

What's Hot and What's Not from FSCO

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The year 2004 was not an eventful one at the *Financial Services Commission of Ontario*.

There were no earth-shattering decisions and no surprisingly new legal developments. Of the more than 180 decisions handed down, only approximately 40 were substantive arbitration decisions following a full hearing on the merits. The rest were motions, preliminary issue hearings, appeals and expense hearings.

For those of you keeping score, out of the 40 substantive arbitration decisions, the insureds were "successful" in 20 and "lost" 16. The other four I would consider to be true "split decisions". Although success and failure can be very subjective, I believe that these statistics are relatively accurate.

In the 27 appeal hearings, the vast majority of the decisions (20) substantially or entirely upheld the result from the arbitration, while only 7 appeals were substantially successful.

After reviewing all of the decisions from 2004, the following, in no particular order, are the decisions that I found to be the most novel and interesting (with apologies to anyone whose case did not make the cut).

Singh and State Farm (FSCO A03 B000118 and 119)

Facts - the applicant was involved in 2 accidents, and claimed IRBs from accident #1 and caregiver benefits from accident #2 (while the IRBs were still being paid).

Issue - s. 36 of the *S.A.B.S.* states that only one type of weekly benefit may be paid to a person in respect of a period of time. Can the insured receive both types of benefits simultaneously when they are claimed as a result of 2 different accidents?

Result - the insured can receive both benefits. S. 36 was held to apply to only a single MVA, such that the insured can claim two different weekly benefits from two different accidents.

Swaby and Allstate, Souchuk and State Farm, Saad and Federation and Liu and

Lombard (Appeal P03-00004, P02-00039, P03-00017 and P02-00030)

Facts - this series of 4 appeals dealt with the definition of "accident", and the application of *Chisholm v. Liberty* (2002), 217 D.L.R. (4th) 145 (Ont. C.A.) to various fact scenarios. The insureds were injured, respectively, as a result of:

- 1) being shot and stabbed in a carjacking;
- 2) slipping and falling after exiting a car to run to another car that had been involved in an accident;
- 3) slipping and falling while filling the car tires with air; and
- 4) being assaulted during a robbery on a bus.

Issue - were the insureds injured as a result of an "accident" and therefore entitled to claim benefits pursuant to the *S.A.B.S.*?

Result - 1) no; 2) yes; 3) yes; and 4) no (**Conclusion** - it is better to slip and fall outside of an automobile, than to be assaulted while in an automobile).

Also see - Sohi and ING (FSCO A03 B001125), where the insured purposefully set himself on fire following an accident and claimed benefits as a result of the burns.

Wilkerson and Allianz (FSCO A03 B000753)

Facts - the insured claimed a special award and wanted various productions from the insurer to support same.

Issue - was the insured entitled to production of the complete accident benefits file from the insurer?

Result - the insured was entitled to production of the complete file. This case contains a good review of the law in this area.

Also see - Partola and Liberty (FSCO A03 B000097) regarding related production issues.

Stelzer and Zurich (Appeal P02 00035)

Facts - the insured had previously proceeded to arbitration regarding certain treatment expenses incurred from January 1997 - June 1998, which arbitration was dismissed. The insured now wished to proceed to arbitration regarding the same treatment expenses, but covering the period of time after June 1998.

Issue - was the insured precluded from proceeding with the second arbitration based on the doctrine of issue estoppel?

Result - the insured was permitted to proceed, since the issue in dispute was not on all fours with the previous arbitration, based solely on the different time periods involved.

Paunova and Allstate (FSCO A02 B001087)

Facts - the arbitration hearing took place over the period May - December 2003. After all of the evidence was heard, but before closing submissions, the insured had an incident where she became dizzy and fell, causing further injuries.

Issue - could the insured re-open her case to call evidence regarding the fall and resulting injuries, and try to prove that it was causally related to the accident?

Result - the insured was permitted to re-open her case. The Arbitrator followed the criteria set out in *R. v. Palmer*, [1980] 1 S.C.R. 759 and found that this case involved the type of rare circumstances which permitted the hearing to be re-opened.

Szabo and CAA (Appeal P03-00015)

Facts - the insured originally told the insurer that he was not employed at the time of the accident. Later, the insured admitted that he was, in fact, employed and working at the time of the accident and requested IRBs. His original non-disclosure was based on his concern that his pre-accident WSIB benefits might be affected by the fact that he was working.

Issue - did s. 48 of the *S.A.B.S.* permit the insurer to deny IRBs on the basis that the insured "willfully misrepresented material facts with respect to an application for a benefit"?

Result - the insurer was permitted to deny benefits based on the material misrepresentation, even though the insured's original misrepresentation resulted in the underpayment, not the overpayment, of benefits, to his detriment.

Jiwa and Royal (FSCO A03 B000156)

Facts - following the full and final settlement of an accident benefits claim, the insurer sent the settlement cheque, payable to the insured, to his paralegal's office. The paralegal endorsed the cheque, deposited it in his account, and never gave the settlement funds to the insured.

Issue - did the insurer breach s. 44 of the *S.A.B.S.*, which required the cheque to be mailed to the address where the insured person ordinarily resides, such that the insurer could be required to pay the settlement funds again directly to the insured?

Result - the insurer breached the clear wording of s. 44 and was required to re-pay the settlement funds to the insured. If an insurer sends settlement funds anywhere but the residence of the insured, it does so at its own risk.

Antony and RBC (Appeal P03-00023)

Facts - the insured elected, pursuant to s. 36 of the *S.A.B.S.*, to receive caregiver benefits, but later wanted to revoke that election and receive income replacement benefits instead.

