

10 Things (More or Less) You Need to Know about the Law (or Changes Thereto)

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Earlier this year the Ontario government released the New Regulations for Auto Insurance. The Regulations will come into effect on September 1, 2010.

The changes impact both the tort and accident benefits system.

The biggest changes, however, involve accident benefits. Those changes are found in Ontario Regulation 34/10 made under the *Insurance Act*.

The reasons for reform are varied, but include possible premium affordability and a move to reduce escalating costs and complexity under the current system.

This article reviews some of the more significant changes within the new system and how they will impact our day-to-day practice.

The article also includes a review of some recent decisions. From a finding that one marked impairment meets the catastrophic threshold, to the latest on collateral benefit deductions, to the finding that a dirt bike is an “automobile”, and to the finding that the prescribed Settlement Disclosure Notice might be deficient, the cases will no doubt have far-reaching implications in the world of accident benefits.

While we have only reviewed a few decisions in this article, there are several more noteworthy cases¹ and each of these will have an immediate and significant impact on the way both insurers and insureds approach their respective cases.

1. THE “NEW SABS”: SIGNIFICANT CHANGES TO ACCIDENT BENEFITS

(a) “MINOR INJURIES”

A new category of “minor injuries” has been introduced to the Statutory Accident Benefits Schedule.

There will be a \$3,500 cap placed on the amount of medical/rehabilitation benefits available to a claimant who has sustained a “minor injury”: see Section 18. The amount is inclusive of assessment costs.

1 See for example: *Heath v. Economical Mutual Insurance Company* 2009 ONCA (CanLii); *McQueen v. Echelon General Insurance Co.*, [2009] O.J. No. 3965 (Ont. S.C.J.); *Liu v. 1226071 Ontario Inc.* 2009 ONCA 571; *Burtch v. Aviva Insurance Company of Canada*, 2009 ONCA 479; *Sorokin v. Wawanese Mutual Insurance Co.*, [2008] O.J. no. 2141 (Ont. S.C.J.), 94 O.R. 93d 81 (C.A.).

There will be no housekeeping, caregiver or attendant care benefits available to claimants who suffer “minor injuries.” Section 18.(1) states as follows:

18.(1) The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed \$3,500 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.

Section 3 of the Regulation defines minor injury as follows:

“minor injury” means a sprain, strain, whiplash associated disorder, contusion, abrasion laceration or subluxation and any clinically associated sequelae.

“sprain” means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear;

“strain” means an injury to one or more muscles, including a partial but not a complete tear;

“subluxation” means a partial but not a complete dislocation of a joint;

“whiplash associated disorder” means a whiplash injury that:

(a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and

(b) does not exhibit a fracture in or dislocation of the spine.

A partial tear injury would be included in the definition.

A Minor Injury Guideline (“MIG”) will provide a framework for goods and services under this new category: see Section 18(1).

Any amounts paid under the MIG will be included in the \$3,500 cap.

In order to exclude clients from the minor injury restrictions and the \$3,500 limit, it is important to look at section 18(2) of the regulation.

Section 18(2) states that the \$3,500 limit provided in section 18(1) “does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.”

Importantly, the regulation requires “compelling evidence”² from the persons health care practitioner to avoid application of the \$3,500 limit.

The determination will not be subject to dispute, provided the health practitioner submits compelling evidence.

There is a definition of who is considered a “health practitioner”, which includes physicians, chiropractors, physiotherapists, occupational therapists, registered nurses, psychologists.

(b) CATASTROPHIC IMPAIRMENT

There are no significant reductions to accident benefits available in catastrophic impairment cases.

The New Regulation expands the definition of “catastrophic impairment” to include single-limb amputees.

A CAT Application can only be completed by a physician if the impairment includes a brain impairment, or, if the impairment is “only” a brain impairment, by a neuropsychologist: see Section 3(5)(a), (b).

(c) INCOME REPLACEMENT BENEFITS

Under the old SABS, there were three routes to eligibility for IRBs under section 4.

1 – Employed, etc.

2 – Not employed, etc.

3 – Entitled at the time of the accident to start work within one year under a legitimate contract of employment that was made before the accident and that is evidenced in writing, etc. (for accidents that occur before April 15, 2004).³

Eligibility is now determined in section 5, which also adds a new provision preventing claimants from “re-electing” IRBs after having previously elected to receive non-earner or care-giver benefits.

