LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Ontario

Date: 2017-09-07
Tribunal File Number: 16-003034/AABS
Case Name: 16-003034 v Economical Mutual Insurance Company

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act,* RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

S.T.

Applicant

and

Economical Mutual Insurance Company

Respondent

DECISION ON A PRELIMINARY ISSUE

ADJUDICATOR:	**Heather Trojek, Vice Chair**
APPEARANCES:	
For the Applicant:	**William Keele, Counsel**
For the Respondent:	**Lisa Armstrong, Counsel**
HEARD:	
Written Submission Filed:	**June 1, 2017/June 23, 2017**
In-person Hearing:	**June 19, 2017**

ISSUE TO BE DECIDED:

[1] Is the applicant precluded from proceeding with her application for ongoing entitlement to attendant care and housekeeping and home maintenance benefits because she missed the statutory two-year time limit to dispute the respondent's denial?

RESULT:

[2] I find that the applicant is barred from proceeding with her application for attendant care and housekeeping and home maintenance benefits despite having a catastrophic impairment because she did not dispute the stoppage of these benefits within two years of the respondent's denial.

FACTS:

[3] The parties agreed that the following facts are not in dispute.

[4] The applicant, S.T. was injured in a motor vehicle accident on September 12, 2008 and sought benefits pursuant to the *Schedule* from Economical Insurance (the "respondent").

[5] She was struck while walking across an intersection and sustained a variety of injuries including multiple fractures in her left shoulder. Following the accident the applicant was hospitalized and required surgery to repair her orthopedic injuries.

[6] After the accident numerous Form 1's or Assessment of Attendant Care Needs forms were completed on behalf of the applicant and the respondent. Rahim Kassam, occupational therapist, assessed the applicant on behalf of the respondent and completed a Form 1 dated March 17, 2010, six months before the two year anniversary of the accident. This is the most recent pre-104 week Form 1 on record and recommends that the applicant receive $1,851.35 per month in attendant care benefits.

[7] On August 11, 2010, the respondent approved an Application for Approval of an Assessment or Examination (OCF-22) in the amount of $1,113.96 for Dr. Becker to conduct a file review for evaluation of catastrophic impairment (CAT) and submit a CAT application (OCF-19), if required. There is no evidence that Dr. Becker completed the approved OCF-22 assessment.

[8] In a letter and Explanation of Benefits (OCF-9) dated August 26, 2010 the respondent advised the applicant that as of September 12, 2010 attendant care and housekeeping and home maintenance expenses incurred more than 104 weeks after the accident would not be paid unless she was determined to be catastrophically impaired. The letter included an Application for Catastrophic

Impairment (OCF-19) for the applicant to complete but was not however submitted at that time.

[9] The applicant was paid a total of $9,512.85 in housekeeping and home maintenance benefits and $66,777.92 in attendant care benefits by the respondent from the date of the accident up until September 12, 2010.

[10] In 2011 and again in 2013 and 2014 the applicant submitted occupational therapy progress reports to the respondent confirming her ongoing need for attendant care services. There is no evidence that expenses for the services were submitted to the respondent.

[11] The applicant did not submit an OCF-19 until May 13, 2015. After the OCF-19 was submitted, the respondent requested that the applicant attend a section 44 multidisciplinary CAT assessment. Based on the findings of this assessment, the respondent informed the applicant in a letter dated November 4, 2015, that her CAT application was approved.

[9] The applicant then submitted claims for attendant care and housekeeping and home maintenance benefits ongoing from 104 weeks post-accident because the respondent had accepted that she was catastrophically impaired. However, the respondent denied her claims for attendant care and housekeeping expenses because she did not dispute the initial denial of these benefits within the two year time period required by the *Schedule*.

[10] The applicant submitted an application dated September 29, 2016 to the Licence Appeal Tribunal – (the "Tribunal") to resolve this dispute.

[11] The parties attended a case conference. They were unable to resolve the issue in dispute and set a date for the hearing.

PROCEDURAL ISSUE:

[12] At the in person hearing which took place on June 19, 2017, the applicant made a last minute request to call Dr. Becker as an expert witness regarding an OCF-22 he completed in August 2010. The respondent opposed. I did not allow the applicant's request because 1) the sole purpose of the hearing as agreed at the case conference was to give oral submissions; 2) the applicant did not give notice required in the *Tribunal's Rules and Practice and Procedure* to call an expert witness; and 3) I was not satisfied that Dr. Becker's testimony would add to the legal issue to be determined at the hearing.

