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10 Decisions that will Impact Your Motor Vehicle Litigation Practice

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This paper addresses eight influential accident benefits decisions from 2014, in combination with two tort decisions regarding developments in threshold case law. It is our hope that our summaries and commentary will help guide your motor vehicle litigation practice for a successful 2015.

To Be Discussed By Canada's Highest Court

1. *Zurich Insurance Company v. Chubb Insurance Company of Canada*, 2014 ONCA 400 - leave to appeal granted to the Supreme Court of Canada

The issue to be determined in this priority case was the applicability of the "pay first and dispute later" rules pertaining to insurers who receive an Application for Accident Benefits when they are not the priority insurer.

Ms. Sukhvinder Singh rented a vehicle from Wheel 4 Rent in 2006. The vehicle was insured pursuant to a "motor vehicle liability policy" issued by Zurich. Chubb issued an accident policy to Wheels 4 Rent which contained no coverage for liability to others with respect to motor vehicle accidents.

After being involved in a single-vehicle accident, and despite having declined to purchase the optional death and dismemberment policy offered by Chubb, Ms Singh submitted an application for Statutory Accident Benefits to Chubb. It declined benefits on the basis that the optional policy was not a motor vehicle policy, and had been declined. Chubb argued the Statutory Accident Benefits scheme did not apply because it was not an "insurer" under the Ontario *Insurance Act*. Eventually, she received benefits from Zurich Insurance Company, which insured Wheels 4 Rent's rental vehicles pursuant to a "motor vehicle liability policy". Zurich administered the claim on a "without prejudice" basis, arguing Chubb was the first insurer to receive the Application and should have paid first.

At arbitration, Arbitrator Stanley C. Tessis determined, based on agreed facts, that Chubb was not an insurer for the purposes of the *Insurance Act* and Regulation 283/95, *Disputes Between Insurers*, because Chubb had not issued a "motor vehicle liability policy" to Wheels 4 Rent or Ms. Singh. Under the arbitration agreement, that meant Chubb was not obligated to pay benefits under the "pay first, fight later" rules, and Zurich should pay.

Zurich appealed and Superior Court Justice Robert Goldstein allowed Zurich's appeal on the grounds that Chubb was an "insurer" under the statutory regime because its policy was a "motor vehicle liability policy" and there was *sufficient nexus* between Chubb and Ms. Singh to require the payment of accident benefits.

The Court of Appeal overturned Justice Goldstein's decision, stating that the judge erred in concluding the Chubb policy was a motor vehicle liability policy. The Chubb policy did not contain any of the necessary elements regarding death and dismemberment which are contained in the highly regulated content of a motor vehicle liability policy in Ontario. As such, Chubb was not required to respond to Ms. Singh's accident benefits claim. There was no consideration of whether a sufficient "nexus" existed between Chubb and Ms. Singh for her to claim accident benefits, because no motor vehicle liability policy existed.

The Supreme Court of Canada granted leave to appeal this decision on November 27, 2014. It will be interesting to see how Canada's highest court will interpret this often argued priority issue.[1] Insurers will certainly benefit from any clarity the SCC can provide with respect to this subject matter.

Regarding Examinations Under Oath:

2. *Singh and State Farm Mutual Automobile Insurance Company* (FSCO A12-007594), August 22, 2014

State Farm brought a motion for an order that the Applicant is not entitled to benefits from October 16, 2012, as she refused to submit to an examination under oath ("EUO"), requested pursuant to s. 33 of the *SABS*. The Applicant responded by bringing a cross-motion for an order preventing State Farm from examining her with respect to income replacement or housekeeping benefits. Given the date of loss, this case was decided in accordance with the *SABS – accidents on or after November 1, 1996.*

The factual basis for the hearing was that State Farm had requested the Applicant attend EUO an August 1, 2012, scheduled for October 16, 2012. The Applicant duly attended the EUO on that date, however refused to answer questions relating IRBs and housekeeping benefits because State Farm had initially agreed to pay the subject benefits and therefore questions regarding entitlement to same were irrelevant.

