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Limitation Considerations, Catastrophic Claims and Accident Benefits

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The application of limitation periods is a common defence raised in insurance litigation. In the area of statutory accident benefits, recent developments in the case law confirm that the Courts and administrative tribunals continue to follow established jurisprudence to ensure a fair and logical outcome for all parties.

Under the *Limitations Act, 2002*, a court proceeding in respect of a claim must be initiated within 2 years of the day on which the claim was discovered. The two year statutory limitation period to dispute any accident benefit claims is set out in section 56 of *Statutory Accident Benefits Schedule – Effective September 1, 2010*, Ont. Reg. 34/10 ("the *Schedule*") which states, "an application under subsection 280 (2) of the Act in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed."

In *Smith* v.*Cooperators General Insurance*, the Supreme Court of Canada established the criteria for the running of a limitation period. In order to be a valid refusal that triggers the two-year limitation period, a decision must be clear and unequivocal, and it must inform the claimant of the dispute

resolution process under the *Insurance Act* in straightforward and clear language. In *Smith*, the Court held that the insurer's notice of denial was insufficient because it notified the insured of the right to mediate the dispute, but failed to provide notice of how to dispute the denial of the existence of the two-year statutory limitation period.[1]

The case law indicates that the clear and unequivocal requirement does not require that the reasons for the insurer's refusal have to be legally correct. In *Turner* v. *State Farm Automobile Insurance*, the Court of Appeal held that the Insurer is required to give reasons for the refusal but there was no requirement to be correct and stated, "the purpose of the requirement to give reasons is to permit the insured to decide whether or not to challenge the cancellation. If the reasons given are legally wrong the insured will succeed in that challenge. Requiring that the reasons be legally correct goes beyond both the requirement in the relevant regulation, and the purpose of such a notice.[2]

The commencement of the limitation period is an important part of the analysis and a clear denial of benefits is sufficient to start the limitation period. In *Sietzema* v. *Economical*, the Court of Appeal found that despite the fact that the insurer's reasons in the Explanation of Benefits were legally incorrect, it was still a clear denial of benefits and was sufficient to start the limitation period.[3]

After the insurer has notified the claimant of its reasons for the termination, further attempts by the claimant to apply for the benefit does not re-start the limitation period. In *Sietzema*, it was also noted that a subsequently Disability Certificate after an insurer's denial was effectively a re-application and there is no right to reapply for further benefits once the benefit has been terminated. The only process is to appeal the termination within the 2 year statutory limitation period. The Court of Appeal followed an earlier appeal decision, *Haldenby* v. *Dominion*, and stated,

> There is nothing in the Insurance Act or the comprehensive SABS regime to require an insurer, on termination of benefits, to give the claimant a further notice advising that he or she may have a right to renew a claim for a benefit that had previously been denied. As this court observed in *Haldenby* v. *Dominion of Canada General Insurance Co.* (2001), 55 O.R. (3d) 470 (Ont. C.A.), at para. 30,
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> > there is no provision in the [Insurance Act] or the SABS which allows a claimant to reapply for further benefits after an insured person's benefits have been terminated by the insurer. The only remedy for the insured person is to appeal the termination of benefits within the two-year period.
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> If we accepted the appellant's argument, the limitation period for making a claim for Non-Earner Benefits never began to run. This would defeat one of the primary purposes of the SABS regime, namely, to ensure the timely submission and resolution of claims for accident benefits. [4]

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[1] *Smith* v. *Cooperators General Insurance*, [2002] 2 SCR 129.
[2] *Turner* v. *State Farm Automobile Insurance*, [2005] O.J. No. 351, at para. 8.
[3] *Sietzema* v. *Economical*, 2014 ONCA 111.
[4] *Sietzema* v. *Economical*, 2014 ONCA 111, 2013 ONSC 4299 (Ont. S.C.J.)

In *Blake* v. *Dominion*, the Court of Appeal considered whether the Plaintiff was statute barred from claiming caregiver benefits and the effect of subsequent new applications and insurer denials. The Court of Appeal upheld the Trial Judge's findings that the action was statute barred and new applications for benefits following clear refusal by the insurer does not re-start the limitation clock.[5]

In Court proceedings, limitation defences have been raised in summary judgement motions. In *Steele* v. *Intact*, the Court found that there was a clear and unequivocal refusal from the insurer, the limitation period runs from the date of the refusal, no mediation took place to extend the limitation period and the applicable limitation period expired. The defendant insurer was granted summary judgement and the claim for non-earner benefits was dismissed.[6]

