CITATION: Sparks v. Primmum Insurance Company, 2026 ONSC 3803
DIVISIONAL COURT FILE NO.: 429/25
DATE: 20260720

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

D.L. CORBETT, FAIETA, LEMAY JJ.

BETWEEN:	)	
	)	
LAUREN SPARKS	)	*Alexander M. Voudouris, Tanner Blomme and Steven Glowinsky*, for the Appellant/Applicant
	)	
Appellant/Applicant	)	
	)	
– **and** –	)	*Eric K. Grossman and Jonathan B. White,* for the Respondent Primmum Insurance Company
	)	
PRIMMUM INSURANCE COMPANY and LICENCE APPEAL TRIBUNAL	)	*Valerie Crystal and Olivia Filetti*, for the Respondent Licence Appeal Tribunal
	)	
Respondents	)	**HEARD: November 20, 2025**

REASONS FOR DECISION

FAIETA J.

[1] Section 54 of the *Statutory Accident Benefits Schedule – Effective September 1, 2010*, O. Reg. 34/10 ("*SABS*") states that if an insurer refuses to pay a benefit, then the insurer shall provide the person with a written notice advising the person of his or her right to dispute the refusal or reduction.

[2] Under s. 56 of the *SABS* an application under section 280(2) of the *Insurance Act*, R.S.O. 1990, c. I.8 ("*Insurance Act*"), in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed.

[3] The Appellant/Applicant, Lauren Sparks, appeals and seeks judicial review, of the Decision of Adjudicator Ulana Pahuta of the Licence Appeal Tribunal ("Tribunal"), dated April 28, 2025 [reported at 2025 CanLII 39273 (ON LAT)] ("the Decision") which found that the respondent insurer's notice informing Mrs. Sparks of her right to dispute the partial denial of her application for benefits under the *SABS* complied with the requirements under section 54 of the *SABS* and thereby triggered the commencement of the two-year limitation period under s. 56 of

the *SABS* of her application. Ms. Sparks submits that the insurer's notice did not comply with section 54 of the *SABS* because it did not inform her about her appeal rights up to and including the Supreme Court of Canada. Ms. Sparks also submits that the insurer's notice was misleading as it stated that she had two years from the date of the insurer's refusal to pay to file an application with the Tribunal to dispute the refusal to pay. She states the notice "… should have advised her of the presumptive 2 year limitation from the date of refusal and then added language to address the issue of discoverability and section 7 of the *Licence Appeal Tribunal Act, 1999*, S.O. 1999, c. 12, Sched. G ("*LATA*"), which deals with extending limitation periods." Ms. Sparks asks that the Court quash the Decision, substitute its own decision finding that the Notice did not comply with s. 54 of the *SABS* and that, as result, her application to the Tribunal was not out of time under s. 56 of the *SABS*.

BACKGROUND

[4] On February 6, 2020, Ms. Sparks was involved in a motor vehicle accident. On February 6, 2022, Ms. Sparks submitted an OCF-18 (Treatment and Assessment Plan) in the amount of $17,967.00 for the purpose of preparing an OCF-19 Catastrophic Impairment Assessment, and obtaining various assessments in support of such claim.

[5] By letter dated February 15, 2022, the respondent insurer notified Ms. Sparks that it had partially approved the OCF-18 in the amount of $14,577.00 and that it refused to pay the balance of her claim. The letter was accompanied by a form entitled "Your Right to Dispute the Insurance Company's Determination of Your Claim for Statutory Benefits". This form states:

> Under the Insurance Act, if your claim for statutory accident benefits has been reduced or denied by your insurance company, **you have a right to dispute your insurance company's determination.**
>
> If you do not agree with the insurance company's decision you may file an application with the Licence Appeal Tribunal (LAT) – Automobile Accident Benefits Service (AABS) within 2 years of the date of reduction or denial.
>
> **WARNING: TWO YEAR LIMIT**
>
> **You have TWO YEARS from the date of your insurance company's refusal to pay, or reduction of a benefit, to file an application with the Licence Appeal Tribunal – Automobile Accident Benefits Service. If you do not apply within two years, you will lose the right to dispute the determination.**
>
> Your insurance company may have an internal complaint review system. While you are encouraged to work with your insurance company to settle your complaint, be warned that it does not extend the two year time limit to make your claim.
>
> **HOW TO FILE AN APPLICATION TO THE LICENCE APPEAL TRIBUNAL – AUTOMOBILE ACCIDENT BENEFITS SERVICE**
>
> To file an application you must complete the following steps:

1. Complete an AABS **Application by an Injured Person** (the "application")

2. Send a copy of the application to the insurance company (this is called "serving" the other party)

3. Complete an **AABS Certificate of Service** to explain how you have sent the copy of the application to the other party; and

4. Submit the completed application and the Certificate of Service to AABS and pay the AABS application fee. …

[6] On April 13, 2023, Ms. Sparks filed an application that disputed the partial denial of benefits. On May 1, 2024, the first of the hearing before the Tribunal, Ms. Sparks unilaterally withdrew her application without any pre-conditions and without an agreement to toll the limitation period.

