjustment Disorder with Depressed Mood, a mild phobia as well as Pain Disorder associated with Psychological factors. The Arbitrator attributed a 22% whole person impairment to these psychological factors. Although the combined whole person impairment rating was only 39%, the Arbitrator then went on to consider whether catastrophic status could be found based on section 2(g) of the *Schedule*.

Section 2(g) of the *Schedule* indicates that catastrophic designation will follow a finding of "marked" or "extreme" impairment pursuant to Chapter 14 of the *Guides*. Chapter 14 instructs the assessor to evaluate psychiatric impairment based upon consideration of four separate areas of functioning being: activities of daily living, social functioning, concentration and desperation. The commentary then defines "marked" and "extreme" as follows:

> *"marked" is a level of impairment that significantly impedes use or functioning. Taken alone, a marked impairment would not preclude useful functioning, but together with marked limitation in another class, it might limit useful functioning. "Extreme" means that the impairment or limitation is not compatible with useful function.* [1]

The same section goes on to state:

> *In the ordinary individual, extreme impairment in only one class would be likely to preclude the performance of any complex task, such as one involving recreation or work. Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special support or assistance, such as that provided in a sheltered environment.* [2]

Until recently, the question of how many areas of functioning needed to be "markedly" impaired for a "marked" impairment overall to apply had not received much attention. In *Desbiens* the parties **agreed** that it was sufficient to have a marked (class 4) impairment in only one realm for a class 4 impairment to apply.

This same approach was followed in *McMichael and Belair*, with the hearings arbitrator finding that a FSCO guideline which stipulated that a class 4 or 5 impairment be identified in two or more functional areas for catastrophic designation to follow as not binding on him.

In *H. and Lombard*, the issue was not addressed in the arbitrator's reasons for decision, although it was accepted in that case that a marked impairment in one sphere was sufficient to trigger catastrophic designation.

In *Pastore and Aviva*, the question of how many spheres need to be markedly or extremely impaired to reach the catastrophic threshold was considered in more detail.

In this case, the arbitrator accepted that the Appellant suffered a marked impairment in her activities of daily living. In addition to her physical restrictions, she suffered from a pain disorder. The psychologist testifying for Aviva felt that the pain was secondary to the physical injuries and....

---

[1] Guides 14/300.

[2] Guides 14/300-301

> *further opined that in assessing someone's physical impairments, the WPI rating includes a rating for pain and the psychological condition relating to pain within the rating itself. Therefore, pain should not be assessed and rated separately under the (g) criterion as this would result in double counting.*

The arbitrator disagreed, and found that a marked impairment in activities of daily living which was due to the intertwined effects of physical injury and psychological reaction was sufficient to trigger catastrophic status.

Thus, with *Pastore*, we have a case where the physical impairments translated into only a 22% WPI. When the pain complaints were rated, the aggregate WPI was 39%. And yet, the insured's psychological response to her physical injuries was sufficient to trigger a catastrophic designation pursuant to clause (g). Following this ruling, there is no reason to believe a soft tissue injury followed by chronic pain cannot cross the catastrophic threshold.

Further litigation regarding this issue will certainly follow.

5. *ING Insurance Company of Canada v. TD Meloche Monnex* 2009 Can Lii 18225 (ON.S.C.) and

6. *ING Insurance Company of Canada v. State Farm Insurance Companies*

These two decisions on appeal from arbitral orders deal with what constitutes a "completed application" for statutory accident benefits in the priority context.

