The Top Five(ish) Accident Benefits Decisions of 2013

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The Minor Injury Guideline

In *Scarlett and Belair*,[1] Director's Delegate Evans allowed an appeal from Arbitrator John Wilson's preliminary issue order[2] that Mr. Lenworth Scarlett's medical and rehabilitation benefits claim fell outside the $3,500 limit for minor injuries under the *Statutory Accident Benefits Schedule—Effective September 1, 2010.*[3] Arbitrator Wilson's decision in *Scarlett and Belair* had been the first to address the interpretation of the *Minor Injury Guideline* ("the MIG") under the *SABS*.

At first instance, Arbitrator Wilson noted that although the MIG was incorporated into the *SABS* it was a "non-binding interpretative aid" that was only "advisory in nature." He also observed that it was the "insurer's burden to prove any exception to or limitation of coverage" and that Belair thereby had the burden of proving that Mr. Scarlett's claim was subject to the $3,500 monetary limit under the *SABS*. Arbitrator Wilson also considered subsection 18(2) of the *SABS* and concluded that the requirement for "compelling evidence" of a pre-existing medical condition to remove an applicant from the scope of the MIG meant that only "credible evidence" was required. In the result, Arbitrator Wilson concluded that Mr. Scarlett's impairment fell outside the scope of the MIG and that he was therefore "not precluded from claiming housekeeping, attendant care, as well as medical and rehabilitation expenses, beyond the $3,500 limit within the Minor Injury Guideline."[4] In arriving at this conclusion, Arbitrator Wilson relied upon cases and legislation that counsel did not put before him and his own French-English translations of the relevant legislation, where the issue of the French version of the legislation was also not argued before him. Belair appealed the order on the basis that Arbitrator Wilson applied the wrong tests, misinterpreted the burden of proof and violated the procedural fairness of the hearing. Delegate Evans agreed.

Director's Delegate Evans began his reasons by considering subsection 3(1) of the *SABS*, which provides that a minor injury "means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury." Delegate Evans noted that the Arbitrator failed to address how Mr. Scarlett's complaints of such ailments as TMJ syndrome and chronic pain were not "clinically associated sequelae". Delegate Evans also observed that in finding that the foregoing complaints were not sequelae, Arbitrator Wilson incorrectly put the burden of proof on Belair when it was indeed Mr.

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[1] (28 Nov 2013), Appeal P13-00014.

[2] add cite of original decision

[3] O Reg 347/13 [*SABS*]. I think this is the incorrect cite - it is 34/10

[4] It is notable also that Mr. Scarlett was not eligible for OHIP and would have been required to pay out-of-pocket for his treatment expenses.

Scarlett's to bear. The Director's Delegate also noted that there was no basis on which Arbitrator Wilson could conclude that "the TMJ issue would not appear to arise as a sequela to a soft tissue injury" and that contrary to Arbitrator Wilson's contention that the MIG was an "interpretative aid", it was indeed binding because it is "specifically issued pursuant to section 268.3(1.1) of the *Insurance* Act". Delegate Evans also noted that the MIG specifies which impairments are clinically associated sequelae to a minor injury. Indeed, Delegate Evans ultimately concluded that even if some of Mr. Scarlett's injuries were not clinically associated sequelae, Mr. Scarlett could still be subject to the MIG if his impairment was *predominantly* a minor injury: a test that Arbitrator Wilson failed to apply.

Delegate Evans noted that Arbitrator Wilson never considered whether Mr. Scarlett's impairment was a predominately minor injury pursuant to subsection 18(1) of the *SABS*. Noting that Arbitrator Wilson simply concluded that "Mr. Scarlett does not deny that he has some minor injuries, and injuries that come within the MIG ... When the *totality of his injuries is assessed*, they come outside of the MIG [emphasis added]."

Delegate Evans also concluded that Arbitrator Wilson incorrectly held that "Belair has not met its burden of showing that Mr. Scarlett's claim is restricted to the parameters of the Minor Injury Guideline." Mr. Evans observed that the case law had established that the "legal onus always remains on an insured: on a claim for payment under an insurance policy..." and that the Arbitrator erred when he concluded that section 14 of the *SABS*, which provides in part that "[e]xcept as otherwise provided in this Regulation, an insurer is liable to pay ... [m]edical and rehabilitation benefits..." was an exclusionary provision. Delegate Evans also noted that the arbitrator's discussion of the burden of proof was important because it affected his conclusions about the MIG.

