IN THE MATTER OF the *Insurance Act*, R.S.O. 1990, c.I.8, as amended,
and Ontario Regulation 283/95

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

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

WAWANESA MUTUAL INSURANCE COMPANY

Applicant

- and -

PEEL MUTUAL INSURANCE COMPANY
and ECONOMICAL INSURANCE COMPANY

Respondents

AWARD

Counsel Appearing

Catherine P. Keyes for Economical Insurance Company

Mark K. Donaldson for Peel Mutual Insurance Company

Introduction

This dispute involves a procedural argument between two insurers that are parties to a priority dispute.

Each of the parties is an insurer licensed to provide automobile insurance in the Province of Ontario. In respect of a claim for statutory accident benefits arising out of a motor vehicle accident, there is a dispute between these two insurers as to whether or not the proper procedure has been followed for Peel Mutual to assert a priority claim against Economical.

Section 268 of the *Insurance Act* sets out priority rules for determining which of multiple insurers has the obligation to fund statutory accident benefits. The statutory scheme with respect to these benefits makes it likely that an insured will have access to a number of different insurers for the payment of benefits. Hence the statute sets out a priority so that those insurers may determine which of them is ultimately saddled with the loss.

Ontario Regulation 283/95 sets out procedural rules for resolving a dispute between insurers with respect to priority. Those procedural rules contemplate that the first insurer that receives a completed application would take steps to assert a reimbursement entitlement against another "higher ranking" insurer. In this context, "higher ranking" refers to the priority rules found in section 268 of the *Insurance Act*.

Not infrequently, there may be more than two insurers potentially liable for the payment of benefits such as the dispute in this case.

In accordance with the procedural regulation, the insurer who has received a completed application has an obligation to administer the benefits vis-à-vis the injured person. That insurer can dispute its obligation by giving notice to other insurers and ultimately pursuing arbitration with respect to any unresolved dispute. The regulation calls for the first insurer that receives the completed application to give a notice of a dispute to other potentially involved insurers. The regulation contemplates that this notice will generally be given within 90 days of receipt of a completed application. A saving provision may apply in limited circumstances.

For the sake of clarity in these reasons, I refer to the insurer that has received the first completed application and who is administering the benefits as the "first tier insurer". I refer to an insurer identified by the first tier insurer as potentially liable, and against whom notice is given for reimbursement claims, as a "second tier insurer".

This case raises the procedural problems which arise when a second tier insurer identifies yet another insurer that is even higher ranking (in accordance with the *Insurance Act*) than the second tier insurer. In those cases the second tier insurer logically seeks to involve the third tier insurer and claim reimbursement from that company.

The procedural question which this raises in this instance is whether or not the second tier insurer, must meet the same procedural hurdles as the first tier insurer must meet when initially giving notice to other insurers. The regulation requires the first tier insurer who has received the completed application to notify other insurers within 90 days. In practice it is common for a prescribed form to be used for this purpose. What is not clear is whether or not a second tier insurer, intending to pursue other insurers, must also provide notice within 90 days as is contemplated as the obligation of the first tier insurer.

I conclude that the second tier insurer does not have that obligation.

In my view, the provisions of Regulation 283/95 do not unequivocally apply those procedural provisions to second tier insurers. At the outset I observe that the notice provisions apply to the insurer who has received a "completed application" and implicitly applies to the insurer who is actually paying the benefits to the claimant. This is not the position of the second tier insurer.

The second tier insurer may not know whether the first tier insurer is paying the benefits under section 2. Section 2 applies only if the insurer is the first insurer to receive a completed application.

The second tier insurer has no right to a "completed application", nor does the SABS claimant have any obligation to provide such a document to the second tier insurer. Yet receipt of the completed application starts the clock running for notice that complies with section 3 of the regulation.

> **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. O. Reg. 283/95, s. 3 (1).**

The first tier insurer is motivated to commence proceedings against a higher ranking insurer, but is not required to commence proceedings against the highest ranking insurer. Given the time constraints imposed it is entirely possible that the first tier insurer will overlook the potential involvement of other higher ranking insurers. The result is that the first tier insurer may well implead, as a second tier insurer, a company that, in turn, should be able to assert another, higher ranking, insurer has responsibility.