IRBs continue to be capped at \$400.00/week subject to optional limit increases, but are now calculated under section 7 of the new SABS as 70% of gross earnings, rather than 80% of net earnings under section 6 of the old SABS.

² The definition of compelling evidence will no doubt be a bone of contention.

³ Under the new SABS, the criteria for the first two routes to eligibility have remained largely unchanged, and the third category (“legitimate contract of employment”) category has obviously been removed.

A provision has also been added requiring an insurer to pay up to \$2,500.00 for an accounting report to determine eligibility for IRBs.

(d) CAREGIVER BENEFITS

The New Regulation has eliminated caregiver benefits for non-catastrophic claims: see Section 13.

The caregiver benefit under the current system is \$250 per week, plus \$50 per dependent.

(e) MEDICAL/REHABILITATION BENEFITS

Medical Rehabilitation limits have undergone a major change. The CAT/Non-CAT distinction has been replaced with three categories with three different limits

- Predominantly minor injury
- Not a predominantly minor injury
- Catastrophic injury.

The \$1,000,000.00 limit on CAT injuries remains the same, however, the \$100,000.00 limit on Non-CAT injuries has been replaced with a \$3,500.00 limit on “Predominantly minor” injuries and a \$50,000.00 limit on injuries that fall between the two definitions.

Limits are now include the cost of assessments by the insured. In other words, an insured can conceivably exhaust a significant portion of his or her med/rehab limits on assessment expenses.

Optional benefits are available, entitling insureds to coverage of up to \$100,000/10 years (instead of \$50,000).

Insureds can also choose to purchase the med/rehab and attendant care enhancement, which will provide entitlement to up to \$1,100,000/Life for non-CAT injuries and up to \$2,000,000/Life for CAT injuries. However, under this enhancement the sum of all medical, rehabilitation and attendant care benefits paid in respect of an insured person for any one accident shall not exceed \$1,172,000 if the insured person did not sustain a catastrophic impairment as a result of the accident, or \$3,000,000 if the insured person sustained a catastrophic impairment as a result of the accident.

(f) ATTENDANT CARE BENEFITS

Attendant care benefits are restricted under the new SABS to claimants who have an impairment that is not a “minor injury” rather than to claimants who suffer an impairment that is not treated in the PAF under the old SABS.

The limits have also changed. In addition to \$3,000.00 monthly limit on attendant care for non-CAT claimants, there is now a \$36,000.00 per accident limit for non-CAT attendant care, with a possible buy-up to \$72,000.00 and \$6,000.00 a month. CAT limits continue to be \$6,000.00 per month up to \$1,000,000.00 per accident.

(g) HOUSEKEEPING & HOME MAINTENANCE BENEFITS

The New Regulation eliminates housekeeping benefits for non-catastrophic claims: see Section 23.⁴

The current system provides for a maximum of \$10,400 for housekeeping benefits for non-catastrophic claims.

Housekeeping benefits in catastrophic claims will be available under the New Regulation provided they are “incurred” and there is a “substantial inability” to perform these services.

Benefits in non-catastrophic cases will be shifted to the tort claim where housekeeping benefits can still be claimed, and likely for market rates.

(h) DEFINITIONAL CHANGES: “INCURRED”

In order to obtain attendant care, caregiver or housekeeping benefits, the claimant will need to establish that the benefit was “incurred” pursuant to Section 3(7)(e):

3(7)(e) subject to subsection (8), an expenses in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,

(i) the insured person has received the goods or services to which the expense relates,

(ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and

(iii) the person who provided the goods or services,

**(a) did so in the course of his or her regular occupation or profession,
or**

(b) sustained an economic loss as a result of providing the goods or services to the insured person.

⁴ Housekeeping benefits are available to insureds who have not sustained a catastrophic impairment but who have purchased optional car insurance coverage for an additional premium.

Thus, the Regulation requires the provider to prove an economic loss as a result of providing the care of services.

The definition and context of proving an economic loss will no doubt be the subject of debate.

This new provision will have an effect on family members who provide services to injured persons.

(i) APPLICATION AND TRANSITION RULES

Section 2(1) of the New Regulation states that, subject to section 68, the benefits set out in the New Regulation are provided under every policy for accidents that occur on or after September 1, 2010.