Delegate Evans disagreed with Arbitrator Wilson's conclusions regarding subsection 18(2) of the *SABS*, which provides that an insured otherwise subject to the MIG may be taken outside the scope of the MIG where there is compelling evidence that the insured had a pre-existing condition that would prevent him from reaching maximal recovery. Delegate Evans noted that Arbitrator Wilson's approach to interpreting "compelling evidence" was strained: the Arbitrator considered the meaning of "compelling evidence" by focusing on the French version of the MIG but without considering the French versions of, *inter alia*, subsection 18(2) of the *SABS*, and that in doing so the Arbitrator also failed to seek submissions from counsel. Indeed, the arbitrator went on to conclude that because the French translation of the MIG lacked the force of the word "compelling", this therefore meant "the authors intended that credible evidence be submitted to take an insured out of the MIG". Delegate Evans noted that the Arbitrator did not give the parties opportunities to make submissions on the French version of the MIG and that additionally, Arbitrator Wilson failed to find the shared meaning behind the two versions of the MIG and that his reasoning was flawed in that he "mixed up the ultimate burden of proof and the sufficiency of the evidence".

Delegate Evans concluded that not only did Arbitrator Wilson fail to apply the correct tests, but in his reasoning and application of the legal principles he violated the procedural fairness of the hearing. Delegate Evans noted multiple instances in which the Arbitrator "raised his own arguments ... conducted his own research and reached his own conclusions without providing

counsel the opportunity to provide submissions". Delegate Evans' concluded that a new hearing was required, one in which there would be procedural fairness and a different arbitrator.

The decision from Delegate Evans is on appeal to the Divisional Court.

In *Augustin and Unifund*,[5] Arbitrator Sapin considered Kadian Augustin's entitlement to medical benefits resulting from a motor vehicle accident. Unifund refused to pay Ms. Augustin medical benefits on the basis that she failed to attend an insurer's examinations to determine whether her injuries fell within the MIG. Unifund also argued that Ms. Augustin was not entitled to mediate the refusal of her medical benefits because she failed to attend the IEs. The issues before Arbitrator Sapin were, *inter alia*, whether Ms. Augustin was precluded from mediating Unifund's refusal of her benefits because she failed to attend an IE for which Unifund sent her notice pursuant to section 44 of the *SABS*.[6]

Arbitrator Sapin considered the application of subsection 55.2 of the *SABS*, which provides

> 55. An insured person shall not commence a mediation proceeding under section 280 of the Act if any of the following circumstances exist:
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> ...
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> 2. The insurer has provided the insured person with notice in accordance with this Regulation that it requires an examination under section 44, but the insured person has not complied with that section.

Arbitrator Sapin noted that Unifund sent Ms. Augustin three separate notices to attend IEs and Ms. Augustin refused to attend all of them and that on this basis, Unifund brought the motion to determine that Ms. Augustin could not dispute her claims pursuant to subsection 55.2. Part of the disagreement between Ms. Augustin and Unifund in respect of subsection 55.2 was whether subsection 55.2 prevented Ms. Augustin from disputing the adequacy of Unifund's notices. Arabitrator Sapin agreed with the applicant, holding that

> on a plain reading of s. 55, ... an insurer's notice to attend an IE that is "in accordance with" the *Schedule* is one of the circumstances specified in s. 55 that must exist before the insurer can rely on s. 55.2 to shut an insured person out of the mediation process under the *Insurance Act*...[and that] insurers must comply with the notice requirements of both s. 38 and s. 44 before s. 55.2 can operate as a bar to mediation.

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[5] (13 Nov 2013), A12-000452.

[6] Arbitrator Sapin also considered whether the applicant was entitled to non-earner benefits and undertook a brief comparative analysis of the notice requirements under sections 38 and 44 of the *SABS*. This paper will only focus on those reasons of Arbitrator Sapin in relation to the MIG. Parenthetically, Arbitrator Sapin held that sections 38 and 44 must be read together such that content of the "reasons" contained in an OCF-9 in respect of a refusal were largely the same as those that should be contained in the notice for examination sent to the applicant pursuant to section 44.

Arbitrator Sapin also concluded that Unifund's notices did not comply with the requirements of sections 38 and 44 of the *SABS*.

Arbitrator Sapin considered the notice requirement contained in subsection 38(8) of the *SABS*, observing that once the treatment plan is submitted by the applicant, the insurer must give the insured notice pursuant to subsection 38(8) which identifies, *inter alia*, "the medical reasons and all of the other reasons why the insurer considers any goods or services, or the proposed costs of them, not to be reasonable and necessary". Arbitrator Sapin also noted that pursuant to subsection 38(9), if the insurer believes that the MIG applies then "the notice under subsection 38(8) must so advise." Arbitrator Sapin went on to consider the Explanation of Benefits sent by Unifund to Ms. Augustin pursuant to section 38 and whether the notice met the requirements contained in the section.

