

**IN THE MATTER OF THE *INSURANCE ACT* R.S.O 1990 c. I.8, AS AMENDED, s. 268 AND ONTARIO  
REGULATION 283/95**

**AND IN THE MATTER OF THE ARBITRATION ACT S.O. 1991, c. 17, AS AMENDED**

**AND IN THE MATTER OF AN ARBITRATION**

B E T W E E N:

SCOTTISH & YORK INSURANCE CO. LIMITED (AVIVA)

Applicant

and

ALLSTATE INSURANCE COMPANY OF CANADA

Respondent

**AWARD**

**COUNSEL**

Andy Smith and Crystal Olorunsogo, counsel for the Applicant, Scottish & York Insurance Company Limited (hereinafter called "Aviva").

Andrew C. McKague, counsel for the Respondent, Allstate Insurance Company of Canada (hereinafter called "Allstate").

**BACKGROUND**

This matter comes before me pursuant to s. 268 of the *Insurance Act* and s. 17 of the *Arbitration Act*. The parties have chosen me on consent to act as a private arbitrator in accordance with Regulation 283/95 of the *Insurance Act* to determine a dispute between two insurers as to which insurer is responsible for paying statutory accident benefits to a claimant who was injured on May 28, 2023.

Aviva insures the claimant's son. The claimant applied to Aviva for statutory accident benefits. Aviva would only stand in priority if the claimant were principally dependent for financial support on his son. Aviva denies this.

Aviva takes the position that Allstate is the priority insurer. Allstate was the vehicle that struck the claimant while he was a pedestrian on May 28, 2023.

All parties agree in terms of s. 268 of the *Insurance Act* that if I find that the claimant was not principally dependent for financial support on his son, then priority rests with Allstate as the insurer of striking vehicle.

## **PROCEEDINGS**

This matter proceeded to a written hearing, and counsel were given an opportunity to make oral submissions. No oral evidence was called.

The parties provided written submissions, various documents and Books of Authority. The relevant documents provided are set out below:

1. Arbitration Agreement dated April 22, 2026
2. Application for Accident Benefits/OCF-1 dated June 19, 2023
3. Copies of the claimant's tax returns (summary) for the years 2022 and 2023
4. Transcripts of the EUO of the claimant dated July 12, 2023
5. Transcripts of the EUO of the claimant's son dated October 15, 2025

## **ISSUE**

The Arbitration Agreement identifies the issue before me as:

"Which insurer is highest in priority to pay statutory accident benefits to and on behalf of the claimant following a motor vehicle accident which occurred on or about May 28, 2023?"

That question can be distilled to a more narrow focus.

The first issue is whether the claimant was principally dependent for financial support on his son on May 28, 2023.

Allstate also raises a second issue which is more procedural. That issue is set out below:

Did Aviva fail in its duty to investigate other priority insurers? And if so, Allstate submits the arbitration should be dismissed and Aviva should remain the insurer responsible for paying statutory accident benefits to the claimant.

## **DECISION**

On the first issue, I find that the claimant was not principally dependent for financial support on his son on the date of loss and therefore in that regard priority rests with Allstate.

On the second issue, I find that there was no duty on Aviva to investigate any other additional insurers that may stand in priority once they had put Allstate on notice within the 90 days pursuant to Regulation 283/95.

## **FACTS**

The claimant was born on May 21, 1941 and was therefore 82 years old at the time of the accident.

The accident itself occurred when the claimant was on Highway 7 near Main Street and he was struck by the Allstate car sustaining various injuries.

The claimant submitted an OCF-1 dated June 19, 2023 to Aviva. His OCF-1 indicated that he was separated and that the basis for the claim with respect to Aviva was because he was a dependant on the Aviva insured/his son.

At the time of the accident the claimant was retired and had been for a number of years. His tax returns for 2022 show a net income of \$23,499 and for 2023 a net income of \$24,742. The source of this income was Old Age Security, CPP, other pensions and superannuation and what was described as net federal supplements. The net federal supplements consisted of Guaranteed Income Supplements (GIS). In 2022 the amount of the GIS was \$8,056 and in 2023 the amount of the GIS was \$5,409. This translates to a monthly amount of \$671.33 in 2022 and \$450.75 in 2023.

The claimant had no other source of income. When taking the total monies set out that the claimant received in each of the years 2022 and 2023, his monthly income in 2022 was \$1,958.25 per month and in 2023 was \$2,061.83 per month.