SUBMISSIONS OF THE PARTIES:

[13] The applicant argued that there was no proper denial of the benefits for the following reasons:

a) The denial was equivocal or unclear;

b) The denial was not valid because the applicant had not been found to be catastrophically impaired and therefore was not entitled to claim the benefits;

c) Since there is no time limit for applying for a catastrophic determination the two year limitation period cannot apply to benefits that flow from it, and;

d) The two year limit is not triggered until the applicant discovers that she meets the test of catastrophic impairment.

[14] The respondent argued that there was a proper denial of the benefits for the following reasons;

a) The denial was clear and unequivocal;

b) It is the denial of specific benefits that triggers the two year time limitation, the fact that the applicant was later found to be catastrophically impaired is irrelevant;

c) Even if its denial was not legally correct it still triggers the two year time clock, and;

d) The principal of discoverability does not apply to the scheme of statutory accident benefits.

REASONS AND ANALYSIS:

[21] This dispute revolves around the statutory requirement to dispute an insurer's denial of benefits within two years. In August 2010, when the benefits in dispute were denied, the *Insurance Act* [1]and the *Statutory Accident Benefits Schedule – Accidents occurring on or after November 1, 1996*, (the "*Schedule*")[2] required an insured person to apply for mediation at the Financial Services Commission (FSCO) within two years of an insurer's denial to pay a claim and prior to applying for arbitration or commencing a court action.[3]

Clear and Unequivocal Denial

[1] *Insurance Act*, RSO 1990, c 1.8, s 279(1) and 281 (2)
[2] *O Reg 403/96*, s 51.

[22] In this case, the one of the issues I must determine is whether the respondent's "denial" in August 2010 was sufficient to trigger the two year time limit for applying for mandatory mediation at FSCO.

[23] The key to determining this issue is to be found in the Supreme Court of Canada decision of *Smith v. Co-operators General Insurance Co.,* ("*Smith and Co-operators*")[4], which states that a limitation period cannot commence unless the insurer's denial is in writing and is found to be clear and unequivocal.

[24] *Smith and Co-operators* outlines the criteria for a clear and unequivocal denial: the reasons for the denial must be "straightforward" and in "clear language". It must also provide information about the different stages in the dispute resolution process which an "unsophisticated person" can understand and include information about the relevant time limits.

[25] Having reviewed the letter and OCF-9, dated August 26, 2010, I find that the respondent's denial of benefits meets all of the requirements set out in *Smith and Cooperators* and therefore constitutes a clear and unequivocal denial of the applicant's entitlement to ongoing attendant care and housekeeping and home maintenance benefits.

[26] Specifically, the letter states that the applicant's attendant care and housekeeping benefits will no longer be paid as of September 12, 2010 and confirms that the stoppage is based on sections 18 and 22 of the *Schedule.*

[27] For clarity, the respondent addressed each benefit separately. One paragraph in the letter and OCF-9 addresses the stoppage of attendant care benefits; a separate paragraph is devoted to the stoppage of housekeeping and home maintenance benefits.

[28] In addition, the accompanying OCF-9 clearly outlines each of the steps in the dispute resolution process should the applicant choose to dispute the denials.

[29] At the bottom of the OCF-9 it is states, "Warning: Two Year Time Limit: You have TWO YEARS from the date of your insurer's refusal to pay or reduce benefits to arbitrate or commence a law suit in court."

[30] The applicant submits that the notice provided by the respondent is not clear and is equivocal because it:

a) Does not contain the words like "refused", "denied" or "stopped";
b) Does not explain that the applicant may not be entitled to the denied benefits even if she is found to be catastrophically impaired at a future date and does not commence an appeal within two year;

[4] *Smith v Co-operators General Insurance Co.,* 2002 SCC 30 at para 14, [2002] 2 SCR 129.

> c) The boxes on page 4 of the OCF-9 which say the benefits are not payable are not checked off.

[30] I disagree with the applicant's submissions. I find the respondent's notice to the applicant to be clear, explicit and devoid of ambiguity.

