IN THE MATTER of the *Insurance Act*, R.S.O. 1990, c. I.8 and O. Reg. 283/95

AND IN THE MATTER of the *Arbitration Act*, 1991, S.O. 1991, c. 17

AND IN THE MATTER of an Arbitration between:

ING INSURANCE COMPANY OF CANADA

Applicant

- and –

STATE FARM INSURANCE COMPANIES

Respondent

AWARD

This matter has come before me as an arbitration to resolve a priority dispute between two automobile insurers. Each of the parties is an automobile insurer carrying on business in the Province of Ontario. Each of them has a connection to an automobile accident which occurred on November 30, 2006, in which the claimant, Munoz, was injured. She was a pedestrian at the time of the accident and was struck by a vehicle insured by State Farm Mutual Automobile Insurance Company. At the time of the accident, she was a new comer to Canada and she was residing with her father. Her father had a policy of insurance with ING Insurance Company of Canada.

The circumstances are such that there is now a priority dispute between ING and State Farm as to which of the two insurers is obliged to pay the statutory accident benefits payable as a result of this accident. This dispute may turn on questions of dependency or other issues of a factual and legal nature that have yet to be determined in this proceeding. However, there is a procedural issue which has arisen which the parties have asked me to rule upon at this stage.

Section 268 of the *Insurance Act* sets out a scheme of priority of benefits in order to differentiate between various insurers that might be called upon to respond and pay statutory accident benefits in a claim situation. Under that section of the *Insurance Act* a priority ranking is set out. This is necessary because under the Ontario Automobile Insurance Program, a number of definitions of insured person apply to statutory accident benefits, with the effect that a person injured in an automobile accident is likely to have more than one insurance policy where they would be regarded as a "insured person". The legislation attempts to set out which of the insurers is obliged to respond when there are multiple insurers that might be claimed against.

Section 268 essentially creates the highest ranking coverage for the policy where an injured individual is a named insured, a spouse of the named insured, or a dependant of the named insured. With respect to pedestrians, the second tier of responsibility to respond falls on the insurer of a vehicle that struck a pedestrian. Hence, on the facts of this case, there would be a debate between State Farm and ING as to which insurer is obliged to respond and that debate may require a need to resolve questions of dependency with respect to the claimant.

Ontario Regulation 283/95 sets out important procedural provisions that apply to these priority disputes. At the outset it is important to note that this regulation creates something of a code in order to deal with the appropriate response to claims when there is a priority dispute, and also sets out a code for determining the disputes between the insurers with respect to those claims. The regulation looks in two directions. It looks first at the obligation of the insurers in respect of the claim of the injured person. It secondly addresses the rights and responsibility between the insurers in order to sort out their legal obligations between themselves.

Section 2 of the regulation introduces the concept of a completed application for benefits. Section 2 indicates that when an insurer receives a completed application for benefits that insurer has an obligation to respond and deal with the claim. Essentially, the regulation deprives the insurer of the option of denying the claimant's application on the basis of a priority dispute. The insurer must respond to the claimant and initiate proceeding against other potentially liable insurers in accordance with the regulation. The public policy reasons in favour of this kind of approach are obvious. The burden of sorting out the priority disputes has been shifted away from the policy holders/consumers/accident victims, and onto the shoulders of the insurers. This obviously serves a number of public policy interests in the circumstances.

As part of the procedural rules which apply to disputes between insurers, the regulation has set out a 90-day time limit for one insurer to give another insurer a notice that there is a priority dispute. According to the regulation, the 90-day time limit commences to run when the first insurer has received a completed application for benefits. When the first insurer has received such an application, that insurer is under a strict timeline to commence proceedings, in accordance with Ontario Regulation 283/95, in order to preserve rights to dispute its obligation to pay the claim.

In the case at hand, there was a motor vehicle accident on November 30, 2006. ING became aware of the accident very quickly. They were the insurer of the father of the injured victim. ING took a number of positive and proactive steps to deal with the claim. They very quickly arranged to meet with the injured individual. An interpreter was necessary but one was obtained. A detailed statement was taken from the claimant describing the accident circumstances, her injuries, her employment status, and her access to benefits.

