SHILLINGTONS LLP | LAWYERS

INSURANCE LAW BULLETIN

April 2010

ACCIDENT BENEFITS & LIMITATION PERIODS: REVISITED

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INTRODUCTION

The *Insurance Act* provides claimants with a two year limitation period for commencing a court or an arbitration proceeding in respect of an insurer's denial of statutory accident benefits.[1] In order for the limitation period to start running, however, an insurer must give the claimant proper notice of its refusal.[2]

The leading case in defining what constitutes "proper notice" is the Supreme Court of Canada's decision in *Smith v. Co-Operators General Insurance Co.*[3] In that case, the majority of the Supreme Court held that an insurer's refusal must include an adequate description of the *SABS* dispute resolution process (as was then required by s. 71 of the *SABS*).[4] The Court held that it was necessary to do so in "straightforward and clear language, directed towards an unsophisticated person."[5]

The issue of "proper notice" was recently revisited in *Golic v. Ing Insurance Company of Canada.*[6] In that case, a claimant commenced a court action for accident benefits. After issuing the claim, he sought to amend it to include certain benefits that had been denied by the insurer nearly eight years prior. The issue before the Court was whether the insurer had given sufficient notice to trigger the

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[1] *Insurance Act,* R.S.O. 1990, c. I. 18, s. 281.1(1). This two year limitation period is paralleled in s. 51(1) of the *Statutory Accident Benefits Schedule* ["*SABS*"], O. Reg. 403/96.
[2] *SABS*, *ibid.* at s. 71
[3] [2002] 2 S.C.R. 129 [*Smith*].
[4] The relevant section is now s. 49, which is worded differently (see discussion below).
[5] *Smith, supra* note 4 at para. 14.
[6] [2009] O.J. No. 5103 ["*Golic"*].

two year limitation period (and thus render that aspect of the plaintiff's claim statute barred).

The plaintiff argued that the notice had not adequately explained the dispute resolution process, and therefore did not meet the requirements laid out by the Supreme Court in *Smith.* The motions court judge disagreed, and held that the claimant was out of time to commence the proposed claims.[7] The plaintiff appealed to the Ontario Court of Appeal.

THE DECISION

The Court of Appeal's analysis began with a review of the refusal letter itself. The letter advised the claimant that he was no longer entitled to weekly benefits, including income replacement benefits. It went on to indicate that the claimant was entitled to "dispute a decision of the insurer by applying for mediation and, if necessary, taking other steps subsequent to mediation pursuant to ss. 279 to 283 of the *[Insurance] Act* (the dispute resolution process)."[8] The insurer enclosed copies of the noted sections of the *Act* as well as a complete copy of the *SABS*, and asked to be advised if the claimant required any other forms. The letter then stated:

> Given that you have already participated in two mediations about your accident benefits claim, we trust you are adequately aware of your rights and obligations with respect to the dispute resolution process outlined in the Insurance Act. However, if you require any further information or guidance, please contact your counsel, or in the event you have no counsel, please write to us with any specific questions you may have.[9]

The Ontario Court of Appeal ultimately held that this notice constituted a proper refusal to pay benefits so as to trigger the running of the limitation period, and that the proposed claims were therefore statute-barred. In doing so, the Court noted that it reached the same conclusion as the motion judge "but by a slightly different path."[10]

In this regard, the motions judge had based his decision on the fact that the plaintiff had already undergone numerous mediations and was an experienced litigant. As such, he held that it would be an abuse of the objectives of the legislation to "permit the plaintiff to feign ignorance and use the consumer protection objectives of the legislation to mask the obvious knowledge he would have required."[11]

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[7] (2008) 94 O.R. (3d) 446. The decision was the subject of a July 2009 Insurance Law Bulletin, available at http://www.shillingtons.ca.
[8] *Golic, supra* note 5 at para. 4.
[9] *Ibid.*
[10] *Ibid.* at para. 21.
[11] *Supra* note 6 at para. 34.

The Court of Appeal, however, interpreted *Smith* as holding that courts must not consider any circumstances beyond the insurer's notice of refusal itself, in determining whether a refusal is adequate.

The Court of Appeal held that the refusal letter was sufficient in itself. In reaching this conclusion, it noted that the letter referred to the statutory dispute resolution process, specifically referred to ss. 279 to 283 of the *Insurance Act,* and enclosed copies of those sections. In addition, the court referred to the fact that the insurer offered to further clarify the dispute resolution process if the claimant had any questions.