[7] On July 30, 2024, and more than two years after receiving notice of the respondent's partial denial of benefits, Ms. Sparks submitted an application to the Tribunal which disputed the respondent's denial to pay $3,390.00 in benefits.

[8] A hearing was held to determine the preliminary issue of whether Ms. Sparks had filed his application beyond the two year limitation mandated by s. 56 of the *SABS*.

[9] Ms. Sparks submitted that the insurer's notice of refusal did not comply with s. 54 of the *SABS* in that it did not:

(a) Notify the insured of her additional right to a reconsideration, judicial review and/or appeal to the Divisional Court, followed by an appeal to the Court of Appeal and then to the Supreme Court of Canada along with applicable timelines and contact information for those courts.

(b) Notify the insured of the issue of discoverability and section 7 of the *LATA.*

[10] To remedy these two concerns, Ms. Sparks submits that the notice of refusal should have contained the language italicized below:

> Under the Insurance Act, if your claim for statutory accident benefits has been reduced or denied by your insurance company, **you have a right to dispute your insurance company's determination**.
>
> If you do not agree with the insurance company's decision you may file an application with the Licence Appeal Tribunal (LAT) – Automobile Accident Benefits Service (AABS) within 2 years of the date of reduction or denial.
>
> **WARNING: TWO YEAR LIMIT**
>
> **You have TWO YEARS from the date of your insurance company's refusal to pay, or reduction of a benefit, *and when you knew or ought to have known you otherwise***

were entitled to the benefits being refused or reduced, **to file an application with the Licence Appeal Tribunal – Automobile Accident Benefits Service. If you do not apply within two years, you will lose the right to dispute the determination.**

Your insurance company may have an internal complaint review system. While you are encouraged to work with your insurance company to settle your complaint, be warned that it does not extend the two year time limit to make your claim.

HOW TO FILE AN APPLICATION TO THE LICENCE APPEAL TRIBUNAL – AUTOMOBILE ACCIDENT BENEFITS SERVICE

To file an application you must complete the following steps:

1. Complete an **AABS Application by an Injured Person** (the "application")

2. Send a copy of the application to the insurance company (this is called "serving" the other party)

3. Complete an **AABS Certificate of Service** to explain how you have sent the copy of the application to the other party; and

4. Submit the completed application and the Certificate of Service to AABS and pay the AABS application fee. …

Should you disagree with the outcome of a Licence Appeal Tribunal decision concerning your entitlement to Accident Benefits, you have the right to seek a Reconsideration form the Licence Appeal Tribunal, of the decision within 21 days from the date of the decision. You also have the right to seek Judicial Review and/or an Appeal of the decision, including the Reconsideration decision, to the Ontario Superior Court of Justice – Divisional Court. Both an Appeal and Judicial Review must be commenced within 30 days of the decision you are challenging.

Should you disagree with any Appeal or Judicial Review decision of the Divisional Court, you may seek permission to appeal to the Court of Appeal for Ontario within 30 days of the date of the decision. Should permission be granted, you can appeal to the Divisional Court and LAT decisions to the Court of Appeal.

Should you disagree with the Court of Appeal decision, you may seek permission to appeal to the Supreme Court of Canada within 30 days of the decision. If you are granted permission, you can appeal the Court of Appeal, Divisional Court and LAT decisions to the Supreme Court of Canada.

The contact information of the Divisional Court, Court of Appeal and the Supreme Court of Canada

Divisional Court
Osgoode Hall
130 Queen Street West W.