Section 68 provides insurance policies already in force before September 1, 2010 are deemed to include the following optional benefits as of September 1, 2010 – until the policies are renewed, or terminated, or lapsed:

Caregiver benefits payable in the circumstances described in section 13 if, as a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she engaged at the time of the accident even if the impairment sustained by the insured person is not a catastrophic impairment, but not for any period longer than 104 weeks of disability unless, as a result of the accident, the insured person is suffering a complete inability to carry on a normal life.

Housekeeping and home maintenance benefit payable in the circumstances described in section 23 even if the impairment sustained by the insured person is not a catastrophic impairment, but not for expenses incurred more than 104 weeks after the onset of the disability.

Medical and rehabilitation benefit of up to \$100,000 in respect of an insured person for any one accident in which the impairment sustained by the insured person is not a catastrophic impairment, instead of the maximum amount specified in clause 18 (3) (a).

Attendant care benefit of up to \$72,000 in respect of an insured person for any one accident in which the impairment sustained by the person is not a catastrophic impairment, instead of the maximum amount specified in subparagraph 2 ii of subsection 19 (3), which is \$36,000. This is essentially the same entitlement to attendant care benefits currently available under the SABS for non-CAT claims.

Any optional benefits purchased under the Old Regulation before September 1, 2010 will also continue to be in force until the policies are renewed, or terminated, or lapsed.

Further, subsections 25 (1), (3), (4) and (5) [Cost of Examinations], Parts VIII [Procedures for Claiming Benefits] and IX [Payment of Benefits], other than subsections 50 (2) to (5) [obligation to provide benefit statements], and Parts X, XI and XII apply with such modifications as are necessary in respect of benefits provided under the Old Regulation with respect to accidents that occurred before September 1, 2010. For that purpose, the following rules apply:

1. References in the New Regulation to the “Minor Injury Guideline” shall be read as references to the Pre-approved Framework Guideline referred to in the Old Regulation that would apply.
2. An amount that would, but for subsection 3 (1.3) of the Old Regulation, be paid under the Old Regulation after August 31, 2010 shall be paid under the New Regulation in the amount determined either under the Old Regulation (other than under section 24), or under subsections 25 (1), (3), (4) and (5) of the New Regulation.

Section 3 (1.3) of the Old Regulation will read as of September 1, 2010:

(1.3) No amount referred to in this Regulation shall be paid after August 31, 2010.

3. An amount described in paragraph 2 that is paid under the New Regulation shall not include any amount previously paid under the Old Regulation.

The Old Regulation also contains transitional provisions under section 3, which take effect on September 1, 2010:

The benefits set out in the Old Regulation are still provided under every policy in respect of accidents that occur on or after November 1, 1996 and before September 1, 2010. However, section 24 [Cost of examinations] and Parts X [Procedures for claiming benefits], XI [DACs], XII [“Mitigation”], XIII [Interaction With Other Systems] and XV [Miscellaneous] no longer apply, meaning the corresponding sections/parts in the New Regulation will apply.

As of September 1, 2010, subsection 3 (1.3) of the Old Regulation will state that no amount referred to in the Old Regulation shall be paid after August 31, 2010. However, subsection 3 (1.4) will provide that an amount that would, but for subsection (1.3), be paid under the Old Regulation after August 31, 2010 shall be paid under the New Regulation, but in the amount determined either under the Old Regulation (other than cost of examinations) or under subsections 25 (1), (3), (4) and (5) of the New Regulation (the new cost of examinations section).

II. TORT

Statutory deductibles will not apply in the case of fatalities. Under the current legislation, there is a \$15,000 statutory deductible for family members. The current deductible applies to claims where the FLA award is less than \$50,000.

Also on the tort-side under the new legislation, an insured person will have the option to purchase an endorsement to his or her insurance policy which will allow him or her to lower the pain and suffering tort deductible from \$30,000 to \$20,000. The same benefit would reduce the FLA deductible from \$15,000 to \$10,000.

We do not believe this endorsement will be very popular.

III. RECENT DECISIONS OF IMPORTANCE

1. *Vanderkop v. The Personal Insurance Company of Canada*⁵

(a) Background

In this case, the Court of Appeal reviewed a trial decision in which the insurer was ordered to pay income replacement benefits without being able to deduct long term disability benefits.