That statement was taken by an ING representative on Friday, December 8, 2006.

ING's course of conduct in this respect is entirely appropriate, and indeed is to be encouraged. They have moved expeditiously to respond to a potential claim. They have been thorough in their investigation. They have been careful to deal with all of the rather complicated requirements of the insurance regime. On December 5, 2006, they sent a letter to the claimant providing an accident benefits package of various documents and enclosing descriptions of the various benefits that would potentially be available to the claimant. They made it very clear in their letter that it was the claimant's responsibility to submit a document described as

"Application for Accident Benefits (OCF-1)" within 30 days. The OCF-1 is a prescribed form. This is the document that all insurers are required to deliver in the context of accident benefits claims.

In fact, the claimant did complete an accident benefits claim form, an OCF-1. It was dated December 20, 2006 and it was received by ING on December 22, 2006. This document is part of a 7 page package. The portion completed by the claimant is 5 pages in length. In the materials that were put before me, there is a copy of the application as completed by the claimant.

It is clear that during the interval between providing the claimant with a package of forms, subsequently followed by a statement interview, but prior to submitting an application, ING paid 2 minor medical expenses for the claimant. These appear to be hospital related expenses totalling less than $200.00. These items were identified in the written statement taken from the claimant. ING processed theses payments. It appears that they did this on December 13, 2006. On that same date there is a note from the ING file indicating the adjuster's plan was to await the application and disability certificate and a diary of 30 days was established to follow up for that application.

It was against this background that I am asked to determined whether or not the transactions prior to December 22, 2006, are sufficient to consider ING having received a completed application for benefits.

In my view, those transactions represent a high calibre of claims handling which is appropriately responsive to notification of a claim. Indeed a much lower level of response might certainly be considered appropriate and would have been compliant with the regulatory obligations.

Clearly, communications from ING to the claimant do not constitute receipt of a completed application. No matter how it is characterized, an application must consist of a transmittal information from the claimant to the insurer. Various cases which were put before me touch on this issue. There is much discussion about the notion that an application need not be on any precise form but needs to be communication with sufficient information as to require the insurer to give a response. In this context, State Farm argues that the detailed statement obtained by ING constitutes an app lication. Counsel has carefully pointed out how the format of the statement essentially covers much of the content that would otherwise be contained in the OCF-1 form prescribed as an application.

The regulatory context for this needs to be understood clearly. In Part 10 of the Statutory Accident Benefits Regulation we find Section 32 which provides as follows:

NOTICE AND APPLICATION FOR BENEFITS

32. (1) A person shall notify the insurer of his or her intention to apply for a benefit under this Regulation. O. Reg. 281/03, s. 11 (1).

(1.1) A person shall notify the insurer under subsection (1) no later than,

(a) the 30th day after the circumstances arose that gave rise to the entitlement to the benefit, or as soon as practicable after that day, if those circumstances arose as a result of an accident that occurred before October 1, 2003; or

(b) the seventh day after the circumstances arose that give rise to the entitlement to the benefit, or as soon as practicable after that day, if those circumstances arose as a result of an accident that occurred on or after October 1, 2003. O. Reg. 281/03, s. 11 (1).

(2) The insurer shall promptly provide the person with,

(a) the appropriate application forms;

(b) a written explanation of the benefits available under this Regulation;

(c) information to assist the person in applying for benefits; and

(d) information on any possible elections relating to income replacement, non-earner and caregiver benefits. O. Reg. 403/96, s. 32 (2).

(2.1) If an insurer that is subject to a Guideline referred to in subsection 68 (3.2) determines, acting reasonably that there is a likelihood that the person may, in connection with the accident, deliver one or more documents referred to in subsection 68 (3.2), the insurer shall provide the following information to the central processing agency referred to in that subsection:

1. The name, address, gender and date of birth of the person.

2. The date of the accident.

3. Particulars of the automobile insurance policy under which the person alleges he or she is entitled to a benefit or benefits, including,

   i. the name of the insurer,

   ii. the policy number, and

   iii. the name of the person to whom the policy was issued.