In or around September of 2022 the claimant and his son moved into a four-bedroom condo in a shared accommodation setting. There is no information as to why the father and son moved in together at that time. However, the claimant remained living in his son's home occupying one out of the four bedrooms until the time of the accident of May 28, 2023. The monthly rent for the condo was \$2,600 a month. The claimant's son paid for the rent. The claimant made no contribution to the rent or any other expenses relating to the condo.

The claimant's evidence with respect to his own monthly expenses was that he paid for his cell phone, transportation, clothing, medication and social activities and also paid for his own groceries. There was some evidence to suggest that he also contributed some groceries towards the household. The claimant's son had children living with him as well. The estimates are that the claimant spent anywhere from \$400 to \$600 per month for groceries and/or possibly \$100 a month towards the family's groceries.

The claimant's evidence was also if his son asked him for money, he gave him some. His son's evidence was he did not receive any money from his father.

The claimant's evidence was that he maintained some savings but he did not draw on his savings for day-to-day expenses as this was covered by his regular government income. There was no evidence as to how much he had in his savings on the date of loss.

The claimant's evidence was his son did not give him any money or cover anything other than the rent and related condo expenses.

The claimant did not own a car. If he needed to drive, he rented a car with insurance.

With respect to the second issue, there are some additional facts that are relevant.

The OCF-1 already referred to indicated that the claimant was separated.

At his EUO on July 12, 2023, approximately two months after the accident, the claimant confirmed that he was separated from his second wife but not divorced. Her name was asked for and the claimant provided it. However, he did not know where she lived, although some possible addresses were discussed. The claimant was asked during the course of the EUO to undertake to provide the last name of his second spouse, her date of birth, her address, her driver's licence and any policy information as to whether she had a policy of automobile insurance. There is no evidence as to what subsequent follow-ups may or may not have been made by Aviva. Efforts to locate a possible spousal policy was the subject matter of a number of pre-hearing discussions in the course of this arbitration.

### **RELEVANT STATUTORY PROVISIONS**

Section 268 of the *Insurance Act* is the key provision dealing with priority. It sets out a hierarchy relating to priority as between insurers to determine which policy is to respond to an individual who applies for statutory accident benefits arising out of a motor vehicle accident.

As noted, there is no dispute between the parties here with respect to the applicability of s. 268 of the *Insurance Act*. In the event the claimant is not principally dependent for financial support on his son, then both parties agree that Allstate is the priority insurer as Allstate insured the vehicle that struck the claimant when he was a pedestrian.

The second key statutory provision is s. 3(7)(b) of the Statutory Accident Benefits Schedule which provides the definition of "dependency". That section is set out below:

"A person is a dependent of an individual if the person is principally dependent for financial support or care on the individual or the individual's spouse."

In this case, we are only dealing with financial dependency.

### **POSITION OF THE PARTIES ON DEPENDENCY**

#### **SUBMISSIONS OF AVIVA**

Aviva takes the position that the claimant was not principally dependent on his son on the date of loss.

Aviva points to the four criteria set out in *Miller v. Safeco* (1986) 48 O.R. (2d) 451 (H.C.J.) affirmed 50 O.R. (2d) 797 (Court of Appeal) that are to be considered when determining financial dependency. Those four criteria are:

1. The amount of dependency;
2. The duration of dependency;
3. The financial needs of the claimant; and
4. The ability of the claimant to be self-supporting.

Aviva starts their submissions with setting out the appropriate timeframe for considering the duration of the dependency. Aviva submits that that timeframe should be from September 2022 to the date of the accident on May 28, 2023. Aviva submits that that time period reflects an ongoing and stable financial relationship between the claimant and his son. It starts from the time they moved into the condominium together up until the time of the accident.

Aviva submits that from there one must determine principal dependency by determining whether the cost of meeting the claimant's needs is more than twice their available resources. This has generally become known as the 51% rule and essentially it requires evidence that the dependency can only be established if the individual gets financial support greater than 51% from another source in order to assist with covering his needs. Another way of putting it is that the claimant cannot cover his needs with more than 50% of his own income and therefore is relying on someone else. This flows from the decision of Arbitrator Samis in *Federation Insurance Company of Canada v. Liberty Mutual Insurance Company*.

Aviva submits that during the selected time period of September 2022 to May 28, 2023 the claimant received \$16,183.92 in income. This is derived by extracting a monthly amount from the claimant's tax returns for 2022 and 2023.

