IN THE MATTER OF SECTION 268(2) OF THE *INSURANCE ACT,* R.S.O. 1990, AND *ONTARIO REGULATION 283/95, AS AMENDED BY REGULATION 38/10*

AND IN THE MATTER OF THE *ARBITRATION ACT,* S.O. 1991, c.17

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

AVIVA INSURANCE COMPANY

Applicant

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO, as represented by THE MINISTRY OF PUBLIC AND BUSINESS SERVICE DELIVERY (aka Motor Vehicle Accident Claims Fund) and CERTAS HOME AND AUTO INSURANCE COMPANY

Respondents

DECISION

COUNSEL:

Nathalie V. Rosenthall for the Applicant, Aviva

Mark A. MacNeill for the Respondent, MVACF

Stephanie Charikar for the Respondent, Certas

BACKGROUND:

1. GR was struck as a pedestrian by a vehicle driven by Sean L on June 15, 2021. She was sixty-four years old at the time. She suffered serious injuries and spent a few months in hospital, following the accident.

2. Ms. R lived with her daughter, son-in-law and their three children in Oshawa, Ontario at the time of the accident. She had immigrated to Canada from Hungary in 2012 in order to assist the family with childcare. Two of her grandchildren are severely disabled. Ms. R's son-in-law was a named insured on a policy issued by Certas Home and Auto Insurance ("Certas") at the time of the accident. The Claimant did not have a driver's licence at the time.

3. The vehicle that struck Ms. R had belonged to Susan L, the spouse of Sean L, who was driving the vehicle at the time of the accident. Susan had been the named insured under a policy issued by Aviva Insurance Company ("Aviva"). She passed away in December 2019, approximately eighteen months before the accident. Sean L contacted Aviva in early January 2021, over one year after Susan had died, and about six months before the accident, to discuss coverage under the policy.

4. The Claimant applied to Aviva for payment of benefits under the *SABS*. Her claims have now been settled on a full and final basis. Counsel advised that the total amount paid to Ms. R is over $1.1 million dollars.

5. Aviva contends that its policy was cancelled in January of 2021 before the accident took place, and that it was therefore not in effect at the time. It sent a Notice of Dispute Between Insurers to the Motor Vehicle Accident Claims Fund ("the Fund") on August 13, 2021, and subsequently commenced arbitration against the Fund in June 2022.

6. I was retained to arbitrate the dispute and convened an initial pre-hearing call in late August 2022. Productions were exchanged and Sean L was examined under oath. A further pre-

hearing was convened in October 2023, at which time the Fund advised that it would be bringing Certas into this dispute. The Fund and Aviva contend that the Claimant was financially dependent on her son-in-law at the time of the accident, and that Certas is accordingly in higher priority to pay the claim.

7. Aviva subsequently issued a second Notice of Commencement of Arbitration on November 30, 2023, directed to the Fund and Certas. Certas appointed counsel and participated in further pre-hearing calls in July 2024, June 2025, December 2025 and January 2026. An Examination Under Oath of the Certas insured and his wife was held in late 2025.

8. A further pre-hearing was convened in February 2026, approximately six weeks before the scheduled arbitration date. Counsel for Certas advised during that call, for the first time, that she would be advancing the argument that Aviva had not complied with its duty under section 3.1(2) of *Regulation 283/95* to complete a reasonable investigation in order to determine if any other insurers were in priority before putting the Fund on notice. Certas argues that if Aviva's notice to the Fund was invalid, then by extension, the notice provided by the Fund to Certas is also invalid. The parties agreed that they would exchange written submissions on all of the issues outlined above, and would also make oral submissions. These took place at a hearing conducted via videoconference on March 31, 2026.

ISSUES IN DISPUTE:

The following issues are identified as being in dispute in the parties' Arbitration Agreement :

1. Has Aviva complied with the requirements in sections 3 and 3.1 of *Regulation 283/95* to the *Act,* and if not, what are the consequences?

2. Was the Claimant principally dependent for financial support on her son-in-law, the Certas insured, at the time of the accident ?

3. Did Aviva comply with the Statutory Conditions in *Regulation 777/93* with regard to cancelling its policy, or was the policy that covered the vehicle that struck the Claimant still in effect at the time of the accident ?

RESULT:

1. No, Aviva has not complied with the requirements in section 3.1 of *Regulation 283/95.* It must accordingly reimburse the Fund for all of its costs and expenses, and pay a $10,000 penalty.

2. Yes, the Claimant was principally dependent for financial support on the Certas insured at the time of the accident.

3. Given my finding above, I need not decide this issue.

THE EVIDENCE:

9. Each party filed a separate Document Brief containing various documents and forms. In sum, I received the notices filed in the context of this dispute, as well as the OCF 1 form submitted to Aviva. Transcripts from Examinations Under Oath conducted of the Claimant, her daughter, her son-in-law and Sean l., the driver of the car that struck the Claimant, were also filed. Aviva filed a copy of the Notice of Cancellation it sent to Sean L on January 13, 2021, as well as transcripts of three phone calls he had with an Aviva representative around that time. I also received the underwriting notes related to the Aviva policy and a copy of Aviva's adjusting log notes spanning the period of its investigation.

10. The evidence relating to each of the three issues identified above is lengthy, but distinct. I will accordingly summarise the key facts relating to each issue separately.

