

**IN THE MATTER OF THE *INSURANCE ACT*,
R.S.O. 1990, c. I.8, Section 268 AND
REGULATION 283/95 THEREUNDER**

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

AND IN THE MATTER OF AN ARBITRATION

B E T W E E N :

UNIFUND ASSURANCE COMPANY

Applicant

- and -

MARKEL INSURANCE COMPANY

Respondent

DECISION WITH RESPECT TO PRELIMINARY ISSUE

COUNSEL

Mark K. Donaldson – Dutton Brock LLP
Lawyer for the Applicant, Unifund Assurance Company
(hereinafter referred to as “Unifund”)

J. Claude Blouin/George Kanellakos – Blouin Dunn LLP
Lawyer for the Respondent, Markel Insurance Company
(hereinafter referred to as “Markel”)

ISSUE

In the context of a priority dispute brought pursuant to s.268 of the *Insurance Act*, R.S.O. c.8, the preliminary issue before me is:

1. Which of Unifund or Markel bears first responsibility for Prabhjot Gujjar’s claim for statutory accident benefits arising out of personal injuries sustained by him in a motor vehicle accident which occurred on January 28, 2009?

In order to make this decision I must consider which insurer first received a completed application for accident benefits.

PROCEEDINGS

The arbitration herein proceeded on the basis of Examination Under Oath transcripts of the evidence of Markel's adjuster Tina Barnes and the claimant's wife Rujvinder Mann, document briefs, books of authority, written submissions and oral argument which took place on December 15, 2014.

APPLICABLE LEGISLATION

A priority dispute arises when there are multiple motor vehicle liability policies which might respond to a statutory accident benefit claim made by an individual involved in a motor vehicle accident. Section 268(2) of the *Insurance Act* sets out the priority rules to be applied to determine which insurer is liable to pay statutory accident benefits.

Since the claimant was an occupant of a vehicle at the time of the accident, the following rules with respect to priority of payment apply:

- (i) *The occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured;*
- (ii) *If recovery is unavailable under (1), the occupant has recourse against the insurer of the automobile in which he or she was an occupant;*
- (iii) *If recovery is unavailable under (1) or (2), the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to statutory accident benefits arose;*
- (iv) *If recovery is unavailable under (1), (2) or (3), the occupant has recourse against the Motor Vehicle Accident Claims Fund.*

Ontario Regulation 283/95 requires the first insurer to receive a completed Application for Accident Benefits to fund such benefits pending settlement of any priority dispute:

2. (1) The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act. O. Reg. 283/95, s 2.

(2) Subsection (1) applies in respect of benefits that may be payable as a result of an accident that occurs before September 1, 2010. O. Reg. 38/10, s 2.

Ontario Regulation 403/96 - Statutory Accident Benefits Schedule, and in particular s.32 sets out the obligations upon an insurer upon being notified of a claim for benefits:

32(1) - A person shall notify the insurer of his or her intention of apply for a benefit under this Regulation.

(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 7th 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.

(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.

FACTS

The claimant was involved in a multi-vehicle accident on January 28, 2009 while operating his employer's vehicle. That vehicle was insured by the Respondent, Markel Insurance Company ("Markel").

The accident was immediately reported to Markel on the day following the collision. Markel opened a claims file and assigned an accident benefits adjuster Tina Barnes. Tina Barnes had communication with the wife of the claimant but Markel failed to provide the claimant with an Application for Accident Benefits.

The claimant subsequently in March of 2009 submitted an Application for Accident Benefits to the Applicant, Unifund Assurance Company ("Unifund").

Unifund adjusted and funded the claimant's accident benefits claim and subsequently notified Markel of the inter-company priority dispute. The notice however was far beyond the 90 day requirement of s. 3(1) of Ontario Regulation 283/95.

Unifund takes the position that Markel was the first insurer to receive a completed Application for Accident Benefits and that Markel ought to have adjusted and funded the claim from the outset, and if appropriate, disputed priority with Unifund thereafter.

