Citation: Fehringer v. Co-operators General Insurance Company, 2026 ONLAT 24-008167/AABS

Licence Appeal Tribunal File Number: 24-008167/AABS

In the matter of an application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8, in relation to statutory accident benefits.

Between:

The Estate of Frederick Fehringer

Applicant

and

Co-operators General Insurance Company

Respondent

DECISION

ADJUDICATOR: **Nadia Mauro**

APPEARANCES:

For the Applicant: Adam Romain, Counsel

For the Respondent: Simran Walia, Counsel

HEARD: **By way of written submissions**

OVERVIEW

[1] Frederick Fehringer, the applicant, was involved in an automobile accident on June 8, 2017, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (including amendments effective June 1, 2016)* (the "*Schedule*"). The applicant was denied benefits by the respondent, Co-operators General Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

[2] On February 9, 2018, the applicant passed away.

[3] An application was filed with the Tribunal on July 2, 2024, in Frederick Fehringer's name.

[4] Upon review of the submissions of the parties, the Tribunal identified that it did not have documentation of the estate trustee with authority to provide instructions for the deceased applicant. The Tribunal sent email correspondence to the parties on March 3, 2026, seeking confirmation of same by no later than March 10, 2026.

[5] On March 9, 2026, counsel for the applicant sent email correspondence enclosing an excerpt of the deceased applicant's Last Will and Testament identifying Gordon Markus Fehringer and Patricia Gabriele Moore as executors. Counsel also provided a new Declaration of Representative identifying "The Estate of Frederick Fehringer" as the name of the represented party.

[6] In light of this new documentation, I issued an Order on April 9, 2026 seeking clarification of whether the application should be in the name of the deceased applicant's estate, and confirmation that the estate is giving counsel instructions in this case.

[7] On April 14, 2026, the applicant's representative sent email correspondence to the Tribunal indicating that the application should be in the name of the "Estate of Frederick Fehringer" and the deceased applicant's estate is providing instructions on this matter. The applicant indicated that it had the consent of the respondent to amend the name to the estate.

[8] Given that the parties consent to the application being brought under The Estate of Frederick Fehringer, I have changed the style cause to reflect same.

ISSUES

[9] The issues in dispute are:

1. Is the applicant entitled to expenses submitted on a claim form ("OCF-6"), dated May 30, 2022, and submitted June 6, 2022, as follows:
    i. $140.00 for a wheelchair rental?
    ii. $295.20 for assistive devices?
    iii. $5,891.00 for lodging?
    iv. $140.00 for a wheelchair rental?
    v. $4,374.00 for lodging?
    vi. $4,334.00 for lodging?
    vii. $4,304.00 for lodging?
    viii. $692.50 for wheelchair assistive devices?
2. Is the applicant entitled to a death benefit of $20,000.00?
3. Is the applicant entitled to $4,108.25 for funeral expenses?
4. Is the applicant entitled to Attendant Care Benefits (ACBs)?
5. Is the respondent liable to pay an award under s. 10 of Reg. 664 because it unreasonably withheld or delayed payments to the applicant?
6. Is the applicant entitled to interest on any overdue payment of benefits?
7. Is the respondent liable to pay costs pursuant to Rule 19.1 of the Licence Appeal T*ribunal Rules, 2023 ("Rules")*?

[10] Although entitlement to ACBs is not an issue before me, the applicant makes submissions with respect to reimbursement of ACBs. Therefore, and keeping in mind the consumer protection mandate of the *Schedule* and the fact that the respondent has also made submissions on this issue indicating that they had notice, I have considered whether the applicant should be reimbursed for ACB expenses.

[11] I have also added the applicant's request for costs to the issues in dispute. Rule 19.2 provides that a party can make a request for costs "at any time before the decision or order is released."

RESULT

[12] The applicant is partially entitled to the expenses listed on the OCF-6 dated May 30, 2022, plus interest.

[13] The applicant is not entitled to ACBs, death benefit, funeral benefit, award or costs.

PROCEDURAL ISSUES

[14] The parties have raised several procedural issues throughout their submissions, however, only the most pertinent to the dispute have been addressed below.