Aviva then relies upon the line of cases which support that in assessing dependency, rather than trying to use mathematical calculations and adding up various expenses and needs versus income, which tends to be quite inaccurate, that a statistical analysis should be used. These have been referred to as the LICO and MBM approaches (Low Income Cut-Off and Market Basket Measure). To that end, Aviva referenced a decision (Arbitrator Samworth) in *Economical Insurance Company v. Wawanesa Mutual Insurance Company* (February 10, 2026) where I stated:

"I have concluded in other cases as have other arbitrators that the analysis is not of the financial dependency of the family unit but rather of an individual and whether that individual can be self-supporting and provide up to 51% of his needs. Therefore, I find the relevant statistic to look at is for individuals who are not in an economic family."

Aviva then relies on the appropriate statistics for LICO and MBM for the Markham Municipality, which was where the claimant resided, and selecting the statistics relating to a one-person

household.

With respect to LICO for a one-person household in Markham in 2022 the threshold was \$20,590 and in 2023 it was \$21,398. Extrapolated and prorated over a three-month period in 2022 and five months in 2023, Aviva submits that the prorated LICO comes to \$14,061.67. As the claimant received income of \$16,183.92 during that period, Aviva submits it was well over 50% of the LICO amount and in fact statistically it came to 115.1%. Therefore, Aviva submits the claimant could not be considered principally dependent on anyone else as he had sufficient money to cover well over 51% of his needs.

Aviva did the same analysis with respect to the Market Basket Measure. For an individual not part of an economic family in 2022 the threshold was \$25,453 and in 2023 it was \$26,461. Prorating over the relevant eight-month period came to \$17,388.67. With an income of \$16,183.92, the claimant still met 93.07% of his needs. Therefore, based on a statistical analysis it is clear, Aviva submits, that the claimant was capable of meeting more than 51% of his own needs. Therefore, when considering the *Miller v. Safeco* criteria of his financial needs and the ability of the claimant to be self-supporting with respect to those needs, Aviva submits that clearly the claimant is independent and cannot be found to be principally financially dependent on his son.

Aviva also relied on the decision of Arbitrator Malach in *Coachman Insurance Company v. The Personal Insurance Company and Certas Direct Insurance* (November 17, 2023). In that case, the claimant was living with her daughter. Her daughter paid the rent. The claimant made no contribution to the household expenses. However, she had significant savings and some investment income. The arbitrator held that just living with a family member does not on its own establish dependency if the individual has the financial means to support themselves.

Aviva also made submissions with respect to the alternate approach that a number of arbitrators have used and have been supported by the courts referred to as the "big picture" approach. Aviva submits the big picture approach is not appropriate here. To that end, Aviva relies on the comments of Justice MacLeod in *Economical Insurance Group v. Desjardins Insurance*, 2020 ONSC 1363 (CanLII). Justice MacLeod stated:

"The 'big picture' approach derives from cases in which either there was insufficient evidence to apply a 50% plus one analysis or in which it simply appeared too arbitrary or nuanced a cutoff when viewed against the overall circumstances of the big picture."

Aviva submits in this case there is no reason to stray from the statistical analysis as there is more than sufficient evidence to establish the dependency analysis based on that approach. Aviva submits there is clear and reliable evidence with respect to the claimant's statistical needs and his available resources and it is not necessary to go to the big picture.

However, even if one looks at the big picture, Aviva submits that the claimant's ability to be self-

supporting while living rent-free with his son still does not establish a principal financial dependency. In that regard, Aviva also notes that the claimant contributed money towards the groceries for the house and was able to maintain savings, although there is no evidence as to how much those savings were.

## **SUBMISSIONS OF ALLSTATE**

Allstate does not disagree that the starting point in any analysis of principal financial dependency would involve an examination of the four criteria in *Miller v. Safeco*.

Allstate also agrees that the relevant time period for the duration of the dependency would be from September 2022 to May of 2023.

Allstate's main submission is that some of the monies attributed to the claimant as part of his financial resources should be excluded. Allstate submits that the GIS that the claimant received and comprised somewhere between 21% and 34% of his income each year should be excluded from his income calculation.

Allstate provided materials that noted that to be eligible to receive a GIS, an individual must be 65 years of age or older, receive the Old Age Security pension and have an annual income below a certain threshold. Allstate submits that this GIS, which is provided to the claimant because of his lack of other financial resources, should be treated the same as a scholarship or student loan funds and be looked at as a "flow through".