Aviva's priority investigation (section 3.1 of regulation)

11. As noted above, this issue was raised by Certas late in the process, well after the hearing date was set. Aviva was asked to produce a copy of its adjusting log notes to the other parties shortly before the hearing, and it is these notes that form the basis for the arguments on this issue. No Examinations Under Oath were requested or conducted of any Aviva representatives involved in the priority investigation conducted.

12. The adjusting notes reveal that an application for benefits was submitted to Aviva on the Claimant's behalf on June 28, 2021. The first adjuster, CH, reviewed the application on June 30, and called the Claimant's representative to obtain more information. Before doing so, he came to understand that the Aviva policy had been cancelled six months before the accident. His notes after his initial review state – "Will conduct Autoplus on insured to verify if another insurer exists. If so, will put them on notice for priority. If not, will have to put MVAC on notice for priority".

13. The adjuster then spoke to the Claimant's representative. He was advised that Ms. R was struck as a pedestrian, and was still in the hospital. She was seriously injured and was at risk of having her leg amputated. The notes documenting the discussion state – "Pedestrian lives with her son and daughter-in-law and looks after 3 grandchildren, two of which are disabled. Will have rep investigate if the pedestrian is a dependent of her son".

14. The next entry, also on June 30, 2021, reproduces an email sent by the adjuster to the Claimant's representative. He requested a copy of the police report so that the driver of the vehicle could be identified, and advised that the Aviva policy had been cancelled prior to the accident. He also stated:

> *In addition, you had indicated that your client lives with her son and daughter-in-law on the date of loss. Can you please address the following:*
>
> 1. *Please confirm if your client is a named insured or listed driver on any auto policy at the time of this loss.*
>
> 2. *If she is not a listed driver, is she a dependent of her son and daughter-in-law?*
>
> 3. *You advise that she takes care of her grandchildren before this accident. What financial arrangements(s) have been arranged in this regard? Does she pay rent and if so, how much and for how long?*

The log notes that follow reference a few internal administrative steps, and a further note, dated July 5th states – "contact with insured completed", but provides no further details.

15. The claim appears to have been transferred to another Aviva adjuster (CB) on July 13th. A note logged on that day confirms that CB called the Claimant's representative to introduce herself and to advise that the file had been transferred. She left a message and requested a call back to discuss "claim status and inquire re medicals ordered". There is no reference to anything related to the dependency inquiries sent earlier.

16. Subsequent notes outline that steps were taken to conduct a license plate search on the Claimant and an Autoplus search on the vehicle that struck her. An entry on July 13 states "notice of dispute to be sent to identified company and/or Motor Vehicle Accident Claims Fund, if no other insurance identified".

17. On August 3rd, the adjuster logs a call to counsel for Ms. R. Her note states – "informed counsel that this is a non-valid policy and therefore likely AB claim will be transferred upon completion of the Priority Investigation".

18. The next note appears ten days later, on August 13, 2021, confirming that a Notice of Dispute was faxed to the Fund. I note that this was only 46 days after the OCF 1 form was submitted to Aviva, or approximately half way through the 'ninety-day period' for providing notice to another insurer. The Notice advises that the Fund is in priority to pay the claim, as Aviva's policy was cancelled on January 13, 2021 and was accordingly not in effect at the time of the accident. It also states that Aviva's investigation confirms "that no other policy was in effect that insures the vehicle involved in the accident. In addition, there is no other policy for the Claimant to access benefits".

19. The adjusting notes do not contain any further references to steps taken or inquires made regarding the Claimant's potential financial dependency on the Certas insured. No documentation or statements were sought from the Claimant or any other family members, and no Examinations Under Oath were requested.

Potential financial dependency on Certas insured

20. As noted above, the evidence indicates that the Claimant lived with her daughter, son-in-law and three grandchildren at the time of the accident. Two of the children in the family suffer from Muscular Dystrophy. Ms. R came to Canada from Hungary in 2012 to assist with the care of her grandchildren. She had no assets or savings, and has not worked outside of the family's home since arriving in Canada. She has a grade eight education and very limited English skills.

21. The evidence indicates that Ms. R received approximately $700 month in social assistance payments at the time of the accident. She also collected COVID related benefits provided by the federal government during 2020. These funds were 'pooled' for the family's use. Aside from this, Ms. R did not contribute to the household expenses such as groceries, utility bills, or mortgage payments. The Claimant's son and daughter-in-law both worked outside of the home, and the evidence suggested that their joint monthly income was between $6,500 and $8,000.

22. The Claimant, her daughter and her son-in-law were all examined under oath as this proceeding progressed. The evidence from these examinations makes it clear that Ms. R relied on her daughter and son-in-law to meet her financial needs. They paid for her food, clothing, television and internet, hair styling and cell phone expenses. When asked whether she could have lived independently "from a financial perspective", both the Claimant and her daughter stated that she could not have done so.

23. Certas contends that the level of caregiving services provided by the Claimant went beyond the usual child care provided by a grandparent, and had significant monetary value to the family. Evidence from the examinations conducted revealed that Ms. R often spent sixteen hours per day looking after the children, providing physical care, helping them eat, dress and do the daily exercises they were required to do. After the Claimant was injured in the accident and could no longer care for the grandchildren, her daughter proceeded to hire her niece, who is a nurse, to help her provide care for the children. Her niece was paid approximately $1,500 per month, and spent on average three days each week providing care.