The length of the parties' submissions

[15] The applicant, in his reply submissions, objects to the respondent's submission length. The applicant submits that pursuant to the Case Conference Report and Order, dated December 19, 2024, the length of the submissions were to be limited to a maximum of 15 pages. While the applicant 'objects' to the form and content, the applicant does not request any relief with respect to the respondent's submissions. Instead, the applicant requests leave to exceed the page limit for his reply submissions.

[16] The respondent filed sur-reply submissions with leave of the Tribunal to address submissions in the applicant's reply as set out below.

[17] Given that both parties have had a chance to make a fulsome response to their respective positions, and in light of my analysis below about the request to strike parts of the submission, I will consider all pages of the parties' submissions, reply submission, and sur-reply submissions.

Misleading suggestion of misconduct and personal attacks

[18] The applicant, in his reply submissions, objects to the respondent's claim that the insured received non-earner benefits ("NEB") after his death at paragraph 3 of the respondent's submissions. The applicant further objects to the respondent's "inflammatory and scandalous" attacks on the applicant's counsel at paragraph 15 and 34 of the respondent's submissions. The applicant asks that these statements be struck, with costs.

[19] The respondent, in its sur-reply, submits that the payment of NEBs beyond the applicant's date of death is a true fact and relies on HCAI screenshots of issued cheques to support this allegation. The respondent further submits that it did not attack counsel but rather laid out facts regarding counsel's unexplained delay.

[20] I am not prepared to strike paragraph 3 of the respondent's submissions because the adjuster log notes corroborate payment of NEBs beyond the date of the applicant's death. In my view, the respondent's submission with respect to the payment of NEBs is attempting to indicate that the delay, which is a central position taken by the applicant, is not attributable to its adjusting of the file.

[21] I am also not prepared to strike paragraphs 15 and 34 of the respondent's submissions because they respond to the allegations made by the applicant's counsel with respect to respondent's adjusting and the applicant's access to benefits. While I do not condone the targeted language directed towards counsel – both parties make strong allegations – and I find that it would be procedurally unfair to strike statements that are made in response to alleged conduct.

[22] Given this, I will not strike paragraphs 3, 15, and 34 of the respondent's hearing submissions.

Classification of the Applicant's Injuries

[23] The respondent submits that at paragraphs 3 and 13-24 of the applicant's submissions, the applicant argues that the insurer misclassified the claim as being within the Minor Injury Guideline ("MIG"), and relied on this misclassification to deny ongoing benefits, and failed to provide the applicant with an OCF-4 as required by s. 32(2). The respondent requests this "issue" be struck as the claim is not within the MIG and a determination of MIG is not in dispute.

[24] The applicant, in his reply submissions, submits that the MIG misclassification meant that he was not entitled to ACBs which are now in dispute. The applicant submits that he only became entitled to ACBs in the last 2 months of his life, after the insurer removed him from the MIG.

[25] While I agree with the respondent that MIG is not an issue in dispute, I am not prepared to strike the applicant's submissions at paragraphs 3 and 13-24 because they speak to the facts and circumstances surrounding the applicant's claim and are relevant to the issues in dispute.

[26] As such, I will not strike paragraphs 3 and 13-24 of the applicant's submissions.

Adjuster Log Notes

[27] The applicant, in his reply submissions, objects to the respondent's use of adjuster notes "in lieu of its evidence in support of its submissions". The applicant argues that the log notes are hearsay evidence, and as such, should be excluded. In the alternative, the applicant argues that the respondent including a complete, albeit redacted, copy of the log notes indicates that privilege has been waived and requests production of the complete unredacted notes including reserves.

[28] The respondent, in its sur-reply submissions, argues that log notes are business records and therefore an exception to the hearsay rule. It submits that documentary evidence should be preferred at the Tribunal over *viva voce* evidence particularly where the hearing format is written. The respondent further submits that it is "preposterous" for the applicant's counsel to submit that the respondent should not rely on log notes where the applicant's counsel relies on the same evidence and that it would be contradictory to the *Evidence Act*, RSO 1990, c E. 23, to argue that the respondent has waived privilege by the use of log notes in its submissions.

[29] I am not persuaded by the applicant's allegation that adjuster log notes are hearsay evidence. The Tribunal has long accepted that pursuant to s. 35 of the *Evidence Act*, adjuster log notes are conducted in the usual and ordinary course of business, and as such, an exception to the hearsay rule.