In *ING v. TD*, the applicants had been passengers in a vehicle insured by TD, which had been involved with in an accident with a third party vehicle insured with ING. The first and only notice of a potential claim by these applicants came to ING in the form of OCF-23 forms submitted by a treating chiropractor some seven months post-accident. The treating chiropractor had selected ING as the company to submit these forms to on the basis that she had seen ING's contact information in the file and she wished to be paid. The contact information that she supplied for the putative claimants on the forms was not full or current. ING attempted to write to the claimants, but mistakenly wrote to all four potential claimants at one address. The company did however achieve cell phone contact with one of the claimants who indicated she would call the claims handler back. She never did. No OCF-1 Application for Accident Benefit was ever received by ING in connection with this matter. However, approximately 15 months post-accident, the claimants' legal representative supplied OCF1 Application forms to TD. TD took the position that ING had been the first insurer to receive completed applications for benefits in this matter, and had not followed the procedures mandated by Ontario Regulation 283/95, (the "priority regulation") thereafter.

The arbitrator, as affirmed by the appeal judge agreed with TD's position. Specifically, the arbitrator held that:

> *(I)t is settled law that a person need not provide a formal application to an insurance company to be deemed to have provided a completed application for benefits. A person need only provide sufficient particulars to an insurance*

> *company to reasonably assist the insurer with the processing of the application and the assessment of the claim.*

The arbitrator then went on to find that the initial OCF-23 forms submitted by the chiropractor contained enough information for ING to follow up to obtain necessary information sufficient to process the claim, but that the company had failed to do so. The appeal judge found as well that the forms were clear notice that the claimants intended to submit a claim for benefits, which would have triggered an obligation on ING's part to provide appropriate application forms, which was not done in this case.

ING's appeal in this matter is pending.

By contrast to the outcome in *ING v. TD*, the very recent appeal of another arbitral decision on the same issue was heard in *ING v. State Farm*. In that case, ING had received notice of the loss shortly after it had occurred, had contacted the claimant and sent her an application package immediately, and had taken further initial steps to investigate the claim, even paying some immediate medical expenses. A completed application for benefits in the OCF1 format was then received. ING notified State Farm of its intention to dispute priority within 90 days of receipt of the application form, but more than 90 days after it had been notified of, and begun to investigate the claim. State Farm took the position that ING was out of time to dispute priority on the grounds that, in the circumstances of this case, ING had a "completed application" for benefits some time prior to receipt of the OCF 1.

In this instance, both the arbitrator and appeal judge agreed with ING. The appeal judge cited much of the arbitrator's ruling with approval, including his comments that, with the procedural amendments to the *Statutory Accident Benefits Schedule*, prior cases addressing what constitutes a completed application for benefits must be treated with caution, including the following statement:

> *The current legal obligation set out in Section 32 of the regulation is unequivocal. The insurer must provide the claimant with application forms. The application forms are regulated prescribed documents. The insured must submit an Application for Benefits.*

The arbitrator had gone on to state his view that a completed application for benefits means a completed OCF-1, except in circumstances where the conduct of the insurer results in waiver or estoppel in this regard. This analysis was fully endorsed by the Strathy J., who concluded:

> *Surely it is in the interests of the insurance industry to have certainty regarding the commencement of a limitation period. This is achieved by saying that "completed application" in s. 3 means an application in the OCF-1 form, except in those relatively rare cases where – whether because of waiver, estoppels, delay or deflection – an insurer who has not received the form has been treated as being the "first insurer" for the purposes of s. 2.*

The ruling in *ING v. TD* was distinguished by Strathy J. on the grounds that the facts in that case and in other cases also distinguished, reflected "unsatisfactory claims handling" on the part of the insurer attempting to shift priority, and stated,

> *The judicial and arbitral findings in those cases, that a "completed application", for the purpose of s. 2 of the Regulation could be something less than a full written application on the OCF-1 form, promoted the policy of that section: to ensure a prompt response to statutory accident benefits claims notwithstanding a potential priority dispute.*

Pending further clarification from the Court of Appeal, it would appear that an insurer uncertain as to whether a claim is being presented should follow up, investigate and operate on the presumption that a claim is forthcoming, while clearly insisting upon receipt of a completed OCF-1, to avoid any waiver arguments in the future.

