OIC A96–000271

BETWEEN:

LISA FUNG-LEE

Applicant

and

ROYAL INSURANCE COMPANY OF CANADA and COSECO INSURANCE COMPANY

Insurers

DECISION ON PRELIMINARY ISSUES

Issues:

Lisa Fung-Lee was injured in a motor vehicle accident on August 23, 1993.Ms. Fung-Lee applied for statutory accident benefits payable under the *Schedule*,[1] from Royal Insurance Company of Canada, ("Royal") and from Coseco Insurance Company, ("Coseco"). Each Insurer alleged that the other should respond to Ms. Fung-Lee's claims for statutory accident benefits.

Section 268 of the *Insurance Act*, R.S.O. 1990, c. I. 8 as amended, sets out the rules for determining which insurer is liable to pay benefits. On May 27, 1995, Ontario Regulation 283/95 made under the *Insurance Act*, known as the "Priorities Dispute Regulation," came into force.

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[1]The *Statutory Accident Benefits Schedule - Accidents after December 31, 1993, and before November 1, 1996*, called "the *Schedule*" in this decision. The *Schedule* is Ontario Regulation 776/93, as amended by Ontario Regulation 635/94.

This Regulation provides that all disputes as to which insurer is required to pay benefits under s.268 of the *Act*, must be resolved by private arbitration and not by arbitration at the Ontario Insurance Commission.

The preliminary issues are:

1. Do I have jurisdiction to determine which insurer is liable to pay Ms. Fung-Lee's statutory accident benefits, or is this a matter for private arbitration under the priorities dispute regulation, Ontario Regulation 283/95?

2. If I have jurisdiction to hear the dispute, which insurer is liable to pay Ms. Fung-Lee's statutory accident benefits?

Ms. Fung-Lee claimed her expenses in respect of the hearing.

Result:

1. This dispute is not covered by the provisions of Ontario Regulation 283/95. I have jurisdiction to determine which insurer is liable to pay Ms. Fung-Lee's statutory accident benefits.

2. Coseco Insurance Company is liable to pay Ms. Fung-Lee's statutory accident benefits.

3. Ms. Fung-Lee is entitled to her expenses in respect of the hearing. Coseco Insurance Company is liable to pay these expenses.

Jurisdiction:

Both insurers in this case are of equal priority under section 268 of the *Insurance Act*. In such circumstances, the choice of which insurer is to pay benefits is in the "absolute discretion"[2] of the person claiming benefits. The dispute between the parties is a narrow one: which insurer did Ms. Fung-Lee choose.

Section 1 of the Priorities Dispute Regulation. provides that "All disputes as to which insurer is required to pay benefits under s.268 of the *Act*," must be resolved by private arbitration and not by arbitration at the Ontario Insurance Commission. It is not necessary for me to decide whether this is a dispute within the meaning of section 1 of the Regulation, since I have determined, for the following reasons, that the Regulation is not retroactive or to be given retroactive effect, and does not therefore apply to this dispute.

The motor vehicle accident occurred on August 23, 1993. Royal alleged that Coseco was liable to pay Ms. Fung-Lee's statutory accident benefits in a letter dated May 11, 1994. Coseco took the position that Royal was liable, in a letter dated January 6, 1995. The priorities dispute regulation, Ontario Regulation 283/95 was published in the Ontario Gazette, and came into force on May 27, 1995. This was approximately one year and nine months after the date of the motor vehicle accident, approximately one year after Royal alleged that Coseco should pay, and more than four months after Coseco alleged that Royal should pay Ms. Fung-Lee's claims.

[2] s. 268(4) of the *Act*

In this case, all of the facts which would trigger the dispute and the dispute itself arose before the Regulation came into force. As I stated in *Daljit Singh and Allstate and Wellington*[3], I find that the Regulation itself contains no express or implied provisions which make it applicable to events which occurred prior to the date on which it came into force.

To some extent, the Regulation is procedural in nature, in that it prescribes that insurers must proceed in a timely fashion to identify, notify, respond to and resolve disputes by agreement or private arbitration. The Regulation provides the means of identifying the parties to the dispute, clarifies that this is primarily a dispute between insurers, unless insured persons choose to become involved, and provides a forum for the arbitration of the dispute.