[30] I also agree with the respondent in that it has not waived privilege by relying on a redacted copy of the adjuster log notes in its submissions and evidence. The applicant's counsel has not directed me to any authority that would support that relying on a complete redacted copy of adjuster log notes somehow implicitly waives privilege. Further, I note that the applicant has also relied on the log notes in his submissions.

[31] Given this, I will not exclude the redacted adjuster log notes from the record, nor will I make any order with respect to the production of an unredacted copy of the adjuster log notes.

Respondent's submissions with respect to wheelchair expenses

[32] The applicant, in his reply submissions, argues that it is procedurally unfair for the respondent to argue in its submissions a position that it did not plead. This is because the respondent plead its basis for the denial was that there was no compelling medical evidence provided to confirm that the assistive devices were

made necessary as a direct result of the accident. To support this, the applicant relies on the insurer's response to the applicant's application. The applicant argues that the respondent should be estopped from arguing a position different from what it set out in its pleadings.

[33] I disagree. It is the applicant's burden to prove entitlement to the reimbursement for the wheelchair expenses. Despite what the respondent 'pleads' in response to the initial application, and the submissions it makes in response to the applicant's submissions, the applicant still has the ability to reply by way of reply submissions. The applicant has not directed me to any authority that would uphold that the respondent could be estopped from arguing a different position than it held in advance of the hearing.

[34] In any event, while the applicant requests the respondent be estopped from arguing a position, the applicant has not indicated what relief it seeks from the Tribunal.

ANALYSIS

[35] Given the importance of the timeline to the analysis in this case, I briefly note the following.

[36] On June 8, 2017, the 94-year-old applicant was walking with his walker when he was struck by a motor vehicle.

[37] The applicant was taken to Scarborough General Hospital, where he remained for approximately 10 weeks before being transferred to a rehabilitation hospital, Providence Healthcare, on August 15, 2017. He stayed at Providence Healthcare for four weeks until he was then transferred to an assisted living facility, Cedarbrook Lodge Residence on or about September 19, 2017.

[38] The applicant was self represented until he retained counsel in and around October 2017.

[39] On November 30, 2017, the respondent sent letter correspondence to the applicant indicating that "after carefully reviewing this information along with other information on file, we have determined that your injuries no longer fall within the Minor Injury Guideline."

[40] On January 31, 2018, the applicant submitted an OCF-18 for an occupational therapy assessment, Form 1 completion, travel, file planning/team communication, report completion, OCF-18 completion, and disbursements, parking.

[41] On February 9, 2018, the applicant passed away.

[42] On February 15, 2018, the respondent partially approved the OCF-18 in the amount of $1,546.63 for the assessment, and Form 1 completion.

The expenses for lodging

[43] I find that the applicant has not established entitlement for reimbursement of the lodging expenses submitted on an OCF-6 dated May 30, 2022.

[44] In the OCF-6 the applicant sought reimbursement for “Cedarbrook Lodge Residence Receipt” (“lodging”) in the following amounts:

$5,891.00 on October 1, 2017

$4,374.00 on November 1, 2017

$4,374.00 on December 1, 2017

$4,374.00 on January 1, 2017

$1,345.00 on February 1, 2018

[45] The applicant’s submissions rely largely on the classification of his medical and rehabilitation benefits status. While the applicant submits that he was misclassified, and therefore, did not know he had access to ACB benefits, the issue before me is whether the expenses incurred for lodging are reasonable and necessary. It is not clear from the submissions or evidence whether the totality of the lodging expenses are for attendant care needs and what services are provided, if any, under the lodging expenses. The breakdown of payment for Cedarbrook Lodge attached to the OCF-6 itemises charges for various things such as, “Room Charge”, “Care Service CSO”, “Cable TV + Phone”, and “Lab Work”. However, the applicant does not make submissions with respect to the cost of these expenses.

[46] Ultimately, the applicant has not met his burden to prove the expenses incurred for lodging were reasonable and necessary. This is because the applicant did not direct or point me to evidence or make submissions with respect to the totality of the lodging expenses, nor whether the goods/services (if any) he received at the convalescent home ought to be paid by the respondent.

[47] Given the foregoing, I find that the applicant has not met his burden to prove, on a balance of probabilities, that the expenses incurred for lodging are reasonable and necessary.

Attendant Care Benefits and the Form-1

[48] Section 19 of the *Schedule* states that an insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of an accident for ACBs provided by an aide or attendant.

