SECTION 53: TERMINATION OF BENEFITS FOR MATERIAL MISREPRESENTATION

MARNI E. MILLER

Pursuant to section 53 of the *Statutory Accident Benefit Schedule, Effective September 1, 2010*, an Insurer has the ability to terminate benefits based on misrepresentations made by an insured person. During the course of investigation of a claim, an insurer may determine that misrepresentations have been made and must determine if those misrepresentations are ones that may require a denial of benefits.

Prior to the *SABS 1996*, there was no available remedy for insurers that were faced with material misrepresentation claims. Pursuant to section 233(2) of the ***Insurance Act,* R.S.O. 1990 c. I-8,** accident benefits are protected from the forfeiture of indemnity under section 233(1). Thus, the answer was to create then section 48 to provide a solution to the issue of fraud that had become, and still is, an enormous financial drain on the industry.

The old section 48 of the previous *Schedule* reads:

> *(1) If an insured person has wilfully misrepresented material facts with respect to an application for a benefit, the insurer may terminate payment of the benefit. O. Reg. 403/96, s. 48 (1).*
>
> *(2) The insurer shall not terminate payment under subsection (1) unless the insurer provides the insured person with notice*

> *of the reasons for terminating payment. O. Reg. 403/96, s. 48 (2).*

The new section 53 reads as follows, just slightly different:

> *An insurer may terminate the payment of benefits to or on behalf of an insured person,*
>
> *(a) if the insured person has wilfully misrepresented material facts with respect to the application for the benefit; and*
>
> *(b) if the insurer provides the insured person with a notice setting out the reasons for the termination. O. Reg. 34/10, s. 53.*

WHAT IS WILFUL, MATERIAL, AND MISREPRESENTATION?

In ***Michalowski and St. Paul Fire and Marine Insurance Company* (FSCO A98-001492, Blackman, July 9, 1999),** Mr. Michalowski indicated on his Application for Accident Benefits that he was unemployed at the time of his motor vehicle accident. He subsequently obtained employment. He did not advise the insurer that he was employed, and continued to seek benefits, although he was not receiving any benefits at the time. Arbitrator Blackman confirmed that the onus was on the insurer to establish that the misrepresentation was wilful, and that the misrepresentation was also material. Mr. Michalowski asserted that section 48 was only applicable to those misrepresentations that were made at the time of applying, in writing, for a benefit. Then Arbitrator Blackman disagreed, and opined that the section was intended to apply to an insured person's ongoing claim for benefits.

Blackman defined misrepresentation, as found in *Blacks Law Dictionary*, as:

"any manifestation by words or other conduct by one person, to another that, under the circumstances, amounts to an assertion not in accordance with the facts".

Blackman found that an omission, in addition to a "positive misstatement of facts" could also amount to a misrepresentation.

In a later case, ***Fisk and ING Insurance Co. Of Canada,*** (FSCO, A02-001682, July 2, 2003), Arbitrator Skinner found that an omission during an examination regarding a claimants employment status did not constitute wilful misrepresentation. While the failure to advise the assessor of his employment status was a misrepresentation, it was not "material" to Arbitrator Skinner, as Mr. Fisk had only returned to work for a brief period of time, and the resulting effect that his employment status had on his entitlement to benefits was not egregious.

The word "wilful", as defined in an earlier case, ***Adu-Poku and Kingsway General Insurance Company,*** **(FSCO OIC A96-000433,** was adopted by Blackman as such: "a deliberate or intentional action". It has thus been adopted by other arbitrators.

Finally, Blackman set out the meaning of "material", as "sufficiently basic or fundamental". He found that material must be of a level to justify the relief as set out in section 48, which includes the denial of all future benefits of which there has been a misrepresentation.

A consideration of whether the misrepresentation is "material" will consider the following factors:

1. What is being misrepresented

2. What is obtained as a result of the misrepresentation

3. The relationship in monetary and other terms between the misrepresentation and the potential benefit available

4. The availability to the insurer of other provisions (see section 47, now section 52)

After ***Michalowski*** set the standard for determining what was material, wilful and misrepresentation, a number of cases took on the issue of determining which party held the burden of providing misrepresentation.

In ***TTC and Wootton,*** (FSCO, P04-00004, November 2, 2004), Director's Delegate Draper stated:

> *The law in Ontario is as such: on a claim for payment under an insurance policy, the claimant has the burden of proving that he or she fits within the scope of coverage. The situation does not change simply because the insurer challenges the facts upon which the claim is based.*

Thus, the burden does not shift to the insurer for example to prove that there was no accident, if a staged loss is being alleged. The insured person retains the requirement to prove their case.

An insured person must prove their case by introducing evidence that meets the civil burden of proof, the balance of probabilities. In ***Dwumaah and RBC General Insurance Company*****, (FSCO A03-000956, May 3, 2005),** Arbitrator Kominar found the insured's version of events so absurd, and inconsistent, that while the Arbitrator was assured that an "incident" did occur between the two vehicles, the evidence was such that the "incident" could not have occurred in the manner in which Mr. Dwumaah described, and as such, he wilfully misrepresented facts in an effort to claim accident benefits.