EVIDENCE OF TINA BARNES (MARKEL ADJUSTER)

A claim was opened by Markel on January 29, 2009. Their property damage adjuster noted that liability was "to be determined – this loss was a thirty vehicle pile-up on Highway 94". Jillian Whitney was the property damage adjuster.

Later on January 29, 2009, Ms. Witney was advised that their driver had suffered a broken leg and was hospitalized in Michigan. It was noted that the file was to be "split for a\b".

Markel appointed an accident benefits adjuster, Tina Barnes, ("Barnes"). Barnes confirmed that this new claim came to the Accident Benefits Department January 29, 2009 and that she handled Gujjar's claim from the outset.

Barnes confirmed that the claim went first to their property department and her supervisor then gave her the file.

When Barnes received the file it contained some of the property notes and a claims opening sheet providing information about the insured and the accident. From that, she prepared the document dated January 29, 2009 confirming "received new claim" and documenting a call to the Insured Contact and leaving a message.

Barnes confirmed that she did not keep handwritten or computer log notes. Rather, all notes were entered on their system, and the adjuster confirmed that all of their documents had been produced.

The a\b adjuster spoke with the claimant Gujjar's wife, Rujvinder Mann, on the telephone on January 30, 2009. She was not able to speak with Gujjar because of his injuries. This was the first contact with the claimant Gujjar as previous contact was with the named insured with Friends Logistecs. Barnes confirmed that at the time of her telephone discussion with Gujjar's wife, his wife was already in Michigan. Barnes asked Gujjar's wife several questions from a list that was pre-printed on Markel's system. Barnes typed in the answers as she spoke to Gujjar's wife. The a\b adjuster was advised that Gujjar had suffered a badly broken leg, infection in the muscle and had undergone two surgeries. The mechanism of the accident was described It was indicted that traffic slowed down and Gujjar was unable to stop due to snowy conditions and rear ended a tractor trailer. Guffar's wife reported that the claim had been reported to worker's compensation.

With respect to this initial contact with the claimant's family on January 30, 2009 (two days following the subject accident) Barnes agreed that she did not read the questions verbatim, but rather would have been more conversational in her discussion with Gujjar's wife. Barnes agreed that she had no independent recollection of the discussion with Gujjar's wife apart from what was recorded in her file. If there is no answer typed in response to a question, the question was either not asked or the person did not know the answer.

Question 8 from the list of questions Barnes asked of Gujjar's wife, reminded the adjuster to notify the claimant of the Application Package that would be sent, to invite them to ask any questions about potential benefits available and to express any concerns they may have. Barnes admitted that she never sent an Application for Accident Benefits Package to Gujjar, Gujjar's spouse or their representative. The decision not to send an Application Package was made by Markel's adjuster. The printed form that the accident benefits adjuster was using in her conversation with the claimant's wife also indicated that the claimant had an election between Ontario and Michigan no-fault benefits and that further information would be emailed to her.

The Markel file includes an email dated January 30, 2009 to the claimant's wife providing a website which outlines the Ontario benefits available and some details of the Michigan benefits available. The e-mail further went on to state:

"All hospital bills and reasonable and necessary medical treatment and rehab is covered, so not to worry about that. However, I will need Pravjot to complete some forms before anything else is payable. Not to overwhelm we will discuss forms on Monday because they will be different depending on what type of no-fault benefits you choose. Once Pravjot and you have made an informed decision please complete the attached Jurisdictional Election Form. If you have any questions please let me know. Please let me know what your mailing address and home telephone number is. I will call you on Monday morning to see how Pravjot is doing."

Gujjar was confined to hospital in Michigan from January 28 to February 3, 2009. On January 30, 2009, a billing clerk with the hospital called Barnes expressing concern as to how the related costs of Gujjar's treatment and hospital stay would be paid and billed. Before Markel would consider payment of the hospital account they required a WSIB Assignment as this was Markel's "protocol". The hospital subsequently faxed their invoices to Markel, but Barnes did not pay them. When the hospital called regarding their account Barnes posted reserves to their system.