When did the applicant discover he was entitled to ACBs?

[49] Under s. 14 of the *Schedule*, Attendant Care Benefits ("ACBs") are not available for impairments that are minor injuries.

[50] The applicant submits that despite having been continuously hospitalized, preventing his return home after the accident, the respondent classified Mr. Fehringer's injuries are falling within the MIG. The applicant submits that the respondent maintained this MIG misclassification despite its acceptance that Mr. Fehringer was entitled to NEBs and acknowledged his complete inability to carry on a normal life. The applicant relies on *Tomec v. Economical Mutual Insurance Company*, 2019 ONCA 882 (CanLII) ("*Tomec*"), in that the very purpose of the SABS, to reduce economic dislocation and hardship of accident victims, was frustrated by the respondent's conduct. The applicant submits from June 2017 to December 1, 2017, the respondent maintained its unsupported position that Mr. Fehringer was disqualified from receiving ACBs, an assessment of those benefits, or anything more than the minimum allowable quantum of rehabilitation benefits.

[51] The respondent submits that the applicant was "never" in the MIG. The respondent submits that this was made clear at the outset when the adjuster visited the applicant and his family in the hospital. The respondent submits that the adjuster visited the applicant and his son at Scarborough General Hospital on August 3, 2017, hand delivering a complete accident benefits package and advised that he had access to $65,000 in medical, rehabilitation, and attendant care benefits.

[52] The applicant, in his reply submissions, submits that despite the respondent stating that the applicant was never in the MIG, letter correspondence and log notes indicate that he was, until removed on November 30, 2017. The applicant submits that this MIG classification meant that he was not entitled to the ACB expenses which are now in dispute. The applicant submits that he only became

aware of entitlement to the ACBs in the last two months of his life after receiving the letter correspondence dated November 30, 2017.

[53] *Tomec* also states that when given the choice, "statutory interpretation that furthers the public policy objectives underlying the *SABS* and one that undermines it, the only reasonable decision is to side with the former": para 45.

[54] Based on the evidence before me, I find that the applicant was removed from the MIG on November 30, 2017. While the adjuster log note for an in-person client visit dated August 3, 2017 states "AB coverage (advised of $65,000 med, rehab & AC benefits)", the Standard Benefit Statement dated September 5, 2017, identifies the applicant's impairment as "Minor Injury". The only clear evidence provided that establishes the applicant's injury status is the letter correspondence dated November 30, 2017, that states "we have determined that your injuries no longer fall within the Minor Injury Guideline". Therefore, given that the applicant was self-represented until October 2017, I find it more probable than not that the applicant understood to be within the MIG until removed by way of letter correspondence on November 30, 2017, and therefore did not have access to ACBs until said date. In other words, I find that the evidence supports that the applicant discovered that he could be entitled to ACBs on November 30, 2017.

Section 42(5) of the Schedule bars the applicant from claiming attendant care before submitting a Form 1

[55] I find that s. 42(5) of the *Schedule* would bar the applicant from claiming ACBs before submitting a Form 1.

[56] Section 42(1) of the *Schedule* provides that an application for ACBs must be in the form of, and contain the information required to be provided in, the approved version of the document entitled Assessment of Attendant Care Needs ("Form-1").

[57] Section 42(5) of the Schedule provides that an insurer is not required to pay an expense incurred before a Form 1 is prepared and submitted to the insurer by an occupational therapist or registered nurse.

[58] The applicant submits that s. 42(5) of the *Schedule* allows the insurer to pay for attendant care services before a Form 1 is completed, and the insurer should not be permitted to manufacture a situation where a Form 1 cannot be obtained because of classifying the applicant's injuries as minor. The applicant further submits that the respondent had every opportunity to assess his needs for attendant care, had medical documentation supporting those needs, and noted

that need in its adjuster logs. The applicant takes the position that the denial of ACBs rests on the demand for the Form 1, which the respondent never told Mr. Fehringer that is required and expressly said was not required before the expenses were incurred. The applicant relies on *Botbyl v. Heartland Farm Mutual Inc*. 2025 ONSC 3349 ("*Botbyl*") in that the insurer must proactively assist in applying for benefits to which an insured may be entitled pursuant to s. 32(2) of the *Schedule*.