Some cases have followed the proposition that once an allegation of misrepresentation is made, that the insurer has the onus of proving same (see ***Szabo and CAA Insurance Company, Fisk and ING Insurance Company of Canada)***

Insurer's have been faced as well with not only misrepresentations in terms of material aspects of the claim, but as above in *Dwumaah,* whether or not an accident actually took place which would give rise to accident benefits.

As in *Wootton* above, Arbitrator Kowalski in ***Azimi and Economical Mutual Insurance Company*** **(FSCO A08-002596, May 25, 2010)** stated that the insured retains the burden of proving their claim, and the onus does not shift to the insurer to prove that there was no accident pursuant to section 2(1) of the *Schedule* (now section 3(1)). In this instance, the insured, and his passenger provided conflicting stories regarding the facts of loss. The investigating officer found no evidence of contact between the two cars, and little evidence of a collision on the roadway, such as any debris field. Reconstruction evidence revealed that the damage to Mr. Azimi's vehicle was consistent with that which had occurred in a prior accident, when the vehicle had been totalled and sold for salvage. Further, occupants of both vehicles were complaining of injuries that were completely inconsistent with the damage found.

Arbitrator Kowalski determined that she did not have to find that the insured was involved in a fraud to find that there was no "accident". She stated she did not have sufficient evidence to find a fraud occurred, but did have sufficient evidence to find that an "accident" as defined had not taken place.

In ***Rizk and Isho and Allstate Insurance Company*** (FSCO A03 B – 000562 and A03-001119, June 11, 2004), where there was evidence that the vehicles came into contact with each other, but the reconstruction evidence determined that it was in a completely different manner than that described by the parties. The insured retained his own reconstruction expert, who provided alternate theories of how the accident could have resulted in the conflicting damage, but did not base any of these theories on any specific evidence. The Arbitrator found that the insureds were unreliable witnesses, and that they wilfully created a scenario in which they could claim accident benefits, and that they willfully misrepresented the facts of that incident. Pursuant to section 48, they were denied entitlement to any of the benefits claimed.

One issue where insurers have difficulties convincing Arbitrator's that an "accident" did not happen and that the insured person made wilful material misrepresentations, is where there is definite evidence of

contact between vehicles, but where the facts of loss are inconsistent as between the occupants. Often times reconstruction reports will confirm that two vehicles came into contact, however there may be inconsistencies as to speed of travel, use of the brake, or evidence that one of the vehicles sped up in a very short period of time from a completely stopped position. Black box evidence is especially of importance. However, even with this evidence, Arbitrator's have been loathe to find that an "accident" did not occur.

In ***Nelson et al. and Economical Mutual Insurance Company*** (FSCO A11-000981, February 4, 2013), Arbitrator Rogers found that the two vehicles involved came into contact with each other, and that misrepresentations made were not "material" to the claim for accident benefits. In this case, the insured took out only comprehensive coverage, shortly before the accident occurred. There was inconsistent damage to the vehicles, that conflicted with the facts of loss. The officer who investigated thought that the insured driver and passengers were all unusually calm, and advised the insurer of his concerns. However, Rogers felt it was implausible that a person would knowingly put himself and his family in harms way in an effort to gain benefit through an insurance claim.

Other issues arise with section 52 matters. In order to argue fraud, and thus deny on the basis of misrepresentation, the issue must be pled. Arbitrator Wilson asserts that section 27.1 of the *Dispute Resolution Practice Code* as well as section 8 of the *Statutory Powers Procedure Act* require that an insured person is entitled to know the allegations put forth by the insurer. Thus, the allegations must be set out in the Response by Insurer to An Application for Arbitration, and not raised just prior or at the hearing. In some instances, an insurer may be given leave to amend their Response in this regard (see ***Deol and Gore Mutual Insurance Company*** (FSCO A13-003801, September 3, 2013)

The issue of whether section 48 applied to benefits that had not been paid, but rather were only being claimed, was dealt with in ***Szabo and CAA Insurance Company (Ontario)*** (FSCO P03-00015, March 31,

2004, appeal for Judicial Review dismissed). In that matter, Mr. Szabo failed to disclose his employment status at the time of his application for benefits. He did eventually advise the insurer, however his omission was determined to be clearly material to the benefit in question. By not addressing entitlement to income replacement benefits for one and a half years, the insurer was prejudiced in its ability to assess Mr. Szabo and properly investigate the nature of the claim. It was determined that section 48 was "intended to impose a penalty beyond repayment in cases of material misrepresentation".