In *Sagan* v. *Dominion of Canada General Insurance*, the Court considered whether the claimant was statute barred from claiming non earner benefits based on the insurer's denial and the law at the time, prior to the Court of Appeal decision of *Galdamez* v. *Allstate*. The Court found that there was a clear and unequivocal denial, the insurer communicated the steps to take to dispute the denial and the limitation period in the Explanation of Benefits. The Court rejected the argument that the insurer's denial was required to be legally correct. The defendant insurer was granted summary judgement and the claim for non earner benefits was dismissed.[7]

The running of a limitation period is not affected by a premature denial. In the context of eligibility for a non earner benefit, which arises at the 26 week mark, the Court has rejected the argument that the limitation does not run before eligibility begins. In *Bustamante* v. *The Guarantee Company of North America*, the Court of Appeal confirmed that the limitation period was triggered when the insurer denied the non-earner benefit by Explanation of Benefits which explained the claimant's right to dispute the refusal, the dispute resolution process and the two year limitation period to dispute the same. In *Bustamante*, the Court of Appeal rejected the appellant's argument that the limitation period does not run for the non-earner benefit while she was entitled to the income replacement benefit and was not eligible for the non-earner benefit. The Court of Appeal upheld the finding of the motion judge dismissing the action for non-earner benefits.[8]

In *Katanic* v. *State Farm*, the Court considered whether a plaintiff's claim for non-earner benefits was statute barred as it was not commenced within 2 years of the denial by the Insurer. In that case, the Insurer denied the non-earner benefit by Explanation of Benefits and the plaintiff argued that the Insurer's denial was premature since entitlement to the non-earner benefit did not crystallize until 26 weeks post accident. The Court found that even if there was a premature denial, nothing was done by

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[5] *Blake* v. *Dominion*, 2015 ONCA 165.

[6] *Steele* v. *Intact*, 2014 ONSC 6999

[7] *Sagan* v. *Dominion of Canada General Insurance*, 2013 ONSC 7886

[8] *Bustamante* v. *The Guarantee Company of North America*, [2015] ONCA 530, at para. 16-20.

counsel until a mediation was commenced and a statement of claim and these events did not occur until well past the statutory limitation period of 2 years from the date of the denial.[9]

Financial Services Commission of Ontario (FSCO)

The limitation cases noted above have also been followed by arbitrators at FSCO.

In *Saini* v. *Allstate*, Arbitrator Murray considered whether the claimant was precluded from proceeding to arbitration on the issue of non-earner benefits because she failed to commence a mediation or arbitration proceeding within 2 years of the Insurer's denial of the non-earner benefit. In that case, the insurer denied the non-earner benefit by Explanation of Benefits based on insurer's examinations pursuant to the *Schedule* (as amended). In that case, the applicant also argued that the insurer denied the non-earner benefit prematurely. The arbitrator followed *Katanic* and held that even if there was a premature denial of non-earner benefits, a mediation was not commenced and the request to add the non-earner benefit to the existing arbitration did not occur until well past the statutory limitation period of 2 years from both events. The motion on a preliminary issue was granted in favor of the Insurer.[10]

In *Raffa* v. *Personal Insurance*, Arbitrator Barrington considered whether the Applicant was statute barred from claiming non-earner benefits. In that case, the arbitrator held that there were inconsistent communications from the Insurer that did not constitute clear or unequivocal notice of a refusal to pay the non-earner benefit and found the limitation period did not run from the date of the denial. The Arbitrator found the claimant was not statute barred and from disputing non earner benefits in the preliminary motion and the arbitration was allowed to proceed.[11]

License Appeals Tribunal (LAT)

The LAT Tribunal has also followed the Court and FSCO decisions on limitation issues.

In *S.A.R.* and *State Farm*, the LAT Tribunal considered whether the claimant's application for non-earner benefits was outside of the statutory limitation period. The adjudicator found the application for non earner benefits was out of time based on the original date when the respondent insurer considered and denied the application for non-earner benefits. The adjudicator found the Application to the LAT Tribunal was past the applicable two year limitation period. In that case, the adjudicator held that additional applications submitted by the claimant and further decisions in response by the insurer did not re-start the limitation period. The adjudicator followed and applied the decision of *Blake*.[12]

An extension of the premature denial issue is whether an application for a benefit has been made and correspondingly whether a denial took place such that the limitation period began to run. In *D.S.* and

[9] *Katanic* v. *State Farm*, [2013] O.J. No. 3605
[10] *Saini* v. *Allstate*, FSCO A13-004053, 2015 CarswellOnt 17948.
[11] *Raffa* v. *Personal Insurance*, A15-000637, 2017 CarswellOnt 3461.
[12] *S.A.R.* and *State Farm*, 2016 CanLII 101380 (ON LAT), 16-000232/AABS.