24. The transcripts from the Examinations Under Oath conducted contain statements by the Claimant and her family members regarding whether a "financial bargain" was struck by the parties in return for the assistance provided. When asked whether she was ever paid for the caregiving that she provided to her grandchildren, Ms. R stated "…I looked after them out of love…my main thing is their welfare and my daughter and son-in-law, of course, look after my needs".

25. The daughter was asked at her EUO whether an "arrangement" was reached with her mother when she came to Canada, such that her mother could live at their house for free, in exchange for her providing care for her children. Her daughter stated – "in our culture there is no such thing as having an arrangement as you just mentioned. It comes out of the love out of their hearts to help a family member if it is necessary…".

26. Counsel advised that the Low Income Cut-Off ("LICO") figure for a one-person household in the Oshawa area in 2021 was $19,283, and the Market Basket Measure ("MBM") figure for the same time period was $22,170.

Cancellation of Aviva policy

27. Aviva issued a motor vehicle liability policy to Susan L. some time in 2018, providing coverage for a 2012 Kia Sportage. Susan passed away in December 2019. The ownership of that vehicle then passed to her husband, Sean L. He had a "G1 licence" at the time of the accident.

28. The evidence indicates that Sean L had a few telephone conversations with a representative from RBC (now Aviva) on January 12, 2021, approximately six months before the accident. Transcripts of three of these conversations were produced by Aviva. The conversations are difficult to follow. The parties discuss various aspects of the cancellation and reissuance of a policy insuring the home Sean L lived in, and the cancellation and reissuance of the policy covering the Kia Sportage, the ownership of which had been transferred to him. The timeline is unclear

and the last discussion suggests that a further phone call would take place. No further phone logs or transcripts have been provided.

29. Aviva has produced a Notice of Cancellation addressed to Sean L, dated January 13, 2021. It states:

> *We have received your recent request to cancel your policy. This is to confirm that your policy has been cancelled effective January 13, 2021 at 12:01 am. Your outstanding balance is $0.00.*

30. Mr. L was also examined under oath in December 2022, after the Priority Dispute was commenced. Much of the evidence he provided is inconsistent with what is contained in the "call logs" filed by Aviva. Notably, he was asked about the discussions he had had with the Aviva representative regarding the cancellation of his wife's policy on January 12, 2021, and he denied that he had consented to the policy being cancelled. He stated "I would never cancel my insurance and not …without having a new one in place".

RELEVANT PROVISIONS:

The following statutory and regulatory provisions were referenced by the parties in their submissions:

Insurance Act

> ***268*** *(2) The following rules apply for determining who is liable to pay statutory accident benefits:*
>
> *2. In respect of non-occupants,*
>
> *i. the non-occupant has recourse against the insurer of an automobile in respect of which the non-occupant is an insured,*
>
> *ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,*

iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to statutory accident benefits arose,

iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund

Ontario Regulation 283/95

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 under that section. O. Reg. 283/95, s. 3 (1).*

(1.1) If the dispute relates to an accident that occurred on or after September 1, 2010, a notice required under subsection (1) must also be given to the Fund if the insurer claims the Fund is required to pay benefits.

3.1 *(1) This section applies to disputes relating to accidents occurring on or after September 1, 2010.*

(2) Before giving a notice to the Fund under section 3, an insurer must,

(a) complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund; and

(b) provide particulars to the Fund of the investigation and the results of the investigation.

7. *(6) If the dispute relates to an accident that occurred on or after September 1, 2010, the failure of an insurer other than the Fund to comply with section 2.1 or 3.1 may be the subject of a special award made by the arbitrator.*

10. *(1) If an insurer who receives notice under section 3 disputes its obligation to pay 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. O. Reg. 283/95, s. 10 (1).*

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

Ontario Regulation 777/93

11*. (1) Subject to section 12 of the Compulsory Automobile Insurance Act and sections 237 and 238 of the Insurance Act, the insurer may, by registered mail or personal delivery, give to the insured a notice of termination of the contract.*

(1.1) If the insurer gives a notice of termination under subcondition (1) for a reason other than non-payment of the whole or any part of the premium due under the contract or of any charge under any agreement ancillary to the contract or if the insurer gives a notice of termination in accordance with subcondition (1.7), the notice of termination shall terminate the contract no earlier than,

> *(a) the 15th day after the insurer gives the notice, if the insurer gives the notice by registered mail; or*
>
> *(b) the fifth day after the insurer gives the notice, if the insurer gives the notice by personal delivery.*

(1.2) Subject to subcondition (1.7), if the insurer gives a notice of termination under subcondition (1) for the reason of non-payment of the whole or any part of the premium due under the contract or of any charge under any agreement ancillary to the contract, the notice of termination shall comply with subcondition (1.3) and shall specify a day for the termination of the contract that is no earlier than,

> *(a) the 30th day after the insurer gives the notice, if the insurer gives the notice by registered mail; or*
>
> *(b) the 10th day after the insurer gives the notice, if the insurer gives the notice by personal delivery.*

(1.3) A notice of termination mentioned in subcondition (1.2) shall,

> *(a) state the amount due under the contract as at the date of the notice; and*
>
> *(b) state that the contract will terminate at 12:01 a.m. of the day specified for termination unless the full amount mentioned in clause (a), together with an administration fee not exceeding the amount approved under Part XV of the Act, payable in cash or by money order or certified cheque payable to the order of the insurer or as the notice otherwise directs, is delivered to the address in Ontario that the notice specifies, not later than 12:00 noon on the business day before the day specified for termination.*

(1.7) If, on two previous occasions in respect of the contract, the insurer has given a notice of termination mentioned in subcondition (1.2) and the full amount payable under clause (b) of subcondition (1.3) has been paid by the time and in the manner that the notice specifies and if a non-payment again occurs of the whole or any part of the premium due under the contract or of any charge under any agreement ancillary to the contract, the insurer may, by registered mail or personal delivery, give to the insured a notice of termination of the contract and subcondition (1.1) applies to the notice, instead of subcondition (1.2).