Arbitrator Sapin observed that subsection 38(8) requires that the notice advise the insured that the insurer believes the MIG applies. Arbitrator Sapin observed that the notice from Unifund simply stated that

> [b]ased on our review of the medical documentation provided to date, we require an assessment by an independent medical assessor, in order to determine if your impairment is predominantly a minor injury as described in the Minor Injury Guideline. Please see the Notice of Examination for further details.

Arbitrator Sapin concluded that this notice did not comply with section 38 because "it does not state that Unifund 'believes' the MIG applies, or why", nor did it state the "medical reasons and all of the other reasons why the insurer considers any goods or services, or the proposed costs of them, not to be reasonable and necessary". Arbitrator Sapin further concluded that the notice from Unifund only advised that Unifund wanted to "determine" if the applicants impairment was predominantly a minor injury and that "wanting to determine" was different from Unifund "believing" the MIG applied. Arbitrator Sapin noted that given that an insured's treatment provider must provide a factual basis from which a claim for treatment outside the MIG can be supported, "it is reasonable to require an insurer who chooses to refuse to pay an initial claim to counter with something more than simply a desire 'to determine if your impairment is predominantly a minor injury as described in the Minor Injury Guideline'". Arbitrator Sapin further noted that in the circumstances of the current case Unifund refused to pay for the treatment pending the IE and that this undermined the purpose of the MIG which is to provide access to early treatment.

Arbitrator Sapin also observed that "stating a belief that the MIG applies is not, by itself, a sufficient reason for refusing to pay a claim for treatment", noting

> [i]f an unexplained belief – a belief without reasons – were the only requirement for refusing treatment claims, an insurer could simply refuse to pay any non-MIG treatment claim on principle; require an insured person to attend an IE; and withhold payment until the person attends and the report has been received.

Arbitrator Sapin further concluded that an insurer including its "belief" that the MIG applies in the notice was not in itself a "medical reason" and that notice under subsection 38(8) required

"medical and other reasons" for why the insurer considered the proposed treatment not to be reasonable and necessary and thereby not payable. Arbitrator Sapin ultimately concluded that as part of the notice requirement contained in subsection 38(8) an insurer must include in the notice the reasons why the insurer believes the insured is subject to the MIG.

Arbitrator Sapin noted that the requirement to include reasons in a notice for denying a medical benefit is new to the *SABS-2010* and that neither the *SABS* nor the MIG contained a definition for "medical reasons". She nonetheless concluded that once the entire context in which the provision is contained is considered---namely, the MIG and the legislature's desire to reduce the cost of examinations—the requirement for "fulsome reasons for refusing to pay for treatment in the early stages of the claims process begins to make sense".

Arbitrator Sapin concluded that to satisfy the requirement for medical reasons the insurer must refer to both the MIG and the treatment provider's opinion in choosing not to pay for treatment pending an IE. She also considered the rule in subsection 18(2) of the *SABS* whereby an insured can be taken from the scope of the MIG if there is compelling evidence that they have a pre-existing medical condition that will prevent maximal recovery. Arbitrator Sapin noted that the insured's treatment provider must provide the compelling evidence from the outset but that compelling evidence was not defined and according to the MIG the medical documentation supporting the compelling evidence is only required "if it is available".[7]

Arbitrator Sapin determined that it "followed logically" that notice under subsection 38(8) required that in denying a benefit the insurer must

> indicate that it has reviewed the Treatment and Assessment Plan and any medical documentation provided; compared it to the criteria in the MIG; and determined either that there is insufficient compelling evidence (of pre-existing injuries or conditions, for example) or insufficient medical documentation to persuade it that the accident injuries fall outside of the MIG, and therefore, the insurer believes the MIG applies and the treatment claimed is not reasonable or necessary (because the treatment does not conform to the MIG treatment protocols, for example).

Arbitrator Sapin concluded that the foregoing methodology would meet the insurer's obligation upon denying benefits to provide "medical reasons" pursuant to subsection 38(8).[8] Arbitrator Sapin noted that the requirement for these reasons would prevent "insurers from deciding to refuse treatment arbitrarily or on principle". Notably, Arbitrator Sapin did not go so far as to accept the argument of Ms. Augustin that the requirement for "medical reasons" meant the insurer required medical reasons from the opinion of a health provider to support the denial or

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[7] The MIG reads in part, "Compelling evidence should be provided using the Treatment and Assessment Plan (OCF-18) with attached medical documentation, **if any**, prepared by a health practitioner [emphasis added]."

