

IN THE MATTER OF the *Insurance Act*, R.S.O. 1990, c.I.8, as amended,
and Ontario Regulation 283/95

AND IN THE MATTER OF the *Arbitration Act*, S.O. 1991, c.17

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

WAWANESA MUTUAL INSURANCE COMPANY

Applicant

- and -

PEEL MUTUAL INSURANCE COMPANY
and ECONOMICAL INSURANCE COMPANY

Respondents

SUPPLEMENTARY AWARD

Counsel Appearing

Christopher J. Schnarr for Economical Insurance Company

Mark K. Donaldson for Peel Mutual Insurance Company

Introduction

This matter came before me for a hearing on a preliminary issue with respect to the question of whether or not Peel Mutual has commenced proceedings against Economical following the necessary procedural steps that are called for in these kinds of disputes.

This is a priority dispute designed to sort out the obligation to pay statutory accident benefits and the context for this is set by section 268 of the *Insurance Act*. Ontario Regulation 283/95 under the *Insurance Act* creates a process for dealing with these disputes between insurers.

Economical takes the position that Peel Mutual has not given timely notice and is non-compliant with Ontario Regulation 283/95.

On January 28, 2011, I gave reasons in this matter concluding that the notice provisions found in Ontario Regulation 283/95 do not apply in these circumstances where Peel Mutual is not the first insurer to receive an application but is an insurer that is the subject of a priority dispute initiated by another insurer.

The parties affected by this decision, Peel Mutual and Economical, have appealed the preliminary issue decision to the Superior Court as provided for by the *Arbitrations Act 1991*. During the course of that appeal, the parties and the court have requested that I address two issues:

1. The effect of Peel Mutual having received a copy of the completed Application for Benefits; and
2. The effect of the saving provision found in subsection 3(2) of Ontario Regulation 283/95.

The “Receipt of a Completed Application” Issue

At the outset the parties agree that the initial "completed application" was sent by the claimant to Wawanesa. Wawanesa dealt with the claimant's entitlement to accident benefits. Pursuant to the regulation, Wawanesa gave notice to Peel. Peel commenced an investigation as a result of receiving the notice. Part of that investigation involved contact with Wawanesa and solicitation of documents from the existing claims file.

The record before me indicates that the Application for Accident Benefits in this matter, on the prescribed form OCF 1, was signed on behalf of the claimant on June 19, 2009 and was received by Wawanesa on July 2, 2009. The transmittal correspondence directly refers to the document as a copy of the application. This is entirely in accordance with my understanding of this case. The claimant made the approach for accident benefits to Wawanesa and Wawanesa, in response to that approach, has been administering the benefits and now invokes Ontario Regulation 283/95 to require a higher priority insurer to deal with these benefits.

Wawanesa formed the intention to dispute the priority issue with Peel Mutual. It appears that Wawanesa, on July 20, 2009, sent a Notice of Dispute targeting Peel Mutual, indicating to Peel Mutual the position that benefits ought to be paid by Peel Mutual, not Wawanesa. The record discloses that Peel Mutual commenced investigation of the circumstances of this loss with a view to determining where priority would fall. During the course of that investigation, and subsequent to Wawanesa having indicated its dispute about priority with Peel Mutual, on September 15, 2009 Wawanesa sent a letter to Peel Mutual that enclosed a copy of the application that had previously been received by Wawanesa.

The argument made is that this latter development, Peel Mutual's receipt of a copy of the application from Wawanesa, triggers a 90 day timeframe during which Peel Mutual, the second tier insurer, is required to give Notice of Dispute to any third tier insurer that it seeks to involve in a priority dispute.

I am mindful of the fact that the format of the document in question is the approved form for making an application for accident benefits known as "OCF-1". In the statutory scheme, this is the form that is required to be completed by an individual asking an insurer to pay statutory accident benefits in respect of the person's injury. This document contains representations made by the individual to an insurer about the person's circumstances. In accordance with the process laden scheme of the statutory accident benefits program, making an application is an important milestone. It triggers obligations on the recipient insurer and starts the administration of benefits. Amongst other things, the insurer towards whom the application is made, needs to be mindful of possible priority disputes.

I am aware that various arbitration decisions have previously discussed the concept of “application” aside from the form of the document upon which the information is submitted. Cases have concluded that a written communication by an insured to an insurer evidencing a request for a payment of a benefit constitutes an “application”. The case law in that vein has taken a different course over recent years especially with regulatory changes about privacy laws and the requirements for signature of an application at the outset of a claim. Nonetheless, it is instructive to see that arbitrators have given some thought as to what constitutes an application and have looked at the substance of the transaction, separate from the form.