However, I find that the Regulation is also substantive in nature, since it fixes duties on the first insurer who receives a completed application for statutory accident benefits, to pay all statutory accident benefits pending resolution of the dispute. Prior to this "the insurer" was required to pay only those benefits which were required to be paid pending resolution of the dispute under the *Schedule*.

If the Regulation were to be applied retroactively to the facts in this case, none of the parties involved would have had actual notice of the provisions of the Regulation prior to the date on which it was filed. By the time the Regulation and the approved form were published, the time for compliance with its provisions would have expired. Since none of the parties would have complied with the provisions of the Regulation, they would have no forum for the adjudication of their dispute, and their substantive rights would be extinguished. I conclude that the provisions of the Regulation ought not to be given retroactive effect. As a result, the facts in this case are not

[3]OIC A-95-000754, June 18, 1997

covered by the priorities dispute regulation, and as an arbitrator at the Ontario Insurance Commission, I am not prevented from adjudicating this dispute.[4]

Is Royal or Coseco liable to pay benefits?

The parties agreed that Royal and Coseco were of equal priority under the provisions of the *Insurance Act*. Under these circumstances, section 268(4) of the *Act* provides that Ms. Fung-Lee in her "absolute discretion, may decide the insurer from which ... she will claim the benefits." Since the motor vehicle accident Ms. Fung-Lee has communicated with each of the insurers through her husband, a physiotherapy clinic, and her lawyer. The question I must determine is which insurer Ms. Fung-Lee chose.

Counsel for Ms. Fung-Lee submitted that his client was neutral as to which insurer was liable to pay her claims for statutory accident benefits. Counsel for Royal submitted that Ms. Fung-Lee chose Coseco, the insurer of the Jeep, which caused the accident, to pay her claims. Coseco submitted that Royal was the first insurer put on notice on March 10, 1994 and that this determines which insurer Ms. Fung-Lee chose. Coseco submits that Royal should have paid Ms. Fung-Lee's benefits instead of deflecting the claim.

The accident involved three motor vehicles. Ms. Fung-Lee was a passenger in a Hyundai which was uninsured. The second vehicle was insured by Royal, and the third vehicle, a Jeep was insured by Coseco. Following the accident, Ms. Fung-Lee's husband, Victor Lee, was convicted of driving without insurance. Mr. Lee testified that he was informed by the investigating police officer that neither he nor his wife were entitled to claim insurance benefits, and that his wife

[4]My reasons are consistent with those of Arbitrator Manji in *Smith and General Accident Assurance Company of Canada and Allianz Insurance Company of Canada*, OIC A-012681 and A-013811, January 30, 1997.

could sue him. Mr. Lee testified that he was really scared by the information he received from the police officer. Although he was injured, he took no steps to claim statutory accident benefits.

Mr. Lee testified that his wife's injuries were more serious than his, and that she had urged him to find out if her rights were different from his, since she had not been driving the car. Mr. Lee testified that he did not comply with his wife's wishes. What stuck in his mind was his experience with the police, the information that neither was entitled to statutory accident benefits, and that his wife could sue him.

The information which Mr. Lee states he received from the police officer was incorrect. While Mr. Lee would be precluded from claiming weekly income benefits by section 17 of the *Schedule*, he might be entitled to other statutory accident benefits. No provision in the *Schedule* prevents Ms. Fung-Lee from claiming any statutory accident benefits.

In November 1993, Ms. Fung-Lee and her husband were referred for physiotherapy treatment for their injuries. They believed that OHIP would pay for their treatment. However, the clinic agreed to treat Ms. Fung-Lee, only, since her treatments would be covered by statutory accident benefits. The clinic referred Mr. Lee to a facility where physiotherapy services were covered by OHIP on the basis that he was not entitled to statutory accident benefits. As noted above, this information with respect to Mr. Lee was incorrect.

Ms. Fung-Lee testified that the owner of the physiotherapy clinic informed her that the clinic would submit the physiotherapy bills to the insurer of the car which collided with the Hyundai in which she had been a passenger. If that insurance company did not pay, they would go after the insurer of the Jeep, and then let the two insurers negotiate who would pay. In any event, one insurer or the other would have to pay. She was satisfied with the clinic's plan, as the bills would

be paid. Ms. Fung-Lee testified that the clinic did not tell her that she could choose which insurer would pay for the bills. She did not know which insurer covered which vehicle at that time.