(2) This contract may be terminated by the insured at any time on request.

(3) Where this contract is terminated by the insurer,

> *(a) the insurer shall refund the excess of premium actually paid by the insured over the proportionate premium for the expired time, but in no event shall the proportionate premium for the expired time be deemed to be less than any minimum retained premium specified;*
>
> *(b) if the termination is for a reason other than non-payment of the whole or any part of the premium due under the contract or of any charge under any agreement ancillary to the contract or if the insurer gives a notice of termination in accordance with subcondition (1.7), the refund shall accompany the notice, unless the premium is subject to adjustment or determination as to the amount, in which case, the refund shall be made as soon as practicable; and*
>
> *(c) if the termination is for the reason of non-payment of the whole or any part of the premium due under the contract or of any charge under any agreement ancillary to the contract and if subcondition (1.7) does not apply to the termination, the refund shall be made as soon as practicable after the effective date of the termination.*

(4) Where this contract is terminated by the insured, the insurer shall refund as soon as practicable the excess of premium actually paid by the insured over the short rate premium for the expired time, but in no event shall the short rate premium for the expired time be deemed to be less than any minimum retained premium specified.

ARGUMENTS & ANALYSIS:

31. I will address the parties' arguments and my analysis and findings on each issue raised separately.

Has Aviva complied with the requirements in sections 3 and 3.1 of regulation?

Parties' submissions

32. Certas contends that the priority investigation conducted by Aviva was deficient, and does not satisfy the requirements set out in section 3.1 of *Regulation 283/95*. Counsel submits that Aviva failed to investigate whether Ms. R was financially dependent on anyone, despite having received information early in the process that she lived with her daughter and family, and cared for her grandchildren. She noted that Aviva's adjuster wrote to the Claimant's representative after first reviewing the claim to ask for information regarding potential dependency and the family's financial arrangements. No follow up was done on this request, and no further steps were taken to investigate dependency before a "notice of dispute" was issued to the Fund.

33. Certas acknowledges that Aviva conducted searches and took various steps to determine whether there was any coverage on the vehicle that struck the Claimant, but argues that their investigation was solely focused on that question. Counsel noted that Arbitrator Bialkowski determined in *Dominion of Canada General Insurance Company v AXA Insurance and MVACF* (unreported, March 31, 2014) that Dominion was obligated to conduct a reasonable investigation to determine whether any other insurers might be required to pay benefits to the claimant before putting the Fund on notice, in circumstances in which there was no coverage under their policy. He stated that the legislative intent of the 2010 amendments to Regulation 283/95 was to "avoid dumping on the Fund", and that these amendments effectively transfer the obligation to conduct an investigation to the insurer who receives the first application for benefits.

34. Certas argues that Aviva's failure to take steps to determine whether the Claimant was financially dependent on her daughter and son-in-law was a failure to "pursue a clear avenue of investigation" (citing Arbitrator Bialkowski in the above case), and that its conduct and lack of

action is akin to "dumping on the Fund", in clear violation of section 3.1. Counsel contended that Aviva should be penalised for contravening this provision, as this type of conduct is precisely what the amendments are designed to prevent. She urged me to dismiss the arbitration and order Aviva to bear all costs associated with the claim, including all benefits they have paid out to the Claimant.

35. Certas submitted that if I am not inclined to dismiss the arbitration on those terms, I should order a "special award" against Aviva, as permitted by section 7(6) of the regulation. Counsel referred to the Court of Appeal's decision in *Ontario (Minister of Finance) v Echelon General Insurance Co.* (2019) O.R.(3d)1, in which the court found that Arbitrator Densem's comment that the special award provision should be "considered in the form of a costs type of sanction" was unreasonable. She noted that the Court of Appeal held that section 7(6) goes beyond that and "permits an arbitrator to resolve the priority dispute by requiring an insurer to fully reimburse the Fund for benefits paid for which the insurer was properly responsible…and apply any sanctions the arbitrator might find to be warranted".

36. The Fund, for its part, frames its argument differently on this point. It does not support Certas' position that Aviva breached the requirements in section 3.1 of the regulation, and is guilty of "dumping on the Fund". Counsel instead contends that Aviva has not met the obligation to conduct a reasonable investigation within ninety days as required by section 3(1) of the regulation, and questioned why Aviva had not taken further steps to investigate the Claimant's potential financial dependency, given that this issue had been flagged at the outset.

37. Counsel for the Fund noted that efforts were made by the Aviva adjuster to determine whether other policies insured the striking vehicle at the time of the accident, whether any other vehicles were involved in the accident, and whether documentation existed to support Aviva's claim that its policy had been properly cancelled, but that no steps were taken to clarify the family's financial arrangements. He also noted that after receiving Aviva's notice, the Fund's adjuster had requested that Aviva obtain a signed "priority statement" from the Claimant, but that Aviva neglected to do so, even though the ninety-day deadline had not yet expired.

