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

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 :

AVIVA INSURANCE COMPANY

Applicant

- and –

INTACT INSURANCE COMPANY

Respondent

DECISION WITH RESPECT TO PRELIMINARY ISSUE

COUNSEL

Derek Greenside – Kostyniuk & Greenside
Counsel for the Applicant, Aviva Insurance Company
(hereinafter referred to as “Aviva”)

Sloane Bernard – Belair Insurance Company
Counsel for the Respondent, Intact Insurance Company
(hereinafter referred to as “Intact”)

ISSUE – 90 DAY NOTICE

[1] In the context of a priority dispute pursuant to s.268 of the *Insurance Act*, R.S.O. 1990, c. I.8 and Ontario Regulation 283/95, the issue before me is to determine which insurer stands in priority to pay statutory accident benefits to or on behalf of the claimant Daniel Chalhoub, with respect to personal injuries sustained in a motor vehicle accident which occurred on February 3, 2016. The preliminary issue to be determined is whether notice of the dispute between insurers was served in compliance with s.3 of O. Reg. 283/95 – Disputes Between Insurers (hereinafter referred to as “the Regulation”) with notice having been served approximately 111 days after receipt of the OCF-1, rather than within 90 days as required by the Regulation.

PROCEEDINGS

[2] The matter proceeded on February 21, 2017 in Mississauga, Ontario, on the basis of Document Briefs and the oral evidence of a claims adjuster from Aviva.

FACTS

[3] The subject motor vehicle accident occurred on February 3, 2016. The claimant, Daniel Chalboub, was a passenger in a vehicle insured by Aviva.

[4] The claimant applied to Aviva for statutory accident benefits. Aviva received the completed Application for Accident Benefits (OCF-1) and the Self-Reporting Collision Report on February 17 or 18, 2016. The OCF-1 was signed on February 10, 2016.

[5] The OCF-1 indicated that the claimant was 18 years old, unemployed and a student residing at 1011-41 Antrim Crescent in Scarborough. He was represented by Laru Legal Services. In Part 4 of the OCF-1, it was indicated that the claimant was not covered by any other policy of insurance.

[6] It was clear from the evidence of the Aviva accident benefits adjuster testifying at the hearing and his log notes, that he realized that the claimant was likely principally financially dependent on his parents or some other person given the claimant's status as an unemployed student. Should that individual have automobile insurance, then priority would likely rest with such insurer. The task was obviously to identify the source of the claimant's financial support and determine if such individual had automobile insurance.

[7] The first notice that the Respondent Intact received of Aviva's intention to dispute priority for payment of accident benefits was the Notice to Applicant of Dispute Between Insurers, sent on June 8, 2016. This was approximately 111 days after Aviva received the claimant's OCF-1 and beyond the 90 day requirement of s. 3(1) of the Regulation.

[8] What transpired between receiving the OCF-1 and serving Notice of Dispute is outlined in the following paragraphs and is based on the documents provided and the oral evidence of an adjuster on behalf of Aviva.

[9] Upon receipt of the OCF-1, the claimant's accident benefits file was referred to a claims representative at Aviva Insurance for processing and administration. This was the first of three representatives handling the accident benefits claim of the claimant during the initial 90 day period post-receipt of the OCF-1. Aviva contacted the claimant's legal representative (Laru Legal Services), on February 25, 2016, to make arrangements to obtain a priority statement and was advised by the claimant's legal representative that they would not agree

to have the claimant provide a statement. No request was made for a Statutory Declaration at that time.

[10] Aviva instructed Kostyniuk & Greenside to complete an Examination Under Oath on February 26, 2016, some nine days after receiving the OCF-1.

[11] Aviva conducted a Name Search for Drivers License Number on the claimant on March 29, 2016. That search confirmed that the claimant was unlicensed. This was the same date that the file was transferred from the initial adjuster at Aviva to another adjuster.