(b) Facts

The Plaintiff, Ms. Vanderkop, was receiving income replacement benefits from the Personal Insurance Company of Canada.

At the same time, Ms. Vanderkop advanced a claim for long-term disability benefits against Manulife Insurance (the “LTD claim”) after Manulife denied her monthly LTD benefit.

The LTD claim was settled for a lump sum amount of \$57,500.00. The Minutes of Settlement provided that the lump sum payment was for all past, present and future claims, including aggravated damages, punitive damages and damages for mental distress.

(c) Issues and Analysis

At trial, the Personal Insurance Company took the position that it was entitled to deduct the amount of the long-term disability settlement as well as the future long-term disability payments which were available and given up by Ms. Vanderkop in her LTD settlement with Manulife.

After the mediation, Personal refused to pay IRBs to Ms. Vanderkop even though she met the test for entitlement.

⁵ [2008] O.J. No. 1937 (Ont. SCJ), [2009] O.J. No. 2616.

It took the position that Ms. Vanderkop did not apply for LTDs with the meaning of section 7 of the Schedule.

It also contended that it could deduct any LTD payments that might have been payable had Ms. Vanderkop successfully litigated with Manulife pursuant to s. 7(1)1(ii) of the SABS.

Section 7(1) 1 reads as follows:

7. (1) Despite subsection 6(1) but subject to subsections 6(2) to (6), the weekly amount of an income replacement benefit payable to a person shall be the lesser of the following amounts:

1. The amount determined under subsection 6(1), reduced by,

i. net weekly payments for loss of income that are being received by the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, and

ii. net weekly payments for loss of income that are not being received by the person but are available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, unless the person has applied to receive the payments for loss of income.

Both the trial judge and the Court of Appeal did not accept either position advanced by the Personal Insurance Company, and held that the Personal was not entitled to any deduction for a payment in respect of the lump sum settlement payment made by Manulife.

The Court of Appeal stated that “IRBs are to be reduced by LTD being received as a result of the accident. The legislation does not entitle Personal to set off hypothetical benefits applied for but refused. Ms. Vanderkop was not in receipt of LTD.”

It further held that “to treat LTD as being available would effectively oblige an insured to litigate with their collateral benefits insurer, at their own risk and expense, for the benefit and at the discretion of, their accident benefits insurer. In our view, SABS places no such obligation on an insured.”

Thus, where a settlement is entered with a long-term disability carrier that does not provide any specific breakdown with respect to how that settlement was reached, the payments do not constitute “a payment under any income continuation plan” in accordance with section 7 of the SABS, and consequently are not deductible from an income replacement benefits that may be ongoing.

The Court discussed the procedure an insurer should undertake in seeking to obtain a deduction in respect of an LTD settlement. It also noted that an insurer has the onus to prove that a settlement of an LTD claim is unreasonable in all circumstances and must establish beyond dispute that an insured would be entitled to ongoing payments and

quantum had a settlement not been entered into. Failure to lead evidence to demonstrate that an insured would be entitled to ongoing LTDs absent a settlement is fatal to a claim to deduct those benefits.

(d) Comments/Concerns

The result of the *Vanderkop* decision is that there will be fewer global mediations involving LTD/AB/Tort defendants since LTD insurers and plaintiffs will attempt to settle their cases separately.

Certainly, from the perspective of Plaintiff's counsel, it will be more advantageous to resolve disputes with LTD insurer separately and subsequently proceed against the tort and accident benefits defendants.

2. *Pastore and Aviva Canada Inc.*⁶

(a) Background

The FSCO appeal decision of *Pastore and Aviva* states that a person injured in a motor vehicle accident requires only one marked (i.e. Class 4) impairment to be considered catastrophically impaired.

The decision further holds that a pain disorder can be considered as a factor in assessing the impact of one's injuries on mental or behavioural disorders.

This is the first time that an appeal decision has held that an individual can have one Class 4 marked impairment and be found to have a catastrophic impairment.

The decision raises the importance of a careful and comprehensive consideration of mental or behavioural impairments in evaluating an insured's entitlement to extended benefits coverage.

(b) Facts

Ms. Pastore suffered several orthopaedic injuries, including a fracture of her left ankle which required several surgeries, as a result of a car accident. She also underwent a right knee replacement.