At some point between January and March 1994, the physiotherapy clinic submitted the first of its invoices for Ms. Fung-Lee's treatment to Royal. On March 10, 1994, Royal's adjuster, Ms. Alegado, telephoned Ms. Lee about the physiotherapy bills. Ms. Fung-Lee handed the phone to her husband, because she wished him to deal with the matter. Ms. Fung-Lee testified that her English was "fair." While she understands English, she feels that she cannot express herself clearly in English and did not wish to deal with an insurance claim. At the hearing, she testified through an interpreter.

The call from Royal came out of the blue. Ms. Fung-Lee and her husband had not discussed which insurer should pay their claims. During the telephone conversation, Ms. Alegado asked Mr. Lee who he felt should pay for his claims, and Mr. Lee responded that the driver of the Jeep, who had caused the accident, should pay. Before seeking his opinion, Ms. Alegado did not inform Mr. Lee that statutory accident benefits would be paid regardless of fault. Ms. Alegado's notes reflect that the "claimants" decided that they would seek payment from the at-fault insurer. In her testimony she acknowledged that her notes reflected a discussion of Mr. Lee's rights only, and not those of Ms. Fung-Lee.

Nevertheless, on May 11, 1994, and again on May 27, 1994, Ms. Alegado returned the physiotherapy bills for Ms. Fung-Lee's treatment to the clinic, denied payment and stated that the at-fault insurer should pay these bills. Four invoices from the physiotherapy clinic addressed to Coseco, dated January 1, 1994 to April 19, 1994 were filed as exhibits. I heard no evidence as to when the physiotherapy clinic sent these invoices to Coseco.

On May 27, 1994, Ms. Alegado sent a letter to Ms. Fung-Lee setting out her options of claiming against Royal or against the other driver. Ms. Alegado enclosed an accident benefits package with the letter. Both Ms. Fung-Lee and Mr. Lee acknowledged that they had seen the letter. I understood this to mean that they received the letter and the accident benefits package.

Ms. Alegado agreed that she had deflected the claim. I am concerned by this approach in the context of a statutory accident benefits scheme which is not based on fault. It is conceivable that this was an unfair and prohibited act under Part XVIII of the *Insurance Act*. Ms. Alegado stated that in her own mind, she knew that Mr. Lee and his wife would come back to Royal for payment. She also acknowledged that if Ms. Fung-Lee had submitted an application for accident benefits to Royal, and provided medical support for the physiotherapy treatment, she would have paid the bill.

Mr. Vinti Sansanwal, Coseco's officer, testified that once Royal received the physiotherapy bills, it was put on notice. He opined that Royal's representative should have helped Ms. Fung-Lee complete the accident benefits claims forms, rather than deflect the claim. In his opinion, Royal had a responsibility to respond to the claim, because it was the first insurer put on notice. The Applicant need not make a deliberate "choice" of insurer.

The approach advocated by Mr. Sansanwal has the merit of being an easy one, avoiding claim deflection strategies by the first insurer, and minimizing the inconvenience to insured persons. Coseco relied on the case of *Ready and Progressive Casualty Insurance Company and Zurich Insurance Company*,[5] in which Progressive denied Mr. Ready's claim before he submitted an application for accident benefits. Mr. Ready then filed an application against Zurich. Arbitrator

[5]OIC A-005403 and A-004768, April 7, 1994,

Makepeace determined that Progressive was liable to pay benefits as it was the first insurer approached by the Applicant.

The facts in the *Ready* case are quite similar to some of the facts in this case. However, the problem is that Ms. Fung-Lee submitted a formal application for benefits to Royal dated July 31, 1996, eight days following the pre-hearing in this arbitration. This was almost three years from the date of the accident, and the second formal application submitted by Ms. Fung-Lee. I heard no evidence or submissions as to how this came about. The timing of the application suggests that it was filed out of an abundance of caution following the pre-hearing and was not indicative of the manner in which Ms. Fung-Lee exercised her discretion.