Ontario Regulation 283/95 recognizes that priority dispute arbitration may well involve several tiers of insurers. Section 10 of the Regulation provides:

> **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. O. Reg. 283/95, s. 10 (1).**
>
> **(2) This Regulation applies to the other insurers given notice in the same way that it applies to the original insurer given notice under section 3. O. Reg. 283/95, s. 10 (2).**
>
> **(3) The dispute among the insurers shall be resolved in one arbitration. O. Reg. 283/95, s. 10 (3).**

It is argued before me that this provision requires me to apply the section 3 time limit for notification not only to a notice under section 3, but also to a notice under sub section 10(1). I find this unpersuasive. Aside from the obvious fact that the regulation does provide for the notices in two different sections, only one of which is subject to the 90 day limit, sub-section 10(2) applies the regulation provisions to other insurers already "given notice" only in the same way that it applies to the original (first tier) insurer.

The first tier insurer is entitled to receive a completed application. The second tier insurer does not necessarily have a completed application, and certainly it is not a condition precedent to its liability as contemplated re first tier insurers. In short, it is impossible for the regulation to apply to the second tier insurers "in the same way" that it applies to the original (first tier) insurer.

To apply the Notice rule to the second tier insurer vis-à-vis a third tier insurer does not fit within the provisions of the regulation. The second tier insurer is necessarily not the "first insurer", nor is it the insurer paying benefits under section 2. The second tier insurer is not entitled to be in receipt of a completed (or any) application from the SABS claimant. The second tier insurer does not enjoy the benefit of SABS sections 31 and 32 that allow the SABS insurer to obtain information from the claimant that might assist in identifying higher ranking insurers that should be shouldering the burden of payment.

While meeting the 90 day deadline might be challenging for the first tier insurer, that standard of response seems completely unsuitable when cast over an insurer that lacks the most basic access to information that might be critical to impleading the ultimately responsible insurer. I don't overlook the provisions of section 6 of the regulation in this regard, but note the lack of any compliance parameters that might give hope for a prompt and fulsome response to inquiries made by an insurer that is not administering the claim. At best section 6 is a poor tool if it is to be used to ferret out priority information in a short time frame.

I conclude that blindly applying the section 3 procedural provisions to second tier insurer actions is not consistent with the wording of the regulation, and is insensitive to the context. To apply the section 3 provisions to second tier insurers would give rise to an injustice, ultimately resulting in the payment of benefits by the wrong insurer. The regulation is designed to facilitate a process that will lead to the cost of a claim being visited upon the correct insurer, without burdening the insured person with prosecution of priority dispute issues. It would be abhorrent to interpret the regulation in a manner which has the opposite result unless that outcome is required by the clear and specific language of the regulation. The language of the regulation does not have that clarity.

Section 10 does generally apply the regulation provisions to disputes between second and third tier insurers. But this can only go so far. The regulation provisions can only be applied to the second tier insurer to the extent that the provisions address circumstances that apply to the second tier insurer. As the second tier insurer does not, in the context of the SABS regulation or other provisions, have the right to receive a completed application, and is not the "first insurer", section 10 cannot be fairly read as applying the very strict provisions of section 3 to the second tier insurer.

I note that this conclusion is consistent with the comments of Arbitrator Robinson in *CAA v. AXA* May 21, 2010 wherein he observed that a very strict interpretation of a provision creating a limitation was required. In that case Arbitrator Robinson did not apply the 90 day time limit to the actions of the second tier insurer. I agree with that outcome.

Arbitrator Jones has suggested he might be inclined to a different disposition in a similar case, but did not find it necessary to come to that conclusion.

The Escape Clause

It is unnecessary for me to address the possibility of Peel Mutual avoiding the 90 day limit by application of section 3 (2) of the regulation but I hasten to point out that Peel Mutual, as a second tier insurer, is not provided with the same legal tools to investigate a claim as might be available to a first tier insurer.

Conclusion

The priority dispute is not precluded by failure to comply with Ontario Regulation 283/95. As agreed by counsel costs will follow the event and I therefore order costs in the amount of $5,000.00 all-inclusive to be paid by Economical to Peel Mutual.

Dated at Toronto this 28th day of January, 2011.

LEE SAMIS
Arbitrator