The Applicant argued that under s. 35(2) of the *SABS*, if an insurer decides to pay benefits it cannot also require the insured to submit to an EUO. State Farm's position was the only restrictions for conducting an EUO are found in section 33 and nothing in the language of s. 35(3) precluded an EUO in the case at hand.

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[1] See for example, *Kingsway General Insurance Co. v. Ontario (Minister of Finance)*, 2007 ONCA 62, 84 O.R. (3d) 507 and *Kingsway General Insurance Co. v. West Wawanosh Insurance Company* (2002), 58 O.R. (3d) 251 (C.A.), both referred to in Chubb.

Arbitrator Bayefsky's decision found exclusively in favour of State Farm. Namely, the Applicant's cross-motion was dismissed; she was ordered to make herself available for an EUO; and the arbitration hearing would be adjourned, *sine die*, until she attended at the requested EUO. Arbitrator Bayefsky found that s. 35(3) required an insurer to respond in one of three ways to the initial application for benefits, but did not diminish the insurer's ability to require an insured's attendance at an EUO. To interpret s. 35(3) in the manner proposed by the Applicant would produce an "absurd result" that the insurer would be prevented from taking any other steps in adjusting the claim once it had chosen one of the three proposed options.

This decision emphasizes the importance of examinations under oath in the gathering of information under s. 33. It further confirms that an Applicant cannot expect to claim benefits without co-operating with reasonable requests for information made by the insurer.

3. *Williams and State Farm Mutual Automobile insurance Company* (FSCO A140-001463), December 5, 2014

Given the result in *Singh and State Farm* above, this decision of this preliminary issue hearing certainly came as a surprise! The good news is that it is under appeal.

Mr. Neil Williams ("the Applicant") applied for accident benefits from State Farm following a motor vehicle accident on August 6, 2008.[2] He received income replacement as of October 7, 2008 and housekeeping benefits in the amount of $10,400.00. State Farm requested the Applicant attend for an EUO, and on November 29, 2013 the examination took place. According to the transcript, the EUO lasted approximately 10 minutes and the Applicant refused to answer any questions relating to housekeeping or income replacement benefits. Pursuant to s. 33(6), State Farm subsequently terminated the Applicant's IRBs for his refusal to submit to an EUO.

At the hearing, the Applicant took the position that State Farm was required to request and EUO within 10 business days of receiving the Application for Accident Benefits (OCF-1) and completed Disability Certificate (OCF-3). The Applicant based his argument on s. 36(4)(c) of the *SABS* which reads:

> *(4) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,*
>
> *(a) pay the specified benefit;*
>
> *(b) give the applicant a notice explaining the medical and any other reasons why the insurer does not believe the applicant is entitled to the specified benefit and, if the insurer requires an examination under section 44 relating to the specified benefit, advising the applicant of the requirement for an examination; or*
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> ***(c) send a request to the applicant under subsection 33 (1) or (2).*** [Emphasis added]

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[2] Despite the date of loss, the Preliminary Issue Hearing considered the *post-September 1, 2010 SABS*.

State Farm took the position that there was no time limit with respect to when it could request an EUO.

Arbitrator Maggie Murray found in favour of the Applicant. It was her interpretation that s. 36 of the *SABS* modified s. 33, "by placing a time limit on when an examination under oath can be requested." Arbitrator Murray stated that State Farm was 1,707 days too late in its request an examination under oath for a specified benefit and was therefore precluded from doing so.

Arbitrator Murray further found that State Farm was not entitled to rely on s. 33(6) of the *SABS* to suspend IRBs. This determination was based on the fact that State Farm was "too late" to conduct the EUO. State Farm was obliged to recommence payment of IRBs because its request for an EUO was not valid under s. 33 because it was not made within the 10 days prescribed by s. 36(4)(c).

We respectfully disagree with the findings in this decision. Arbitrator Murray stated that she used the principles of statutory interpretation set out by the Supreme Court of Canada, namely that legislation should be read in its entire context and its normal grammatical sense. From this rule, she concluded that s. 36(4)(c) *modified* s. 33 of the *SABS*, however this conclusion overlooks the fact that s. 36(4) deals with the possible responses to the application for a specified benefit and does not serve to change the insurer's ability to conduct an examination under oath under s. 33. Arbitrator Murray's interpretation gives rise to the same "absurd result" referred to in *Singh* that no other steps would be able to be taken in adjusting the claim after the 10 day period in which an insurer is required to respond to a benefit.