On February 2, 2009, Markel was advised Sunny Grewal of Friends Logistics that Gujjar was an employee of an owner/operator and was covered by WSIB. On her Examination Under Oath Tina Barnes indicated that based on this she concluded that this would be a WSIB claim. She admitted that the claimant would still have an option of signing the Assignment, pursuing a tort action and claiming accident benefits, however given the liability situation concluded he would be pursuing WSIB. Markel immediately phoned the hospital and told them the claim would be covered by Workers Compensation or under private auto insurance and that forms would have to be filled out by the claimant. On her Examination Under Oath, Tina Barnes indicated that if the claimant chose Ontario or Michigan benefits Markel would have paid. There is nothing in the Markel notes to indicate this was explained to the hospital or the claimant's wife. Markel phoned the claimant's wife that same day and "explained that the claim would be covered by WSIB, explained the forms that Roxanne (at the hospital) will bring to get signed and e-mailed Rosie a copy of the Form 6 Reference Guide."

The Worker's Report (Form 6) and WSIB Assignment were faxed to the hospital on February 2, 2009, signed and returned the same day. No Application for Accident Benefits (OCF 1) was faxed. No OCF 1 application had ever been forwarded to the claimant. However, the WSIB Assignment signed by both claimant and insurer confirms "the Claimant has applied to the insurance company for certain accident benefits".

During her examination Barnes agreed that Gujjar would have been considered an "insured person" under Markel's policy as he was an occupant of the Markel insured vehicle at the time of loss.

Barnes concluded that Gujjar's claim would go to workers' compensation as, in her view, Gujjar was 100% at fault for the accident. Barnes assessed Gujjar's liability for the accident based upon information from his employer, his wife and perhaps information from the property adjuster. When Barnes received the completed workers' compensation documentation, she reviewed same, including the worker's description of the accident. Barnes agreed that Gujjar's

description of the accident would have changed her view of this only being a possible WSIB claim. Barnes agreed that Gujjar was not necessarily 100% at fault for the accident.

Markel spoke with the claimant's wife on April 2, 2009. Markel was advised that she was in the process of completing the last documents in order to make a claim with them. On her examination under oath Tina Barnes indicated that she was left with the impression that Gujjar did not want to claim accident benefits. Markel indicated that they had received invoices from the hospital and would forward them to her so she could submit them to WSIB. That same day Tina Barnes wrote to the claimant's wife confirming that the WSIB claim was being pursued and Markel was closing its file.

Markel never retained a local adjuster to speak with either Gujjar or his wife while they were in Michigan. Markel never investigated a potential priority dispute and Markel did not send out any Notices of an inter-company priority dispute.

When discussing Ontario versus Michigan accident benefits with Gujjar's wife Barnes "implied" that Markel would handle the claim. This was implied by Markel's adjuster identifying herself as the accident benefits adjuster on the claim. During discussions with Gujjar's wife Markel's adjuster "assumed that was implied" that accident benefits would be available from Markel. Markel never sent Gujjar an A/B Application Package, an OCF-1, an OCF-3 nor a document explaining Ontario benefits. Rather, Markel emailed Gujjar's wife a link to the FSCO website.

EVIDENCE OF RUJVINDER MANN (WIFE OF CLAIMANT)

Rujvinder "Rosie" Mann ("Mann") is the spouse of the claimant, Gujjar. Mann first learned of her husband's accident in Michigan from the her husband's friend, Rupinder Sandel. Mr. Sandel is also her cousin. Mann learned of the accident on January 28, 2009.

After she heard about the accident she drove to Michigan. They went on January 29, 2009 due to bad weather.

Gujjar sustained some fairly serious injuries, involving a couple of surgeries. He was in hospital in Michigan for approximately one week, and Mann stayed until he was released.

Mann was contacted by someone from Markel named Tina after her husband's employer advised Markel of the accident. The only contact from Markel was a couple of calls.

During the first call Mann was at the hospital and was asked about where the accident happened and her husband's injuries. Her husband was not able to take the call himself.