7. *Danilov and Unifund*, Arbitrator Robert Bujold, FSCO A07-001441

This preliminary issue hearing proceeded on the basis of an agreed statement of facts. Mr. Danilov was involved in an accident on November 29, 2005. At the time, he was operating a vehicle owned by Greogiy Gnidenko. There was a pink slip that was presented to the investigating officer indicating that the vehicle Mr. Danilov was driving was insured with Unifund, through a broker by the name of Ensurco Insurance Group. That pink slip was fraudulent in that Unifund had never written a policy in favour of Mr. Gnidenko or Mr. Danilov, and had no prior relationship with either of them. Unifund likewise had no relationship with Ensurco. There was no evidence that Mr. Danilov was complicit in the fraud. Economical, who participated in the hearing, was the insurer of the third party vehicle involved in the accident.

Although Mr. Danilov applied to Unifund for benefits, Unifund took the position that it was not the first insurer to receive a completed application for statutory accident benefits, on the grounds that there was no nexus between itself and Mr. Danilov. Ultimately, the arbitrator rejected Unifund's position, finding that it was the first insurer to receive a completed application for accident benefits from Mr. Danilov.

The arbitrator began by reviewing the principles governing the question of what constitutes "sufficient nexus" in the priority context as follows:

- *The priority regulation is "designed to ensure that injured persons will get prompt determination of their entitlement to accident benefits, even if they have chosen the wrong insurer. It is inherent in this scheme that an insurer may have to pay benefits that another insurer should be paying, but only on an interim basis. If the first insurer to receive a completed application wants to shift responsibility to another insurer, it must follow the procedures in the regulation;*

- *"insurer" in the context of the regulation must be interpreted broadly based on the claim being asserted, not the ultimate determination;*

- *The threshold for establishing nexus is not a high one;*

- *Although the threshold is not a high one, the choice of insurer cannot be arbitrary. A link must be established between the applicant and the named insured, in the particular circumstances of the claim;*

- *A valid policy of insurance need not be in effect for there to be a sufficient nexus between the application and insurer to trigger the obligation to respond;*

- *An insurer may not need to respond to a claim where the applicant candidly admits that he or she has simply applied for benefits from a randomly selected insurance company, without asserting any contractual relationship or nexus.*

In this case, the arbitrator agreed that there was in fact objectively no relationship between Mr. Danilov and the insurer, although noted that the decision to apply for benefits from Unifund was not random or arbitrary. He relied upon the information contained in the police report in deciding which insurer he should apply to. It was significant that Mr. Danilov was not complicit in the fraud in this case as, "Certainly, there can be no nexus where an applicant attempts to create a relationship by participating in a fraud." Similarly, the arbitrator referenced the consumer protection objectives of the legislation in coming to his decision that Unifund was the first insurer to receive a completed application for benefits, which objectives would presumably not have been engaged in the event of fraud on the part of the applicant.

8. *Vanderkop v. The Personal Insurance Company of Canada* 2009 ONCA 511 (CanLii).

In this case, the Court of Appeal reviewed a trial decision in which the Appellant was ordered to pay income replacement benefit without being able to claim a deduction for possible long term disability benefits.

The car accident in question had occurred in February of 1997. Ms. Vanderkop was a secondary school teacher The Personal took the position that she was not entitled to receive income replacement benefits and maintained this position for over two years. The insured initially used sick credits to complete her school term. In addition to being refused income replacement benefits, she was initially denied long term disability benefits as well. In February of 1998, Ms. Vanderkop attempted to return to work, but was ultimately not able to sustain her employment and never worked again after the conclusion of that term.

The Personal did ultimately accept entitlement to an income replacement benefit from the 104 week mark onwards. Manulife never paid LTDs and in June of 1999, Ms. Vanderkop commenced an action against Manulife, claiming LTDs from September 1997 onwards.

In November of 2002, a global private mediation was conducted between Ms. Vanderkop, The Personal and Manulife. The mediation resulted in a full and final settlement with Manulife in the amount of $57,500, but no settlement with The Personal. The Personal did not encourage Ms.