We anxiously await the results of the appeal. For the time being, we recommend that insurers continue with EUOs as per the normal course and rely on the *Singh* decision discussed above which is of equal weight to *Williams*.

Loss Transfer in 2014

4. *TD General Insurance Company v. Markel Insurance Company,* 2014 ONSC 6461

TD Insurance appealed Arbitrator Lee Samis' decision that loss transfer indemnification is a "right that only accrues to the highest priority insurer, in this case the Respondent (Markel)". Arbitrator Samis' decision meant that TD was prohibited from seeking loss transfer indemnification.

The facts in this case are as follows: on November 26, 2008, Mr. Marok was involved in a motor vehicle accident while a passenger in a large commercial vehicle insured by Markel. He had been hired by a trucking company to assist, with another driver, in making a trip to Western Canada. No contract was signed between Marok and the trucking company.

Following the accident, Marok submitted an Application for Accident Benefits to TD, the insurer of his personal vehicle. On February 20, 2009, TD first sent Markel a *Notice of Dispute Between Insurers*, stating that priority rested with Markel. Two weeks later, TD sent a Loss Transfer Request for Indemnification to Markel requesting full indemnification. Markel denied that priority rested with it and on February 23, 2010, TD served a *Notice of Commencement of Arbitration* on Markel.

The *Notice of Arbitration* was served outside the limitation period prescribed by O. Reg. 283/95, s. 7(3). Section 7(3) of the regulation requires that an insurer initiate arbitration proceedings within one year of serving a *Notice of Dispute*.

The issues on appeal were whether Arbitrator Samis was mistaken in finding that Marok's use of the truck insured by Markel was considered "regular use" of the vehicle. Additionally, TD argued that Arbitrator Samis was incorrect in concluding that the loss transfer provisions of the *Act*[3] could only apply to the priority insurer.

Justice Lederman upheld the Arbitrator's decision that Marok's use of the Markel-insured vehicle was "regular" and it was irrelevant how long his usage had been prior to the accident. As such, if TD had not missed the limitation date to argue priority, priority would have rested with Markel. It was confirmed that the loss transfer provisions of the *Insurance Act* were developed to balance the costs of no-fault benefits between different classes of vehicles. Section 268 suggests that loss transfer is contemplated only after the resolution of any priority disputes. The Arbitrator was correct in interpreting that s. 275 of the *Insurance Act* applies only to the highest priority insurer. TD was required to pay the accident benefits of Mr. Marok and not permitted to seek indemnity from Markel, because only the true priority insurer is permitted to make a loss transfer claim.

This decision provides counsel in priority and loss transfer disputes with an important reminder to take heed of the limitation dates under O. Reg. 283/95 and confirms that only the true priority insurer has standing to claim loss transfer.

5. *State Farm Mutual Automobile Insurance Co. v. Old Republic Insurance Co. of Canada* [2014] O.J. No. 3033, 2014 ONSC 3887.

This loss transfer matter arose out of a motor vehicle accident in 2007. The accident occurred when a heavy commercial vehicle, insured by Old Republic ("the Old Republic truck"), struck a car that then hit a third car, insured by State Farm ("the State Farm vehicle"). Both the State Farm vehicle and the middle vehicle were stopped at a traffic light when the accident occurred.

The driver of the State Farm vehicle submitted a claim for accident benefits to State Farm. State Farm sought loss transfer indemnification from Old Republic pursuant to

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[3] See s. s. 275(1) of the *Insurance Act*.

Rule 9(4) of the *Fault Determination Rules*. Old Republic argued that because the Old Republic truck had not directly collided with the State Farm vehicle, there could be no allocation of fault under Rule 9(4).

At arbitration, Arbitrator Shari Novick found in favour of State Farm. She found it was sufficient that the Old Republic truck "commenced" the chain of accidents that led to the collision with the State Farm vehicle.