[8] Parenthetically, Arbitrator Sapin also noted that the requirement to provide medical reasons eliminated the expense associated with the automatic initial IE.

that the insurer should be required to hire in-house medical staff to conduct the initial review of the treatment plans, or that only medically trained adjusters could make these decisions.

Arbitrator Sapin revisited the requirement for "compelling evidence" and agreed with the reasons of Arbitrator Wilson in *Scarlett and Belair*, which reasons had not yet been rebuked quite decidedly by the Directors Delegate. She reasoned that "compelling evidence likely means credible or believable evidence" but that such evidence could often only be determined in hindsight and that the insurer was "entitled to be wrong in its initial, pre-IE determination that an insured person has not presented compelling evidence that his or her injury falls outside the MIG".

In the result, Arbitrator Sapin rejected Unifund's argument that it refused to pay for Ms. Augustin's treatment plan because it did not have enough medical information to determine whether the claim fell within the MIG. She noted that this was

> not what [Unifund] told [Ms. Augustin] in its Explanation for Benefits. Nor did Unifund state that Ms. Augustin's treating practitioner had failed to provide compelling reasons to explain why the MIG should not apply. By failing to include these medical reasons in its response, I find Unifund's s. 38(8) notice was defective.

On its face, the foregoing reasons from the Arbitrator seem arbitrarily technical and could indicate that had Unifund simply stated, "your treatment provider has failed to provide compelling reasons to explain why the MIG should not apply" and "we therefore believe your claim falls within the MIG" that the notice would then have been sufficient.

Arbitrator Sapin concluded that there was two consequences to Unifund's failure to provide notice in compliance with subsection 38(8). First, Unifund could not rely on subsection 52.2 to prevent Ms. Augustin from mediating her claims. Second, Unifund was prohibited pursuant to subsection 38(11) from taking the position that the MIG applies and was required to pay for goods and services in the subject treatment plan until proper notice is received by the applicant. It was left unanswered how "proper notice" would affect the insurer's exposure after it is received by the applicant.

This decision seems decidedly out of step with the clear comments made by the Court of Appeal in *Stranges v. Allstate*[9] to the effect that even with a procedural misstep by the insurer, the claimant still has an obligation to prove substantive entitlement to be able to collect a benefit.

Presumably because the issue in the case involved such a modest amount of money, and more likely, because it did not realize at the time how broadly this decision might be applied, Unifund did not seek leave to appeal this decision.

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[9] add cite

Rule 49 Offers

In *Amyotte v Wawanesa Mutual Insurance Co*,[10] a panel of the Divisional Court of Ontario considered an appeal from the judgment of Justice Parayeski in which he granted the motion by the Defendant Wawanesa enforcing a settlement of claims for statutory accident benefits.

The plaintiff (appellant) in *Amyotte* had claimed for, *inter alia*, housekeeping benefits and extra-contractual damages. Shortly before the matter was to go to trial, counsel for the plaintiff requested a final offer from the defendant, to which the defendant's lawyer replied, "Payment to the Plaintiff of $15,000 inclusive of interest in full and final settlement of all accident benefits claims of the Plaintiff and all claims against the Defendant in the within action...[and] partial indemnity costs". Plaintiff's counsel replied, "We accept the offer and the action is settled". Days later the defendant's lawyer sent the plaintiff a full and final release for execution as well as a settlement disclosure notice and five days later the plaintiff's lawyer replied, indicating the offer had been accepted with respect to those claims which were the subject of the litigation only and not future claims for benefits: "We only settled the lawsuit that was outstanding in action number 05-21618. Your release does not restrict the release of the policy to the issue in that lawsuit. May I please have a second draft indicating that only the lawsuit benefits have been released."

The issues on the appeal to the Divisional Court were whether the plaintiff was entitled to rescind the settlement agreement and if not, whether the defendant was entitled to enforce it by way of judgment in the appeal.

The parties agreed that the defendant's initial offer was stated to be a "Rule 49" offer in the defendant's covering email but disagreed about whether the offer *qualified* as a Rule 49 offer. Justice Matlow for the unanimous panel considered Rule 49 of the *Rules of Civil Procedure*, noting that to qualify as a Rule 49 offer, the offer must comply with subrule 49.02(1): "49.02. (1) A party to a proceeding may serve on any other party an offer to settle any one or more of the claims in the proceeding on the terms specified in the offer to settle." Justice Matlow then considered the application Section 9.1 of the *Automobile Insurance Regulation*,[11] observing that the "*Regulation* applies to the settlement of claims for all statutory accident benefits" and noting the *Regulation* provides that

> before a settlement of a claim for statutory benefits is entered into between an insurer and an insured person, the insurer is required to give the insured person a written notice containing certain relevant information and "a statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer".