Now I am being asked to look at the form of the transaction rather than the substance. Truly, Peel Mutual’s representative received a copy of the application form on or about September 20, 2009. But can this be said to be an application? It certainly was an application when it was sent to Wawanesa because at that time the claimant was requesting consideration of entitlement to benefits from Wawanesa. But when this document was submitted by Wawanesa to Peel, it was not with the expectation of the claimant that Peel would begin administration of accident benefits. Nor is there any evidence that the claimant would have any expectation of Peel being obliged to pay statutory accident benefits. More accurately, the copy of the application form was submitted by Wawanesa to Peel as a production in furtherance of Wawanesa’s pursuit of a priority dispute that had already been commenced by a notice on July 17, 2009.

A critical feature of the application form is to include information that will allow an insurer to evaluate, or commence consideration of a claim. But, in addition, when the form is submitted to an insurer, the claimant expressly grants the insurer consent, pursuant to privacy law, in order to allow the insurer to collect, use, or disclose personal information. I have no difficulty understanding how this is important when the claimant makes an application. It gives Wawanesa the permission it needs to deal with personal information. But it cannot be said that the claimant has given that permission to Peel, or any other insurer that might subsequently come into possession of a copy of the form from some other source. In this important respect the receipt of a copy of an application form by Peel is fundamentally different than a submission of a completed application by the claimant to Wawanesa.

Economical asks me to consider an argument that turns on an interpretation of section 3 of Ontario Regulation 283/95. That regulation provision addresses disputes between insurers and the initiation of such disputes.

The essential characteristics of this regulation are to address "priority disputes" between insurers. As a result of the broad range of "insured persons" found in the SABS, and injured individual may have the status of being an insured person in relation to numerous policies of insurance. Section 268 of the *Insurance Act* creates a priority regime between the various insurers.

The regulation creates a dispute resolution process for sorting out controversy about relative priority of insurers.

Critically, the regulation is constructed to isolate the insured person from the intercompany controversy, to the extent possible. The insured person does not have the onus of showing which insurer has the highest priority. The insured person must cooperate in the investigation of that issue by the insurer administering benefits, but the investigation and dispute resolution burden is assigned to the insurers involved in the controversy.

Section 2 of the regulation is designed to see that the injured person has access to benefits without taking on the burden of, or awaiting the outcome of, a priority dispute.

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

The regulation requires that the first insurer that receives a completed application should deal with the claim. An insurer that disputes its obligations, essentially asserting that another insurer has a high-ranking priority, has the onus of pursuing that issue against the other insurer directly. It is not a matter which the insurer can raise as a defence to the presented claim.

The regulation creates a procedural context for the resolution of inter-insurer disputes. Firstly, having ensured that the insured claimant is positioned to have his or her claim processed, the regulation contemplates that the insurer will serve a Notice of Dispute on any other insurer alleged to be higher ranking. The regulation puts a time limit on delivery of this notice, and it starts that time running with the insurer's receipt of a "completed application". The time limit is 90 days, if it applies at all. The time limit does not apply in certain conditions described in the regulation.

The regulation further requires that disputes between insurers must be resolved by arbitration in accordance with the *Arbitrations Act 1991*. That is the dispute resolution mechanism which has brought this matter before me.

Other provisions of the regulation address ancillary process issues.

The argument made by Economical at this juncture is that the 90 day time limit applies to Peel Mutual in this case. I do not agree. It is asserted that the 90 day time limit applies to Peel Mutual because, in the course of post notice communications with Wawanesa, a copy of the "completed application" was sent to Peel. It is suggested that Peel should have given Notice of Dispute to Economical within 90 days of having received the copy of the "completed application" that Wawanesa had in turn received from the claimant.

Economical argues for a strict application of subsection 3(1) of the regulation. That provision is as follows:

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.

Economical takes the position that Peel was in "receipt of a completed application for benefits" as of September 20, 2009 and, therefore was required to commence a priority dispute against Economical no later than 90 days thereafter.

Economical advocates an extremely rigid application of subsection 3(1). If Economical's position is correct, that this provision applies to second tier insurers, then I point out that section 3(1) would preclude a priority dispute by Peel Mutual against Economical if Peel had not been provided with a copy of the completed application. If subsection 3(1) applies to second tier insurers, then it would require that the second tier insurer have a copy of the completed application before giving notice. This interpretation would otherwise deprive the second tier

insurer of the ability to engage a higher ranking insurer in the process. This would be completely wrong, and would be an interpretation made in defiance of the context.