Old Republic appealed on the basis that the decision puts at risk the economic viability of no-fault benefits in Ontario. Old Republic argued that, if the fault determination provisions were construed in the manner proposed by State Farm, it would significantly increase the risks to be assumed by insurers of heavy commercial vehicles.

On appeal to the Superior Court, Justice Perell found that Rule 9(2) applied to vehicles involved in a multiple vehicle collision, even if the two vehicles had not directly collided. Justice Perell wrote that Old Republic's interpretation of Rule 9(4) would reverse the intended purpose of the loss transfer provisions. Justice Perell ruled that it was consistent with the intent of the loss transfer legislation to find that Old Republic should assume the cost of the accident benefits claim of the State Farm vehicle. Rule 9(4) imposed liability on the Old Republic truck.

This decision will be appealed at the Ontario Court of Appeal in 2015.

If Rule 9(4) continues to be interpreted per Justice Perell and Arbitrator Novick rulings, what would happen in an accident caused by a heavy commercial vehicle and involving eight other cars? Or ninety-eight other cars? The interpretation in this decision leads to the conclusion that loss transfer would apply to the accident benefits claims of *all ninety-eight vehicles* with the insurer of the heavy commercial vehicle being responsible to indemnify for each claim. How will an insurer protect against this sort of risk, and, more importantly, why would it want to? Insurers of large commercial vehicles should hope that Old Republic is successful in its appeal.

The Minor Injury Guideline

6. *Lo-Papa and Certas Direct* (FSCO A12-005538), May 14, 2014

This decision confirmed Director's Delegate David Evans' decision in *Scarlett and Belair* and provided a "little" more insight in to the ongoing debate of when the Minor Injury Guideline should apply to an insured's injuries, and when treatment should be made outside the $3,500.00 cap.

Ms. Lo-Papa was injured in a motor vehicle accident in October 2010 and applied for accident benefits from Certas. Certas took the position that her injuries fell under the MIG, but Ms. Lo-Papa maintained she needed additional care outside the $3,500.00 MIG limit. She complained of continuing to suffer from headaches, lower back and leg pain. She also alleged to be moody, anxious and depressed. She had no pre-existing injuries.

Arbitrator Barry Arbus confirmed that the onus of proof rested on Ms. Lo-Papa to prove that her injuries were not predominantly minor in nature or, that a pre-existing condition prevented recovery under the MIG limits.

We appreciated this decision as more of a guiding light in the complicated MIG world. It always makes me smile to think the MIG was implemented to provide easier adjusting of more minor accident benefits claims but has perhaps done the opposite!

Interest, Interest and More Interest!

7. *T.N. and Personal Insurance Company of Canada*, (FSCO A06-000399), November 20, 2014

We could not possibly omit this now infamous decision of Arbitrator Bayefsky.

$14 Million in interest for past benefits?![4] This decision, as well as an interim order and Arbitrator Bayefsky's 2012 order are being appealed by Personal.

On October 29, 2000, the Applicant was catastrophically impaired in a motor vehicle accident and applied for accident benefits from Personal. On July 26, 2012, Arbitrator Bayefsky made an order stating, among other things, that the Applicant was not precluded from receiving IRBs and had not failed to submit an application for attendant care or housekeeping benefits. She was not barred from arbitrating any of these benefits.

The only issues at the 2014 Arbitration hearing were whether the insurer was liable to pay a special award and if interest was owed on past-attendant care and income replacement benefits as well as benefits for nutritional counseling.

Regarding interest on IRBs, Arbitrator Bayefsky found that "the mere fact that the issue of substantive entitlement to benefits is resolved prior to a hearing does not automatically preclude a consideration of the matter of interest", or a special award. Although the insurer had been successful on the issue of self-employment at the earlier hearing, this did not affect its liability to pay interest on post-104 week IRBs. Personal had denied entitlement to the benefit three times and then abandoned its substantive argument regarding entitlement. Interest was found payable on post-104 week IRBs and the Applicant's delay in filing for mediation and arbitration was disregarded.

