CITATION: Higashi v. Western Assurance Company, 2020 ONSC 7616
DIVISIONAL COURT FILE NO.: DC-19-2551
DATE: 20201210

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

SWINTON, J.A. RAMSAY AND FAVREAU JJ.

BETWEEN:	
MELONIE HIGASHI Appellant	SANDI SMITH for the Appellant
– and –	
WESTERN ASSURANCE COMPANY Respondent	ERIC K. GROSSMAN and ARYEH SAMUEL for the Respondent
	HEARD at Ottawa (by videoconference): November 18, 2020

J.A. Ramsay J.

[1] This is an appeal under s.11(6) of the *Licence Appeal Tribunal Act, 1999*, S.O. 1999, c. 12, Sched. G, from a decision of the Licence Appeal Tribunal relating to an application under the *Insurance Act*. The standard of review is correctness: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65 at para. 37. The appeal is limited to a question of law.

[2] The appellant is an insured person who was injured in a motor vehicle accident. She disputed the respondent's refusal to continue weekly Income Replacement Benefits ("IRBs"). Accordingly, under s.280(2) of the *Insurance Act*, R.S.O. 1990, c. I.8, she applied to the Tribunal to decide the dispute.

[3] Section 56 of the *Statutory Accident Benefits Schedule* in O.Reg. 34/10 made under the *Insurance Act* provides:

> 56. An application under subsection 280(2) of the Act in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed.

[4] The adjudicator ruled that the application had not been brought within the limitation period and dismissed the application.

[5] The vice chair of the Tribunal dismissed an application for reconsideration. He held that reconsideration should not go ahead until the application for catastrophic benefits is complete. That application is still before the Tribunal.

Is the appeal premature?

[6] The parties agree that this appeal should proceed notwithstanding the decision of the vice chair and the outstanding application for catastrophic benefits. We agree that in the particular circumstances of this case the two applications are separate, and that the more just and efficient way of proceeding would be to hear the appeal. We do not consider this to be a departure from the principle against interlocutory appeals in administrative law proceedings set out by this court in *Traders General Insurance Company v. Rumball*, 2019 ONSC 1412. Here, one party has been finally prevented from proceeding with an appeal respecting IRBs. The outcome of the catastrophic benefits has no bearing on this issue. It would be more efficient to decide now whether she can proceed with the IRBs application, rather than to leave that question to be decided after the catastrophic benefits application. If she succeeds on the catastrophic benefits application, the IRBs still remain in issue. If she is unsuccessful on the catastrophic benefit application, the IRB issues remain distinct from the catastrophic benefit issues. However, were we to allow this appeal, both applications could proceed together before the Tribunal, thereby avoiding duplicate or contradictory evidentiary findings.

The history of the proceedings

[7] The appellant was injured in a car accident on September 30, 2012. The respondent paid income replacement benefits for 104 weeks. In early 2014 the insurer requested two further disability certificates (OCF-3). It also requested six independent medical examinations under section 44 of the Schedule. The appellant underwent the examinations. On July 2, 2015 the insurer sent the appellant a letter and explanation of benefits package (OCF-9) refusing further benefits. It also included a copy of the final independent assessment report it had received from a neuropsychologist. The other six reports had been provided to the appellant in August 2014. The appellant's doctor who had completed the OCF-3s only received one of the seven reports, the last one. Under s.37(5) of the Schedule, he should have been sent all seven.

[8] If benefits were properly refused on July 2, 2015, the limitation period would have run to July 2, 2017. On June 22, 2017 the appellant filed an application to the Tribunal.

[9] In September 2017 the appellant decided to withdraw her application in order to give her time to obtain a catastrophic impairment assessment, with a view to filing a new application

when it was ready. The parties agreed that the limitation period would be extended until April 13, 2018. The appellant did not file her new application until October 19, 2018.

The issues

[10] At the hearing before the Tribunal, the respondent argued that the application was out of time.

[11] The appellant argued that the refusal of July 2, 2015 was not a valid refusal of benefits for the purpose of s.56 of the Schedule and that the limitation period had therefore not begun to run. It was not valid because the insurer did not fulfil its duty under s.37(5) of the Schedule to give a copy of all the reports of the practitioners who performed the section 44 examinations to the practitioner who completed the appellant's disability certificates (OCF-3).

[12] Subsection 37(5) of the Schedule provides:

> (5) Within 10 business days after receiving the report of an examination under section 44, the insurer shall give a copy of the report to the insured person and to the person who completed the disability certificate, if one was provided in accordance with subsection (1). O. Reg. 34/10, s. 37 (5).

[13] The adjudicator held that the refusal of benefits was clear and unequivocal and that the omission to give copies of the reports to the practitioner who completed the OCF-3 was not fatal to the validity of the refusal. Therefore, the application to the Tribunal was out of time.

Breach of s.37(5)

[14] I agree with the Tribunal that the breach of the obligation in s.37(5) to give a copy of all the independent assessment reports to the appellant's practitioner was not fatal to the running of the limitation period.