Justice Matlow observed however that "it has been authoritatively held that the *Regulation* does not apply to settlements made pursuant to a *true* Rule 49 offer [emphasis in original]." Justice

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[10] 2013 ONSC 4361, [2013] OJ 3321 (QL) (Div Ct).

[11] RRO 1990 Reg 664 [the *Regulation*].

Matlow referred to the Court of Appeal for Ontario decision in *Igbokwe v HB Group Insurance*[12] as supporting this position. In *Igbokwe*, Labrosse J for the unanimous Court wrote

> Section 9.1 was never intended to affect Rule 49.
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> The difficulties that would result from offers to settle, under Rule 49 received on the eve of trial and during trial, particularly jury trials, do not permit s. 9.1 and Rule 49 to work in tandem. Once an action has been commenced, the relationship between claimant and insurer become adversarial.
>
> Offers to settle litigation fall under Rule 49 and the rule is a complete code. Section 9.1 was not designed to accord special rights or impose obligations on claimants and insurers in settling their court proceedings.

On the basis of *Igbokwe*, Matlow J observed that the result in the appeal would depend on whether the Defendant's offer was a Rule 49 offer. Noting that if it was, then "a binding settlement was made by the parties. If it did not qualify, the *Regulation*, including the plaintiff's right to rescind, applied".

Justice Matlow observed that the Defendant's offer contemplated that in return for the payment the Plaintiff would be giving up her right to *all* past and future claims for statutory accident benefits. Justice Matlow also observed that in her statement of claim the Plaintiff only claimed for past housekeeping benefits. Justice Matlow then turned to rule 49.02, noting that an offer would only qualify as Rule 49 offer if it "would settle any one or more of the claims in the proceeding" and that the Defendant's offer "contemplated the settlement of much more than that." For this reason, Matlow J. concluded the Defendant's offer could not be a Rule 49 offer and that as a result, the *Regulation* applied and the plaintiff was entitled to rescind the offer for whatever reason she wished. On this basis, Matlow J concluded the judgment of Parayeski J reflected palpable and overriding errors and that it must be set aside.

Notably, in *Igbokwe*, there was also a settlement for a full and final resolution of past and future claims for accident benefits, however the Court of Appeal did not appear to consider whether—as in *Amyotte*—the offer "contemplated the settlement of much more" than what was claimed for in the pleadings.

Non-Earner Benefits & Limitation Periods

In *Sietzema v Economical Mutual Insurance Company*,[13] the Court of Appeal for Ontario grappled with whether an application for non-earner benefits was time-barred.

Ms. Sietzema was involved in a motor vehicle accident on November 11, 2005 and fifteen days later filed an application for statutory accident benefits with her insurer. She was also employed

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[12] 55 OR (3d) 313 leave to appeal to the SCC refused in 2001.

[13] 2014 ONCA 111.

at the time of the accident and her application package included an Employer's Confirmation Form. Her application package also included a Disability Certificate from her family doctor. The Certificate indicated that Ms. Sietzema was substantially unable to perform the essential tasks of her employment and that she was therefore entitled to an income replacement benefit ("IRB"). The Certificate also indicated under the category "non-earner benefits" ("NEB") that Ms. Sietzema did not suffer a complete inability to carry on a normal life and that she therefore did not meet the disability test for the non-earner benefit. In response to her application, the insurer sent Ms. Sietzema an OCF-9 Explanation of Benefits form which indicated, *inter alia*, that she was ineligible for the NEB on the basis that she was employed at the time of the accident. The Statement of Claim in the action was issued on April 14, 2011.

On the motion for summary judgment brought by the defendant insurer in the Superior Court, Ms. Sietzema argued, *inter alia*, that her insurer misled her regarding her entitlement to NEBs and that she thought she could never receive the NEBs because she was working. Justice Sloan disagreed, holding that even if the appellant was misled, she had retained a lawyer in 2006 whom advised her of her rights and that this advisement would include her entitlement to statutory accident benefits. Justice Sloan further noted that her lawyer "would have known the limitation periods were running" and that the OCF-9 "contained a clear refusal to pay the Non-Earner Benefits, and this triggered the limitation period". Ms. Sietzema argued Sloan J was wrong and appealed.

The unanimous panel of the Court of Appeal noted that the reason given by the respondent insurer for Ms. Sietzema ineligibility for the NEB was wrong. In his endorsement, Juriansz JA stated:

> She was not eligible for Non-Earner Benefits because she qualified for Income Replacement Benefits and the *SABS* did not permit her to receive both benefits. Although it was generally assumed in the insurance industry in 2005 that employment at the time of the accident precluded receipt of Non-Earner Benefits, this court's decision in *Galdamez v. Allstate Insurance Company of Canada*[14] ... clarified that, rare though the situation might be, a person who was able to continue to work might nevertheless qualify for Non-Earner Benefits.