Vanderkop to enter into the agreement with Manulife, nor did they alert her to the fact that they would take the position that they were entitled to reduce future payment of IRBs as a result of this settlement.

After the mediation, The Personal refused to pay further IRBs on the grounds that it was entitled to deduct LTDs that might have been payable had Ms. Vanderkop successfully sued Manulife. At the trial of this matter, Manulife did not participate and no witness from Manulife was called to testify about the settlement. Likewise, The Personal called no witnesses.

On this point, The Personal took the position that, in settling her LTD claim, Ms. Vanderkop had essentially withdrawn her claim for LTDs, meaning that she had not applied for them within the meaning of section 7 of the *Schedule*. This position was rejected by both the trial judge and the Court of Appeal, who found that Ms. Vanderkop had simply compromised her claim to settle with Manulife. The Personal argued that the long term disability benefits were in fact "available" to her within the meaning of section 7(1) 1(ii) of the *Schedule* even though she had voluntarily settled her claim. This argument was likewise rejected on the grounds that, "(t)o treat LTD as being available would effectively oblige an insured to litigate with their collateral benefits insurer, at their own risk and expense, for the benefit and at the discretion of, their accident benefits insurer. In our view, *SABS* places no such obligation on an insured."

However, the Court did note Ms. Vanderkop's agreement that The Personal could have recovered the value of the LTD settlement had it followed appropriate statutory procedures and continued to pay income replacement benefits, deducting weekly payments for loss of income as reflected in the LTD settlement.

Read together with *Cromwell v. Liberty Mutual*, this case would suggest that it is essential for an accident benefits insurer seeking to obtain a deduction in respect of an LTD settlement to obtain and lead evidence regarding the basis of the LTD settlement, ideally alerting the insured to the position to be taken by the accident benefits carrier in advance of the settlement. Unlike the trial level decision in *Cromwell*, the Court of Appeal ruling in *Vanderkop* would suggest that there is a presumption that an LTD settlement reflects net weekly payments for loss of income, although the deduction in respect of ongoing exposures can only be obtained following the procedure set out in the *Schedule*.

9. *Sorokin v. Wawanesa Mutual Insurance Company* 2009 ONCA 152 (CanLii)

In February of 2009, the Court of Appeal dealt summarily with the question of whether interest is owed on interest payable pursuant to section 46(2) of the *Schedule*. The insurer had appealed from the summary judgment ruling of Boswell J., who found that interest at the SABS rate was payable on an interest payment which had been withheld for some time after the underlying benefits in question had been paid. Wawanesa argued that interest itself was not a "benefit" under the *Schedule*, and therefore could not attract interest at the section 46 rate of 2% per month, compounded. The motion judge noted the authorities on this point and stated:

> *...the term "benefit" is not defined in the SABS, nor is it defined in section 1 of the* Insurance Act*. It is defined by the Concise Oxfort Dictionary as "an*

> *advantage or profit gained by something" or alternatively, "a payment by an insurance scheme to someone entitled to receive it….*
> *…In my view, the accumulation of that interest is a benefit that accrued to the Plaintiff.*

The Court of Appeal found it unnecessary to decide whether "interest must be considered a "benefit" for all purposes." The interest payment set out at section 46 of the *Schedule* was triggered by the simple fact that there was a sum payable but unpaid and therefore overdue for approximately 19 months. The appeal was therefore dismissed.

10. ***Golic v. ING Insurance Company of Canada*** **2008 Can Lii 69502 (ON.S.C.)**

This ruling relates to the applicability of the *Smith v. Co-operators* consumer protection standards to an unusual set of circumstances.