[59] The respondent submits that pursuant to s. 42(5), an insurer is not required to pay attendant care benefits before a Form 1 is submitted and that the onus is on the applicant to provide the insurer with the Form 1. The respondent further submits that retroactive payments may be permitted due to urgency, impossibility, or impracticability of submitting a Form 1 prior to incurring expenses. The respondent argues the applicant did not provide updates, a Form 1, or an opinion from a medical professional at the treating facility to shed light on his attendant care needs, despite having "almost half a year" to set up an occupational therapy assessment.

[60] At the outset, I note that this is a difficult case involving an applicant who has since passed away. While I am sympathetic to the applicant's passing and untimely submission of the OCF-18 for an orthopedic assessment, without a completed Form 1, under the *Schedule*, the respondent is not required to reimburse any attendant care expenses incurred.

[61] The applicant argues that the respondent expressly states that it agreed to pay for expenses prior to the submission of a Form 1, pointing me to an adjuster log note dated August 4, 2017. The adjuster log note states "Discussed with Kruti to review invoices from convalescent homes to determine what we are paying for. Kruti will assign claim to OT (after offering client a few options)." Although I find this log note to be vague, I am not persuaded that it confirms the assertion that the respondent advised the applicant it would pay for expenses prior to the submission of the Form 1.

[62] The adjuster log notes also indicate on September 11, 2017, that the respondent received an email from the applicant's son stating, "still in rehab hospital & needs assistance with ADLs". An Adjuster log note dated October 19, 2017, indicated that "legal has been retained as of Oct 2017. OBC, left a msg for legal rep to call me back to get an update on if the claimant has been discharged from Providence Healthcare yet or not." On November 10, 2017, the adjuster log notes state "[the applicant] is at a nursing home at Cedarbrook Lodge" and "they are in the process of completing an OT ax [sic] at the nursing home for his AC needs".

Therefore, the evidence supports that the respondent was not made aware of the applicant's transfer to the convalescent home until November 2017. Furthermore, despite discussing the completion of "an OT ax" in November 2017, the OCF-18 for an occupational therapy assessment and completion of a Form 1 was not submitted to the respondent until January 31, 2018.

[63] The applicant does not make submissions with respect to the length of time between the MIG determination on November 30, 2017, and the submission of the OCF-18 to the respondent for consideration. While the Form 1 was not completed due to the applicant passing in February 2018, I find that the applicant has fallen short of establishing why the Form 1 was not completed immediately after he discovered he may be entitled to ACBs. In other words, regardless of the ambiguity surrounding the applicant's injury classification, I find that the applicant has not established that the respondent is liable to pay for ACBs expenses incurred prior to the completion of the Form 1.

[64] I also distinguish *Botbyl* from the present case because the evidence supports that the applicant was advised of his benefits from the outset of his claim. The adjuster log notes indicate on August 3, 2017, that the applicant was provided with the accident benefits application package and forms. Again, regardless of the applicant's injury classification, the evidence supports he was advised of the various accident benefits.

[65] Finally, the applicant requests relief from forfeiture pursuant to s. 129 of the *Insurance Act,* and/or that the insurer be estopped from insisting upon the completion of a Form 1 prior to paying the incurred expenses for lodging. However, he did not elaborate on the factors the Tribunal should take into consideration in granting this relief. As a result, I find the applicant did not meet his onus in proving that the principle of relief of forfeiture applies.

Conclusion

[66] Given my analysis above, I find that the applicant has not proven, on a balance of probabilities, that he is entitled to reimbursement for lodging/ACB expenses.

The expense for the wheelchair and assistive devices

[67] I find the expenses for the wheelchair and assistive devices are reasonable and necessary, in part.

[68] In the OCF-6, dated May 30, 2022, the applicant sought reimbursement for the following:

Date	Description of Good/Service	Amount
2017-09-18	Wheelchair Rental	$140.00
2017-09-26	Assistive Devices	$295.20
2017-10-16	Assistive Devices for Wheelchair	$692.50
2017-10-18	Wheelchair Rental	$140.00

[69] The applicant submits that he required “the pole” to help him transfer out of bed and the rental of the wheelchair because his injuries prevented him from using a walker. The applicant submits that at the time of the denial, the respondent was already in possession of the medical records explaining why Mr. Fehringer could no longer use his walker after breaking his shoulder, injuring both of his elbows, and could not weight-bear due to his injuries to his hip and knee.