In *Galdamez*, the Court of Appeal for Ontario had observed that it was possible that the insured could meet the test for disability with regard to NEBs while maintaining employment. Writing for the unanimous Court, Simmons JA had noted that

> ... in jobs where mobility is not a requirement (e.g. department store greeter, telemarketer, etc.) and the job was not of great importance in the claimant's pre-accident life, it may be possible for a claimant who returns to his or her pre-accident employment following an accident to satisfy the test for non-earner benefits.

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[14] add cite

The Court in *Seitzema* noted that despite the error in the OCF-9 received by Ms. Sietzema, the document nonetheless explained her right to dispute the insurer's assessment and at the bottom of the document there was a prominent warning regarding the relevant limitation period. The warning read, "WARNING: TWO YEAR TIME LIMIT" and explained that Ms. Sietzema had two years from the date on which the insurer refused to pay a benefit to arbitrate or commence the lawsuit. Ms. Sietzema retained her lawyer in January 2006 shortly after she received the OCF-9 from her insurer. She also returned to work on February 13, 2006 and her IRBs were terminated a few weeks later on March 2, 2006. On February 3, 2010, more than two years from the date on which she received the OCF-9, her lawyer wrote the insurer asserting a claim for NEBs and arguing the appellant had not been informed of the termination of her IRBs. The lawyer argued there had not been a "refusal" of the NEBs and that the limitation period had not begun to run.

On the appeal, Ms. Sietzema again argued that her insurer misled her because she thought she was never eligible for NEBs because she had been working on the date of the accident. As a result, she did not apply for the NEB when her IRBs were terminated in March 2006. She further argued that at the time her IRBs were terminated the respondent insurer should have informed her of her right to apply for the NEBs. Ms. Sietzema relied on the decision of the Supreme Court of Canada in *Smith v Co-Operators General Insurance Co*[15] in support of her argument. In *Smith v Co-Operators*, Gonthier J for the majority of the Supreme Court reasoned that because insurance law is geared towards consumer protection, the courts must impose "bright-line boundaries between the permissible and the impermissible without undue solicitude for particular circumstances that might operate against claimants in certain cases". The majority of the Court in *Smith* held that the limitation period had not begun to run because the insurer failed to notify the claimant of the applicable time constraints. On the basis of *Smith*, Ms. Sietzema argued her "insurer breached its duty to provide her with a written explanation of the benefits available and to assist her in applying for them" pursuant to subparagraphs 32(2)(b) and (c) of the *SABS*.

The Court of Appeal disagreed. The Court observed that Ms. Sietzema's argument was essentially that she was not given the correct reason for her ineligibility for the NEBs and that this argument was answered by earlier jurisprudence from the Court of Appeal which established that "clear and unequivocal notice given by the insurer, cancelling the insured's benefits, was sufficient to trigger the limitation period, notwithstanding the insurer gave legally incorrect reasons for cancelling the benefit".[16] Applying the law to the facts of the current case, the Court observed that the OCF-9 sent to Ms. Sietzema "clearly stated" that she had been approved for the IRBs but was not eligible for the NEBs. The Court further observed that the OCF-9 gave Ms. Sietzema clear notice of her rights in relation to the dispute resolution process and of the two-year limitation period. Notably, the Court also observed that on cross-examination Ms. Sietzema admitted she had been aware she was being denied NEBs by her insurer. For the foregoing reasons, the Court held the limitation period had begun to run on the date on which the claim for

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[15] 2002 SCC 30, [2002] 2 SCR 129.

[16] Citing *Turner v State Farm Mutual Automobile Insurance Company*, 2005 CanLII 2551.

NEBs was refused. The Court also noted that there is nothing in the *Insurance Act* nor the *SABS* which requires the insurer upon the termination of benefits to give the claimant further notice when or if the claimant has the right to renew a claim for a previously denied benefit.