Mr. Golic was seriously injured in a motor vehicle accident on August 26, 1995. On March 8, 2007, he issued a statement of claim against ING, seeking entitlement to attendant care benefits, housekeeping and home maintenance and case management services from 1998 onwards. Approximately a year and a half later, he sought to amend his claim to seek Income Replacement Benefits and/or Other Disability Benefits from January 31, 1997 when other disability benefits had been terminated and ongoing. ING did not consent to the proposed amendments, and therefore a motion to amend the pleadings was heard before Quigley J. of the Superior Court of Justice.

The history to this proceeding was complex, and germane to the ultimate dismissal of Mr. Golic's motion. Mr. Golic had been represented by five or six different lawyers since the date of his accident, and had also been self-represented at various points in time. He had participated in mediation before the Ontario Insurance Commission and then through the Financial Services Commission in respect of disputed claims on at least three separate occasions, either represented by counsel or on his own behalf. He had participated in at least two prior mediations respecting his entitlement to weekly benefits, both of which were marked as failed. On May 5, 2008, the issue of Mr. Golic's entitlement to a weekly benefit was again mediated before the Financial Services Commission, over the insurer's objection that the mediation should not occur on the grounds that exceeded the jurisdiction of FSCO, in that the claim in question was time-barred, and also on the basis that the claims had been mediated and failed on two prior occasions. The FSCO mediator issued a report indicating another failed mediation of weekly benefits, and also noting the jurisdictional issue, although not dealing with it substantively.

At the hearing of the motion, Mr. Golic took the position that the two year limitation period set out at section 281(2) of the *Insurance Act* had not been triggered, given the alleged failure by the insurer to explain to him the remedies available to him upon the termination of his weekly benefits, in the manner articulated by the Supreme Court of Canada in *Smith v. Co-operators.*

Of significance, in January of 2000, shortly after Mr. Golic had written to ING to advise that he was once again self-represented, ING sent a detailed letter to Mr. Golic, attempting to set out his right to seek dispute resolution under section 279 to 283 of the *Act*, requesting that he contact the

insurer with any questions he may have, and providing a copy of the relevant sections of the *Act.* Quigley, J. noted that this letter was very significant but, "regardless of any other administrative assistance it may have offered to him, it is evident that ING did not provide Mr. Golic with a plain layman's explanation of the dispute resolution process set out in ss. 279 to 283 of the *Insurance Act* when it sent that letter." Notwithstanding this finding, Quigley J. disallowed Mr. Golic's proposed amendment.

After discussing the general principles governing the amendment of pleadings, Quigley J. concluded that Mr. Golic had failed to meet the test required to justify the amendment of pleadings. Specifically, he had failed to demonstrate that the amendment sought would not cause prejudice to the defendant which could not be compensated for in costs and secondly, he had failed to establish the existence of special circumstances.

Instead, the Court found that the circumstances in the Golic case were so far removed from those in *Smith v. Co-operators*, that the consumer protection considerations which were triggered in that case would not even apply:

> *While Mr. Golic argues that* Smith *supports his request to amend a 13 year old action to add new claims for benefits, almost nine years after the insurer notified him of the termination of his benefits, the facts and history of this case shows it to be of an entirely different colour than that which the Supreme Court of Canada faced in* Smith. *Against that factual background, this case does not engage the same consumer protection concerns as were present in this case. Rather, it raises the corollary question of whether it would be just, in the face of obvious prejudice that ING would suffer trying to gather evidence in respect of such a stale claim, to permit Mr. Golic to continue to rely on the insurer's actions in 2000 as the basis for avoiding the limitation period that would otherwise have expired in 2002 and terminating his right to bring new claims after that date….*
>
> *Here, given that the record shows that Mr. Golic had proceeded to mediation of his benefits claims on three separate occasions before receiving the January 2000 letter, and one since then, it verges on hyperbole to assert here that he would not have been and was not fully aware of exactly what procedural options were available to him, and the time within which those rights needed to be acted upon, after being informed by the insurer in January of 2000 of the termination of his benefits.*

This ruling is pending appeal.