4. The claim number assigned by the insurer.

5. Any other information reasonably required by the central processing agency to enable it to carry out its obligations to the insurer under this Regulation. O. Reg. 533/06, s. 3.

(2.2) An insurer's obligation to provide the information referred to in subsection (2.1) may be discharged by,

(a) providing the information to the central processing agency; or

(b) confirming, correcting or supplementing the information previously provided to the central processing agency. O. Reg. 533/06, s. 3.

(3) The person shall submit a signed application for the benefit to the insurer within 30 days after receiving the application forms. O. Reg. 403/96, s. 32 (3); O. Reg. 533/06, s. 4 (1).

(3.1) If an insurer receives an incomplete application for a benefit under this Regulation, the insurer shall notify the person within 10 business days after receiving the incomplete application that the application is incomplete and shall indicate what is missing. O. Reg. 281/03, s. 11 (2); O. Reg. 546/05, s. 5 (1); O. Reg. 533/06, s. 4 (2).

(3.2) Subsection (3.1) applies only if,

(a) the insurer, after a reasonable review of the incomplete application, is unable to determine without the missing information if a benefit is payable; or

(b) the application has not been signed by the person. O. Reg. 533/06, s. 4 (3).

(4) If a person is required by an insurer to submit an additional application in respect of a benefit that the person is receiving or may be eligible to receive, the person shall submit the additional application to the insurer within 30 days after receiving the additional application forms from the insurer. O. Reg. 403/96, s. 32 (4).

(5) If subsection (3.1) applies in respect of an incomplete application, no benefit is payable before the person provides the missing information or signs the application, as the case may be. O. Reg. 281/03, s. 11 (2); O. Reg. 533/06, s. 4 (4).

(6) Despite any shorter time limit in this Regulation, if a person fails without a reasonable explanation to notify an insurer under subsection (1) within the time required under subsection (1.1), the insurer may delay determining if the person is entitled to a benefit under section 35, 38, 39 or 41 and may delay paying the benefit until the later of,

(a) 45 days after the day the insurer receives the person's application; or

(b) 10 business days after the day the person complies with any request made by the insurer under subsection 33 (1) or (1.1). O. Reg. 546/05, s. 5 (2).

These provisions clearly establish a 3 stage procedure for a claims transaction. Initially the onus is on the person to notify the insurer of an intention to apply for a benefit. Thereafter, the insurer has an obligation to promptly provide the insured person with the appropriate application forms and other documentation. The insured person then has an obligation to submit a signed Application for Benefits within 30 days after receiving the application forms. Following these steps there is an obligation on an insurer to proactively advise an insured person if the application is incomplete, etc.

I point out that the various rules around the application process have changed many times over the last 13 years. There are new provisions and new significance to the various provisions. As a result, I am somewhat wary of the case law that is older. It deals with a time when the legal obligations were somewhat different. The current legal obligation as set out in Section 32 of the regulation is unequivocal. The insurer must provide the claimant with application forms. The application forms are regulated prescribed documents. The insured must submit a signed Application for Benefits.

In my view, this is an important aspect of the claims process. In particular, I note that the prescribed form of application now includes, in part 12, an authorization and consent that allows the insurer to disclose person information from the claim for the purpose of recovering payment from other insurers. In other words, the application form contains the authorization and consent for transfer of information to facilitate the resolution of a priority dispute. It is to be noted that the prescribed form that an insurer must use to give a notice under Ontario Regulation 283/95 to another insurer contains personal information about the injured policyholder. Accordingly, it is appropriate that such a notice be preceded by an authorization for such disclosure from the insured individual. If the injured individual has completed the OCF-1, this aspect is addressed. No matter how much information is transmitted to the insurer, if the insurer has not sufficient authorization to allow them to legally communicate with another insurer, then the insurer cannot give a notice of dispute and preserve its priority rights. Therefore, in the context of initiation of a priority dispute between insurers, I must conclude that the completed application includes not only sufficient information as to allow an insurer to understand and respond to a claim, but also requires sufficient authorization as to allow an insurer to give the notice of disputes required by the regulation. To hold otherwise would contemplate situations where an insurer would be unable to exercise the rights that the statute has created to recover indemnity from higher priority insurers. Of course, I am loath to give such an interpretation to the scheme.