Certas Home and Auto, the adjudicator found that an application for a non earner benefit can be made even in the face of a non supportive Disability Certificate. In that case, the adjudicator found there was a valid denial from the insurer from which the limitation period began to run and applied this to the facts of the case.[13] In *Sagan*, the claimant did not submit a Disability Certificate with the Application for Accident Benefits OCF 1 and the Court of Appeal held that a claimant cannot delay the start of the limitation period, by not submitting a disability certificate. On this issue the Court of Appeal stated,

> "the statutory regime is designed to ensure timely submission and resolution of accident benefits. It is not in keeping with this overall purpose to suggest that a claimant can delay the start of the limitation period — perhaps indefinitely — by not submitting a disability certificate."[14]

The argument that an actual application for the benefit has not been submitted and therefore the insurer's denial and corresponding limitation period has not run has only been successful in the context of an attendant care benefit. In *M.R.* v. *Aviva*, the LAT adjudicator agreed that the claimant had not applied for an attendant care benefit by not submitting an Assessment of Attendant Care Needs (Form 1) as the *Schedule* specifically requires that a Form 1 is to be submitted to claim attendant care benefits. In that case, the adjudicator found that as the claimant did not submit the Form 1, an application was not made and therefore the limitation period could not have commenced from the insurer's denial.[15] The case law indicates that attempts to use this type of same argument in the context of other benefits have not been successful.[16]

The date from which the limitation period begins to run is the date that the insured receives the Insurer's written notice of the refusal to pay the benefit. In *V.A.* and *Co-operators*, the adjudicator found the insurer provided written notice on March 5, 2015 of the refusal to pay income replacement benefits and absent any evidence to the contrary that this was delivered by personal service on the same day, it was deemed to have been received by the insured on the 5th business day after it was sent by regular mail pursuant to section 64(18) of the *Schedule*.[17]

A recent decision from the LAT continues to show that the clear and unequivocal requirement remains key to the applicability of any limitation defence. In *O.A.* and *TD*, the claimant submitted an initial Disability Certificate submitted completed by a physiotherapist indicated she was not substantially disabled from performing the essential tasks of her pre accident employment. The claimant then sent the Application for Accident Benefits (OCF 1) and left the part 8 of the application blank (whether her injuries prevented her from working) noting only that she was on maternity leave. The insurer responded to the Application and sent a letter requesting a completed Disability Certificate. A second Disability Certificate was not submitted until 2 years later when she retained counsel and this also left

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[13] *D.S.* and *Certas Home and Auto Insurance Company*, 2016 CanLII 73693.
[14] *Sagan*, supra.
[15] *M.R.* v. *Aviva Insurance Company*, [2016] CANLII 78332 (ON LAT).
[16] *M.Y.* and *Allstate*, 2017 CanLII 15836 (ON LAT), at para. 25; *S.T.* and *Economical*, 2017 CAnLII 59507 (ON LAT) at para.43.
[17] *V.A.* and *Co-operators*, 2017 CanLII 62166 (ON LAT).

part 6 blank. A third Disability Certificate was provided with the explanation that part 6 did not apply. The Insurer brought a preliminary motion to dismiss the LAT application on the basis that she was preclude from proceeding with her claim for IRBs as she missed the 2 year limitation period and she failed to provide a completed disability certificate to support entitlement to the IRB. The adjudicator found that the insurer could not rely on the letter requesting a completed Disability Certificate as clear and unequivocal notice that she was not entitled to income replacement benefits since it did not specify that she was not eligible for benefits and found there was no clear refusal to pay the income replacement benefit. On the issue of a completed disability certificate, the adjudicator reviewed the applicable sections of the Schedule and found that a "completed disability certificate" referred to in section 36(3) means a disability certificate that contains enough information to allow an insurer to determine whether an insured person is entitled to a specified benefit, such as IRBs, or at least allows an insurer to be able to identify whether it needs to request more information from the insured person either from the insured under section 33 or a medical practitioner by an insurer's examination under section 44 of the *Schedule*.[18]

Limitation Issues and Catastrophic Impairment

The issue of limitation periods has also been considered in the case law with respect to claims for catastrophic impairment and related benefits. These decisions have also followed the existing case law.

In *Somerville* and *State Farm*, Arbitrator Rogers held that the claimant was precluded from arbitrating entitlement to housekeeping and home maintenance benefits once the insurer terminated the benefit despite a later application for catastrophic impairment 5 years after the denial. The motion for preliminary issues was granted in favor of the insurer on this issue[19].

Recent decisions at the LAT have followed the existing case law on limitation defences.