[70] The respondent submits that pursuant to s. 38(2) of the *Schedule*, an insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or assessment that was incurred before it was submitted to the respondent. The respondent submits that the applicant did not put forth any submissions with respect to the exceptions to s. 38(2) under s. 38(2)(c)(ii). The respondent further submits that these expenses exceed the maximum allowance exception of $250.00 and the applicant has not put forth evidence on why an OCF-18 was not submitted prior to approval, despite being represented as of October 2017.

[71] I disagree with the respondent’s position that the applicant has not provided evidence to show that the applicant required a wheelchair rental above and beyond what was being provided at the hospital and full-service retirement home. The receipts for the rental wheelchair are dated September 18, 2017, and October 18, 2017, and the evidence and submissions of the parties suggest that the applicant was no longer in hospital during this time. I have not been pointed to evidence that supports the applicant had free access to a wheelchair at Cedarbrook Lodge. Therefore, given that occupational therapist, Saira Alibhai, at Providence Healthcare requisitioned a wheelchair on August 15, 2017, and noted the applicant to be wheelchair dependent, I find that the wheelchair rental is a reasonable and necessary expense.

[72] However, I agree with the respondent in that the applicant has not directed me to evidence to support that the “assistive devices for wheelchair” are reasonable and necessary. The applicant does not make submissions with respect to the costs of the assistive devices, nor does the applicant make submissions with respect to their use or purpose. As such, I find that there is insufficient information to make a determination on the reasonableness and necessity of the assistive devices for wheelchair in the amount of $692.50.

[73] Lastly, the evidence supports that the reimbursement sought for assistive devices in the amount of $295.00 dated September 26, 2017, is for a “Used health craft Superpole with Super Bar” (“Superpole”) in the amount of $250.00, and “Superpole Installation and Set-up” (“installation fee”) in the amount of $40.00, plus HST. While the respondent submits that the applicant had access to around the clock occupational therapy and personal support worker care at the assisted living home, and therefore the transfer pole is not reasonable and necessary, the evidence supports otherwise. The physiotherapy referral report of Vincent Chan, dated September 15, 2017, indicates that “using a Superpole with Superbar attachment, [the applicant] is able to transfer from bed to chair with one person assisting. Without the Superpole/Superbar, requires Ax2 to transfer.” Mr. Chan identifies transfer goals of increasing ROM and strength of left shoulder and elbow, practice transfers using Superpole, and improve standing balance and tolerance. As such, I find that it is more probable than not that the Superpole is reasonable and necessary expense, even with the assistance of occupational therapist, or personal support workers. The applicant does not make submissions with respect to the cost of the installation/set-up fee. Given that the $40.00 installation fee would exceed the maximum allowable under s. 38(2) of the *Schedule*, coupled with the lack of submissions, I do not find this expense to be reasonable and necessary.

[74] In sum, I find that the applicant has proven, on a balance of probabilities, that the expenses for the wheelchair rental, in the amount of $140.00, and Superpole, in the amount of $250.00 are reasonable and necessary. However, I find that expenses for the installation fee, in the amount of $40.00, and assistive devices for wheelchair, in the amount of $692.50, are not reasonable and necessary.

Death Benefits

[75] Section 26(2)(5) of the *Schedule* states that an insurer shall provide a death benefit payment of $10,000.00 to a person in respect of whom the insured person was a dependant at the time of the accident. Death benefits are claimed by way of a completed OCF-4 by or on behalf of the spouse and dependant(s) of the deceased and any other person entitled to claim for benefits.

[76] In my interpretation of s. 26 of the *Schedule*, neither the deceased applicant nor the estate of the deceased applicant is able to bring an application for death benefits as they could not be the beneficiary of said benefits. The benefits attach to nature and relationship of the insured persons as defined by s. 26(2) of the *Schedule*. That is, the benefit is payable if the applicant seeking payment of the benefit is the spouse, dependent, or any other person entitled to claim for death benefits under the *Schedule*.

[77] As such, I find that the applicant is not entitled to a death benefit.