[31] The applicant did not point me to any section of the *Schedule* or the *Insurance Act* or other authority which require an insurer to use specific words such as "refuse" or "stop" in a denial.

[32] The fact that the respondent did not check off the boxes on page four of the OCF-9 does not change my view of the clarity of the notice.

[33] In support of her position that the respondent's denial was equivocal or unclear, the applicant relies on the FSCO decision in *Kehoe v. Allstate ("Kehoe"),*[5] where the arbitrator decided that the insurer's denial was not clear because, among other factors, the insurer did not tick certain boxes on the OCF-9. I disagree that this decision supports the applicant's position. I find the only similarity between *Kehoe* and the case before me is that the insurer did not check off boxes on the OCF-9.

[34] I agree with the respondent that the Arbitrator in *Kehoe* found other factors invalidating the denial, including the lack of information regarding the dispute resolution process – which is not the case here. In this case, I find the respondent complied with the criteria in *Smith and Co-operators*, including its explanation of the dispute resolution process, and that the unchecked boxes do not take away from the validity and clarity of the respondent's denial. For these reasons I find *Kehoe* distinguishable.

[35] I disagree with the applicant's submission that for the respondent's denial to be clear and unequivocal, it should have outlined the potential consequences of the applicant's failure to dispute the denial in the event she might be found to be catastrophic at some point in the future. I find this would be holding the respondent to a standard of perfection that the Court of Appeal in *Turner v. State Farm* ("*Turner*")[6] has determined is not required:

> The purpose of the notice requirement is to ensure that the insured person has enough information to decide whether to dispute or accept the refusal. However while insurers are expected to take seriously their obligation to give written reasons for refusing benefits, the legislative objective of promoting early claims assessment and ongoing communication between parties suggests they should not be held to a standard of perfection.[7]

[5] *Kehoe v. Allstate Insurance Co. of Canada*, [2016] O.F.S.C.D. No. 146 (QL).

[6] *Turner v State Farm Mutual Automobile Insurance Company*, [2005] OJ NO 351, 2005 CanLII 251 (ONCA).

[7] *Ibid* at para 8.

[34] For these reasons I find that the respondent's denial complies with all the factors required by *Smith and Cooperators.* Having found that the respondent issued a clear and unequivocal denial, I also find that the two-year time limit to dispute the denial began to run as of August 26, 2010.

[35] Since the applicant did not dispute the respondent's denial until she commenced this proceeding on September 29, 2016, six years after her benefits were denied, I find she missed the two year time limitation and is therefore barred from proceeding with her application with respect to attendant care and housekeeping and home maintenance benefits.

Validity of Denial and Consumer Protection

[36] In addition to arguing that the denial is unclear and equivocal, the applicant submits that the respondent's denial in august 2010 cannot be valid because she had not been found to be catastrophically impaired and therefore was not eligible to claim attendant care and housekeeping and home maintenance benefits. Simply put, there can be no denial or triggering of the limitation period for a benefit where there is no eligibility or ability to submit a claim for that benefit in the first place, so the denial is not valid or legally correct.

[37] Further, the applicant argues that as there is no time limit for filing a CAT application – a principle that both parties agree is well-established in the jurisprudence - there should then be no time limit for disputing a denial of benefits that potentially flow from a determination of catastrophic impairment.

[38] The respondent disagrees. It submits that the fact there is no time limit on filing a CAT application does not release the applicant's obligation to dispute a clear and unequivocal denial of specific benefits within the required two-year time limit. I agree.

[39] The applicant's argument was made and rejected in *Mayo v. Economical* ("Mayo"),[8] where the fact situation was virtually identical to the one before me. In that decision, the Arbitrator found that although a CAT designation may further entitle an insured to a higher tier of benefits, this does not absolve the insured from his or her obligation to adhere to the two year time limitation period established by the *Schedule* and the *Insurance Ac*t when faced with a clear and unequivocal refusal to pay the benefits.

[40] Although FSCO decisions are not binding on me, I find Mayo persuasive as it is consistent with the Court of Appeal decision in *Sietzema v. Economical* ("*Sietzema*")[9], submitted by the respondent. The Court held that an insurer's

[8] *Mayo v. Economical Mutual Insurance Co.*, [2016] O.F.S.C.D. No. 342 (QL).