Toronto, ON M5H 2N5
Telephone: 416-327-5100
Website: https://www.ontariocourts.ca/scj/divisional-court/

Court of Appeal for Ontario
Osgoode Hall
130 Queen St. W.
Toronto, ON M5H 2N5
Telephone: 416-327-5020
Website: https://www.ontariocourts.ca/coa/

Supreme Court of Canada
301 Wellington St.
Ottawa, ON K1A 0J1
Telephone: 1-888-551-1185
Website: https://www.scc-csc.ca/home-accueil/index-eng.aspx

STANDARD OF REVIEW

[11] An appeal from a decision of the Tribunal relating to a matter under the *Insurance Act* may be made on a question of law alone: See *LATA*, s. 11(3). On an appeal from a decision of an administrative tribunal, appellate standards of review apply. Thus, on a question of law, the standard of correctness applies: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at para. 37.

[12] The question of whether the notice provided by the insurer to Ms. Sparks complies with the requirements of section 54 of the *SABS* is a question of mixed fact and law. However the dispute regarding the content of the notice required by section 54 of the *SABS* raises an extricable question of law that is subject to the statutory appeal.

[13] On an application for judicial review, the presumptive standard of review for questions of fact or mixed fact and law is reasonableness. The parties agree that the standard of review on this application for judicial review is reasonableness. A decision is reasonable where the decision is transparent, internally coherent, displays a rational chain of analysis, and is supported in relation to the facts and the law that constrain the decision-maker.

[14] In *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, the Supreme Court of Canada described the scope of a reasonableness review, at paras. 15, 68 and 85, as follows:

> [15] In conducting a reasonableness review, a court must consider the outcome of the administrative decision in light of its underlying rationale in order to ensure that the decision as a whole is transparent, intelligible and justified. What distinguishes reasonableness review from correctness review is that the court conducting a reasonableness review must focus on the decision the administrative decision maker actually made, including the justification offered for it, and not on the conclusion the court itself would have reached in the administrative decision maker's place. …

> [68] Reasonableness review does not give administrative decision makers free rein in interpreting their enabling statutes and therefore does not give them licence to enlarge their powers beyond what the legislature intended. Instead, it confirms that the governing statutory scheme will always operate as a constraint on administrative decision makers and as a limit on their authority. Even where the reasonableness standard is applied in reviewing a decision maker's interpretation of its authority, precise or narrow statutory language will necessarily limit the number of reasonable interpretations open to the decision maker — perhaps limiting it one. Conversely, where the legislature has afforded a decision maker broad powers in general terms — and has provided no right of appeal to a court — the legislature's intention that the decision maker have greater leeway in interpreting its enabling statute should be given effect. …
>
> [85] Developing an understanding of the reasoning that led to the administrative decision enables a reviewing court to assess whether the decision as a whole is reasonable. As we will explain in greater detail below, a reasonable decision is one that is based on an internally coherent and rational chain of analysis and that is justified in relation to the facts and law that constrain the decision maker. The reasonableness standard requires that a reviewing court defer to such a decision.

ISSUES

[15] This appeal and application for judicial review raise the following issues:

(1) Did the Adjudicator err in finding that a notice under s. 54 of the *SABS* does not require that an insurer notify a claimant of every step of the reconsideration and appeal process, nor provide timelines and contact information for the various Courts?

(2) Did the Adjudicator err in finding that the Notice under s. 54 of the *SABS* was not misleading?

ISSUE #1: DID THE ADJUDICATOR ERR IN FINDING THAT A NOTICE UNDER SECTION 54 OF THE *SABS* DOES NOT REQUIRE THAT AN INSURER NOTIFY A CLAIMANT OF EVERY STEP OF THE RECONSIDERATION AND APPEAL PROCESS, NOR PROVIDE TIMELINES AND CONTACT INFORMATION FOR THE VARIOUS COURTS?

[16] In her Decision, the Adjudicator states:

> [15] With respect to outlining every step of the dispute resolution and appeal process, including timelines and contact information for the various Courts, I note that s.54 of the Schedule requires that an insurer provide a written notice advising the claimant of their right to dispute the refusal. It does not mandate specifics of every step of the reconsideration and appeal process. The applicant argues that a broad and liberal interpretation of s. 54 requires that an insurer must "do much more than simply quote the act" or provide information on the first step of the process. However, the applicant has not provided any support for this position, by way of a Tribunal or Court decision.

> [16] Rather the applicant argues that all of the decisions that followed *Smith v. Cooperators* were incorrectly decided. With respect, I disagree with the applicant's position. I do not see anything in the Schedule or caselaw that requires that the complete chronology of the dispute resolution process be articulated to an insured in a denial letter. While the Supreme Court of Canada in *Smith* held that an insurer is required to inform the person of the dispute resolution process, I do not see in Smith a requirement that the entire appeal process be detailed.
>
> [17] I further am persuaded by the decisions cited by the respondent that a denial notice is compliant if the insured person has enough information to decide whether to accept or dispute the refusal. I agree with the reasoning in *18-004416 vs. Intact Insurance Company*, 2019 CanLII 34593 (ONLAT), where the Tribunal held that providing information "sufficient to trigger action by the applicant is, in my view, the key point of disclosure [of the dispute resolution process]."