[12] The Examination Under Oath was scheduled to proceed at the offices of Network North Reporting & Mediation on April 19, 2016. The claimant's legal representative requested that the proposed Examination Under Oath be rescheduled to May 5, 2016 and a different location closer to where the claimant lived. This would be 78 days following receipt of the OCF-1, leaving less than two weeks to identify the claimant's parents and determine whether they had automobile insurance in the event the claimant failed to show on the scheduled Examination Under Oath, or did not have details of insurance that his parents had on the vehicle we now know the parents owned.

[13] The claimant failed to attend the scheduled Examination Under Oath on May 5, 2016 and a Certificate of Non-attendance was obtained.

[14] On May 16, 2016, the accident benefits file was transferred to a third adjuster at Aviva for further handling. This was 89 days after receipt of the OCF-1. Importantly, to this date no Statutory Declaration had been requested and no investigator had been retained.

[15] On May 17, 2016 and 90 days after having received the OCF-1, this third Aviva adjuster instructed a private investigator to make efforts to secure the identity of the claimant's parents.

[16] On May 18, 2016, a letter was sent to the claimant's representative indicating that benefits would be suspended pursuant to s. 33 of the Statutory Accident Benefits Schedule (SABS) for failure to attend the scheduled EUO.

[17] On May 19, 2016, a request was made for a Statutory Declaration to be provided by the claimant. The request was made by fax and included a form with a series of questions requiring the claimant to essentially fill in the blanks. Section 33 of the SABS requires a claimant to provide a Statutory Declaration, if requested, failing which benefits could be suspended. The Statutory Declaration form was not returned until September 1, 2016. The completed form indicated that the claimant resided with his parents and that he was dependent on them. It did not provide details as to whether his parents owned a vehicle or details of any insurance on any such vehicle. It did not provide the name of his parents.

[18] The investigator reported to Aviva on June 7, 2016 that he had spoken to the property manager at the building where the claimant resided and was able to secure the identity of the claimant's father (Abdul Aziz Chalhoub) and a description of the family motor vehicle at the address at which the claimant resided. The investigator provided Aviva with the information he had received from the property manager by phone and in a later written report.

[19] That same day Aviva requested an Auto Plus search on the claimant's father, which revealed some 11 minutes after the Autoplus request that Intact Insurance insured the claimant's father and mother (Sabah Nasser) under policy 7M7524381 between May 23, 2013 and May 23, 2017, which would include the date of the subject accident. Within 30 minutes according to the log notes, Aviva sent their Notice to Applicant of Dispute Between Insurers to the claimant and Intact Insurance Company on June 8, 2016, approximately 111 days after having received the OCF-1.

ANALYSIS AND FINDINGS

[20] Section 1 of Ontario Regulation 283/95 – Disputes Between Insurers requires all disputes as to who should pay an insured's benefits under section 268 of the *Insurance Act* to be settled in accordance with the Regulation. Section 3(1) of the Regulation states that no insurer may commence a private arbitration without notifying the other insurer of its intention to do so within 90 days of receiving a completed application for accident benefits subject to a savings provision outlined in s. 3(2):

> **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).
>
> (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. O. Reg. 283/95, s. 3 (2).

[21] The issue here really is whether Aviva can satisfy the savings provision as set out in s. 3(2) of the Regulation, failing which its priority dispute as against Intact would be dismissed for having failed to meet the notice requirements under the Regulation.

[22] Intact takes the position that Aviva failed to take reasonable investigations within 90 days and therefore cannot take advantage of the savings provisions set out in s. 3(2) of the Regulation.

[23] Aviva, in response, maintained that it did take reasonable investigations within 90 days and therefore can take advantage of the savings provision of s. 3(2).