[15] The starting point on this issue is the decision of the Supreme Court in *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, which dealt with the adequacy of notice of a denial of benefits. In that case the insurer did not fulfil its duty under s.71 of the Schedule as it then read to inform the insured of the process for challenging the refusal of benefits. The Supreme Court held that the refusal did not operate to start the limitation period because it did not convey the information that the legislature intended should be conveyed to the insured.

[16] Here, the Tribunal found that the notice provided by the respondent to the appellant was proper and in accordance with the Schedule and the *Smith* decision.

[17] The appellant cites *Klimitz v. Allstate Insurance Company of Canada*, 2014 ONSC 7108, aff'd 2015 ONCA 698, leave to appeal refused 2016 CanLII 21913 (SCC), and submits that omission to comply with the requirements of s.37(5) of the Schedule prevents the limitation period from running. I do not agree that *Klimitz* stands for that proposition.

[18] In *Klimitz*, the insurer denied benefits and gave reasons that referred to the reports of two independent assessors. It gave the insured a copy of one report but not the other. Two years later it gave the insured a copy of the second assessor's report. Within two days the insured applied to an arbitrator to decide the dispute.

[19] At the time s.37(1) of the Schedule provided, "the insurer shall give the person notice of its determination, with reasons". Subsection 37(5) required the insurer to give a copy of independent assessments to the insured and the practitioner who had issued the certificate of disability within 5 days of receipt. The arbitrator held that the omission to provide copies of the second assessor's reports did not invalidate the refusal for the purposes of the limitation period.

[20] The delegate of the Director of the Financial Services Commission of Ontario reversed the arbitrator's decision on appeal. The delegate held that the limitation period did not begin to run until the insured received the second assessor's reports. He held that s.37(5) was not linked to the limitation period, but the obligation to give reasons for the refusal in s.37(1) required the insured to have a copy of the assessments on which the insurer relied so that she could decide whether to apply for relief. On judicial review, the Divisional Court held that the delegate's decision was reasonable and upheld it. On appeal from the Divisional Court, the Court of Appeal agreed. The court said, "The Director's Delegate was entitled to deference in the interpretation of his home statute."

[21] The decision had nothing to do with the obligation to give a copy of the assessment to the insured person's practitioner. It had to do with the requirement to give a copy to the insured, and the effect of non-compliance on the adequacy of the reasons for the refusal. It also had to do with the reasonableness of the delegate's decision, not its correctness.

[22] In *Beric v. The Guarantee Company of North America*, 2020 ONLAT 18-009494/AABS the adjudicator held that failure to give a copy of the independent assessment reports to the doctor who completed the OCF-3 invalidated the refusal for the purposes of the limitation period. The adjudicator said,

> The applicant had a right for her physician to be fully informed and provided with critical information that formed the very basis of the denial. Without this critical step, M.B.'s ability to decide whether or not to challenge the cancellation was seriously compromised and placed her at a clear disadvantage.

[23] I disagree. As long as the insured has a copy of the reports, she can show them to her doctor if she wants his views on entitlement to benefits, which is essentially a legal question. I do not think that the legislature had in mind that the doctor would be involved in the decision to challenge a refusal of benefits.

[24] It is s.37(4) of the Schedule that deals with the sufficiency of the reasons for refusing benefits:

> (4) If the insurer determines that an insured person is not entitled or is no longer entitled to receive a specified benefit on any one or more grounds set out in

> subsection (2), the insurer shall advise the insured person of its determination and the medical and any other reasons for its determination. O. Reg. 34/10, s. 37 (4).

[25] The purpose of the requirement to give reasons is to permit the insured to decide whether or not to challenge the cancellation: *Turner v. State Farm Mutual Automobile Insurance Co.* (2005), 195 O.A.C. 61, paragraph 8. The reasons need not be legally correct: *Sietzema v. Economical Mutual Insurance Company*, 2014 ONCA 111.

[26] Subsection 37(5) on the other hand is not linked to refusal of benefits in particular. It obliges the insurer to give a copy of the independent assessment to the insured and to the practitioner who completed the disability certificate whether benefits are to be continued or not. The independent assessment would be useful to the practitioner with respect to the care of the insured whether benefits are continued or not.

[27] I think that the ordinary meaning of the words of the section in the context of the Act and considering its purposes leads to the conclusion at which the adjudicator arrived. The failure to give copies of some of the reports to the appellant's doctor did not invalidate the refusal of benefits for the purpose of the limitation period.

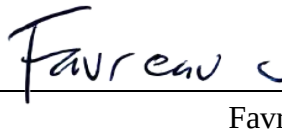
[28] On July 2, 2015 the appellant had what she needed to know that the respondent had made an unequivocal determination to discontinue her benefits and the medical reasons therefor. She had copies of the independent assessments upon which the determination was based. She was given enough information to know whether or not to challenge the cancellation of benefits. There is no reason why the limitation period should not have started to run.

[29] I would dismiss the appeal with costs to the respondent in the agreed amount of $7,500.

J.A. Ramsay J.

I agree 

Swinton J.

I agree 

Favreau J.

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REASONS FOR JUDGMENT

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