Justice R.D. Reilly for the Ontario Superior Court dealt with issues similar to those in *Sietzema* in *Conrad v State Farm*.[17] In *Conrad*, the plaintiff was involved in a motor vehicle accident and applied for non-earner benefits and completed the required OCF-3 Disability Certificate. The application for the NEBs was denied in the form of an OCF-9 that was mistakenly not signed by a representative from the insurance company. Nevertheless, the form clearly indicated that the plaintiff was ineligible for an NEB. The form indicated that for the plaintiff to be eligible for the NEB she "must suffer a complete inability to carry on a normal life more than 26 weeks following the accident" and advised the Plaintiff that "[b]ased on Dr. Rammohan's Disability Certificate (OCF-3) dated September 29/05, you do not suffer a complete inability to carry on a normal life. As such, you are not considered eligible to receive a non-earner benefit". The OCF-9 further indicated the availability of the dispute resolution process and as in *Seitzema* it clearly indicated the plaintiff would have two years from the date of the insurer's refusal to commence a lawsuit or arbitration. The plaintiff argued the refusal of her NEB was "ambiguous and misleading and was at the very least insufficient to trigger the commencement of any limitation period that might otherwise apply to her launching an action." The plaintiff also took the position that the because the explanation of benefits contained in the OCF-9 was "not sufficiently clear" the limitation period did not start to run and her claim was not time-barred.

Justice Reilly considered the plaintiff's arguments in light of the Supreme Court of Canada's decision in *Smith*. Justice Reilly noted Gonthier J's observation that

> the insurer is required ... to inform the person of the dispute resolution process contained in ss. 279 – 283 of the *Insurance Act* in straightforward and clear language, directed towards an unsophisticated person. At a minimum, this should include a description of the most important points of the process, such as the right to seek mediation, the right to arbitrate or litigate if mediation fails, then mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process. Without this basic information, it cannot be said that a valid refusal has been given.

Justice Reilly also noted his earlier decision in *Spadafora v The Dominion of Canada General Insurance Company*,[18] in which he held that the delivery of an OCF-9 purporting to deny, *inter alia*, NEBs and which failed to include "any written explanation as to ... the basis for the denial of benefits and any written notice of the insured's right to dispute the denial ..." could not cause the limitation period to run.

Justice Reilly observed that "[i]n terms of the plaintiff's appreciation of the refusal of benefits ... I must consider the fact that in the Spring of 2006, the plaintiff had retained counsel" and that he

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[17] 2014 ONSC 4.

[18] 2013 ONSC 182.

could "presume that the plaintiff has been represented by counsel and has had access to legal advice over the past several years". Justice Reilly also noted that he was guided by, *inter alia*, the decision from Justice Sloan of the Ontario Superior Court in *Seitzema*.[19] Justice Reilly noted that in *Seitzema*, Sloan J noted, "Once the plaintiff retained a lawyer to seek advice on her rights, she can no longer plead ignorance or that Part 3 of The Form was misleading to her personally because she was unsophisticated with respect to auto insurance." Justice Reilly noted that Sloan J went even further, observing that Ms. Seitzema's lawyer

> would have known sometime in early 2006 that limitation periods were running. Absolutely no explanation was given to this court to explain why the lawyer did not file anything until he filed for mediation in April, 2010.

Although the subsequent endorsement from the Court of Appeal for Ontario in *Seitzema* did not focus on the claimant having retained counsel as the basis for the running of the limitation period, the panel for the Court of Appeal did refer approvingly to Sloan J's decision. In *Conrad*, Reilly J noted that the denial of the plaintiff's NEBs occurred on October 14, 2005 and that as of May 2006 she had retained counsel whom "on her behalf, within the two year period following the accident ... could have launched an appropriate claim". Justice Reilly concluded that limitations periods "must be observed" and that "[g]iven the years that have elapsed, the plaintiff's claim for non-earner benefits is barred".

Thus, it would appear that the "bright light boundaries" espoused by the Supreme Court of Canada in *Smith* may be dimming a bit.

Multiple Accidents and Catastrophic Impairment Designation

Justice H.A. Rady considered whether multiple accidents could combine into one catastrophic impairment application in *The Dominion of Canada v Chambers*.[20] In *Chambers*, Dominion brought an application seeking an order that section 45 of the *SABS* prohibits an insured from submitting an application for the determination of catastrophic impairment on the basis that multiple car accidents resulted in the insured suffering cumulative effects that rendered them catastrophically impaired.

Teresa Ann Chambers was involved in three car accidents. The first accident occurred in May 2003 and she allegedly suffered soft tissue injuries and various related sequelae. The second occurred one month after the first in June 2003 and she alleged she suffered additional soft tissue injuries and exacerbations of her previous impairments. The third accident occurred almost two years later and Ms. Chambers again complained of soft tissue injuries and an exacerbation of her

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[19] The *Seitzema* appeal was not heard until January 28, 2014, fourteen days from the date on which Justice Reilly released his reasons in *Conrad*. Justice Reilly was also guided by the decision from Justice Milanetti in *Katanic v State Farm Mutual Automobile Insurance Co*.

[20] 2013 ONSC 6122.

prior impairments. She also alleged she suffered from depression. After each of the three accidents she submitted an application for accident benefits.