[24] General legal principles which have emerged over the years applicable to the issue before me include:

> The purpose of the 90 day period is to permit the insurer who first receives a completed Application for Benefits to gather factual information which will allow it to determine whether another insurer is responsible to pay the benefits.
>
> > *State Farm Mutual Automobile Insurance Company of Canada v. Ontario* (*Minister of Finance)* [2001] O.J. No. 1115
>
> The 90 day limit within which an insurer must notify another insurer of its intention to commence a private arbitration is to be strictly construed.
>
> > *Kingsway General Insurance Co. v. West Wawanosh Insurance (2002) O.J. No. 528 (C.A.)*
>
> Whether or not 90 days is a sufficient time to make a determination that another insurer may be responsible to pay the accident benefits is a question to be decided based on the facts of each case. The arbitrator must decide whether the insurer had enough facts to make a determination within 90 days. If not, the arbitrator must then consider whether the insurer made reasonable investigations within the 90 day period.
>
> > *Dominion of Canada General Insurance Co. v. Certas Direct Insurance Co.* [2009] O.J. No. 2971
> >
> > *Primmum Insurance Co. v. Aviva Insurance Co. of Canada* [2005] O.J. No. 1477
> >
> > *Coseco Insurance Company v. Allstate Insurance Company* (Arbitrator Stephen Malach, November 15, 2001)
> >
> > *Liberty Mutual Insurance Co. v. Zurich Insurance Co.* (2007) 88 O.R. (3d) 629
>
> In order to obtain relief, an insurer must show that 90 days was not sufficient time to make the determination that another insurer was liable and it must show that it made reasonable investigations to determine if another insurer was liable during that 90 day period.
>
> > *Liberty Mutual Insurance Co. v, Zurich Insurance Co., supra*
>
> Whether or not the insurer has been provided with accurate information by the insured is a factor in determining whether the 90 day period was sufficient.
>
> > *Primmum Insurance Co. v. Aviva Insurance Co. of Canada*, supra
> >
> > *Dominion of Canada General Insurance Co. v. Certas Direct Insurance Co.*, supra

Deciding whether or not reasonable investigations were made during the 90 day period is also dependant on the facts of each case. However, investigations must be "reasonable", which is not the same as perfect. The fact that in retrospect other investigations might have been seen to be helpful, does not mean the investigations which were undertaken do not meet the test of reasonableness.

> *Primmum Insurance Co. v. Aviva*, supra
>
> *Federated Insurance Company of Canada v. CGU Insurance Company of Canada* (Arbitrator Stephen Malach, September 2, 2003)

In determining the reasonableness and the timeliness of investigations, it must be remembered that insurance adjusters are extremely busy individuals working on many complex matters at the same time. They should not be held to a standard of perfection.

> *Coseco Insurance Company v. Lombard Insurance Co.* (Arbitrator Guy Jones, June 3, 2004)

Where little or no reliable information is available upon which to conduct follow-up investigations, minimal investigations may be found to be reasonable.

> *Ontario (Minister of Finance) v. Co-Operators General Insurance Company* (Arbitrator B. Robinson, February 22, 2002)

Where the Applicant or the representative indicates on the Application for Accident Benefits that no other insurance is available when in fact such coverage is available, then such misinformation serves to mislead the insurer.

> *Coachman Insurance Company v. ING Insurance Company of Canada* (Arbitrator Stephen Malach, March 1, 2007)

[25] There are two passages from the decision in *State Farm Insurance v. ACE INA Insurance* (Arbitrator Samis – August 22, 2011) that are most instructive and must be considered. At page 8, Arbitrator Samis writes:

> "An abundance of case law, referred to by counsel, confirms that this is a test of reasonableness to be applied in every case. The standard of claims handling is not a standard of perfection. It accomplishes nothing to hypothesize some theoretical line of investigation or inquiry that, if made at the right time and to the right person, would have revealed the necessary information for the priority dispute. In the abstract, such an analysis is completely impractical and meaningless. What we need to understand is whether or not the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90 day period, and whether or not the insurer, acting reasonably, did not have sufficient time within the 90 days to make a determination about the other insurers liability."