38. Aviva urged me to find that it had complied with both section 3 and 3.1 of the regulation. Counsel submitted that its adjusters had conducted a reasonable investigation before forwarding notice to the Fund, and emphasised that notice had been provided within the allowable ninety-day timeframe. Counsel for Aviva contended that it was a complex investigation, as the Claimant spent more than two months in the hospital so was unavailable for an EUO, the named insured under the Aviva policy was deceased, and the details surrounding the policy cancellation were complicated. She noted that many searches were conducted and that the particulars of these, and the information they revealed, were forwarded to the Fund. She argued that both requirements of section 3.1 had therefore been met, and that Aviva should not be found to have "dumped" this claim on the Fund.

39. Counsel for Aviva submitted that the question of whether an investigation meets the standard of "reasonableness" has been the focus of many cases over the years. She contended that the courts have determined that an investigation should not be reviewed with the benefit of hindsight, and that a standard of perfection should not be applied. She resisted the suggestion that the Aviva adjuster ignored an obvious avenue of inquiry when he did not probe for more information about the family's financial arrangements, suggesting that the fact that a claimant lives with other family members does not necessarily mean that she or he is principally dependent on them for financial support.

40. Counsel for Aviva noted that Arbitrator Bialkowski generated a list of suggested searches and inquiries that an insurer who receives the first application should undertake in the *Dominion v AXA & MVACF, supra,* case, and advised that Aviva had done most of those before it provided its notice to the Fund.

41. Finally, Aviva contended that if I do find that the steps it took to investigate priority do not meet the standard of reasonableness, and find that it did contravene section 3.1 of the regulation, I should not conclude that Aviva is barred from proceeding with this dispute. Counsel noted that

even though Arbitrator Bialkowski determined that Dominion's investigation fell short of being reasonable in the *Dominion v AXA & Fund* case cited above, he declined to find that they had "dumped the claim" on the Fund. She highlighted his comments that a breach of section 3.1 does not bar the applicant from proceeding with an arbitration, and noted his decision to use the authority in section 7(6) to issue a "special award" to deny Dominion its costs of the arbitration, despite their success on the merits.

Analysis and Findings – section 3.1 of regulation

42. Section 3.1 of the regulation provides that a first insurer must do two things before providing notice to the Fund – it must complete a "reasonable investigation" to determine if any other insurer is liable to pay benefits in priority to the Fund, and it must provide particulars of the investigations it conducted to the Fund. On the evidence filed, I find that while Aviva complied with the second requirement, it did not comply with the first. A careful review of the log notes filed leads me to conclude that Aviva fell short of completing a reasonable investigation to determine whether any other insurer was liable, before putting the Fund on notice approximately six weeks after receiving the OCF 1.

43. It is clear from the adjusting notes that the focus of Aviva's investigation was on whether its policy had been cancelled prior to the accident, and whether another insurer company insured the vehicle that struck Ms. R. on the date of loss. Two adjusters were involved in this claim – CH initially reviewed the claim and was in contact with Ms. R and her representative, and CB took over on July 13, 2021, approximately two weeks after the claim was received. As noted above, CH had a phone discussion with Ms. R's representative a few days after the claim was submitted, and was advised that the Claimant lived with her daughter and family, and looked after her grandchildren. He made a note that further investigation should be conducted regarding whether she was financially dependent of her son.

44. CH then wrote to the Claimant's representative and referenced the fact that Ms. R lived with her daughter and family. He specifically asked her to address whether Ms. R was a dependent

of her son and daughter-in-law, whether she paid rent to them (and if so, how much and for how long) and what the financial arrangements were in the household. It is clear from these references that CH was "live to this issue" at the very beginning of the investigation, and knew that it should be explored.

45. Inexplicably, the notes do not show that any steps were taken to follow up or clarify information related to these questions. The references that follow relate solely to the Claimant's medical condition and the status of Aviva's policy. The claim is then transferred to a new adjuster (CB) on July 13th**.** Again, the notes do not evidence any investigation by CB into whether the Claimant might have been financially dependent on anyone in the household. They refer to various searches being conducted to clarify whether any other policies cover the vehicle that struck the Claimant. When no other policies are revealed, CB faxed a Notice of Dispute to the Fund on August 13, 2021, six weeks after the claim was received.

46. The Fund acknowledged Aviva's notice, and requested further information to assess its position on priority. At least two requests were made to Aviva for a "signed priority statement" from the Claimant, but none were obtained. The Claimant was not examined under oath until well after this proceeding was commenced in October 2024.

47. I find on the evidence filed that Aviva's investigation did not comply with section 3.1 of the regulation. It is unfortunate that this issue was not raised by either of the Respondents until very late in the process. As a result, the only evidence submitted on this issue was Aviva's log notes. Neither of the adjusters who worked on Ms. R's claim were examined under oath. I assume that if any further documentation existed to support other steps having been taken by either adjuster, this would have been produced by Aviva's counsel.