Furthermore, the time allotment for investigation, 90 days, is not rationally applied equally to first insurer and second tier insurers. The first insurer has lines of communication, and access to information guaranteed by regulation and forms, but a second tier insurer does not have the same investigatory tools and access available. In my view subsection 3(1) is not applicable to the second tier insurer.

I conclude that the fact that Peel Mutual was provided with a copy of the originally submitted application during the course of the dispute process does not mean that Peel was in "receipt of a completed application for benefits" at the time that a copy of the document was produced because:

1. The document is not addressed to Peel Mutual.
2. The document was not provided to Peel by the "applicant".
3. The document is a copy.
4. The document was not submitted with the intention of starting the claims handling process or for the purpose of making a claim. The substance of the communication was not an application for benefits.
5. The receipt of the document does not grant Peel consent to collection, use and disclosure of information.
6. Receipt of a copy of a form is not the same as being in receipt of an application in substance.

In my view this is not "receipt of a completed application for benefits" within the meaning of the regulation.

Economical argues that the language of the regulation, referring to "No insurer" as opposed to the "first insurer" indicates a legislative intention that the 90 day time limit applies to second tier insurers. I do not see that as a clear consequence of the language. Indeed it is possible that the insurer paying the benefits, and seeking reimbursement from the second tier insurer, might not be the "first insurer". This occasionally happens in a deflection case. And it might happen in a case where the application is sent to the wrong insurer, and is consensually turned over to a higher ranking insurer for handling. For example, where an application is sent to the insurer of an "at fault vehicle" and it is immediately recognized that this is not a tort claim component, the claimant might redirect the application to the insurer of the vehicle he or she occupied. That insurer would not be the "first insurer" but would be the insurer having carriage of the SABS claim. Accordingly I do not accept that the absence of the term "first insurer" in subsection 3(1) denotes application of 3(1) to second tier insurers.

Further, Economical argues that its position promotes a legislative intention of providing an efficient dispute resolution mechanism. Frankly, I find that the position advocated would have the opposite effect. It would inject a new issue into priority disputes, "when did the second tier insurer receive a copy of an application" and that will create further questions about entitlement in those cases where the second tier insurer commences the dispute before receiving a copy of the application. The advocated interpretation would require second tier insurers to devote substantial resources to conducting an investigation within 90 days. The diversion of precious resources to this endeavour makes the system inefficient, and increases the likelihood of an unintended outcome.

The Saving Provision Issue

I have been asked to consider whether or not the saving provision contained in section 3(2) of Ontario Regulation 283/95 applies in this case. The effect of finding that provision applicable would be to relieve Peel Mutual of the obligation to give notice within 90 days of receipt of a completed application. This is alternative relief for Peel and is only of significance in the event that it is concluded that Peel had received a “completed application” and had not given notice to Economical within 90 days of receipt of that application.

Subsection 3(2) of the regulation provides:

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

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

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

There is some previous case law addressing the application of this provision. This is certainly not surprising given the stark consequences of failure to give timely notice in cases where subsection 3(1) applies. Application of the subsection 3(1) notice has the effect of saddling an insurer with a Statutory Accident Benefits claim that, by statute, was properly payable by another insurer. Section 268 of the *Insurance Act* sets out those priority rules, but all of that legislative direction has no effect if there is non-compliance with the procedural requirement of subsection 3(1) of Ontario Regulation 283/95 as this provision appears to deprive the insurer of any remedy to give effect to the legislative priority scheme. The result is that a loss can be visited upon an insurer based on receipt of an application rather than being based on the statutory priority rules, or the terms and conditions of the benefits program. Such an outcome clearly defeats the purpose of section 268 of the *Insurance Act* and frustrates ordinary insurance expectations.

Indeed, applying the procedural constraint found in Ontario Regulation 3(1) necessarily has a unintended consequence:

1. It puts the ultimate costs of the loss on the wrong insurer;
2. It leaves the handling of the SABS claim, and its funding, with an insurer which was not within the reasonable expectations of either of the parties (had they turned their minds to the legislation); and
3. It causes the payment of the loss to be made by an insurer who has received no premium for that risk, at the same time exculpating an insurer that has received the premium for the risk of that loss.

Given the rather severe and counter intuitive consequence of non-compliance with subsection 3(1), it is entirely understandable that the regulation contains a saving provision intended to provide some relief for an insurer that might be saddled with a claim as a result of the operation of subsection 3(1). In this case, I am asked to consider the application of that saving provision to the facts of this transaction.