[17] Ms. Sparks submits that that the content of the Notice does not protect consumers as it does not inform a claimant of the opportunity to request a reconsideration under the Tribunal's Rules, the right to appeal under the *LATA* and/or file an application for judicial review with the Divisional Court, the right to appeal to the Ontario Court of Appeal and then to the Supreme Court of Canada, along with information regarding all applicable timelines and contact information for the Courts.

[18] This case raises the issue of the proper interpretation of s. 54 of the *SABS*. In *Arts (Litigation Guardian of) v. State Farm Insurance Co*., [2008] O.J. No. 2096, R, MacKinnon, J. stated at para. 16:

> The *SABS* are remedial and constitute consumer protection legislation. As such, they are to be read in their entire context and in their ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of the legislature. The goal of the legislation is to reduce the economic dislocation and hardship of motor vehicle accident victims and as such, assumes an importance which is both pressing and substantial.

[19] The above statement was approved by the Ontario Court of Appeal in *Tomec v. Economical Mutual Insurance Company*, 2019 ONCA 882, 148 O.R. (3d) 438, at para. 42.

[20] In *Smith v. Co-operators General Insurance Co.,* 2002 SCC 30, the Supreme Court of Canada considered s. 71 of O. Reg. 776/93 which was the predecessor to s. 54 of the *SABS*. At time, under s. 281(1) of the *Insurance Act* a claimant for accident benefits that disputed an insurer's refusal to pay benefits could commence a proceeding in a court, refer the issues to an arbitrator under s. 282, or with the insurer agree to an arbitration under the Arbitrations Act, 1991. This first step of the dispute resolution process was mediation as s. 281(2) prohibited the commencement of any such steps unless mediation had been sought and failed. Section 281(5) provided that any such step "must be taken within two years after the insurer's refusal to pay the benefit claimed …".

[21] Section 71 of O. Reg. 776/93 stated:

> If an insurer refuses to pay a benefit that a person has applied for under this Regulation or reduces the amount of a benefit that a person received under this Regulation, the insurer shall inform the person in writing of the procedure for resolving disputes relating to benefits under section 279 to 283 of the Insurance Act. [Emphasis added]

[22] In *Smith*, the insurer notified the applicant that it had terminated accident benefits and further advised the applicant that "… you have the right to ask for mediation through the Ontario Insurance Commission. …". The mediation was held and failed. The applicant issued a statement of claim more than two years after the insurer's termination of benefits. The Court held that the applicant's claim was not time-barred by s. 281(5) as no proper refusal had been made and thus the limitation period had not begun to run. The Court, at paras. 14-15, stated:

> In my opinion, the insurer is required under s. 71 to inform the person of the dispute resolution process contained in ss. 279 to 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, that 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.
>
> Given that s. 71 of the *SABS* imposes a requirement to inform the claimant of the dispute resolution process as discussed above, and given that the respondent only informed the appellant of the first step of this process, a proper refusal cannot be said to have been given. Since a proper refusal was not given, and since the limitation period under s. 281(5) of the *Insurance Act* only begins to run upon a refusal, that limitation period was not triggered by the notice sent on May 8, 1996. [Emphasis added]

[23] Before April 1, 2016, the Financial Services Commission of Ontario ("FSCO") was empowered to resolve statutory accident benefits disputes through mediation and then arbitration. Under the *Insurance Act*, a claimant who wished to dispute the refusal of an application for accident benefits was required to attend mediation. If mediation failed, a claimant could commence a court proceeding, or refer the dispute to an arbitration at FSCO, or with the agreement of insurer, submit the dispute to any person for arbitration under the Arbitration Act, 1991.

[24] Amendments to the *Insurance Act* that took effect on April 1, 2016, simplified the dispute resolution by eliminating mediation, litigation and private arbitration as avenues for disposition. The process to dispute accident benefits now only requires that the claimant submit an application to the Tribunal to hear the dispute.