According to the claimant's wife Barnes did not provide Mann with any information as to what she should be doing. Barnes did not leave Mann any contact information. Mann did not think she had further contact with Markel until after she and her husband got home.

The witness recalls completing some paperwork while she was at the hospital in Michigan. She does not recall the nature of the paperwork. It was simply brought to her in a binder. The claimant's wife believes that the paperwork that was brought to her in a binder while at the hospital was brought by someone who worked for the hospital. Mann did not recall receiving paperwork from Markel. While she was at the hospital Mann did not have any personal contact with a representative of Markel nor after she returned to Canada.

Mann has no recollection of having received an A\B Application from Markel.

The witness did not recall receiving any e-mail from Markel.

The person who phoned her from Markel did not explain about accident benefits in either Ontario or Michigan. The witness had no recollection of that and agreed it was possible that she had forgotten parts of the conversation due to her husband's condition.

Mann is not aware of Markel having funded any expenses related to her being in Michigan or for transporting her husband home.

Two of her husband's friends came to Michigan and drove them back to Brampton. These friends covered the related expenses. Mann covered her own food expenses and stayed in her husband's room while at the hospital in Michigan.

She believes that her husband hired a lawyer at the end of February, 2009. She believed that the lawyer was going through WSIB first.

The witness had no information with respect to the Application for Accident Benefits or why that was submitted to Unifund as opposed to Markel.

The witness identified her writing and signature on the WSIB documentation but did not recall reading those pages or the reason why she was completing them.

The witness denies having been given documentation with respect to Michigan's no-fault benefits.

Mann recalls seeing and completing the WSIB Form 6 – Workers Report of Injury and Disease Form.

Mann received bills from the U.S. hospital and was aware that there was an argument going on as to who should pay them.

The witness had no recollection of Barnes telling her where she should apply for accident benefits or that she should apply to WSIB.

Apart from her husband advising the hospital that it would be difficult for him to get back to Brampton, Mann had no other recollection about seeking financial assistance for the transfer of her husband from Michigan to Ontario.

DOCUMENTARY EVIDENCE

An Application for Accident Benefits was completed by or on behalf of Gujjar and was signed March 12, 2009. That Application was sent by fax to Unifund under cover of letter dated March 18, 2009. The Application was submitted to Unifund as the insurer of Mann's vehicle.

Unifund forwarded a Notice to Applicant of Dispute Between Insurers form to Gujjar, his solicitor and Markel under cover of letter dated March 15, 2011.

By letter also dated March 15, 2011 Markel refused to accept responsibility for Gujjar's claim as notice of the priority dispute had been sent beyond the notice period provided in s.3(1) of Ontario Regulation 283/95.

On or about September 12, 2011, Unifund initiated these arbitration proceedings.

ANALYSIS AND FINDINGS

Markel takes the position that notice of a priority claim was given by Unifund beyond the 90 day period required by s.3 of Ontario Regulation 283/95 and accordingly Unifund's application ought to be dismissed. In response, Unifund claims that Markel was the first insurer to receive a completed Application for Accident Benefits and accordingly Markel ought to have adjusted and funded the claim from the outset, and if it felt it was not the priority insurer, then disputed priority with Unifund.

It is clear that Unifund's notice to Markel did not take place until well beyond the 90 days required by the Regulation aforesaid.

In dealing with Unifund's assertion that Markel was the first insurer to receive a completed application it is important to note that the subject accident occurred prior to September 1, 2010 when amendments were made to the Insurance Act by way of Ontario Regulation 283/95 requiring the application for accident benefits to be on the approved OCF 1 form. Prior to September 1, 2010 it was not required that the application be on an approved OCF 1 form. Jurisprudence developed that information provided by the claimant did not necessarily have to be on the OCF 1 form but that "once an insurer has received sufficient information that it can obtain any further necessary information, it must obtain that additional information and begin to pay benefits". The Ontario Court of Appeal in *ING Insurance Co. v. TD Insurance (2010) O.J. NO. 3549* at paragraph 60 indicates:

"The goal of Regulation 283/95 is to "pay now, dispute later". By adopting a flexible – rather than a formalistic – approach to deciding what documents amount to a completed application for benefits, the Courts have encouraged insurers to do just that. Once an insurer has received sufficient information that it can obtain any further necessary information, it must obtain that additional information and begin to pay benefits. This interpretation furthers the goal of 'pay now' as the insurer cannot rely on shortcomings in written documentation as a ground for refusing to pay benefits".