Funeral Benefits

[78] The applicant submits that, but for the accident which forced him into institutions, he would not have been exposed to the communicable diseased, C-Difficile, that caused his death, nor would he have been vulnerable to it. The applicant further submits that but for the respondent's unreasonable MIG classification, and its failure to assist their unrepresented insureds' access to ACBs, he might have been able to retain attendant care from the comfort of his home. Instead, he was forced into residence at a nursing home where contracting communicable diseases is a known and foreseeable consequence.

[79] The respondent submits that the applicant's death cannot be said to be directly related to the accident, and the applicant has failed to meet the onus of proving same. The respondent argues this is because there is no correlation made in the medical records, nor does the applicant cite any evidence that would support the C-Difficile infection was derived due to the applicant being in a nursing home following the accident.

[80] In his reply submissions, the applicant submits that contracting a hospital-acquired infection is a foreseeable risk of being placed in institutions such as the living facility. The applicant relies on the Court of Appeal decision in *Case v. Pattison*, 2023 ONCA 529 ("*Case*"), wherein it was held that "we must analyze whether the harm suffered was within the risk of harm created by the accident."

[81] Unlike my finding for death benefits, in my interpretation, the language of s. 27(1) does not attach to dependency for the benefit to be payable. Rather, the benefit is payable circumstantially, being that the accident must have caused the death of the insured person. Therefore, while the issue before me pertains to funeral benefits claimed by the deceased, the decision before me hinges on whether the applicant would have passed away "but for" the accident.

[82] Having considered the evidence before me, I find that the applicant has not satisfied the "but for" test.

[83] The "but for" test does not conclusively establish legal causation, the cause that attracts legal liability. As noted in the Court of Appeal in *Chisholm v. Liberty Mutual Group,* 2022 CanLII 45020 (ON CA) ("*Chisholm*"), the purpose of the "but for" test is an exclusionary test which serves to "eliminate from consideration faulty irrelevant causes. It screens out factors that made no difference to the outcome…the but for test does not conclusively establish legal causation." According to *Chisholm,* legal entitlement also "requires not just the use or operation of the car to be a cause of the injuries, but that it be the direct cause".

[84] Both parties make submissions with respect to how C. Difficile disease is contracted, however, submissions are not evidence. I place little weight on internet searches for C. Difficile as evidence, because this is not a medical or expert opinion and, in my view, not credible evidence in proving causation in this case. The applicant does not direct me to a medical opinion or expert evidence, nor is it clear from the evidence where and how the applicant contracted C. Difficile.

[85] More importantly, the applicant has not directed me to evidence that would support a finding that the applicant was medically vulnerable as a direct cause of the accident, such that, but for the accident, he would have contracted a disease like C. Difficile that resulted in his passing approximately 7 months after the accident. I note the applicant's medical history indicates he has anemia, probable myelodysplastic syndrome, dementia, left bundle brank lock, cholecystectomy, and decreased hearing, and had "CCAC", which I interpret to be support from a community case access centre, attend to him 2 times per week. The applicant has not provided any evidence or medical opinion that speaks to C. Difficile and its interaction with his pre-accident conditions. In the same respect, the applicant has not directed me to evidence or medical opinion that would support that he would have been less likely to contract C. Difficile in any other setting of which he ordinarily attended or was exposed to given his age, pre-accident morbidities, and his reliance on healthcare workers at home.

[86] As such, I find that the applicant's representative has made submissions with respect to the role the accident played in causing the applicant's death which are speculative, in that they are not rooted in the medical evidence before me.

[87] I also distinguish *Case* from the present matter because the reasoning relied on in *Case* centres around duty of care, and that is not the correct legal principle to be applied to the within issue.

[88] Given the above, I find that the applicant has not provided sufficient medical information or evidence to establish that but for the accident, the applicant would not have passed away. As such, I find that the applicant is not entitled to a funeral benefit.

Interest

[89] The applicant is entitled to interest on any overdue benefits pursuant to s. 51 of the *Schedule.*

Award

[90] The applicant sought an award under s. 10 of Reg. 664. Under s. 10, the Tribunal may grant an award of up to 50 per cent of the total benefits payable if it finds that an insurer unreasonably withheld or delayed the payment of benefits.

[91] While the applicant does not make submissions with respect to an award in his initial hearing submissions, in his reply submissions, the applicant argues that the insurer failed to request an OCF-4 upon learning of the applicant's passing, never responded to the applicant's OCF-4, and never provided any reason for its denial. The applicant submits that this failure to comply with s. 32(3) was unreasonable and imprudent.