[26] And at page 9, Arbitrator Samis writes:

> "I consider it important to acknowledge that it is far too easy for us, remote in time and at a distance from the sometime frenzied activities of the SABS claims departments, to impose too high a standard of conduct on the SABS claims handlers. I completely accept the principle that we must be reasonable in our assessments and we need to take into account the numerous pressing demands that are faced by the SABS claims handlers in the ordinary course of events. I accept this without question."

[27] Applying these legal principals to the facts before me, and having considered the comments of Arbitrator Samis, I am satisfied that Aviva has not met the requirements of the savings provision set out in s. 3(2) of the Regulation. I find that it did not take reasonable steps within 90 days of receiving the OCF-1 to identify another insurer possibly standing in priority and that 90 days was a sufficient period of time to do so. I have taken into consideration the fact that Aviva's investigation was hampered to some extent by:

- Misrepresentation contained in the OCF-1
- Refusal by the claimant's legal representative to allow the claimant to provide a statement to the insurer or their representative
- Claimants refusal to attend an Examination Under Oath

[28] I have also considered the position advanced by Aviva that their efforts to identify another insurer standing in priority were on an escalating scale commensurate with the lack of co-operation and final failure to attend on the scheduled Examination Under Oath and ought be deemed a reasonable effort in the circumstances.

[29] I am more persuaded though and feel bound by two appellate decisions referred to me by the Respondent Intact establishing that section 3(2) is to operate strictly because an insurer is entitled to know at an early stage that it will be managing and be responsible for the payment of benefits. These two cases demonstrate the lengths an insurer must go through to prove that they took reasonable steps during the crucial 90 day period, even in the face of a lack of co-operation on the part of the claimants and misinformation provided which to some extent existed in the case before me.

[30] The first case is that of *Liberty Mutual Insurance Co. v. Zurich Insurance Co.* (2007) 88 O.R. (3d) 629. In that case, a 13 year-old claimant was riding a bicycle when he was struck by a vehicle insured with Liberty. At the time of the accident, the claimant was living with his father who was on a trip to China. Liberty received the Application for Accident Benefits on July 4, 2001. The 90 day notice period would therefore expire on October 2, 2001. The Application for Accident Benefits incorrectly listed the claimant as residing with his mother and that he was not covered under any policy of insurance. Liberty undertook 19 different methods to attempt to determine whether there was another policy that would respond which focused on attempted communications with the mother, with the claimant's solicitor's office and surveillance of vehicles that were parked at the mother's home. The claimant's mother and counsel were non-co-operative. On July 14, 2001, the claimant's father returned from China and the Court accepted that his vehicle would likely have been parked in the driveway. On August 22, 2001, Liberty received a copy of the Motor Vehicle Accident Report which indicated that the claimant in fact resided with his father, at which

point Liberty contacted counsel for the claimant for an explanation as to the discrepancy. No answer was forthcoming.

[31] On November 1, 2001 (after the expiry of the notice period), an investigator attended at the father's home where they discovered that the father had a vehicle and that the claimant was a dependent on his father. On December 12, 2001, Liberty sent its notice to Zurich with respect to this priority dispute; which was just a little over two months past the limitation period.

[32] The Court found as a matter of fact that the mother had intentionally misled Liberty, that there was documentation that indicated that the claimant resided with his mother and that counsel for the claimant had been non-co-operative. Indeed, the Court found that the lengths that Liberty had undertaken to locate another insurer were extraordinary. Despite these findings of fact, the Court found that Liberty had notice by August 22, 2001 (on account of the Motor Vehicle Accident Report), that the claimant may be residing with his father. Armed with this information, the Court found that Liberty ought to have sent a representative to the father's home where they might have seen the father's vehicle in the driveway and determined the insurer of the vehicle (Zurich). The Court found that Liberty ought to have been able to make these determinations within 90 days and that since they did not; that they were prohibited from proceeding with the priority dispute.

[33] In the final analysis, Mr. Justice Perell concluded that notwithstanding the fact that the investigations that the insurer undertook were reasonable, it had not shown that 90 days was insufficient to identify another insurer that might stand in priority. He concluded that it was not impossible for Liberty to find out about the claimant's natural father within 90 days, despite the difficulties with which it was confronted because of the confusing names, multiple addresses, misinformation and the adjuster's competing demands of work.