From a psychological perspective, Ms. Pastore was diagnosed with a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

⁶ FSCO AO4-002496, FSCO P09-00008, December 22, 2009

A CAT DAC found that she had a Class 4 marked impairment in the sphere of activities of daily living but that she did not meet the 55% Whole Person Impairment under section (f).

(c) Issues & Analysis

A five-day arbitration hearing was held in April 2008 before Arbitrator Nastasi (the "Arbitrator") to determine whether Ms. Pastore had sustained a catastrophic impairment as defined in clauses 2(1.1)(f) or (g) of the Schedule.

The Arbitrator found that Ms. Pastore's combined whole person impairment rating was 39 per cent, which included a 22 per cent whole person impairment for her psychological impairments.

Accordingly, the Arbitrator concluded that Ms. Pastore had not sustained a catastrophic impairment under clause 2(1.1)(f) of the Schedule, since the combination of impairments did not result in 55 per cent or more impairment of the whole person, which is required for a catastrophic determination under this section.

The Arbitrator then went on to consider whether catastrophic status could be found based on section 2(g) of the Schedule.

Section 2(g) states that catastrophic designation will follow a finding of "marked" or "extreme" impairment, pursuant to Chapter 14 of the American Medical Association Guidelines (the "AMA Guides"). Specifically, clause (g) provides that a "catastrophic impairment" means an:

impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

The AMA Guides specifically address four areas or spheres of functioning under the mental or behavioural impairments:

- (1) activities of daily living;
- (2) social functioning;
- (3) concentration, and;
- (4) adaption.

Furthermore, a class of impairment is assigned to each of these four areas of functioning as follows:

- Class 1 is no impairment;
- Class 2 is mild impairment;

- Class 3 is moderate impairment;
- Class 4 is marked impairment;
- Class 5 is extreme impairment.

The commentary defines “marked” and “extreme” as follows:

“marked” is a level of impairment that significantly impedes use or functioning. Taken alone, a marked impairment would not preclude useful functioning, but together with marked limitation in another class, it might limit useful functioning.

“Extreme” means that the impairment or limitation is not compatible with useful Function.

The same section goes on to state:

In the ordinary individual, extreme impairment in only one class would be likely to preclude the performance of any complex task, such as one involving recreation or work.

Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special support or assistance, such as that provided in a sheltered environment.

The question of how many spheres need to be marked or extreme in order to reach the catastrophic threshold was considered in more detail by the Arbitrator in Pastore.

Following a detailed analysis, the Arbitrator found that Ms. Pastore suffered a marked impairment in her activities of daily living. In addition to her physical restrictions, she suffered from a pain disorder.

Accordingly, the Arbitrator held that the insured’s impairment fell within a class 4 marked level of impairment with regard to her activities of daily living and thus met the definition of catastrophic impairment.

In reaching her conclusion, the Arbitrator reviewed the court decision of *Desbiens v. Mordini*⁷ which noted in obiter that it would be sufficient to establish a catastrophic impairment for the insured to establish a class 4 or 5 impairment in any one of the areas of functioning (emphasis added). The Arbitrator found “there was nothing in the language of clause (g) to suggest that the approach taken by the Court in *Desbiens* is incorrect.”

The Superintendent’s Guidelines for undertaking DAC assessments notes that two marked impairments are required to render a catastrophic determination under the (g)

7 2004 CanLII 41210 (ON S.C.)

criterion. On this issue, the Arbitrator applied the principle of liberal interpretation to the *Schedule*.

She also determined that the SABS Guidelines are only an assessment tool for physicians, are not incorporated into the legislation and, as a result, she was not bound by such Guidelines.

The Arbitrator concluded that, given the importance of each area of functioning, the loss of any one alone is significant and adequate to meet the definition of catastrophic impairment:

It is clear that these areas represent the most basic and core aspects of function – they are the things that define us. The four areas are interrelated with significant overlap between them.

If an individual has reached a marked level of impairment in any one area, then they are being deprived of a level of function in a basic and core area of life. This amounts to a serious loss. It is highly unlikely that in such a case the other areas of function would not also be negatively affected in some way.