Arbitrator Wilson addresses lateness in raising the issue of misrepresentation in ***Ogboe and TD General Insurance Company*** (FSCO A12-000697, May 31, 2013). The arbitration hearing in this matter was scheduled to commence on April 29, 2013. The insurer amended its Response on March 27, 2013, to include claims of misrepresentation as against the insured. The accident itself took place on June 27, 2010, almost three years prior. There was an indication that the insurer had evidence of fraud at least prior to the prehearing, but the allegations were not raised until just prior to the hearing date. While Arbitrator Wilson did permit the Insurer to amend the Response, as well as granted an adjournment, he did so with very strong language admonishing the insurer for waiting so long to raise the issue of material misrepresentation. He also agreed that due to the possibility of conflicting findings, as there were multiple arbitrations arising out of the one loss, the matters should be consolidated to avoid inconsistent findings.

REMEDIES AVAILABLE

While section 53 provides a remedy under which an insurer is able to deny benefits on the basis of material misrepresentation, where benefits have already been paid, the insurer is able to attempt to claim such benefits back pursuant to section 52 of the *Schedule.*

Repayments to insurer

> ***52.*** *(1) Subject to subsection (3), a person is liable to repay to the insurer,*
>
> *(a) any benefit described in this Regulation that is paid to the person as a result of an error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud;*
>
> *...*
>
> *(2) If a person is liable to repay an amount to an insurer under this section,*
>
> *(a) the insurer shall give the person notice of the amount that is required to be repaid; and*
>
> *...*
>
> *(3) If the notice required under subsection (2) is not given within 12 months after the payment of the amount that is to be repaid, the person to whom the notice would have been given ceases to be liable to repay the amount unless it was originally paid to the person as a result of wilful misrepresentation or fraud. O. Reg. 34/10, s. 52 (3).*
>
> *(4) An insurer that has given a notice referred to in clause (2) (b) may obtain repayment in the manner described in the notice. O. Reg. 34/10, s. 52 (4).*

A number of cases have ordered repayment on this basis (see ***Molnar and Coachman Insurance Company,*** (FSCO A02-001029, January 31, 2003, ***Alagaratnam and TD Home and Auto Insurance Company,*** (FSCO A06-002472, October 15, 2007)).

As noted, the requirement that notice be given within 12 months after the payment of the amount to be repaid is not applicable in cases where fraud or misrepresentation occurs.

EXAMINATIONS UNDER OATH

A further remedy, and one that should be utilized at the commencement of the claim, is section 33 of the *Schedule.* Requesting an Examination Under Oath is integral to the initial investigation and assessment of the claim. However, not all insurers use this tool, nor use it to their advantage. It is important to have the insured provide answers to the questions that arise from the issues at hand under oath, both in terms of the materiality and the misrepresentation. There are often times that no EUO has been utilized, and the insured has not been given an opportunity to provide a fulsome answer to the issues. Both in terms of good faith, and in terms of obtaining the most well rounded information, it is essential to use section 33 as an investigative tool. Clearly, the timing of the EUO is critical as well, where the motivation for an insured to attend is more focused where they are receiving benefits, than later in the claim where benefits have been terminated. There is no incentive for an insured to attend at an EUO where no benefits are being paid, as the remedy is contained within the section, that being suspension of benefits.

"*In my view, the scope and relevance of questions to be permitted on an examination under oath is determined with reference to the language and purpose of the Schedule, and not on the narrow basis of information provided by the claimant or of the benefits being claimed as of the date of the examination.*

The only limit placed by the Schedule's provision upon the examination under oath is that its scope is limited to "matters that are relevant to the person's entitlement to benefits under this Regulation.

...I consider that fairly full disclosure by a claimant must be made if benefits are to be assessed and received. This is particularly so in light of the fact that an insurer may conduct only one such examination, and its scope is defined in fairly broad terms."

(see ***Aviva Insurance Company of Canada v. Balvers***, (2007) CanLii 17193(ON SC))

"*Section 33(1.1) does not limit the insurer to examining a person who is receiving benefits under oath. It permits an insurer to examine a person who applies for benefits, whether the person is receiving them or not."*

(see ***Echelon General Insurance Co. V. Henry***, (2011) O.J. No. 3054)

Statutory Condition 6(4) permits an Examination of the insured where there is loss or damage to the insured automobile. The scope of that examination "*extends to all matters material to the insurer's liability and extent thereof which the insurer has an objective and reasonable basis to explore.*"

Statutory Condition 6(4) does NOT "cease to apply once the relationship between the Insurer and the insured becomes adversarial or when litigation is commenced".

There is a clear legislative basis for the right to examine pursuant to Statutory Condition 6(4).

(see ***Baig v. Guarantee Co. Of North America***, (2007) O.J. No. 4727 (ON CA)

In addition, the remedy for non compliance of attendance at an EUO is built right into section 33:

33 (6) The insurer is not liable to pay a benefit in respect of any period during which the insured person fails to comply with subsection (1) or (2).

Thus, by incorporating section 33, and then section 52 and 53, the insurer can limit and contain claims that attempt to defraud by way of material misrepresentation.