[34] The Respondent Intact has also referred me to the decision of *Primmum Insurance Co. v. Aviva Insurance Co. of Canada* (2005) O.J. No.1477 (S.C.J.). This was an appeal from an Arbitration Decision wherein the Arbitrator concluded that Primmum had breached Section 3(1) of the Regulation and had not conducted the necessary reasonable investigations so as to rely on Section 3(2)(b) of the Regulation. In this case, the 17 year-old claimant was a passenger in a stolen vehicle. In her Application for Benefits she indicated that she was living with her mother and common law stepfather and dependent on them. Primmum proceeded to accept this information and began paying accident benefits on the basis that the claimant was an "insured person" under their policy as being principally financially dependent on their named insured. It was later learned from a medical report served six or seven months later, that the claimant was living with her boyfriend at the time of the accident and was on Social Assistance.

[35] On appeal before Mr. Justice Ducharme of the Ontario Superior Court of Justice, the Appellant Primmum submitted that the 90 period was not sufficient because it was given inaccurate information by the insureds, which prevented Primmum from obtaining the necessary facts which would have enabled it to determine that it was not liable to pay statutory accident benefits. The Appellant argued that Primmum was intentionally misled by its insureds and that even if the misrepresentation or non-disclosure was not intentional, if the insurer relies on the incorrect or incomplete information in determining liability, then for the purposes of Section 3(2)(a) of the Regulation, the 90 day period is not sufficient time to make the determination. The Respondent took the position that the possibility of incorrect information is the reason that insurers are permitted 90 days to make their determination of

liability. The Respondent took the position that the insurer seeking to rely on Section 3(2) must demonstrate that the evidence was not available to them within the 90 day period and that the evidence was available to Primmum, if only they had asked the correct questions. Mr. Justice Ducharme concluded that with respect to Section 3(2)(a), the principal issue is not whether the non-disclosure or misinformation provided to the Appellant was the result of dishonesty or some other more innocent reason. Rather, the only issue under Section 3(2)(a) is whether the receipt of the inaccurate information renders the 90 day period insufficient for the investigation of the particular case. He held that it was for the insurer who seeks to rely on Section 3(2) to demonstrate why, in the particular case, the non-disclosure or misrepresentation made the 90 period inadequate. It was concluded that the 90 day period was more than enough time to conduct an investigation and that the Appellant's problem was that they did not do so. Mr. Justice Ducharme then proceeded to deal with the reasonable investigations necessary to satisfy Section 3(2)(b) of the Regulation. He concluded that in making such assessment of reasonableness, it is appropriate to consider both what was done to investigate the claim, as well as what was not done. He ultimately concluded that with a proper investigation that was available to the insurer within the 90 day period, it could have obtained the necessary information to determine the other priority insurer. He agreed with the Arbitrator's Decision that Primmum had failed to satisfy the requirements of Section 3(2)(b) of Regulation 283/95.

[36] These two cases referred to me by the Respondent stand for the proposition that despite misinformation or lack of co-operation on the part of the insured, the true test is whether the correct information could be obtained with reasonable investigation within the 90 day period. These Appellate decisions place a heavy onus on insurers to complete a thorough investigation within 90 days of having received an application for benefits, even if it is to satisfy itself that the information provided in the application is accurate. I feel bound by the heavy onus that the Appellate courts have established in situations involving priority disputes. I am satisfied that with reasonable efforts the identity of the claimant's parents and whether they had automobile insurance could have been obtained within 90 days of having received the OCF-1. Ultimately the identity of the parents and automobile insurance was obtained on simply the basis of the information contained in the OCF-1.