[9] *Sietzema v Economical Mutual Insurance Company*, 2014 ONCA 111, 118 OR (3d) 713.

denial of a benefit, even if it is legally incorrect, will trigger the two-year time limit. Although the fact situation in *Sietzma* is different from the one before me in that the case involved a non-earner benefit, I find the legal principle with respect to the denial to be the same.

[41] The respondent argues, and I agree, that even if I found its denial to be legally incorrect, I would still be unable to find in the applicant's favor due to the case law. I accept the respondent's submission that the Court of Appeal in *Sietzema* held that an insurer's denial of a benefit, even if it is legally not correct, will start the two year time limit. Being a decision of the Court of Appeal I am bound by the finding in *Sietzma*.

[42] The applicant cited a number of decisions in support of her position. I find that these decisions were either distinguishable, irrelevant and/or were failed to support the arguments she advanced.

[43] The applicant relies on the decision of *16-000216 v Aviva Insurance Company of Canada* ("*16-000216*")[10], Based on my review of this decision, Vice-Chair Richards held that 1) advising an applicant that she does not qualify for attendant care benefits because her injuries are being treated under the Minor Injury Guideline is not a valid denial; and 2) a claim for attendant care benefits cannot be made and hence denied if a Form 1 has not been submitted by the applicant.

[44] The applicant submits that similarly, it is legally incorrect to terminate post-104 week attendant care and housekeeping benefits prior to the applicant being found to be catastrophically impaired. However, I find this case can be distinguished because, unlike *16-000216*, the applicant in this case submitted multiple Form 1s and was paid attendant care benefits for two years. The denial issued by the respondent clearly and unequivocally denied a specific set of benefits, attendant care and housekeeping and home maintenance. Because of these distinguishing factors, I did not find that the decision made by Vice Chair Richards to be helpful or relevant to the applicant's case.

[45] The applicant argues that two recent Court of Appeal decisions, *Machaj v. RBC General Insurance Co.* ("*Machaj*") [11] and *The Guarantee Company v. Dong Do* ("*Do*")[12], also support her claim that the respondent's denial is not valid or legally correct.

[46] I do not agree. The applicants in both *Machaj* and *Do* were determined by their respective insurers not to be catastrophically impaired and were then denied access to the next tier of benefits associated with that designation. In this case

[10] *16-000216 v Aviva Insurance Company of Canada*, 2016 CanLII 78332 (ON LAT), 2016 CarswellOnt 18069 (WL Can).

[11] *Machaj v RBC General Insurance Co*mpany, 2016 ONCA 257.

[12] *The Guarantee Company v Dong Do et al.,* 2015 ONSC 1891 (CanLII) 125 OR (3d) 585.

the applicant was denied specific benefits and only afterwards was she determined by the insurer to be catastrophically impaired in accordance with the *Schedule*.

[47] In *Do,* the central issue was whether an insurer's refusal to designate an insured as catastrophically impaired constitutes a refusal of a benefit and, if so, whether that refusal triggers the limitation period. The Divisional Court agreed that the Director's Delegate at FSCO correctly upheld the arbitrator's finding that the insurer's denial of a CAT determination did not trigger the beginning of the 2 year imitation period because it is determination which potentially entitles applicants to a higher level of benefits but is not itself a benefit.

[48] Likewise, the Court of Appeal in *Machaj* found that an insurer's letter denying a determination of catastrophic status cannot be converted into a denial for specific benefits simply by stating that the applicant does not qualify for increased benefits. In its unanimous decision the Court states at paragraph 6, that there is "a clear distinction to be drawn between the claim for determination of catastrophic status and a claim for the specific benefits to which an injured person is entitled if found to have suffered a catastrophic injury."[13]

[49] Both decisions, in my opinion, confirm that it is the denial of specific benefits which triggers the two year time limitation. The rulings do not support or the applicant's proposition that the limitation period on the denial of specific benefits cannot begin to run until an insured has been determined to be catastrophically impaired and hence "eligible" to receive the next tier of benefits.

[50] Having found that the respondent's denial is clear and meets all the factors required by *Smith and Co-operators*, and being bound by *Sietzema*, I find that the two year limitation clock was triggered when the respondent terminated the applicant's benefits in 2010.