48. I accept that adjusters should not be held to a standard of perfection in their investigations. As has often been said, the criteria for a "reasonable investigation" of priority will depend on the facts of each case. In *Dominion v. AXA & the Fund, supra,* Arbitrator Bialkowski

stated that any reasonable investigation of priority should consider the ways in which a claimant can qualify as an "insured person" under the SABS, as if a claimant meets that definition, the insurer who issued the policy under which they were insured would be on the 'first tier of priority'. He suggested that to meet the threshold of reasonableness, an insurer should make inquiries to determine whether a claimant was a named insured or listed driver under a policy, the spouse or dependent of someone named on a policy, or had "regular use" of another vehicle with insurance. I agree with these comments.

49. I would also state that in order to meet the standard for a "reasonable investigation" set out in section 3.1, an insurer cannot only pursue one avenue of inquiry. Regardless of how diligently an insurer may pursue information regarding one potential priority issue, the provision requires that a 'multi-pronged approach' be taken. Section 3.1 requires the first insurer to determine "if ANY other insurer or insurers are liable to pay benefits in priority to the Fund". Given these words, in my view, an insurer's investigation will not be reasonable if it is not open to other potential avenues suggested by information obtained, that could lead to a finding that another insurer is in priority. In this case, the information provided by the Claimant's representative at the very outset about her living arrangements should have raised the question of potential financial dependency. The notes made by the first adjuster suggest that he had 'flagged" this as an issue. For whatever reason, he chose not to pursue more information on potential financial dependency, and the second adjuster ignored the issue entirely.

50. These mistakes could have been corrected if the Aviva adjuster had provided the Fund's representative with a signed "priority statement" from the Claimant, as they had requested on at least two occasions. It is not clear why this request was not fulfilled. I note that the Fund asked for a signed statement before the expiry of the ninety-day period, and despite Aviva having already provided notice to the Fund of its intention to dispute its obligation to pay benefits, it could easily have provided timely notice to Certas as well, if it had obtained the information requested.

51. Section 7(6) of the regulation provides that the failure of an insurer to comply with section 3.1 "may be the subject of a special award made by the arbitrator". Certas contends that an insurer who is guilty of "dumping on the Fund" should pay the ultimate penalty and absorb all benefits and costs associated with the AB claim. Interestingly, the Fund does not argue that Aviva "dumped" this claim on the Fund, and merely asserts that it did not conduct the reasonable investigation that it was required to.

52. Given my finding that Aviva breached section 3.1, I find it less important to determine whether the actions taken (or not taken) should be described as "dumping" on the Fund than considering what the legislators intended the proper remedy to be in these circumstances. Arbitrator Bialkowski discussed the breadth of a section 7(6) remedy in his decision in *Dominion v. AXA & the Fund, supra,* decided in 2014. Having found that Dominion's investigation was unreasonable because it had overlooked an avenue of possible insurance coverage, he declined to rule that they were precluded from pursuing the arbitration they had commenced. The arbitrator determined that while a remedy under section 7(6) should act as a deterrent to other insurers, an insurer who breaches section 3.1 should not be barred from proceeding with an arbitration. He found that the appropriate "special award" in that case was to deny Dominion its costs of the arbitration, despite the fact that they were successful on the merits.

53. Counsel for Certas noted that the above arbitration award was decided a few years before the appeals were heard in the case of *Ontario v Echelon, supra,* and submitted that the approach regarding section 7(6) has evolved since that time. She argued that the 2010 amendments were added to the regulation in order to protect the Fund, and that when these provisions are breached, deterrence is an important factor. She noted the Court of Appeal's statement in the Echelon case that section 7(6) is meant to go beyond 'costs sanctions' and "permits an arbitrator to resolve the priority dispute by requiring an insurer to fully reimburse the Fund for benefits paid for which the insurer was properly responsible…and apply any sanctions the arbitrator might find to be warranted". She submitted that Aviva should be found to be liable for the benefits paid out,

and should fully reimburse both of the respondents (the Fund and Certas) for its investigation costs and legal fees.

54. I have reviewed the Court of Appeal's decision in the Echelon case closely. It involved a situation where Echelon had initially paid benefits to a claimant who was injured in a snowmobile incident, but then persuaded the Fund to take over the claim because it believed that the snowmobile was not covered under its policy. The Fund accepted priority for the claim because it also believed that Echelon's policy did not extend coverage to the snowmobile. The Fund later realised that the snowmobile was insured under the "other auto" provision of the Echelon policy, and commenced arbitration against Echelon, seeking reimbursement for the benefits it had paid. Echelon resisted, and argued that the Fund should not be permitted to resile from its agreement to pay benefits.

55. The arbitrator determined that Echelon was liable to repay the Fund and take over responsibility for the claim. Echelon appealed to the Superior Court, and lost. The judge found that Echelon's failure to conduct a reasonable investigation under section 3.1 was fatal to its notice to require the Fund to pay benefits to the Claimant. He found that as proper notice was not provided, there was no dispute that could be subject to arbitration, and the arbitration was therefore "void from the outset".

56. Echelon sought and was granted leave to appeal to the Court of Appeal. Justice Lauwers noted that one of the purposes of *Regulation 283/95* was to ensure that the Fund "is liable to pay statutory accident benefits with public money only if there is no private insurance available for that purpose". He held, however, that the appeal judge was incorrect in concluding that the arbitration was void from the outset, and that there was nothing in the Act or *Regulation 283/95* that "compels or could even justify the result of voiding the arbitration award", given that section 7(6) of the regulation directly addresses the failure of an insurer to comply with section 3.1.