For example, Allstate relies on the decision in *The Personal Insurance Company v. Allstate Insurance Company*, 2019 CanLII 64827, a decision of Justice Gordon of the Superior Court. In that case, Justice Gordon stated that a dependency analysis cannot simply be based on cash flow and to have that include scholarships or student loans. This would effectively eliminate all university students from being dependants on their parents and would be contrary to the principle that insurance is consumer protection and should broaden coverage and not restrict it.

Allstate also relies on the decision in *Jevco Insurance Company v. TD General Insurance Company* (Arbitrator Densem, October 16, 2015). In that case, Arbitrator Densem noted that a government loan, grant, or scholarship money that is given to a student to cover the cost of their education-relating expenses should be a neutral factor and removed from the dependency calculation. It simply goes to paying the school expenses and does not provide support for needs.

Allstate submits that the GIS should be considered the same. As the claimant receives these monies due to his lack of financial resources, then it should be considered like a scholarship or a student loan as they flow through to cover his needs. Similar to the comments by Justice Gordon in *Personal v. Allstate (supra)*, Allstate argues that if one includes this type of financial support as a source of income, that it would effectively prevent people with very low incomes or retirees from accessing the insurance of their children upon whom they otherwise might be considered dependent and is therefore contrary to the schedule.

Allstate submits that if you extract from the income on the tax return the amount of the GIS, that then supports their position that the claimant would become principally dependent for financial support on his son as it would reduce his available income. Allstate submits that to find the claimant was financially independent when he is receiving a government supplement that is designed for people who cannot support themselves would be an untenable and an irrational conclusion.

Allstate also submits that in relying on the big picture analysis, the evidence supports that the claimant was dependent on his son. Irrespective of what type of income came in, the claimant was dependent on his son to pay for his room, his board and related condo expenses. In addition, Allstate argues the claimant himself completed his OCF-1 declaring that he was dependent on his son. This should be afforded significant weight, according to Allstate.

Therefore, Allstate submits that I should find the claimant's principal dependency on his son, and accordingly priority would continue to rest with Aviva.

#### **AVIVA REPLY**

Aviva's reply was through their oral submissions. Aviva submitted that the comparison of the GIS to OSAP (the student loan process) is not a fair comparison. Aviva submits GIS is a general source of income designed to be spent on exactly the sort of daily expenses that the claimant has. It is income to cover needs which is exactly what principal financial dependency is to consider.

Aviva submits it is real money deposited into an account and considered as income for the purposes of tax returns.

Even if you eliminate GIS, Aviva conducted calculations to show that the claimant would still not be principally dependent on his son. If the GIS were excluded, the prorated income for the relevant time period would be \$11,916.17 and when one considered the LICO, the claimant would be able to cover 84.7% of his needs and with respect to the MBM 68.5% of his needs.

#### **ANALYSIS AND DECISION WITH RESPECT TO THE ISSUE OF DEPENDENCY**

On the issue of principal financial dependency, I find that the claimant was not principally dependent for financial support on his son on the date of loss of May 28, 2023.

I have carefully considered the facts presented by the parties and their arguments and the case law that has been referred to.

I agree with Aviva that this is a case where a statistical analysis is appropriate. However, I do note that even if I had accepted the big picture analysis, I would still conclude that the claimant was not principally dependent for financial support on his son on the date of loss.

In reaching this conclusion, I have carefully reviewed the four criteria set out by the Court of Appeal in *Miller v. Safeco (supra)*. As has been pointed out by many judges and arbitrators, when assessing these four criteria one must recognize that the mathematical side of dependency is only part of the equation. I must also examine all other factors to ensure that if a mathematical or statistical analysis is being relied on, it accurately reflects the claimant's circumstances on the date of loss. In this particular case, I am satisfied that the statistical analysis is appropriate and accurately reflects the claimant's circumstances on the date of loss.

With respect to the duration of dependency, the parties agree that the relevant time period is from September 2022 to May of 2023. This is the time period that the claimant and his son had moved in together into a condominium and were in shared living circumstances.