On Appeal, Aviva submitted the following arguments:

- (a) The Arbitrator erred in law in finding that it was sufficient for Ms. Pastore to have suffered a marked impairment in only one of the four areas of functioning on page 14/301 of the Guides;
- (b) The Arbitrator erred in law in finding that Ms. Pastore suffered a marked impairment in the one area of assessment, having erred in including physical impairments with mental or behavioural impairments.

Aviva argued that it was inconsistent to find that an insured was catastrophically impaired under Chapter 14 based on one Class 4 impairment when she did not meet the 55% whole person impairment test, which included both psychological and physical impairments combined.

The Director's Delegate did not find it to be inconsistent that when looking at 55% whole person impairment Ms. Pastore was given a psychological rating in a moderate range but when making a determination under mental or behavioural provisions she could be given a marked impairment.

Aviva also argued that one must separate impairments that are related to pain that is a consequence of the physical impairments and that it cannot be counted again when dealing with mental and behavioural disorders. It submitted that the Arbitrator erred in basing her assessment of marked impairment in the sphere of Activities of Daily Living based on all causes responsible for Ms. Pastore's limitations (that is, her knee and

ankle injuries, pain from these injuries as well as pain that did not have a somatic cause, depression and anxiety).

The Director's Delegate rejected this argument stating: "there is no statutory requirement that an Arbitrator dissect the mental or behavioural disorder into supposed constituent parts...".

He did not accept the argument that the mental or behavioural disorder must be "solely due to a psychological impairment".

Thus, the decision stands for the proposition that one marked impairment is sufficient to meet the definition of catastrophic impairment pursuant to section 2(1.1)(g) of the *Schedule*.

The decision further holds that pain can be considered when assessing physical impairment for a whole person impairment rating and then again when assessing a mental or behavioural impairments.

(d) Comments/Concerns

Following this ruling, it is now more likely than ever that chronic pain cases could meet the catastrophic threshold.

The *Pastore* decision will definitely lead to an increase in the number of catastrophic claims.

As a result, insurers will need to strategically assess whether they want spend the time and money disputing the catastrophic determination issues or instead attack the case on entitlement to a specific benefit only.

1. *Rougoor v. Co-Operators General Insurance Company*⁸

(a) Background

Christine Rougoor was insured under a standard Ontario automobile policy with Co-Operators for each of several family-owned vehicles. She was listed as principal driver for one off-road dirt bike and as a secondary driver for another off-road dirt bike.

Rougoor was seriously injured in Florida while riding a dirt bike of the same make and model as one of the dirt bikes insured under her Ontario policy with Co-Operators. That Florida dirt bike was owned by a friend. Under Florida law, the friend was not required to insure his dirt bike and he had not done so.

8 2010 ONCA 54 (CanLII)

Co-Operators denied Rougoor's claim for accident benefits under her policy. The application judge dismissed her application for a declaration of entitlement. She appealed to the Court of Appeal.

The issue was whether the Florida dirt bike was an "automobile" within the meaning of Rougoor's policy or under an extended definition of "automobile" under any applicable legislation.

(b) Finding

The Court of Appeal allowed the appeal, finding that the Florida dirt bike was an "automobile" within the wording of Rougoor's insurance policy.

The Court found that she had purchased insurance to cover the risk of riding dirt bikes, and that her policy provided such coverage by treating her dirt bikes as "automobiles". As Rougoor's dirt bike in Ontario was an "automobile" for the purpose of coverage under the policy, the dirt bike in Florida must also be considered to be an "automobile" under the terms of the policy. Section 2.2.3 of Rougoor's policy extended coverage for any "other automobile" driven by her in Canada or USA.

Therefore, she was entitled to claim accident benefits under her policy.

(c) Comments/Concerns

Since *Regele* and *Morton*, we have had reason to believe that the concept of "what is an automobile" was limited. However, *Rougoor* highlights that the scope of "what is an automobile" is expandable. The decision extends coverage to any device that is in fact the kind of vehicle insured under the subject policy of insurance.

Therefore, insurers that list devices under their automobile policies can likely expect to have to extend coverage for accidents when their insureds are operating similar devices.