Since I am required to determine how Ms. Fung-Lee exercised her discretion, I do not think that my inquiry should end with notification of the first insurer. I should also go on to examine what took place between Ms. Fung-Lee's agents and both insurers. In about September 1994, Ms. Fung-Lee received a letter from the physiotherapy clinic stating that she was responsible for payment of the physiotherapy account. Mr. Lee testified that he then telephoned the clinic, and spoke with the owner, who suggested that his wife retain a lawyer.

After Ms. Fung-Lee retained counsel, Mr. Cozzi submitted her first completed application for accident benefits to Coseco, dated December 12, 1994, claiming weekly income benefits and physiotherapy expenses. Lawyers are presumed to act as agents for and on the instructions of clients. I heard no evidence to rebut this presumption. I find that the filing of the first completed application for accident benefits with Coseco is determinative of how Mrs. Fung-Lee exercised her discretion under s. 268 of the *Insurance Act*. Ms. Fung-Lee's testimony that she wanted the insurer of the Jeep, Coseco, to pay her claim, confirms this. I conclude that Ms. Fung-Lee chose Coseco and that Coseco should pay Ms. Fung-Lee's claims.

Coseco received Ms. Fung-Lee's application on January 4, 1995. Coseco queried the absence of a medical report recommending physiotherapy treatment, the failure to comply with section 22(1) of the *Schedule* and the absence of any explanation which might constitute a reasonable excuse for non-compliance with that section.

Section 22 (1) of the *Schedule* requires the claimant to give initial notice of claim within thirty days from the date of the accident, or as soon as practicable thereafter, and to provide a completed application for benefits within ninety days after giving notice. However, section 22 (2) goes on to provide that if the claimant has a reasonable excuse and complies with the time frames set out in s. 22(1) within two years of the date of the accident, the claim is not invalid.

I find that Ms. Fung-Lee complied with the time frames within two years from the date of the accident. I must now determine whether Ms. Fung-Lee had a reasonable excuse. I find that initially Ms. Fung-Lee was unsure of her rights to claim statutory accident benefits. She was coping with her injuries and sufficiently unsure of her facility with English that she asked her husband to act on her behalf. Unfortunately, her husband did not do so, but remained focussed on the information he received from the police officer, that neither he nor his wife could claim insurance benefits and that his wife could sue him.

In November 1993, Ms. Fung-Lee was informed that her physiotherapy treatments would be covered by insurance benefits. The physiotherapy clinic undertook to submit the bills to both insurers and have them sort out who was to pay. According to the invoices her physiotherapy treatments continued until April 19, 1994. In September 1994 the clinic informed Ms. Fung-Lee that the bills were her responsibility and suggested to her husband that they should retain a lawyer.

I find that Ms. Fung-Lee was entitled to assume that if she continued to receive physiotherapy treatments that the clinic's arrangement to collect payments from the insurers was working and it was reasonable for her to assume that one or both insurers had accepted her claim. I find that up to September 1994, when she was informed that she was responsible for the bills, Ms. Fung-Lee's delay was reasonably excused. However, her application for accident benefits to Coseco was dated December 31, 1994. There was no evidence from the Applicant to explain a delay of approximately 3 months in submitting her application. Counsel for the Applicant advised only that he " was retained after May 27, 1994." I have no evidence which establishes that Coseco was prejudiced by this delay.

In the case of *Lily Steele and Zurich Insurance Company*,[6] Arbitrator Palmer found that the Applicant's delay in submitting her application for benefits was reasonably excused for a period of time, followed by a further unexplained delay of approximately 4 months. Arbitrator Palmer found that on balance, overall, Ms. Steele had a reasonable excuse for her delay in submitting her application for accident benefits. In light of that decision, and in the absence of any evidence of prejudice to the insurer, Ms. Fung-Lee's delay of approximately 3 months, is not untoward.

Expenses:

Ms. Fung-Lee claimed expenses in respect of the hearing. Counsel for both Insurers did not oppose her request. I exercise my discretion in the circumstances of this case to award Ms. Fung-Lee her expenses in respect of the hearing.

[6] OIC A-001024, December 3, 1992

Order:

1. Ontario Regulation 283/95 does not prevent me from determining which insurer is liable to pay Ms. Fung-Lee's claims for statutory accident benefits.