57. In reviewing the arbitrator's award, Justice Lauwers noted his comment that section 7(6) is "not intended to provide a remedy which essentially determines the merits of the priority dispute", and that it was a "costs type of sanction" for an insurer's failure to comply with section 3.1, provided that the Fund was otherwise successful on the merits of the claim. Justice Lauwers determined that the arbitrator's interpretation of section 7(6) was unjustifiably narrow. Despite that finding, he allowed the appeal, overturned the Superior Court's decision and restored the Arbitrator's award , as he found it to be "a reasonable award".

58. In my view, the facts of this case are significantly different from the circumstances in the Echelon case, and the Court of Appeal's comments about the appropriate remedy must be appreciated in that context. The Fund is not the Applicant in this case, and has not paid any benefits to the Claimant. That is an important fact, that in my view distinguishes these two cases. In addition, the fact that the Fund does not support Certas' argument that Aviva "dumped" the claim on the Fund is also an important 'piece of the puzzle'. The only way that the Fund could be liable to pay benefits to Ms. R. is if she is determined not to be principally dependent for financial support on her son-in-law, and if the Aviva policy is determined to have not been in force on the date of loss.

59. I accordingly do not accept Certas' argument that Justice Lauwers' comments in the above case should lead to the conclusion that Aviva is barred from proceeding with this priority dispute. I note that while section 3(1) of the regulation states that "no insurer may dispute its obligation to pay benefits…unless it gives written notice within 90 days of receipt of a completed application for benefits", section 3.1(a) simply provides that an insurer must "complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund". Section 3.1 is not phrased as a 'prohibition for proceeding', whereas section 3(1) is. The drafters of section 3.1 would clearly have been aware of the language of the earlier section, and the fact that they chose not to replicate it can be interpreted to mean that they did not intend that an insurer who did not comply would be barred from proceeding.

60. What is the proper remedy for a breach of section 3.1 in these circumstances? In my view deterrence should be an important feature of any remedy, so that the policy underlying the protections outlined for the Fund can be upheld. I find that this can be achieved by requiring Aviva to pay the Fund's full costs, including legal fees, investigation fees and any other expenses related to their participation in this dispute, as well as a further lump sum, as a penalty or sanction pursuant to section 7(6). Taking all of the circumstances outlined above into account, I find that $10,000 is an appropriate amount for this sanction. This sum sends a message that insurers must heed the clear direction in section 3.1 and the other 2010 amendments that provide protection to the Fund, and that there is a higher threshold when it comes to putting the Fund on notice. However, while Aviva's investigation was improperly and narrowly focused on one issue, it did at least take various steps in order to uncover other potential coverage. If it had not done so, I would have awarded a higher lump sum as a "special award".

Was the Fund's notice to Certas valid?

61. Certas argues that if the notice provided by Aviva to the Fund was improper, then by extension the notice that the Fund subsequently provided to Certas is invalid. I do not agree. While I acknowledge the logic of the argument that Aviva should not be able to "reach through" and rely on the Fund's notice to Certas if Aviva's own investigation was deficient, the priority scheme outlined in *Regulation 283/95* permits that to happen. As I determined in *Co-operators Mutual Insurance v Intact Insurance & Northbridge Insurance* (January 17, 2018), a first insurer is obligated to provide notice to another insurer that it claims is in higher priority under section 3(1), Section 10 then permits that insurer to provide notice to a third insurer, if it claims that insurer has equal or higher priority under section 268 of the *Act.* I stated as follows at para. 60 of that decision:

> *I find that if the drafters of Regulation 283/95 had intended that the first insurer only be permitted to provide notice to an insurer on a higher priority "rung", they would have used clear words to convey that message. In my view, a close reading of section 3 and section 10 do not lead to that conclusion. Instead, these provisions acknowledge the reality that determining priority may take a few steps. Section 3 is designed to "get the party started". Section 10 allows that*

once the fun begins, others may join in and it does not really matter who arrived with whom, and at what time.

62. While perhaps not the most eloquent description of the priority scheme, this decision was upheld on appeal (November 30, 2018, Diamond, J.), and further leave to appeal was denied.

63. Certas also argued that the Fund is not an "insurer" for the purpose of section 10, but cited no arbitral or judicial authority for that proposition. I see no basis for that argument in the regulation. Given that the 2010 amendments focused on the role of the Fund in the priority scheme, I find it likely that this would have been clearly expressed if the drafters had so intended.

Was the Claimant principally dependent for financial support on the Certas insured?

64. The parties agree that if Ms. R is found to be financially dependent on her son-in-law, she would be an "insured" under his Certas policy and Certas would be in highest priority by virtue of section 268(2)2(i) of the *Act,* regardless of whether or not the Aviva policy remained in effect on the date of loss.

65. The facts surrounding this issue are not in dispute. As set out above, the Claimant was sixty-four years old at the time of the accident. She lived with her daughter and son-in-law since arriving in Canada in 2012, and they looked after all of her financial needs. She contributed the approximately $700 per month that she received in social assistance payments to the household. These arrangements were in effect for several years before the accident in June 2021.

66. Ms. R. also provided significant care for two of her three grandchildren who suffered from Muscular Dystrophy. She had a grade eight education, did not speak English and had not worked outside the home since coming to Canada. Both Ms. R and her daughter advised at their EUOs that she could not have lived independently from a financial perspective at the time of the accident.