I must determine whether Markel had sufficient information so as to be treated as a completed application and would it have had sufficient information if the insurer was required to comply with s. 32 of the *Statutory Accident Benefits Schedule - Ontario Regulation 403/96*. Section 32 of the *SABS* sets out the process by which an Application for Accident Benefits is submitted to an insurer. Once notified of an intention to apply for a benefit "the insurer shall promptly provide the person with (a) the appropriate application form; (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".

In the case before me the claimant was never provided with an accident benefits application form despite Markel protocols to provide same and despite the WSIB Assignment which was

executed by Markel and contained a paragraph which confirmed that the claimant “had applied to the insurance company for certain insurance benefits (No-Fault Accident Benefits, under the applicable Regulation of the Insurance Act)”. I find that Markel was aware of a potential accident benefits claim when it opened a file the day following the subject accident when it learned that the driver of the insured vehicle had suffered a broken leg and was in hospital in Michigan. On January 30, 2009 it posted reserves of \$150,000 for med/rehab, \$8,000 for attendant care, \$3,000 for visitor expenses and \$10,000 for income replacement benefits among other things.

Markel’s adjuster spoke to the claimant’s wife on January 30, 2009. Question 8 of Markel’s protocol list of questions was to remind the adjuster to advise the claimant that an Application Package would be sent and to invite questions as to potential benefits that might be available. The Application was never sent. There is nothing in the adjuster’s notes indicating that it was explained to the claimant or his wife that they were entitled to claim accident benefits while deciding to make a claim for workers compensation or while waiting for a decision from the Board as to whether WSIB benefits were payable.

Markel was aware at an early stage that the hospital was presenting a claim. This was a claim presented on behalf of the claimant and essentially the equivalent of the OCF 23 presented by the chiropractor in *ING v. TD* (supra) which was upheld by the Ontario Court of Appeal as a “completed application” for benefits.

I am satisfied that if an application had been forwarded to the claimant along with the WSIB Assignment both would have been signed and returned. It is clear from a review of the evidence contained in the Examination Under Oath transcript of Rujvinder Mann that she and her husband were unsophisticated and of limited means. They obviously needed assistance to get the benefits to which they were entitled in a prompt fashion while deciding to claim workers compensation or while waiting for the Board’s decision. The whole purpose of the WSIB Assignment is to ensure the claimant receives assistance quickly while deciding to make a claim or while waiting to see if a claim is accepted by the Board while at the same time protecting the automobile insurer to ensure it is repaid if it is determined workers compensation benefits are payable.

The Ontario Court of Appeal in *ING v. TD* (supra) found an OPF-23 form submitted by the claimants treating chiropractor and containing information with respect to the claimant and the nature of injuries to be a “completed application”. The OCF-23 is a form used by a health practitioner to initiate pre-approved treatment for an injury defined in a Pre-Approved Framework (PAF) and also to request insurer approval of other treatment provided. In the spirit of the Ontario Court of Appeal decision in *ING v. TD* (supra) I am therefore satisfied that Markel had sufficient information and the ability to obtain further information so that it effectively had received a completed application long prior to Unifund receiving the OCF 1 in March of 2009.

The Ontario Court of Appeal in *ING v. TD* (supra) completed a careful analysis as to circumstances where information provided to the insurer would be considered a completed Application. This analysis is found at pages 10 and 11 when it reconciled its decision with the situation in *ING v. State Farm* (2009) 97 O.R. (3d) 291 where the court held that the mere taking of a statement from the injured claimant and in the absence of a request for the payment of benefits could not be treated as a “completed application” given the conduct of the ING adjuster who immediately provided the claimant with an accident benefit package including an application for benefits and a written description of the accident benefits available, as well as the fact that an OCF 1 was received just 12 days after taking the statement. The arbitrator at first instance praised ING, saying that it displayed a “high calibre of claims handling which is appropriately responsible to notification of a claim”. The arbitrator wrote at p.2 :

“ING’s course of conduct in (respect of the statement) is entirely appropriate, and indeed is to be encouraged. They 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 what would be potentially available to the claimant.”