Seven years after the third accident Ms. Chambers submitted an OCF-19 for the determination of catastrophic impairment. The application was completed by Dr. George Gale, who listed the date of the accident as "May 18, 2003, June 20, 2003 and February 3, 2003" and ultimately concluded that the respondent met the definition of catastrophic impairment based on the "Whole Person Impairment Rating" of 55% or more and on the basis of a mental or behavioural disorder as a result of the cumulative effects of the three motor vehicle accidents. Dominion returned the OCF-19 to the applicant and requested that one OCF-19 be completed for each of the three accidents. Ms. Chambers responded that she need only complete one OCF-19 for the cumulative effect of all three accidents.

Dominion accepted Ms. Chambers' argument that multiple accidents could contribute to her current condition but disagreed that an insured should be able to "reach back in time" to access benefits. Dominion argued that if Ms. Chambers could submit one OCF-19 in support of a CAT determination resulting from the cumulative effects of three accidents then she would potentially have access to three times the available benefits. Ms. Chambers argued that the jurisprudence and rules of statutory interpretation permitted multiple accidents forming part of a single CAT application. Dominion responded by also citing jurisprudence and rules of interpretation to support its argument that the *SABS* only permitted an application being brought in relation to one accident.

Justice Rady supported Dominion's interpretation of the law. She concluded that in her view, "section 45 of the *SABS* must be interpreted as referring to a single accident". Justice Rady noted that section 3 of the *SABS* was important because the section "makes it clear" that the determination of catastrophic impairment is being made with reference to one accident.[21] Justice Rady found further support for this proposition in the OCF-19 itself. Justice Rady concluded, "The repeated reference to *an* accident or *the* accident persuade me that the ordinary meaning of those words as singular must prevail" (emphasis added) and that in the subject case, "neither the first nor second accidents alone were sufficient to render the plaintiff catastrophically injured. It was the third accident that might have done so" but that "looking at the added impact of that accident being superimposed on pre-existing injuries possibly sustained in earlier accidents, should not effectively render each accident liable to a retroactive catastrophic impairment determination." Justice Rady also agreed with Dominion that there was practical problems with the Ms. Chambers' argument in that her interpretation of the law would make it "practically difficult, if not impossible" for insurers to reserve against a claim. Indeed, Justice Rady noted that Ms. Chambers' proposed interpretation of the law could lead to absurd results:

> Consider, as well, if there were three different insurers who provided SABS to a plaintiff for three different accidents. It seems untenable that an insurer for a relatively minor accident that adjusted and closed the file appropriately and promptly could find itself liable for benefits at some time in the future because

[21] For example, Justice Rady referred to subsections 3(3) and subclause 3(5)(c) which refer to "the accident".

> injuries in a subsequent accident or accidents, taken cumulatively, cause the plaintiff to become catastrophically impaired.

In the result, Rady J declared and ordered that section 45 of the *SABS* required that an insured specify only one accident in an application for catastrophic impairment.

Post-104 IRB Eligibility

The Court of Appeal for Ontario released brief reasons with far-reaching implications in relation to post-104 week IRB eligibility in *Wadhwani v State Farm Mutual Automobile Insurance Company.*[22]

In *Wadhwani*, the insured sued her insurer for, *inter alia*, income replacement benefits. At trial, the judge held that Ms. Wadhwani was required to establish that she was eligible for income replacement benefits in the 104 weeks after the date of the accident under subsection 4(1) of the *Statutory Accident Benefits Schedule—Accidents on or after November 1, 1996*[23] if she sought to qualify for post- 104 week IRBs pursuant to section 5. One of the grounds for Ms. Wadhwani's appeal was with regard to the trial judge's interpretation of the relationship between subsection 4(1) and section 5 of the *SABS-1996.*

On the appeal, Ms. Wadhwani argued that she should be able to return to work during the 104 weeks after the accident and "reassert" a claim for IRBs sometime thereafter if she became entirely unable to work as a result of injuries from the accident. She further argued that on the reassertion of the claim for IRBs the limitation period would only begin to run when the insurer refused to pay the benefits claimed.

The Court of Appeal unanimously agreed with the trial judge's interpretation of subsection 4(1) and section 5 of the *SABS* and rejected the arguments by Ms. Wadhwani in brief reasons. The Court noted that the appellant's argument was previously rejected by the Court and that "the trial judge was correct in her interpretation of the relationship between the provisions"—those provisions being subsection 4(1) and section 5 of the *SABS-1996*. As a result of the Court's decision in *Wadhwani*, insureds that seek post-104 week income replacement benefits must first qualify for the pre-104 week IRBs.

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[22] 2013 ONCA 662.

[23] O Reg 462/96 [*SABS-1996*].