[92] The applicant further submits that it was excessive, imprudent, and unreasonable to have misclassified the applicant as MIG for 6 of the 8 months that he lived after the accident. The applicant submits that this prevented him from obtaining ACBs and completing a Form-1, when the adjuster knew that an OT assessment was needed but failed to coordinate same. Lastly, the applicant submits that it was unreasonable for the insurer to deny paying for the wheelchair rental when he was unrepresented and not informed of the requirement to submit expenses for preapproval through HCAI.

[93] The respondent, in its sur-reply, submits that any delays in attendant care or death benefits were due to the fact that the insurer waited on a Form 1 the applicant's counsel promised but never delivered. The respondent submits that

the insurer waited on updates from counsel for years before it was advised that the applicant had died. The respondent concedes that its only error was not sending out a MIG removal letter at the outset of the claim, however, the respondent submits that this ought to be mitigated by the fact that the applicant's family was advised of same during its initial visit with the claims adjuster.

[94] I am not prepared to grant an award in this matter. While the applicant contends that the respondent misclassified the applicant under the MIG for a period of time prior to the applicant obtaining counsel, and it was unreasonable to deny the wheelchair rental, I find that this is wrong adjusting rather than behaviour that would rise to a level that would substantiate an award. The applicant has not provided any other evidence to indicate that the applicant's injuries were purposefully misclassified.

[95] Moreover, given that I have found the applicant is not entitled to funeral and death benefits, there is no basis for me to grant an award with respect to the circumstances surrounding the OCF-4.

[96] Given the above, I find that the respondent is not liable to pay an award.

COSTS

[97] Rule 19.1 provides that a party may request costs of the proceeding if they believe that the other party has acted unreasonably, frivolously, vexatiously, or in bad faith during the proceedings. Rule 19.4 further sets out the requirements for that request, which must include the reasons for the request and the particulars of the alleged conduct.

[98] The applicant submits that costs should be granted given the respondent's unreasonable conduct including their attempts to capitalize on their failure to comply with s. 32(2); ignoring requests to pay benefits once they were made; and unreasonably misclassifying their extremely vulnerable insured's injuries as MIG when they knew he had an obvious fracture and needed ACBs. The applicant further submits the respondent redacted evidence in the adjuster logs that revealed further evidence of their bad faith.

[99] The respondent submits that is continued to wait on, and follow up for information, from the applicant and was not provided until the claim neared the Case Conference many years after the applicant's death. The respondent submits there is no merit to a claim that it acted unreasonably, frivolously, vexatiously, or in bad faith.

[100] Rule 19.1 may award costs where a party's conduct falls below the standard of reasonableness expected in Tribunal proceedings. The applicant's allegation of the respondent's unreasonable conduct is not related to the conduct of the respondent during the within proceedings. The applicant has also not directed me to evidence of unreasonable behaviour, nor has made submissions, with respect to the respondent's conduct during Tribunal proceedings.

[101] As such, I find that the applicant has not met the test set out in Rule 19.

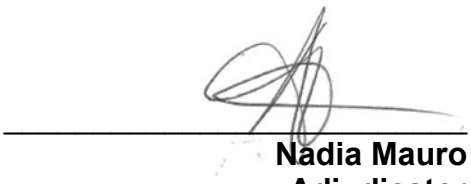
ORDER

[102] I find that:

1. The applicant is entitled to the following as listed on OCF-6 dated May 30, 2022, plus interest, as follows:
    i. $140.00 for a wheelchair rental
    ii. $250.00 for assistive devices (Used HealthCraft Superpole with Super Bar)
    iii. $140.00 for a wheelchair rental
2. The applicant is not entitled to the following as listed on the OCF-6, dated May 30, 2022:
    i. $5,891.00 for lodging
    ii. $4,374.00 for lodging
    iii. $4,334.00 for lodging
    iv. $4,304.00 for lodging
    v. $40.00 for assistive devices (Superpole Installation and Set-up)
    vi. $692.50 for wheelchair assistive devices
3. The applicant is not entitled to a death benefit;
4. The applicant is not entitled to funeral expenses;
5. The applicant is not entitled to ACBs;
6. The respondent is not liable to pay an award; and

7. The respondent is not liable to pay costs.

Released: May 13, 2026



Nadia Mauro
Adjudicator