2. Coseco Insurance Company is liable to pay Ms. Fung-Lee's claims for statutory accident benefits.

3. Coseco Insurance Company shall pay Ms. Fung-Lee her expenses in respect of the arbitration.

June 23, 1997

Suesan Alves
Arbitrator

Date

APPENDIX A

Hearing:

The hearing was held at the offices of the Ontario Insurance Commission, in North York, Ontario, on October 29, 1996, before me, Suesan Alves, Arbitrator.

Interpretation services were provided in the Cantonese and English languages by Alexander Cheung.

Diane Adele Barrow of Legal Transcript Services recorded the proceedings.

Present at the Hearing:

Lisa Fung-Lee, the Applicant was present at the hearing. She was represented by Peter B. Cozzi, Barrister and Solicitor

Royal Insurance Company of Canada was represented by Wayne Edwards, Barrister and Solicitor

Coseco's Officer, Vinti Sansanwal was present at the hearing. Coseco was represented by David Zarek, Barrister and Solicitor

Witnesses:

Lisa Fung-Lee, Victor Jackman Lee, Honor Alegado, Vinti Sansanwal

Exhibits:

Four exhibits were filed.

Other documents before the arbitrator:

Reports of Mediator
Application for the Appointment of an Arbitrator
Response from Coseco
Response from Royal
Letter from pre-hearing arbitrator.

APPENDIX B

ONTARIO REGULATION 283/95
made under the
INSURANCE ACT

Made: April 12,1995
Filed: May 10. 1995

DISPUTES BETWEEN INSURERS

1. All disputes as to which insurer is required to pay benefits under Section 268 of the *Act* shall be settled in accordance with this Regulation.

2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the *Act*.

3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the *Act* unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay benefits under that section.

(2) An insurer may give notice after the 90 day period if,

(a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the *Act*; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day, period.

(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall he resolved in an arbitration under section 7.

4. An insurer that gives notice under section 3 shall also give notice to the insured person using a form approved by the Commissioner.

5. (1) An insured person who receives a notice under section 4 shall advise the insurer paying benefits in writing within 14 days whether he or she objects to the transfer of the claim to the insurers referred to in the notice.

(2) If the insured person does not advise the insurer within 14 days that he or she objects to the transfer of the claim the insured person is not entitled to object to any subsequent agreement or decision to transfer the claim to the insurers referred to in the notice.

(3) An insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 1 4 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the *Arbitration Act, 1991*.

6. The insured person shall provide the insurers with all relevant information needed to determine who is required to pay benefits under section 268 of the *Act*.

7. (1) If the insurers cannot agree as to who is required to pay benefits or if the insured person disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the *Arbitration Ac*t, 1991.

(2) The insurer paying benefits under section 2 any other insurer against whom the obligation to pay benefits is claimed or the insured person who has given notice of an objection to a change in insurers under section 5 may initiate the arbitration but no arbitration may be initiated after one year from the time the insurer paying benefits under section 2 first gives notice under section 3.

8. (1) Except as provided in this Regulation, the *Arbitration Act, 1991* applies to an arbitration under this Regulation.

(2) The decisions of an arbitrator made under this Regulation shall be public.

9. (1) Unless otherwise ordered by the arbitrator or agreed to by all the parties before the commencement of the arbitration. the costs of the arbitration for all parties. including the cost of the arbitrator, shall be paid by the unsuccessful parties to the arbitration.

(2) The costs referred to in subsection (I) shall be assessed in accordance with section 56 of the *Arbitration Act,* 1991.

10. (1) If an insurer who receives notice under section 3 disputes its obligation to pav benefits on the basis that other insurers. excluding the insurer giving notice, have equal or higher priority under section 268 of the *Act* it shall give notice to the other insurers.

(2) This Regulation applies to the other insurers given notice in the same that it applies to the original insurer given notice under section 3.

(3) The dispute among the insurers shall he resolved in one arbitration.

11. If the Motor Vehicle Accident Claims Fund receives an application for benefits, sections 4 and 5 do not apply and the insured person is not entitled to initiate or participate as a party in an arbitration under section 7.

ENDNOTES