[51] I also agree with the respondent's submission that the limitation period contained in the *Insurance Act* and the *Schedule* play an important role in the world of statutory accident benefits. In *Haldenby v. Dominion* ("*Haldenby*")[14] the Court of Appeal highlights the vital role that limitation periods play in effecting the predictable and timely resolution of disputes.

[52] The Court in *Haldenby* goes on to state that:

> There is no provision in the *Schedule* for an insured to reapply for a benefit once it has been terminated, the only remedy

[13] *Machaj*, *supra* note 10 at para 6.
[14] *Haldenby v Dominion of Canada General Insurance Co.* (2001) 55 OR (3d) 470 at para 6, 2001 CanLII 16603 (ONCA).

> open after an insured's benefits have been terminated by an insurer is to appeal the termination in the two year time period.[15]

[51] I note that despite being provided with a CAT application and the respondent's approval of an OCF-22 for Dr. Becker to conduct a pre-CAT file review in August 2010, the applicant waited 5 years to submit a CAT application. In spite of the respondent's clear warning in 2010 of the two year time limit, the applicant filed an application disputing the insurer's denial in 2016, 4 years after the expiry of the limitation period.

[52] The applicant argues that to find in favour of the respondent runs counter to the consumer protection objective of the *Schedule*. Based on the Court's findings in *Sietzema*, *Haldenby* and *Turner*, I find that the objective of consumer protection must be balanced against other objectives, such as the finality and certainty that limitation periods provide.

DISCOVERABILITY

[56] I dismiss the applicant's argument that the limitation period does not begin to run until the applicant discovered that she was catastrophically impaired. As the respondent adeptly argues, the Divisional Court in *Kirkham v. State Farm*[16], established long ago that the principle of discoverability is an approach that is acceptable in court actions and does not apply in the scheme of statutory accident benefits.

[57] The applicant directed me to no authorities that would indicate otherwise. Most of the cases I was referred to involved tort claims for pecuniary and non-pecuniary damages and not statutory accident benefits.[17] One case dealt with a wrongful dismissal claim.[18]

[58] The respondent argues and I agree that in accident benefits, the two year limitation period according to the *Schedule* and in the *Insurance Act* is triggered by the insurer's refusal to pay a benefit(s) and does not encompass the doctrine of discoverability. The respondent referred me to and I am guided by the FSCO decision of *Ramalingam and State Farm Mutual Automobile Insurance Company ("Ramalingam")*[19]*.* In *Ramalingam*, the insurer argued that the *Limitations Act,* 2002 and applicant's self-knowledge of his medical condition and the discovery of the requisite facts triggered the two year time clock for

[15] *Ibid* at para 30.
[16] *Kirkham v State Farm*, 1998 OJ No 6459, 1998 CarswellOnt 2811.
[17] *Peixerio v Haberman,* [1997] 3 SCR 549, 1997 CanLII 325*; Chenderovitch v John Doe,* [2004] OJ No 681 (QL) 2004 CanLII 20029 (ON CA)*; Ng and Tsang v Beline, 2008 CareswellOnt 5957*.
[18] *Shilling v Anishnabe Wiisookadaadiwin Treaty No.3 Corp,* 2002 CarswellOnt 4463.
[19] *Ramalingam v. State Farm Mutual Automobile, Insurance Co.*, [2010] O.F.S.C.D. No. 75 (QL).

disputing the determination of a catastrophic impairment. The Arbitrator rejected this argument and, in my opinion correctly found that, sections 279 to 283 of the *Insurance Act* form the complete scheme for the resolution of all disputes concerning benefits and that the doctrine of discovery and the *Limitation Act*, 2002 do not apply.[20]

[59] Even if I am wrong in this regard, I find that there is no evidence that the applicant was unaware that she likely would be determined to be catastrophically impaired if she submitted an OCF-19 to the respondent. This is evidenced by the fact she submitted an OCF-22 for Dr. Becker to complete a file review relating to catastrophic impairment and the fact that she continued to submit updated assessments regarding her ongoing need for attendant care benefits after the two year anniversary date of the accident.

[60] For all the reasons stated above, I find that the respondent denied attendant care and housekeeping and home maintenance benefits appropriately and that the applicant did not comply with the two year time limitation period to dispute the denial of these benefits.

ORDER

[61] This application is dismissed.

Released: September 7, 2017

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Heather Trojek, Vice-Chair

[20] *Ibid* at para 20.