With respect to the ability of the claimant to be self-supporting, I accept the submissions of Aviva that I should consider the full amount of the claimant's available income as shown on his tax returns. I accept Aviva's submissions that in the relevant time period the claimant had an income of \$16,183.92. I do not accept Allstate's argument that the guaranteed income supplement that forms part of that income should be excluded. There is nothing to suggest that this would not be considered as income in the hands of the claimant. While it may be designed for people of a certain level of financial needs, it is not like a student loan that is designed to provide payment for non-essential needs like tuition or books. The income supplement is to provide for the needs of low income individuals which would include housing, food and clothing, all the very needs that are part of the statistical analysis set out in the market basket measure to determine the cost of an individual's needs over the course of any one year.

I am satisfied that the GIS should be treated as any other income that is given to a claimant whether it be through ODSP, CPP disability benefits or CPP old age benefits. This is to replace or supplement somebody's income in order to provide for their needs. It is not analogous to the student loan or the cases cited by Allstate dealing with scholarship money, grants or government loans to cover educational costs.

Therefore, the claimant in this case had \$16,183.92 to cover his statistical needs.

With respect to his financial or other needs (the third criterion in *Miller v. Safeco*), I agree with Aviva that using either the market basket measure or the low income measure is an appropriate way of calculating somebody's needs rather than trying to do so by collecting personal information about the various needs and expenses of a household. This is consistent with many decisions over the last few years from various arbitrators.

Using either of these measures, the claimant would be found to have available from his income of \$16,183.92 more than 51% of the funds available to satisfy his statistical needs.

I agree with Arbitrator Malach in his decision in *Coachman v. The Personal (supra)* that where an individual is simply living with a family member and that family member covers all the household expenses including rent, that that does not on its own establish principal financial dependency if

the individual otherwise had the means to support themselves.

An example that is often used is if an individual is a millionaire but lives in the home of a family member and that family member pays all the expenses and the millionaire contributes nothing, that does not make him principally dependent for financial support on that individual. The same is true in this case.

This is not a case where I find that I must look at the big picture. I agree with Aviva that there is clear and reliable evidence with respect to the claimant's available income resources and statistical needs for me to make a decision on that basis without needing to look at the big picture.

I therefore conclude that the claimant was not principally dependent for financial support on his son and accordingly Allstate is the priority insurer in accordance with s. 268 of the *Insurance Act*.

### **ISSUE 2: Duty of Aviva to investigate other insurers after putting Allstate on notice**

#### **RELEVANT STATUTORY PROVISIONS**

The relevant legislative provisions with respect to this issue are found in Regulation 283/95 of the *Insurance Act*, as amended.

There are two sections that are relied upon by the parties with respect to their submissions on this issue and that form part of the basis for my decision.

The first is s. 3 as set out below:

"3(1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

(1.1) If the dispute relates to an accident that occurred on or after September 1, 2010, a notice required under subsection (1) must also be given to the Fund if the insurer claims the Fund is required to pay benefits.

(2) An insurer may give notice after the 90-day period if,

- (a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and
- (b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period."

"3.1(1) This section applies to disputes relating to accidents occurring on or after September 1, 2010.

- (2) Before giving a notice to the Fund under section 3, an insurer must,
- (a) complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund; and
  - (b) provide particulars to the Fund of the investigation and the results of the investigation."

Section 10 is as follows:

"10(1) If an insurer who receives notice under section 3 disputes its obligation to pay benefits on the basis that other insurers, excluding the insurer giving notice, have equal or higher priority under section 268 of the Act, it shall give notice to the other insurers."

#### **SUBMISSIONS OF ALLSTATE**

Allstate submits that there was clear evidence shortly after the receipt of the OCF-1 that should have alerted Aviva to the existence of a potentially higher priority insurer. This was the fact that the claimant was still married, albeit separated but not divorced, and therefore arguably there could be an automobile policy with the separated spouse that the claimant may still have had access to.

In support of this, Allstate points to the claimant's EUO on July 12, 2023, less than two months after the accident, where he confirmed he was separated but not divorced from his spouse.

In addition, on the OCF-1 the claimant checked the box that he was separated. In these circumstances, Allstate submits that Aviva then had a duty to make reasonable investigations with respect to attempting to locate the spouse, determine if she had an automobile policy that was in place at the time of loss and that might stand in priority to the Aviva and/or Allstate policy.

While an undertaking was requested from the claimant's counsel to provide this information, Allstate submits that it was insufficient for Aviva to rely on that source and that they had a duty to conduct independent investigations by taking reasonable steps of their own when information was not provided by the claimant in a timely fashion.