On the subject of attendant care, Arbitrator Bayefsky found that the fact the Applicant had not submitted a Form 1 until *more than 6 years after the date of loss* was irrelevant. According to Arbitrator Bayefsky, the insurer had "ample information" in the early states

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[4] We note that the calculation of interest was incorrect as it was based on attendant care payments in excess of the $1 million dollar policy limits.

of the claim and could have addressed the issue of attendant care benefits.[5] The insurer had known since December 19, 2000 that the Applicant required attendant care and therefore attendant care benefits became due on January 19, 2001 (30 days after the deemed application). Interest was due as of this date.

Following this decision, the case law is clear that if a claimant is credible and an insurer (at least for accidents pre-September 1, 2010) has sufficient information to assess attendant care, then regardless of whether the claimant submits a Form 1, the insurer may have exposure to attendant care. A further concern is that a special award was ordered against the insurer for depriving the Applicant of important care and assistance. The award was in the amount of $750,000.00 and is also under appeal.

Non-Earner Benefits

8. *Bustamante v. The Guarantee Company of North America*, 2014 ONSC 6978

Following the 2012 Court of Appeal decision in *Galdamez*[6], our office (and likely yours!) saw an influx of cases claiming Non-Earner Benefits for applicants who were working at the time of the accident and whose claims were many, many years old. The claims were often frivolous and appeared to be searching for one more kick at the accident benefits can. We anticipate that the *Bustamante* decision will mean an end to these claims.

The Plaintiff Bustamante was involved in a motor vehicle accident on June 3, 2004. Her disability certificate (OCF-3), dated August 18, 2004, indicated that she met the tests for both income replacement and non-earner benefits. On August 20, 2004, the Plaintiff completed an Election of Weekly Benefits (OCF-10) in which she chose to claim IRBs. The insurer advised her on September 1, 2004: "As you qualify for an income replacement benefit, you are not eligible to receive non-earner benefits."

In September 2009, the Plaintiff advised the insurer that she wished to apply for NEBs. Despite the insurer's three requests for a disability certificate, the Plaintiff did not provide one until June 6, 2011. The disability certificate provided that she met the test for NEBs. The benefit was denied and subsequently mediated at FSCO. Following the failed mediation, a court action was commenced for payment of NEBs.

Justice Ramsay found that the Plaintiff's claim was statute-barred by s. 281.1 of the *Insurance Act* as she was required to mediate the denial of NEBs, within 2 years of the first denial in 2004. The Plaintiff was not entitled to make a second claim for the benefit. Summary judgment was granted and the action was dismissed, including the claim that Guarantee's actions had been fraudulent, suspicious and aggressive, thus warranting a claim for bad faith against it.

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[5] This is a puzzling statement as Personal had prepared its own Form 1 on September 17, 2001 that showed the Applicant did not require any attendant care.

[6] *Galdamez v. Allstate Insurance Company of Canada*, 2012 ONCA 508.

Importantly, Justice Ramsay awarded Guarantee $20,000.00 in substantial indemnity costs against the Plaintiff.

Developments in Threshold Case Law

9. *Hansen v. Williams*, 2014 ONCA 118

In this decision, the Defendant Williams ("the Appellant") appealed on the basis that the trial judge erred in providing her charge to the jury regarding non-pecuniary damages. The Appellant further appealed on the basis that the jury award of $200,000.00 for non-pecuniary damages was inordinately high.

The Plaintiff had commenced the action following a motor vehicle accident on July 19, 2007. In the accident she sustained "thoracic outlet syndrome" and headaches. She maintained at trial that these injuries affected her ability to perform housework, socialize, participate in family interaction and work in the course of her pre-accident employment as a court clerk. There was no issue of liability.

At trial level, in the Defendant's closing submission, it was suggested that the jury consider an award between $5,000 - $10,000.00 for injuries that lasted 6 months. In the Plaintiff's closing submissions, counsel urged the jury to consider $5,000 - $10,000.00 every 6 months for the duration of the Plaintiff's life. The judge, in her charge to the jury, advised that the Plaintiff's submission was not the proper calculation of general damages and the jury should consider "the amount that is appropriate to reasonably compensate the plaintiff for her pain and suffering and loss of amenities of life" resulting from the subject accident. The Defendant objected to this charge, stating that the jury had not been given sufficient guidance on assessing general damages. The trial judge did not recharge the jury.