[25] To reflect the current dispute resolution process, se. 71 of O. Reg. 776/93 was replaced with s. 54 of the *SABS* which states:

> If an insurer refuses to pay a benefit or reduces the amount of a benefit that a person is receiving, the insurer shall provide the person with a written notice advising the person of his or her right to dispute the refusal or reduction. [Emphasis added]

[26] Ms. Sparks submits that, given its language, the notice requirements under s. 54 of the *SABS* is broader than its predecessor, s. 71 of O. Reg. 776/93. She submits that the scope of the notice required by section 71 was limited to dispute resolution process at FSCO rather than the entire dispute resolution process available to an insured. As such the "guardrails" on the notice created by the phrase "procedure for resolving disputes relating to benefits under section 279 to 283 of the *Insurance Act*" are not found in s. 54 of the SABS with the result that the notice "must encompass every level of dispute process, including appeals and judicial reviews to the Court".

[27] There is little merit to this submission.

[28] In advocating for the inclusion of a description of all possible avenues of reconsideration, appeal and review, Ms. Sparks overstates the effect of the consumer protection purpose of the *SABS* given the clear and unambiguous language in s. 54 of the *SABS*.

[29] Section 54 only requires an insurer to provide notice of the "right to dispute the refusal …" The only "right to dispute the refusal" to pay accident benefits is found in s. 280(2) of the Insurance Act which states that a claimant may apply to the Tribunal to resolve a dispute. The availability of reconsideration under the *LATA* and the avenues for appeal and judicial review do not amount to a "right to dispute" the insurer's refusal to pay accident benefits but rather represent a right to dispute an Adjudicator's decision or a Court's decision that follow an insurer's refusal to pay accident benefits. The absence of the so-called "guardrails" on s. 54 does not change this analysis.

ISSUE #2: DID THE ADJUDICATOR ERR IN FINDING THAT THE NOTICE UNDER SECTION 54 OF THE *SABS* WAS NOT MISLEADING?

[30] The Notice states, in bold font, that:

> **You have TWO YEARS <u>from the date of your insurance company's refusal to pay</u>, or reduction of a benefit, to file an application with the Licence Appeal Tribunal – Automobile Accident Benefits Service. <u>If you do not apply within two years, you will lose the right to dispute the determination</u>.** [Underlining added]

[31] In her Decision, the Adjudicator states:

> [18] In terms of the proposed additional language relating to discoverability and s. 7 of the LAT Act, the applicant again does not provide any caselaw in support of her position that a denial notice is misleading and incorrect when it states that a claimant has two years from the date of the denial to file an application with the Tribunal. Rather, she proposes additional language including that the applicant has two years from "when you knew or ought to have known you were otherwise entitled to the benefits being refused" and that if the limitation period was missed, "in very rare and exceptional cases, the Licence Appeal Tribunal may grant an extension".
>
> [19] I am not persuaded that the principles in *Smith* require the additional language relating to discoverability and s. 7 of the LAT Act. <u>The additional descriptive language proposed by the applicant imposes a higher standard than that mandated by the Legislature and Courts.</u> <u>I agree with the decisions cited by the respondent that a standard of perfection is</u>

> not required, and that the purpose of the denial notice was to ensure whether the applicant had sufficient information to decide whether to accept or dispute the refusal. I find that the EOB [Explanation of Benefits] dated February 15, 2022 satisfied this requirement.

[32] In her Notice of Application for Judicial Review, Ms. Sparks states:

> … the insurer's Refusal Notice ("Notice") was misleading in that it stated there was a hard 2-year limitation period to file an Application with the LAT disputing the denial. In reality, the 2-year limitation only begins running upon the discoverability of a cause of action. Ms. Sparks' position was that the Notice should have advised her of the presumptive 2-year limitation from the date of refusal and then added language to address the issue of discoverability and s. 7 of the LAT Act which deals with extending limitation periods.

[33] Given that the Adjudicator accepted the Insurer's reasoning, I repeat the Insurer's submissions to the Adjudicator on this point:

> … the purpose of the notice requirement is to ensure whether the person has enough information to decide whether to accept or dispute the refusal and to trigger action. The additional information, including … information on discoverability ands. 7 of the LAT Act, holds the respondent to a standard of perfection that the Court of Appeal in *Turner* [*Turner v. State Farm Mutual Automobile Insurance Co.*, [2005] O.J. No. 351 (C.A.)] determined was not required. [Emphasis added]

[34] The Adjudicator erred in their description of the purpose of s.54 of the *SABS* by relying on *Turner*. *Turner* is distinguishable. That case did not deal with an insurer's obligation to provide notice of a claimant's right to dispute an insurer's refusal to pay benefits. A different obligation to provide notice was addressed. The issue in *Turner* was whether the insurer had given sufficient reasons for cancelling accident benefits under s. 24(8) of the *SABS* as it then existed. The Ontario Court of Appeal held that the notice was sufficient to trigger the limitation period even if the reasons were not legally correct.