67. Certas contends that the care provided by the Claimant to her grandchildren went well beyond the "usual" childcare services. Counsel submitted that a monetary value should be imputed to the services she provided, and that this should betaken as evidence that she had the ability to be self-supporting. Counsel argued that if Ms. R had not provided these services, the family would have had to hire a professional Personal Support Worker to provide care, which would have been a significant expense for the family. She acknowledged that arbitrators generally adopt a "big picture" analysis and find that older claimants who live with their children and young families are financially dependent on them. She submitted that the circumstances in this case are unique, and call for a different result, given the high level of care provided by Ms. R to her disabled grandchildren and the fact that she came to Canada for the stated purpose of providing this care.

68. The courts have provided guidance on whether an elderly person who lives with their child(ren) and provides unpaid services to the family is principally dependent for financial support on them in the following key decisions – *Security National Insurance v Wawanesa Mutual Insurance* (Arbitrator Robinson, April 30, 2012, overturned on appeal by Morgan, J. 2013 ONSC 7589, arbitral decision restored by Ont. C.A. at 2014 ONCA 850); *Allstate Insurance Company v. Intact Insurance Company* (Arbitrator Novick, October 2015, upheld on appeal by Faieta, J. 2016 ONSC 5443); *Dominion of Canada v. Intact Insurance Company* (Arbitrator Bialkowski, March 12, 2022). As acknowledged by counsel for Certas, the above decisions direct that a holistic or "big picture" approach be taken to assessing financial dependency in these types of cases, with a 'carve out' for circumstances in which a clear "financial bargain" has been struck.

69. I stated as follows in *Allstate v Intact, supra :*

> *In my view, when a grandparent receives free room and board and the payment of their other expenses from a child with whom they live, and provides caregiving and housekeeping services to the family in order to assist parents who work outside of the home, this relationship of interdependence should generally not lead to a finding that the claimant is financially independent. If the grandparent ceased providing those services – either because they are injured in a car accident, or become ill for some reason – their needs will continue to be met, in most cases, by that household.*

> *In some instances, a financial "bargain" may be struck between the parties, which may lead to a different result. In this case, however, despite the figures reported on her tax returns, the evidence is clear that Ms. Yan did not receive any compensation for the services that she provided. She testified that it was customary in her culture for a grandparent to live with a child and help care for the grandchildren, without pay, and this is what she was doing. I therefore do not attribute any monetary value to the caregiving services provided by Ms. Yan*.

These paragraphs were also excerpted in the court's decision upholding my award. Justice Faieta also stated (at para. 22 of his decision) that my finding that no monetary value ought to be imputed to the caregiving services provided was reasonable.

70. While I agree with counsel for Certas that the level of childcare provided by the Claimant far exceeded the babysitting services provided by some of the grandparents in the cases cited above, I do not think that this fact should dictate a different result. It was clear from the parties' EUO evidence that Ms. R provided the services that she did through a sense of care, love and cultural expectation. She did not expect any monetary compensation. The fact that the family would have paid a significant amount if they had hired a professional caregiver for the children also does not dictate a different result than those reached in the cases cited above.

71. Ms. R lived with her daughter's family, and they met all of her financial needs. She spent most of her time caring for her grandchildren, two of whom had special needs. In my view, it would be inappropriate to impute a monetary value to the services provided by the Claimant. This arrangement was mutually supportive to the parties involved, rather than a "financial bargain".

72. I therefore conclude that when the factors outlined in the *Miller v Safeco Insurance* [1984] O.J. No. 3383 (ONSC), rev'd by ONCA [1985] O.J. No. 2742 – namely the amount and duration of the Claimant's financial dependency, her financial needs and her ability to be self-supporting – are considered, Ms. R. was principally dependent for financial support on her daughter and son-in-law, the Certas insureds, at the time of the accident. She was accordingly an "insured" under the Certas policy.

Was the policy issued by Aviva that covered the Kia vehicle that struck Ms. R still in effect?

73. Given my finding on financial dependency above, I need not determine this issue. If the Aviva policy remained in effect on the date of loss, they would fall on the 'second priority rung' in accordance with section 268(2)2(ii) of the *Act*, below Certas.

For the reasons expressed above, Certas is the insurer in highest priority to pay Ms. R's claims by virtue of section 268(2)2(i) of the *Act.*

ORDER :

I hereby order as follows:

1. Certas is liable to repay all the benefits paid out by Aviva in accordance with the *SABS,* less the $10,000 penalty imposed under section 7(6) of the regulation. No interest is payable on this amount.

2. Aviva shall reimburse the Fund for all of its costs and expenses incurred as a result of its involvement in this priority dispute. This should include legal costs on a substantial indemnity basis, adjusting fees, and any other reasonable expenses related to responding to the notice received and participating in this proceeding.

3. All arbitration fees shall be split equally between Aviva and Certas.

COSTS:

Given the mixed result, and the manner in which this case proceeded, I find that Aviva and Certas should bear their own costs. As set out above, Aviva should reimburse the Fund for all of its legal costs. If any disputes arise relating to this issue, I invite the parties to contact me and a further pre-hearing will be convened in order to discuss this.

DATED at TORONTO, ONTARIO this 31th DAY OF JULY 2026

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Shari L. Novick, Arbitrator