When reviewing the saving provision, I must first observe that the language used seems to be quite strict. The provision asks us to consider whether or not 90 days was an insufficient length of time for an insurer make a determination. Contemplated in a vacuum, no insurer could ever cross this hurdle. The act of making a determination is the analysis of information. This part of the transaction could never take 90 days and no insurer would ever get the benefit of subsection 3(2). Such an interpretation would offend the rule against tautology. The drafters of the regulation must have meant to give some meaningful relief by the language employed in subsection 3(2) and we need to discern the scope of that relief.

I observe that in these priority disputes the determination that another insurer may be a higher ranking insurer in any given case is a conclusion that can only be reached by the aggregation of information that might need to be collected from a number of sources. Furthermore, that information, pertinent to determination of a priority concern, would touch on disparate topics. Prudent consideration of priority issues would require, at the outset, investigation and evaluation of complex issues. Depending on the conclusions reached, the insurer might then have challenges to identify an insurer that has a higher priority based on the facts that apply to the claimant's life circumstances. Then, if the insurer has crossed those hurdles, the insurer would be in a position to prepare a notice of priority dispute and to deliver it appropriately to the identified insurer. As to the fact investigation, the insurer will typically need to consider the following:

1. Whether the claimant is a named insured under one or more policies of automobile insurance.
2. Whether the claimant is the spouse of a person who is a named insured under one or more policies of automobile insurance.
3. Whether the claimant is a dependant of a person who is a named insured or a spouse of a named insured under one or more policies of automobile insurance.
4. Whether the claimant is a person for whom an automobile is made available for regular use by an employer or entity as contemplated by the regulations.
5. Whether the claimant is a listed driver in the policy documentation of some other automobile insurance arrangement.¹

The information that must be collected to evaluate these issues is not all obtainable from the claimant. In fact, some of this information may be unknowable by the claimant, for example, where the claimant is dependent of somebody who in turn has a vehicle made available for his or her regular use. The dependant may know nothing of that available vehicle. Accordingly, the prudent insurer investigating priority possibilities faces a formidable challenge to marshal the relevant evidence that might give rise to a determination that another insurer is responsible to pay the accident benefits.

The insurer must confront this challenging matrix of factual and legal issues at the outset of a claim, when attention is sorely needed to other claims matters such as the treatment and rehabilitation of the injured individual. Hence, we need to take great care not to lose sight of the

¹ This is an abbreviated list of the circumstances subject to consideration. For example, an insurer might have to consider whether or not the claimant is a dependant of a person who is the spouse of a person for whom a vehicle is made available for regular use. The complexity of the inquiry can compound greatly.

operational environment where the regulation provisions are applied. The standard that we hold the insured to is one of reasonableness. The question that must be determined is whether or not the insurer was not reasonably able to determine the identity of a higher priority insurer within 90 days.

An argument can be made that the regulation does not allow the leeway implicit in a “reasonableness” test. But that supposition ignores the reality of the transactions being regulated. A very narrow reading of the regulation might suggest an interpretation that requires me to only look at whether or not the determination could conceivably have been made within 90 days, as discussed. In fact, the process is much more complex and necessarily entails an examination of what information was acquired, at what point, with what follow up or consequence?

I agree with the reasoning of Arbitrator Guy Jones in examining the possible application of subsection 3(2) of the regulation:

“... courts and arbitrators have also noted that accident benefits adjusters are extremely busy individuals handling many complex files One must remember that what is required is not perfection. With the benefit of hindsight, almost any other insurer that exists could be found if certain steps had been taken. The test is one of reasonableness. The saving provisions of section 3(2) of Regulation 283/95 were put there for a reason, and the test should not be so high as to make it almost meaningless.”²

In the 2007 case of *Liberty v. Zurich*, Mr. Justice Perell considered the applicable standards embedded in subsection 3(2). In this regard I find it instructive that the court applies an approach to 3(2)(a) as well as to 3(2)(b) that recognizes that the existence of an available means to make a determination within the 90 day period is “relevant but not in itself determinative”.³

I particularly note that insurers are not to be held to a standard of perfection. There is acknowledgment that insurers presented with accident benefits claims should have their conduct measured with due regard for the context of a busy, process laden, under resourced, business. We should be loathe to adopt procedural rules which would compel insurers to divert their efforts away from attention to the needs of their injured customers, only to fulfill the elusive goal of a perfect investigation.

I conclude that the test which I must apply given the case law and the context of SABS claims handling practices is to determine whether or not Peel Mutual could reasonably have determined that Economical was a higher ranking insurer, within 90 days of having received a “completed application”.

The facts about Peel Mutual’s activities in this case are set out in some depth in the record. Peel was represented by an independent adjuster whose records have been examined. The individual has testified in a discovery process. So we have a reasonably complete picture of the claims activity undertaken by Peel during the first months of their knowledge of this claim.