[35] As explained in *Turner*, at para. 8, the purpose of the notice of the requirement under s. 24(8) of the *SABS* may have been to ensure that a claimant has enough information to decide whether or not to dispute the refusal, whereas the purpose of notice under s. 54 of the *SABS* is to "completely and clearly provide insured persons with the information needed to enable them to challenge the refusal to pay or the reduction of payment": *Smith*, para. 9.

[36] The obligation under s. 54 of *SABS* for an insurer to provide "… written notice advising the person of his or her right to dispute the refusal …" of a claim for accident benefits requires an insurer to provide information on how and where to file a dispute but also when to file a dispute. The Notice addressed how, where and when to file a dispute. Information about when to file a dispute does not require an insurer to meet a standard of perfection but simply meet the standard expressed in *Smith*, at para. 14, that information about "the relevant time limits that govern the entire [dispute] process" is required to be provided by an insurer.

[37] Ms. Sparks submits that the statement in the Notice that she "will" lose the right to dispute the insurer's denial of her claim for accident benefits if she does not file an application with the

Tribunal within 2 years of the date of the refusal to pay accident benefits is incorrect and misleading.

[38] The Insurer disputes that the 2 year time limit under s. 56 of the *SABS* is subject to the principle of discoverability as outlined in *Tomec v. Economical Mutual Insurance Company*, 2019 ONCA 882. However, this point was settled by the Ontario Court of Appeal in *The Personal Insurance Company v. Tagoe*, 2024 ONCA 894. At paragraph 18, the Ontario Court of Appeal states:

> As a starting point, we accept TPIC's concession that the discoverability rule applies to IRB claims. Claims for *SABS* benefits, whether during the 104 weeks after an accident or later, are now both subject to the two-year limitation period in s. 56 of the *SABS*. This provision is essentially similar to the former s. 51(1), which this court held in *Tomec* did not establish a hard limitation period. [Emphasis added]

[39] The Insurer suggests that no harm would come from telling a claimant that there is a hard two-year limit on filing an application.

[40] While the application of the discoverability principle to an accident benefit claim may infrequently postpone the commencement of the two-year limitation period, there are circumstances where it has had such effect such as a case where the injuries from an accident become worse over time after an initial denial of a claim: See *Pena v. Allstate Insurance Company of Canada*, 2021 CanLII 117443.

[41] The Insurer further submits that Ms. Sparks' proposed language for a s. 54 notice would be confusing and cause more harm than good. That may be the case, however, the obligation rests with an insurer under s. 54 to communicate in straightforward and clear language that communicates that a claim for accident benefits must be filed within two years from the date of denial. Just as it is not incumbent on the insurer to advise of the complete course of potential reviews and appeals that could be sought from a LAT decision, it is not incumbent on an insurer to brief a claimant on principles of limitations law. If it was thought that advising a claimant that claims "may" be barred, rather than that they "will" be barred if the two-year deadline is not met, the information might be considered more complete and accurate, but it would run the risk of misleading some claimants into thinking that there is a flexibility to the limitation period that does not, in fact, exist. To provide a more detailed explanation of the principles of discoverability and tolling of limitation periods would detract from the clarity of the warning. When it is recalled that the limitation period commences with the denial of the claim – which is the very same document that includes the deadline to dispute the claim – the risk of confusion should be evident. I would conclude that the LAT's decision meets the consumer protection goal of s. 54, and that the alternatives proposed by the Appellant do not meet those goals as effectively.

[42] Although the Adjudicator erred in her reliance on *Turner,* it was reasonable for the Adjudicator to find that the Insurer's Notice complied with the requirements of section 54 of the SABS.

CONCLUSIONS

[43] The appeal and application for judicial review are dismissed. No costs are ordered as none of the parties seek their costs.

Faieta J.

Faieta J.

I agree:

D.L. Corbett J.

I agree: _____

LeMay J.

Released: July 20, 2026

DIVISIONAL COURT FILE NO.: 429/25
DATE: 20260720

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SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

D.L. CORBETT, FAIETA, LEMAY JJ.

BETWEEN:

LAUREN SPARKS

Appellant/Applicant

– **and** –

PRIMMUM INSURANCE COMPANY

Respondent

REASONS FOR DECISION

FAIETA J.

Released: July 20, 2026