Allstate submits that Aviva simply sat back, having found Allstate as a possible priority insurer, and failed to take any reasonable steps to investigate whether there may be another insurer who might stand in priority who should be put on notice.

Allstate relies on s. 3.1 of Regulation 283/95 and submits that it requires insurers to canvass all

obvious sources of priority coverage and to take active steps to identify other policies including possible spousal policies or dependency policies and not simply rely on limited or incomplete information.

Allstate submits that s. 3 requires that the insurer who puts other insurers on notice has a heavy onus to prove that investigations have been done within the 90-day period that are reasonable and comprehensive in order to identify all possible insurers, even in circumstances where there can be misinformation or lack of co-operation.

Allstate relies on the following cases with respect to their argument:

1. *Security National Insurance Company v. Intact Insurance Company*, Arbitrator Bialkowski, March 18, 2018;
2. *Primmum Insurance Company v. Aviva Insurance Company of Canada*, 2005 CanLII 11975 (ON SC);
3. *Liberty Mutual Insurance Company v. Zurich Insurance Company*, Arbitrator Guy Jones, June 2006 upheld on appeal: *Liberty Mutual Insurance Company v. Zurich Insurance Company*, 2007 CanLII 54080 (ON SC).

Allstate submits that Aviva has not provided any evidence in order to meet its heavy onus that it took reasonable steps to try to locate the claimant's spouse and determine whether she had an auto policy that might respond. Allstate submits that failure to do so must result in this application being dismissed.

## **SUBMISSIONS OF AVIVA ON ISSUE 2**

Aviva's position is that there is no statutory or regulatory or jurisprudential basis for imposing a duty on Aviva to conduct widespread investigations with respect to various insurers that may stand in priority and to ensure that all of those parties are put on notice within the 90-day period or subsequent to the 90-day period.

Aviva submits that that type of obligation only arises in a very narrowly defined set of circumstances set out in s. 3 (2) of the Regulation and in cases dealing with the Fund under section 3.1.

Section 3(2) of the Regulation does set out a duty on the insurer that receives the OCF-1 to establish that reasonable investigations were made if they put an insurer on notice of a priority dispute outside of the 90-day period. They must also establish that the 90 days was not sufficient in order to locate that additional insurer.

Aviva submits that that is simply not the case here. Aviva put Allstate on notice within the 90-day period. There is no duty on Aviva having put Allstate on notice to complete any further

investigations into any other potential priority insurers that may respond.

That duty, submits Aviva, only arises if the Fund is involved. This was a legislative change that was made subsequent to September of 2010 to avoid what is generally referred to as "dumping". This made reference to the practice prior to the addition of s. 3.1 to Regulation 283/95 of an insurer conducting minimal investigations in circumstances where there may be an uninsured vehicle and instead simply putting the Fund on notice within 90 days and then leaving it up to the Fund to spend public monies to investigate other sources of priority. To avoid this, the section was amended to provide that when giving notice to the Fund, the insurer must provide evidence that they completed a reasonable investigation to see if there was another insurer or insurers that might be liable to pay benefits in priority to the Fund and to also provide the Fund with particulars of that investigation and the results. The latter so that the Fund would have everything at their fingertips to determine whether they are most likely to be the priority insurer without having to expend significant sums to conduct investigations on their own.

Aviva submits that s. 3.1 only applies to circumstances with the Fund and that otherwise s. 3 of the Regulation does not set up any requirement of that first insurer to provide evidence of what investigations it conducted within the 90-day period unless it falls within the exception.

Aviva relies on the decision of Justice Pollak in *Co-operators General Insurance Company v. Ontario (Minister of Finance)*, 2014 ONSC 515 on this issue.

This was a case that arose out of a motor vehicle accident that occurred in June of 2010 prior to the regulatory change made with respect to the fund that took place on September 1, 2010, adding in s. 3.1(2).

In this case, Co-operators commenced an arbitration against the Fund claiming that they stood in priority to Co-operators with respect to the payment of statutory accident benefits. The Fund raised a preliminary issue that it had no obligation to pay benefits as there were other insurers who had not been put on notice and which stood in higher priority under s. 268 of the *Insurance Act*. Specifically, the Fund argued that the TTC insurance potentially had priority over the Fund and that Co-operators had failed to put TTC on notice and was therefore in breach of s. 3(1) of the Regulation. Notably, the Fund did not give the TTC notice under s. 10 of the Regulation which permits the party who has been given notice by the first party insurer to add other insurers that they feel should respond despite the original 90 days having passed.

