Fraudulent Pink Slips: Do I Have to Pay Accident Benefits?

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There may be several insurance companies involved in any given motor vehicle accident. Although Ontario Regulation 283/95 (the *"Priority Regulation"*) establishes a regime to determine which insurer is liable to pay accident benefits, an injured person may not necessarily apply to the correct insurer in the first instance. In order to ensure that injured persons will get prompt determination of their entitlement to accident benefits, the *Priority Regulation* requires that benefits be paid, at least on an interim basis, by the first insurer to receive a completed application.

The case law has established that this obligation to "pay now, dispute later" is only triggered where there is a "sufficient nexus" between the applicant and the insurer. Interestingly, although this phrase has been mentioned in countless cases, courts have stopped short of providing a hard and fast definition of "sufficient nexus". Rather, the nature of the nexus or connection will vary from case to case. What is clear is that the threshold for establishing a nexus is not a high one, and courts have indicated that only in the most extreme cases, where the connection with the insurers is totally arbitrary should the insurer refuse to pay.

In some cases, an insurer may be obligated to respond to an application for accident benefits, even where no valid policy of insurance exists. One question that has arisen is whether a fraudulent "pink slip" (i.e. one that was not actually issued by the insurer) constitutes a "sufficient nexus". According to two recent decisions of the Ontario Financial Services Commission, the answer to this question will usually depend on whether the applicant was complicit in the fraud.

Danilov v. Unified Assurance Company and Economical Mutual Insurance Company arose from a motor vehicle accident which took place on November 29, 2005. Danilov was a passenger in a vehicle owned by Gnidenko. According to the police report, Gnidenko's vehicle was purportedly insured with Unifund Assurance Company pursuant to a pink liability card. However, Unifund neither wrote nor issued the policy, and no similar policy was in force at the time of the accident. In fact, neither the applicant nor the owner of the vehicle had ever contracted with or approached Unifund for a policy. The broker named on the pink card had no relationship whatsoever with Unifund, and was not authorized to write, issue, or sell policies on its behalf. Nevertheless, the applicant had initially applied to Unifund for accident benefits, and the question before the arbitrator was whether Unifund was liable to pay, as the first insurer to receive an application.

The arbitrator acknowledged that "there can be no nexus where an applicant attempts to create a relationship by participating in a fraud". However, there was no evidence before him to suggest that Danilov had, in fact, been complicit in fraud. Rather, he had relied on the information available to him on the police report in applying to Unifund, and although that

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information turned out to be incorrect, his choice of insurer was “clearly not arbitrary or random”. In the arbitrator’s view, this was enough to establish the “sufficient nexus” necessary to trigger Unifund’s obligation to respond to the application for accident benefits.

The arbitrator decided that to hold otherwise would “risk compromising the predictability and integrity of the ‘pay now, dispute later’ scheme” and would “undermine its purpose of extricating applicants from the consequences of choosing the wrong insurer”. The arbitrator also relied on the consumer protective objective of insurance legislation, and the requirement that its provisions be “interpreted in a large and liberal manner consistent with its remedial purpose”.

The fraudulent pink slip issue was recently revisited in *Ahmed v. Royal & Sunalliance Insurance Co. of Canada*. In that case, the applicant who produced the pink slip could not remember the name of the broker who issued it, had no proof of payment for the insurance premiums, and aside from two photocopies of bogus liability certificates, had nothing to support his contention that he thought he was insured. The arbitrator found that the applicant did not believe that he was actually insured.

In reaching this conclusion, the arbitrator relied not only on the applicant’s lack of credibility, absence of corroborating witnesses, and the suspicious “dearth of documentary evidence”, but also on his admission that he had automobile insurance policies with other insurers. As such, the applicant would have known that certain documentation should have been provided by the insurer, had the alleged policy been legitimate. Accordingly, he failed to establish sufficient nexus, and Royal & Sunalliance was not obliged to respond to his application for accident benefits.

The arbitrator acknowledged that, under the case law, the first insurer to receive an application for accident benefits should only refuse to pay in the “most extreme cases, where the connection with the insurer is totally arbitrary.” She decided that the case before her was an example of such an extreme case, and compared Mr. Ahmed’s application to “pulling the name of an insurer out of a hat”. She distinguished her decision from situations where “applicants do genuinely believe (and have grounds to believe) that they are insured with a particular insurer”, such as victims of a fraud perpetrated by an otherwise genuine and verifiable broker.

Conclusion

Insurers who receive applications for accident benefits when there is a question as to the liability policy should make appropriate inquiries to ascertain what information and/or documentation, if any, the application is based on. If the applicant is unable or unwilling to provide such information, the insurer may not be required to respond, especially if the applicant is unable to provide sufficient evidence to suggest that they at least *believed* they were insured. However, this threshold is a low one, and unless it is clear that the applicant’s choice of insurer is random or arbitrary, an insurer should strongly consider agreeing to “pay now, dispute later”.