Interestingly, the Court also based its conclusion on the fact that the insurer had reasonably assumed that the claimant was informed of the dispute resolution process, pursuant to his involvement in previous mediations. However, the Court emphasized that this assumption was set out in the letter itself, and noted that the insurer invited inquiries from the claimant if he had any. As such, the court concluded that "it was the letter that made...the reasonable assumption" [emphasis added], suggesting that the reasonableness of this assumption was therefore a relevant consideration in determining whether the notice was adequate. The suggestion that a court should not consider a claimant's litigation experience in assessing the adequacy of a refusal, but can consider whether an insurer made a "reasonable assumption" based on that claimant's experience, is a confusing one. Unfortunately, the Court did not provide further elaboration in this regard.

COMMENTARY

The Court of Appeal's decision in *Golic* affirms the "consumer protection objectives" underpinning the notice requirements of the *SABS*. As the Court held, they underscore "the need to ensure that an insured is properly informed about the dispute resolution process at the time an insurer refuses to pay benefits".[12] Notices of refusal will therefore be measured against this standard.

The *Golic* decision also suggests that courts will not give consideration to any factors, other than the refusal letter itself, in determining whether an insured is properly informed about the dispute resolution process. The Court's apparent acceptance of a reasonable assumption based on "outside information" seems inconsistent with this general rule. Hopefully, this issue will be clarified in future cases.

In the meantime, however, insurers should ensure that their notices are clear and meet the requirements set out by the Supreme Court of Canada in *Smith.* At a minimum, this should include "a description of the most important points of the

[12] *Golic* at para. 19.

process, such as the right to seek mediation, the right to arbitrate or litigate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process."[13] As well, notices should include reference to and copies of sections 279-283 of the *Insurance Act*, and an offer to answer any inquiries the claimant may have about the process.

Furthermore, in light of the decision in *Golic*, insurers should not rely on the fact that a claimant is an experienced litigant, has retained counsel, or any other extraneous circumstances, to relieve itself of its obligation to provide a proper refusal.

Post-Script

Since *Golic* was decided, the Superior Court of Justice released its decision in *Gill v. Economical Insurance Co.*, which also dealt with whether a refusal was sufficient to trigger the two year limitation period.[14] The court stressed that a refusal must be made in "clear and unequivocal terms", and affirmed that a limitation period will not run until both a written notice of refusal and the reasons for the refusal have been given. In that case, the notice letter indicated that the claimant's husband was acting in the course of his employment at the time of the accident, and was therefore "eligible to receive workplace and safety benefits." The court held that this reference was not a direct refusal of benefits under the automobile legislation. The insurer argued that the letter had the "clear intent" of a refusal, and referred to an OCF-9 form, attached to the letter, which indicated that expenses were not payable. However, the OCF-9 also included a reference suggesting that, once the insurer received additional documents, they would be "in a position to consider [the] claim." The court concluded that the materials sent by the insurer were open to interpretation and therefore could not be said to be "clear and unequivocal". As such, the limitation period did not apply.

Insurers should therefore use careful wording in their notices that clearly state that the letter constitutes a refusal. As the Court held in *Gill*: "There is no reason why a covering letter could not simply indicate that the letter constitutes a refusal pursuant to the relevant legislation, with reasons given, followed by a reference to the two year limitation period and commencement date. That would be clear and unequivocal, and fair to both parties."[15]

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[13] *Smith, supra* note 4 at para. 14.
[14] *Gill v. Economical Insurance Co.,* [2009] O.J. No. 5347 ("*Gill*").
[15] *Ibid.* at para. 12.

A Note About Current Notice Provisions

It should be noted that the courts' decisions in both *Smith* and *Golic* were based on the notice requirements set out in s. 71 of the *SABS.* However, the notice requirements of the *SABS* were amended in 2003, and s. 71 no longer exists. Its successor provision is s. 49, which reads somewhat differently:

> If an insurer refuses to pay a benefit under this Regulation or reduces the amount of a benefit that a person is receiving under this Regulation, the insurer shall provide the person with a written notice concerning the person's right to dispute.

The main difference between s. 49 and the former s. 71, according to one arbitration, is that the insurer's obligation to inform a claimant about his/her right to dispute is "now no longer specifically linked to the dispute resolution procedure created under sections 279 to 283 of the *Insurance Act.*"[16] In other words, the new wording may *broaden* an insurer's obligation to inform a claimant, particularly where additional dispute resolution procedures may be relevant. For example, in that case, the underlying dispute involved the interaction between the *SABS* and the *Workplace Safety and Insurance Act, 1997*. As such, the Arbitrator held that the insurer was required under s. 49 to provide the insured person with information about how disputes between the *SABS* and the *Workplace Safety and Insurance Act, 1997* were resolved. The Arbitrator also held that the guiding principles established in *Smith* had not changed with the new amendments, and the insurer still had to describe the dispute resolution procedure created under ss. 279-283 of the *Insurance Act.* Although it appears that this issue has not yet been considered by a court, insurers should be mindful of these additional issues.

[16] *Lin v. ING Insurance Co. of Canada*, [2008] O.F.S.C.D. No. 70 at para. 58.