When we look into this activity it is important for us to understand that, at that time, Peel would not have known of the subsequently discovered priority issue, or the basis of it. In fact, a review of the completed application document would tend to indicate that there was no priority issue

² *Zurich v. Royal*, Arbitrator Guy Jones, April 2008

³ 88 O.R. (3d) 629 at paragraph 31

vis-à-vis Economical or some other higher ranking insurer. There was no disclosure of any circumstance which ought to have alerted Peel to the possibility of a higher ranking coverage elsewhere.

Peel was initially concerned about the assertion that the claimant was in a relationship with Peel's named insured that would make the claimant a "spouse" as that term is used in the *Insurance Act*. That concept can be challenging, and fact sensitive.

The key components of Peel's investigation of this claim at the outset were twofold. Firstly, the adjuster made arrangements with the legal representative of the claimant to conduct an interview. Secondly, the representative conducted searches, including sending away for an "ISB" search. The initial steps for both lines of inquiry were taken promptly, within days of "receipt of the completed application".

The logistics of the interview proved to be somewhat difficult. The meeting was scheduled and rescheduled. The adjuster had to work with the availability of the claimant and the availability of the claimant's representative. I point out that Peel, not being the insurer paying the statutory accident benefits, had only limited rights to insist on the cooperation of the claimant and was not in a position to insist on information within a predetermined time frame. Peel was not in a position to demand more than minimal cooperation from the claimant or the claimant's representative. Nonetheless, they sought out that cooperation and with some difficulty ultimately achieved their goal of having an interview with the claimant.

That interview took place on December 15, 2009. At that time, for the first time, Peel became aware of the fact that the claimant had access to a possible policy of insurance issued by a company (Economical) that was the insurer of a company vehicle made available for the claimant's spouse.

It appears that there may have been conversations with the "spouse" or his representative at an earlier time where that question might have been asked, but it was not asked until the formal interview. I see no significance in this. At the time, the possibility of a company car coverage was not known or suspected. It was the kind of thing that was only going to be discovered in a methodical and lengthy interview process.

With respect to the searches, the facts are more challenging. It seems that an ISB search on the "spouse" was requested promptly on September 14, 2009. It appears from subsequent searches that it was likely that the response to that search request would have indicated a possible coverage with a company car insured by Economical. But the adjuster did not see a response to the search request, and did not follow up for a response at any time within the 90 days following September 20, 2009.

With respect to the events leading up to the interview, the adjuster seems to have been persistent. There were initial arrangements for late September. Then there was an issue raised challenging the right to the information. An arrangement was proposed for October 26, 28 or 29. Those dates were rearranged to December 2, 2009. Unfortunately he did not show up on December 2 and a further arrangement was made for December 15, when the statement was finally obtained.

In addition to this, the adjuster was obtaining information from Wawanesa, and had instructed a background check on the "spouse".

In all of this, I find nothing deficient in the conduct of the investigation except the failure to note the absence of a response to the requested ISB search. That is something that should have been followed up on. If it had been followed up on, a new focus of inquiry would have been identified.

Bearing in mind that the primary goal of the adjuster was to consider spousal issues, the ISB report would not be expected to yield any useful information on the spousal status. Hence the product of that search request was entirely ancillary to the then focus of inquiry. The review of that search result was a prudent approach to “crossing the t’s and dotting the i’s” in the claims process, just as the interview would go beyond the narrow focus of “spousal” issues. In that context I need to consider whether the failure to conduct an additional search, or follow up in some way, was unreasonable. In this respect the handling was imperfect. But in the context of the status of the case at that time it was not unreasonable. It was a loose end that would be expected to be noticed after the interview process and indeed, at that juncture, Peel’s representatives were very much alive to the issue of a company car. But that was more than 90 days after the “receipt of completed application”.

So while, in hindsight, it would have been better for Peel to follow up for the response to the request to ISB, the absence of follow up was not unreasonable when Peel had various pending arrangements to obtain information directly from the “spouse” through the arranged interview.

To the extent that Peel’s investigation was imperfect, I do not find it to have been unreasonable in all of the circumstances.


Based on the investigation it was not possible to make a determination of Economical’s involvement within 90 days of the purported “receipt of a completed application”.

Conclusions

Peel Mutual’s receipt of a copy of the OCF 1 form from Wawanesa is not “receipt of a completed application” within the meaning of the regulations.

The saving provision of section 3 of the regulation apply and the 90 day time limit is not applicable.

Dated at Toronto this 21st day of June, 2011.



LEE SAMIS
Arbitrator