[37] It was clear from the adjuster initially assigned to the claimant's accident benefits claim and testifying on behalf of Aviva, that priority was an issue that was identified from the outset. The OCF-1 revealed that the claimant was 18 years old, unemployed and a student living in an apartment in Scarborough. It ought to have been evident that the claimant was likely principally financially dependent on his parents or some other individual and if that person had automobile insurance, then such insurer would stand in priority to Aviva according to the hierarchy set out in s. 268 (2) of the *Insurance Act*. Determining the identity of the parents ought to have been an immediate goal of those handling the claim for Aviva. With the names of the parents identified, it would be easy to determine through an Autoplus search (as was eventually successfully done) if they had automobile insurance at the date of the accident. I find that with reasonable efforts, the identity of the parents and the insurance that they had could have been determined.

[38] The oral evidence of the Aviva adjuster indicated that there were several means available to an insurer to obtain information from the claimant that would assist in determining if another insurer stood in priority. Firstly, the claimant can be asked to provide a voluntary statement which would deal with information with respect to priority. Such an attempt was made, but the legal representative would not allow his client to provide such a statement. Secondly, the insurer can request a Statutory Declaration from the claimant which

the claimant is required to provide within ten days, failing which the insurer can suspend the payment of benefits as set out in s. 33 of the SABS. This is a tool used to promote co-operation from a claimant. A Statutory Declaration was never requested during the 90 days post-receipt of the OCF-1. I find that this was a reasonable step that ought to have been taken when the claimant refused to provide a voluntary statement. I further find that if a Statutory Declaration had been requested and a suspension of benefits used in the event of non-co-operation, the identity of the parents and available insurance would likely have been obtained. We know that a Statutory Declaration was ultimately obtained confirming that the claimant was dependent on his parents. The questions as to insurance particulars were not answered, but follow-up with ongoing suspension of benefits would, in my view, have resulted in the names of the parents and details of available insurance being obtained. Thirdly, use of an Examination Under Oath can be used to obtain relevant information with respect to priority. This was arranged at an early stage but the original date scheduled was cancelled and a further date arranged for May 5, 2016, which was just 12 days prior to the expiry of the 90 day limitation. I find that Aviva ought to have anticipated a possible no show or the claimant not having information regarding insurance at the scheduled Examination Under Oath. An investigator ought to have been retained to proceed with an investigation if the information was not forthcoming at the scheduled Examination Under Oath. On a priority basis, I am of the view that the identity of the parents would likely have been obtained within days of the claimant's failure to attend on May 5, 2016 and within the 90 days prescribed by the Regulation. It must be kept in mind that all the investigator was provided ultimately was that contained in the original OCF-1. With reasonable inquiry, I believe the identity of those residing at 1011-41 Antrim Crescent would readily have been obtained in a fashion used by the investigator ultimately, being a discussion with the property manager, or in some other fashion. Furthermore, a review of the log notes of Aviva fails to reveal any attempt to contact their named insured, who was driving the vehicle in which the claimant was a passenger, to determine her knowledge with respect to financial dependency and the identity of those likely providing such support to the claimant. She was never asked how she knew the claimant, who he lived with and her knowledge as to the names of his parents. This would have been a reasonable step in the investigation to identify the claimant's parents.

[39] Looking at the facts before me in the simplest fashion, Aviva, knowing that the 18 year-old full-time student was in all likelihood dependent on his parents, needed only their names and a quick Autoplus search to identify Intact as a possible priority insurer. The OCF-1 indicated the address where he was living. With the tools available, as set out in the paragraph above, I am satisfied that 90 days was a sufficient amount of time to make such determination with reasonable effort. Aviva has accordingly failed to satisfy the strict requirements savings provision set out in s. 3(2) of O. Reg. 283/95.

ORDER

It is hereby ordered:

1. That the priority dispute herein is dismissed;

2. That Aviva pay the costs of Intact with respect to this arbitration on a partial indemnity basis;

3. That Aviva pay the costs of the Arbitrator.

DATED at TORONTO this 27th)

day of February, 2018.)

KENNETH J. BIALKOWSKI
Arbitrator