2. *Jetty v. ING Insurance Co. of Canada*⁹

(a) Background

As a result of injuries sustained in a motor vehicle accident on July 31, 2003, Dean Jetty applied to ING Insurance for accident benefits. Mediation was conducted by FSCO regarding Jetty's entitlement to income replacement benefits. The July 28, 2005 Report of Mediator confirmed settlement of this issue. Concurrently, the ING's lawyer sent Jetty's lawyer a release and a Settlement Disclosure Notice. These were returned on August 3, 2005, having been signed by Jetty on July 29, 2005.

⁹ 2010 ONSC 1091 (CanLII).

By letter dated September 7, 2005, Jetty rescinded the settlement, stating that ING had not complied with subsection 32(2) of the SABS and the Commissioner's Guideline No. 2/96 respecting IRB entitlement and calculation. More specifically, Jetty's lawyer advised that ING had failed to comply with the Settlement Regulation, by not informing him of his entitlement under subsection 6(5) of the SABS to 80% of his net losses from self-employment. He also advised that ING's representative had not signed the notice, contrary to subsection 9.1(2) of the Settlement Regulation. Of note, the Settlement Disclosure Notice had the name of ING's lawyer and his phone number on the disclosure notice.

A preliminary issue came before Arbitrator Killoran as to whether Jetty had indeed settled his IRB claim. The arbitrator held that the claim was not settled, because:

1. ING failed to have its signature on the Settlement Disclosure Notice. This was not a technical or inconsequential error, but was required by the mandatory language of the Settlement Regulation to both formalize and finalize the settlement process.
2. The statement in the Settlement Disclosure Notice that the maximum IRB available to Jetty was \$400 a week was not correct. As evidenced by its accountant's reports upon which it relied, ING knew that Jetty was self-employed and was entitled to have 80% of his business losses added to his IRB. ING was obliged to state this in the Settlement Disclosure Notice.

Those findings were upheld on appeal. With respect to the signature issue, the Director's Delegate held that when the legislation or regulation in question does not prescribe the manner of signature, it is necessary to consider the purpose or intent of the regulation. In this case, the Regulation is geared towards the protection of the consumer. "Consumer protection is not enhanced if, as a matter of routine, neither principal is required to put pen to paper, the insured confirming that he or she has received and read the Settlement Disclosure Notice and the insurer certifying that the information in the Notice is complete and correct". He also held that the signature page of the Settlement Disclosure Notice uses the words "representative of the insurer", not "legal representative of the insurer". Furthermore, the "Notice and Caution" in the Settlement Disclosure Notice states that the form "must be completed and signed by your insurer."

ING then applied for judicial review.

(b) Findings

In dismissing the application for judicial review, the Divisional Court held that the FSCO decisions were reasonable. The Court held that the insured could have been misled by a statement that the maximum income replacement was \$400 per week, as statutory entitlement for self-employed claimants was 80 per cent of losses.

The Court stated in obiter that if the only basis for the decision to allow Jetty to rescind the settlement agreement had been the fact that the Settlement Disclosure Notice was signed in typed form by the insurer's lawyer, then the Court's view as to the reasonableness of that decision would have been different.

The Court opined that, while doing what one can to ensure that the insurer provides complete and accurate information to the insured is consistent with the purpose of the regulation, it would be unreasonable to suppose that this goal would be achieved or furthered by a requirement that the insurer sign in a particular way, namely by "putting pen to paper". The common law allows for a signature to be handwritten, stamped or typed, providing that the affixing of the signature conforms with the intent of the legislation. In this case, the intent of the legislation would not be affected or undermined if the signature of the insurer is typed, rather than hand-written.

Further, the Court opined that it was an unreasonable conclusion that the term "representative of the insurer" precluded the insurer's lawyer from signing as that "representative". A lawyer is an agent of his or her client. The lawyer is assumed to have authority to act on the client's behalf and to effect a compromise of the client's claims. The Settlement Regulation does not change these assumptions.

(c) Comments/Concerns

The Settlement Disclosure Notice is a "prescribed form", which is approved by the Superintendent. Insurers are required to use this form, yet the form itself appears to expose insurers to rescinded settlements because the form fails to disclose adequately the maximum IRB limits (at least in certain circumstances). Had ING added onto the prescribed form its own disclosure about the maximum IRB available to Jetty, could he then have argued that ING failed to use the prescribed form because the disclosure had been modified?

With respect to the signature issue, probably the safest way to avoid trouble would be to have the representative of the insurer (i.e., the handling adjuster) sign the form.