In *Mayo* and *Economical*, Arbitrator Schnapp considered whether the claimant was outside the 2 year limitation period to dispute the insurer's denial of the attendant care and housekeeping benefit and precluded from proceeding to arbitration. In that case, the claimant claimed attendant care and housekeeping benefits, the insurer paid benefits and entitlement was terminated at the 104 week mark. A letter and standard Explanation of Benefits OCF 9 was sent to the claimant which contained language regarding the dispute resolution process and a warning of the 2 year limitation period to dispute the insurer's refusal to pay benefits. The claimant disputed the refusal to pay 8 years after the termination of benefits. Various arguments were raised by the claimant including change in counsel, a discussion with the adjuster that there was no denial at the time, completion of subsequent Form 1s and the subsequent claim for catastrophic impairment. The arbitrator reviewed the case law and the arguments raised and held that there was a clear and unequivocal notice of stoppage, there was no

[18] *O.A.* and *TD General Insurance Company*, 2017 CanLII 69447 (ON LAT).
[19] *Somerville* and *State Farm*, FSCO A12-006767.

separate entitlement to the attendant care and housekeeping benefit that arises at the 104 week mark, and to find there was retroactive entitlement that commenced post 104 weeks once the insured has been determined to have suffered a catastrophic impairment would be to place uncertainty and prejudice on the insurer and result in an unfair and illogical outcome. The claimant was found to have missed the 2 year limitation to dispute the insurer's refusal to pay attendant care and housekeeping benefits.[20] This decision was appealed but the case has since settled.

In *S.T.* and *Economical*, Adjudicator and Vice Chair Trojek considered whether the clamant was precluded from claiming attendant care and housekeeping as she missed the 2 year time limit to dispute the insurer's denial. This had similar facts. The Insurer paid attendant care and housekeeping benefits up to 2 years post accident and further entitlement was terminated by letter and Explanation of Benefits setting out the dispute resolution process and the insured's right to dispute the denial. The Tribunal followed the case law on limitation periods, noting the FSCO decision of *Mayo* and *Economical* which she was noted to be persuasive, and found on the facts before her, there was a clear and unequivocal denial, there was a denial on specific benefits and the limitation period had expired.[21]

In *S.T.* and *Economical*, the cases of *Machaj* v. *RBC*[22] and The *Guarantee* v. *Do*[23] were distinguished as both dealing with insurers that determined the claimant not to be catastrophically impaired and a denial of the next tier of benefits associated with the catastrophic designation. The Tribunal found that these cases stood for the proposition that it is the denial of a specific benefit which triggers a limitation period. In *S.T.*, the Tribunal found that the insurer's denial was proper and the claimant did not comply with the 2 year limitation period to dispute the denial of the benefits. A request for Reconsideration at the LAT is pending.[24]

A recent Court of Appeal decision, *Smith* v. *Allstate*, has indicates that an insurer's denial is sufficient to amount to a denial for all of the weekly benefits. This was an appeal of a summary judgment motion dismissing a claim for statutory accident benefits on the ground that the limitation period had expired. The Court of Appeal agreed with the finding by the motion judge that the insurer's denial was sufficient to amount to a denial for all income replacement benefits including non earner and caregiver benefits. The Court of Appeal, relying on *Turner* v. *State Farm*, went on to state that even if the reasons for the denial by the insurer to justify the refusal of non earner or caregiver benefits were wrong or insufficient, reasons were given and those reasons do not have to be legally correct. In *Smith v. Allstate*, the Court of Appeal held that the insurer's denial was complete and unequivocal and in the circumstances of the case was sufficient to trigger the running of the limitation period. The motion decision is not available but the Court of Appeal decision has been released.[25]

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[20] *Mayo* and *Economical*, FSCO A14-008047.
[21] S.T. and Economical, 2017 CanLII 59507 (ON LAT).
[22] *Machaj* v. *RBC*, 2016 ONCA 257.
[23] *The Guarantee Company* v. *Dong Do et al*., 2015 ONSC 1891 (CanLII) 125 OR (3d) 585.
[24] *S.T.* and *Economical*, 2017 CanLII 59507 (ON LAT).
[25] *Smith* v. *Allstate*, 2017 ONCA 843, November 2, 2017.

A review of the case law on limitation defences in the area of statutory accident benefits indicates that limitation periods will be upheld when there is a clear and unequivocal denial and there is a denial of the specific benefit in dispute. The recent decisions on the applicability of limitation periods on benefits after a determination of catastrophic impairment have not changed the existing case law on limitation periods and confirm that insurers can rely on a proper denial of a specific benefit as a complete defence to the claim and limitation periods play a "vital role in effecting the predictable and timely resolution of disputes". [26]

[26] *Haldenby* v. *Dominion* (2001) 55 OR(3d) 470 at para 6.