In my view, it makes much more sense that we should interpret the commencement of the 90 days as having commenced with the receipt of the OCF-1 in circumstances where that form has been completed and has been required by the insurer. It may be that in various fact situations it would be appropriate to conclude that the insurer is estoppped from relying on the non-delivery of an OCF-1, or may have waived a requirement for an OCF-1. I do not find those circumstances applicable here. ING has been clear that they required the completed application form and they in fact received the completed application form. Their internal documentation shows their reliance on the return of that form in order to go forward with claims handling. I see no reason to suppose that ING took any tactic other than the approach that they

should have the properly completed form including the disclosure authorization on their file in order to move forward with the claims handling.

It was argued that ING's payment of the medical expenses around December 13th should be taken as an acceptance that the information provided as of that point constitutes a completed application. This is not supported by the documentation on the file. At the very date, December 13th, that ING has paid some incurred expenses they unambiguously noted their intention to await the completed application in order to move forward with the matter. I do not think that it is appropriate to conclude that payment of 2 minor medical expenses is somehow an action which precludes the insurer from continuing to acquire a completed application nor is it a statement that the information provided to date constitutes a completed application. As fulsome as the information available to the insurer might be, it was not sufficiently complete to allow them to give a notice of dispute to another insurer. It did not include the disclosure authorization. In my view, it would make no sense to say that that incomplete information starts a time limit running, which the insurer would be incapable of meeting absent disclosure authorizations.

I am also concerned about the notion that an insurer that promptly and diligently investigates a potential claim should be held to be prejudiced as a result of that investigation. In effect this is the argument that is made against ING. As a result of having interviewed th e claimant, arranged an interpreter, and taking a detailed statement about pertinent factual situations, it is suggested that they should be considered as having received a completed application earlier than otherwise is the case in the documentation. In my view, we should adopt procedural rules that encourage this kind of prompt and detailed claims handling, and do not discourage it.

In addition, I have difficulty conceiving of the statement taken as an application by the claimant. While it certainly addresses many of the factual circumstances which would be relevant to sustaining a claim, this was very much a process of the insurer going about its course of collecting information and is not, as far as it can be seen, an effort unilaterally by the claimant to make an application for benefits. In my view, there is a distinct difference between an insurer's information gathering activities and a claimant's submission of information for the purpose of applying for benefits. There certainly could be a considerable overlap between these 2 activities but the concepts are somewhat different.

Nor do I see this as a case where certain surrounding circumstances would somehow justify saying that the insurer should be considered as having received a completed application in the absence of a form. There is no documentation submitted in lieu of a form. There were no communications where the claimant has, in writing, requested benefits. There are no issues of deflection or other conduct on the part of an insurer which would justify concluding that the insurer should be deemed to have received a completed application on anything other than the prescribed form.

Counsel have referred me to various cases on this issue. I am aware that the cases do contemplate that there can be a "completed application" on something other than the approved form. I question the development of this case law in view of the changes in section 32 of the regulation and the very important changes in the OCF-1 with respect to privacy disclosure since the origination of the underlying cases. This train of authorities has its roots in a time when the process was different and the legal ramifications were unlike the present circumstances.

In today's environment, an insurer that wishes to instigate a priority dispute should have the signed application. Similarly a claimant who wishes to advance an accident benefits claim must provide a signed Application for Benefits. In my view, I would only consider other communications to constitute a "completed application" for the purpose of a priority dispute in very limited circumstances where an insurer has essentially waived a completed application, or is estopped from insisting on a completed application or in other similarly compelling circumstances.

Conclusion

I conclude that the completed Application for Benefits was received by ING on December 22, 2006.

If counsel wish to address me with respect to the question of costs of this preliminary issue hearing, please do so within 30 days.

Dated at Toronto this 15th day of April, 2009.

Lee Samis

LEE SAMIS
Arbitrator