The arbitrator held that Co-operators had no obligation under s. 3(1) to do any additional investigation or to put any other insurers on notice and that it was not in breach of the Regulation.

Co-operators argued that the key phrase under s. 3 was the words "who it claims is required to pay". If Co-operators claims that only one other insurer has priority then its only obligation is to give notice to that insurer.

The Fund argued that the Regulation should be construed "conjunctively and harmoniously to make the provision meaningful". This meant, according to the Fund, that Co-operators had an obligation to conduct a reasonable investigation within 90 days and to put every insurer who it claims may be required to pay statutory accident benefits on notice.

With respect to that argument, the arbitrator held that the use of the words "who it claims" means that it gave the insurer the right to choose which insurer, which it alleges is in higher priority, it chooses to give notice to and therefore Co-operators had satisfied its obligations under s. 3.

In analyzing these issues, the court did note that the Regulation had been amended since the whole process began and s. 3.2 now responded in many ways to the Fund's arguments that revolved around the issue of "dumping".

The court concluded that the arbitrator was correct and stated as follows:

"I do not accept the Fund's submission that the words of the Regulation impose a duty to investigate on Co-operators. There is no jurisprudence, on point, to support the Fund's interpretation. The jurisprudence relied on by the Fund deals with the question of whether the time for giving notice to another insurer should be extended beyond s. 3(2) of the Regulation. It is not, in my view, reasonable to suggest that the legislature imposed a duty on the insurer to conduct an investigation through inference, as suggested by the Fund. The Fund's argument is not supported by and violates the basic rules of statutory interpretation. Section 3(2) specifically imposes a duty to investigate in a specific situation, namely to determine whether more time should be granted to an insurer to give notice to another insurer. This view is consistent with the arbitrator's findings."

Lastly, Aviva notes that as in the *Co-operators and Ontario* case (*supra*), Allstate in this case has not availed itself of its rights under s. 10 to add in another insurer that may have equal or higher priority under s. 268 of the *Insurance Act*. If Allstate believed there was another policy that should respond, then Aviva submits that this was their recourse rather than suggesting that this arbitration should be dismissed on the grounds that Aviva failed to investigate.

## **ANALYSIS AND DECISION ON ISSUE 2**

With respect to this issue, I agree with the submissions of Aviva. Firstly, I feel I am bound by the decision of Justice Pollak in *Co-operators v. Ontario* (*supra*) where she found that Co-operators did not have a duty to conduct investigations and put other insurers on notice under s. 3(2) of the Regulation. Justice Pollak interpreted the Regulation as allowing Co-operators to make its investigations within the 90 days and then choose which insurers it would put on notice and it had no obligation to go any further than that.

In applying that to this case, there can be no other conclusion other than that Aviva had no

obligation to conduct any additional investigations once it put Allstate on notice. If Allstate felt there was another insurer that should respond, specifically a spousal policy, then Allstate could conduct these additional investigations and then put that insurer on notice pursuant to s. 10 of the Regulation.

Even if I were not bound by the decision of Justice Pollak, I would agree with it. It is consistent with the case law. It is consistent with the intent of the Regulation, the wording of the Regulation, and the case law particularly that has developed around s. 3(1), s. 3.1 (the Fund) and s. 10.

The fact that when the Regulation was amended on September 1, 2010 and s. 3.1 was added to put a duty on an insurer to provide proof of investigations for other available insurers and only limited that duty to the Fund suggests that there was no similar duty when the Fund was not involved and investigations were being done within that 90-day period.

Accordingly, I find that Aviva did not have a duty to do additional investigations and the argument of Allstate on this issue is dismissed.

#### **AWARD**

I find that the claimant was not principally dependent for financial support on his son on May 28, 2023 and accordingly Allstate Insurance Company of Canada is the priority insurer with respect to the payment of statutory accident benefits in accordance with s. 268 of the *Insurance Act*.

#### **COSTS**

As Aviva has been entirely successful in this matter, I find that Allstate is responsible for paying the costs of the arbitration and any related disbursements. In addition, I find Allstate is responsible to pay to Aviva its legal fees and disbursements on a partial indemnity scale.

I have not fixed the amount of costs payable. If the parties cannot agree then they can request a further pre-hearing and we can set up a written hearing to deal with the issue of costs.

DATED THIS 11<sup>th</sup> day of June, 2026 at Toronto.



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