Issue - was a s. 36 election revocable?

Result - a s. 36 election is revocable. If it is after the 30-day election period, the insured must have a reasonable explanation. Further, in order for the election to be valid

in the first place, the insurer must provide sufficient information for the insured to make an informed election.

Totic and Primmum (Appeal P03 B000023)

Facts - the insured applied for a death benefit in 1999, but only supplied sufficient support for the application (i.e. proof of dependency) in 2002.

Issue - was interest on the death benefit payable from the time of the application, or from the time that the supporting documents were provided?

Result - in accordance with the clear wording of s. 41 of the *S.A.B.S.*, the death benefit is payable within 30 days after the insurer receives the application. Therefore interest was payable from 1999. It should be noted that the insurer did not make a formal s. 33 request for information following receipt of the application.

Virk and Liberty (FSCO A03 B000023)

Facts - an unborn child was injured *en ventre sa mere* in an accident, was born one day after the accident and subsequently died due to accident related injuries.

Issue - was the child's mother entitled to a death benefit?

Result - the mother was entitled to the death benefit. Although the child was not a "person" at the time of the accident, the child acquired all legal rights upon birth and was clearly dependant on mother at the time of death.

Cameron and Pilot (FSCO A03 B000714)

Facts - the insured attended a D.A.C. as requested, but insisted on videotaping the assessment. The D.A.C. refused to permit the videotaping, and therefore would not go ahead with the assessment.

Issue - did the insured fail to make himself "reasonably available" for the D.A.C. assessment such that he was precluded from proceeding to arbitration?

Result - the insured did make himself reasonably available for the assessment and could therefore proceed to arbitration. There is no absolute prohibition on recording assessments. The insured gave valid reasons for his request, and the D.A.C. failed to provide any reason as to why the assessment could not be videotaped.

Iankilevitch and CGU (Appeal P03-00013)

Facts - the insured significantly delayed providing documents to the insurer, requested pursuant to s. 33 of the *S.A.B.S.*, to support the quantum of his IRB.

Issue - did a breach of s. 33 by the insured result in a forfeiture of the benefits owing during the period of the delay, or simply a suspension of the benefits which must then be paid when the information is received?

Result - a s. 33 breach will only result in a suspension of benefits, not a forfeiture of benefits. The breach does affect the entitlement to interest (as well as any special award claimed by the insured), but it does not affect the entitlement to the benefits themselves once the information is provided by the insured.

Kozdra and Canadian General (FSCO A01 B000390)

Facts - the insurer properly served three surveillance tapes on the insured, intending to rely upon them at the arbitration. At the arbitration hearing, the insurer submitted four tapes to the Arbitrator. The fourth tape had not been served on the insured through inadvertence.

Issue - was the insurer prevented from relying upon some or all of the surveillance tapes due to Rule 40 of the *Dispute Resolution Practice Code*?

Result - the insurer was prevented from relying upon **all** of the surveillance tapes. Rule 40 states that, if the insurer intends to rely upon any surveillance, all tapes must be served on the insured at least 30 days before the hearing. Since the insurer had not complied with Rule 40, it could not rely upon any of the surveillance.

Also see - Cheraghi-Sohiv and Zurich (FSCO A03 B000148) wherein the insurer was ordered to disclose the existence of surveillance, even if the insurer did not intend to rely upon that surveillance.

Sivaloganathan and Liberty (Appeal P03 00035)

Facts - the insured attended a disability D.A.C., which concluded that the insured continued to be disabled. Five months later, the insurer attempted to terminate the benefits again.

Issue - can the insurer start the termination process again after a "positive D.A.C.", or must the insurer dispute the original D.A.C. findings through the dispute resolution process?

Result - the insurer cannot attempt to re-start the termination process. In accordance with s. 37 (5) of the *S.A.B.S.*, the insurer may dispute the obligation to pay the benefits, but it must pay the benefits pending the resolution of the dispute. However, the insurer may re-start the termination process as a result of the test change for IRBs after 104 weeks.

Tan and Royal & Sunalliance (FSCO A04 B000656) *first Bill 198 FSCO decision*

Facts - the insured incurred the expense of an in-home assessment, and later submitted an OCF-22, pursuant to the Bill 198-revised *S.A.B.S.*, for the insurer to approve payment of the assessment.

Issue - does the OCF-22 have to be submitted before the assessment takes place?

Result - s. 24 (1.1) of the *S.A.B.S.* is clear in stating that the insurer is not required to pay for an assessment expense if it is incurred before obtaining the approval of the insurer, or before a D.A.C. report regarding the requested assessment is delivered. Since the assessment expense in question was incurred before either of these events, it was not payable by the insurer.

After reviewing the decisions from 2004, a number of trends can be discovered. The vast majority of decisions would not permit insurers to conduct insurer examinations after the pre-hearing. It was determined that these assessments were only being conducted to bolster the insurer's case, and were not being conducted in accordance with the *S.A.B.S.* The arbitrators continued to be frustrated with the representation provided by many paralegals, and they made several cost awards against the paralegals, personally. In fact,

many unrepresented insureds fared better than those represented by paralegals. Although insureds were successful in most of the claims for s. 24 expenses, the arbitrators did not hesitate to reduce the amount of the account, holding that many of the expenses were unreasonably high.

In conclusion, while 2004 was not an overly interesting year for FSCO decisions, the future looks very promising. All of the Bill 198 changes should serve to make 2005 a much more exciting time at the *Financial Services Commission of Ontario*.

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