The Court of Appeal ruled that if there was an error in the Plaintiff's submissions it had been corrected during the charge to the jury. Further, a trial judge is "uniquely placed" to evaluate errors and determine if they can be corrected. The Court of Appeal found that the trial judge provided the jury with adequate guidance to assess damages.

On the subject of general damages, the Court of Appeal found that only in a case where the award is so plainly unreasonable and unjust as to satisfy the court that no jury reviewing the evidence as a whole and acting judicially could have reached it. This was an extremely high threshold to meet and the Appellant had provided little information with respect to "thoracic outlet syndrome" to assist the court in its ruling. It was therefore not warranted that the Court of Appeal should intervene with the findings of the general damages award.

The appeal was dismissed with costs payable to the Plainitff/Respondent.

It should be noted that at trial a threshold motion was brought in which the Plaintiff was found to have met the statutory threshold.

10. *Djermanovic v. McKenzie*, 2014 ONSC 1335 (CanLII)

This decision again explored the interplay between judge and jury concerning the statutory threshold. The Plaintiff sustained injuries following a motor vehicle accident in 2008. Liability for the accident was not an issue. A threshold motion was brought by the Defendants following the hearing of a 10-day trial.

The trial judge chose to reserve his decision regarding the threshold motion until after the jury had rendered its award.

The jury eventually returned with a verdict assessment of $10,000.00 for general damages and $18,600.00 for past loss of income.

Relevant background facts regarding the Plaintiff were that he was 41 years old at the time of the accident. He had been raised in Croatia where he completed a college course in mechanics. He worked for his father's construction company until being forced to leave Croatia, bringing with him his wife and young child. In 2000, his family came as refugees to Canada. Between 2000 and 2008 he alternated between working as a truck and taxi driver. His plan was to become a professional bodybuilder and in his spare time he lifted weights on a daily basis; ran 10km three times a week and swam for an hour twice a week. Bodybuilding was "his life," not just a hobby.

The Plaintiff's accident related injuries were initially reported as pain in his neck and headaches. A few months later he experienced depression and went on an antidepressant. In 2010, he began receiving psychological therapy and also saw a social worker on a regular basis. The Plaintiff's household chores were not affected. He continued to lift weights, but he could only lift approximately half of his previous maximum weight. He did not return to running or swimming, but continued to socialize with his friends as he had prior to the accident.

The Plaintiff's respective doctors had diagnosed PTSD and chronic pain. The chronic pain diagnosis was rebutted by a defence assessor. The defence psychiatric assessor also found that his psychiatric conditions did not warrant a diagnosis of anxiety disorder, depression or pain disorder.

As always in a chronic pain case, the Plaintiff's credibility was a major issue. The trial judge noted numerous inconsistencies with respect to the frequency and duration of the Plaintiff's symptoms. Neither the jury, nor the trial judge, appeared to find the Plaintiff likable and the trial judge concluded that his injuries did not meet the threshold. It was significant that the Plaintiff's alleged decrease in his weightlifting capabilities did not trump the fact that his overall activities of daily living remained unchanged.

The case is also interesting in terms of the similarities between the verdicts by the judge and jury, and the commonalities between their perspectives, namely the finding that

both their awards were closely parallel. This is certainly not always the case when it comes to a threshold finding.[7]

Conclusion

Will threshold law ever become crystal clear for judges, insurers and counsel? Will the Supreme Court provide a desirable answer to the application of the "pay first dispute later" rules? Many developments continue to be made in both AB disputes and threshold litigation, we look forward to seeing what changes 2015 brings.

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[7] See, for example, *Leochko v. Rostek*, 2013 ONSC 7899, where the judge appeared to favour the Plaintiff and the jury only awarded minimal non-pecuniary damages. However, in *Ryckman v. Pottinger*, 2013 ONSC 2857, Justice Parayeski relied heavily on the findings of the jury with respect to threshold.