The steps taken by ING in the case above were not taken by Markel. An application package was not sent by Markel despite its protocol to do so. A printed description of benefits was not provided. The claimant’s wife was simply sent an e-mail with the FSCO website which would describe Ontario benefits - an e-mail the claimant’s wife denies receiving. The fact situation before me can therefore be distinguished from the fact situation in *ING v. State Farm* (supra) and is more akin to the facts in *ING v. TD* (supra). Having received the invoice from the hospital on behalf of the claimant, having been provided with contact information and nature of the injuries by the wife of the claimant and having signed the WSIB Assignment stating that the claimant had applied to the insurance company for benefits I am satisfied that this is sufficient to constitute a “completed application”.

The Ontario Court of Appeal has also emphasized the importance of compliance with s.2 of Ontario Regulation 283/95 (requirement to provide an application for benefits and explain benefits available) in the decision of *Kingsway General Insurance v. Ontario 2007, ONCA 62* at paragraphs 19 and 20:

“Section 2 of regulation 283 is critically important in the timely delivery of benefits to victims of car accidents. The principle that underlies section 2 is that the first insurer to receive an application for benefits must pay now and dispute later. The rationale for this principle is obvious: persons injured in car accidents should receive statutorily mandated benefits promptly; they should not be prejudiced by being caught in the middle of a dispute between insurers over who should pay, or as in this case, by an insurer’s claim that no policy of insurance existed at the time.

Insurers cannot avoid their obligation under section 2 by claiming that another insurer should pay or that an insurance policy was cancelled shortly before the accident. If they could deny an application for accident benefits on either of those grounds, section 2 would be rendered meaningless. Thus, arbitrators and the courts have developed a nexus test for triggering an insured’s obligation under section 2. As long as there is some nexus – some connection – between the insurer receiving an application for benefits and the insured, the insurer must pay pending the determination of its obligation to do so.”

In my view these principles should equally be extended to situations where not only claimant is caught in the middle of a priority dispute between insurers but also a situation where the claimant has yet to decide whether to make a Workers Compensation claim or is waiting for a decision by the Board to accept a claim.

In the case here there was a nexus between Markel as insurer of the vehicle the claimant was driving at the time of the collision. Markel ought to have paid pending the determination of its obligation to do so in a priority dispute and/or pending the claimant’s decision with respect to making a workers compensation claim. Either way the insured ought not to have suffered. The claimant’s wife left her four children in Brampton to be with her husband in hospital in Michigan. She ought to have had the peace of mind to know that appropriate arrangements were being

made to cover her visitor's expenses/travel expenses and the costs of transporting her husband safely back to Canada - expenses the adjuster admitted on her Examination Under Oath would have been paid for by Markel. Given the seriousness of the injuries sustained it was obvious that the claimant was in immediate need of attendant care and rehabilitation assistance on his discharge from hospital. As I have indicated earlier, I am satisfied that if an Application had been forwarded as required by s.2 of Ontario Regulation 283/95 along with the WSIB Assignment both would have been signed and immediate, much needed assistance would have been available to the claimant.

On the basis of the aforesaid, I find that Markel was the first insurer to have received a completed application.

ORDER

On the basis of my findings aforesaid, I order that Markel was the first insurer to have received a completed application for accident benefits and ought to have been adjusting and paying the accident benefit claim of Mr. Gujjar.

I look forward to receiving submissions as to whether Markel is now precluded from disputing priority with Unifund, the amount of indemnity, costs and interest.

I will reserve any order with respect to the arbitrators costs pending resolution of all issues.

DATED at TORONTO this 9th)
day of January, 2015.)

KENNETH J. BIALKOWSKI
Arbitrator