



Appeal P04-00016

OFFICE OF THE DIRECTOR OF ARBITRATIONS

JOSEFINA VIEIRA

Appellant

and

ROYAL & SUNALLIANCE INSURANCE COMPANY OF CANADA

Respondent

and

CHUBB INSURANCE COMPANY OF CANADA

Intervenor

BEFORE: David R. Draper
REPRESENTATIVES: Mary Meropoulos for Mrs. Vieira
Joan Takahashi for Royal
Eric K. Grossman for Chubb
HEARING DATE: November 18, 2004

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, **it is ordered that:**

1. The appeal is allowed, and paragraph 1 of the arbitration order dated March 25, 2004, is revoked and replaced with the following order:
 1. As the first insurer to receive a completed application for accident benefits from Josefina Vieira, Royal is obliged to respond to her claims for accident benefits, subject to an order under O.Reg. 283/95, *Disputes Between Insurers*, that another insurer has priority.

2. If the parties are unable to agree on expenses, the matter may be resolved in accordance with Rule 79 of the *Dispute Resolution Practice Code*.

David R. Draper
Director of Arbitrations

February 15, 2005

Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

This appeal involves the relationship between the dispute resolution process under the *Insurance Act* and private arbitration under the *Priorities Regulation*.¹ The specific question is whether the Arbitrator erred in law in deciding an issue that should be determined under the *Priorities Regulation*. For reasons that follow, I conclude that the appeal must be allowed.

II. BACKGROUND

Mrs. Vieira claims that on July 31, 2001, she was standing on the sidewalk, waiting for a bus, and fell while trying to avoid a three-car accident that took place nearby. Just over a month later, she submitted an application for accident benefits to Royal & SunAlliance Insurance Company of Canada (“Royal”). In her application, she claimed that she was covered by her son Tony’s policy. She explained this in a written statement given to Royal in August 2001, as follows:

My son Tony is the registered owner of 1973 Chevrolet Corvette. Tony insures the car with Royal Insurance. Tony and Josefina [Mrs. Vieira] may be the registered owner of a 1986 Pontiac Trans Am. I believe that car is insured. I will have copies of both ownerships furnished to my representative.

On September 12, 2001, Royal denied Mrs. Vieira’s claim on the basis that her loss was not covered under Tony’s policy. More specifically, it claimed that:

- although Tony had a policy for another vehicle, the Trans Am was not insured until August 20, 2001, one month after the accident;
- Mrs. Vieira was not listed as an additional insured or additional driver on the policy;
- Mrs. Vieira was not dependent on Tony, as she was working and he was not.

¹ Ontario Regulation 283/95, *Disputes Between Insurers*, as amended.

Royal suggested that Mrs. Vieira pursue her claim for accident benefits with the insurer of one of the vehicles involved in the accident, which she did. In late September 2001, she sent an application for accident benefits to Chubb Insurance Company of Canada (“Chubb”), citing a specific Chubb policy number. She advised Chubb that she did not have her own insurance and was not a dependant of any policyholder.

Chubb responded on October 16, 2001. It took the position that according to the *Priorities Regulation*, Royal was required to respond to her claim because it received the first application. Chubb returned Mrs. Vieira’s application and suggested that she contact Royal if she wanted to pursue her claim. Chubb also wrote to Royal, explaining its position. The letter concludes as follows:

The onus is on Royal & SunAlliance to prove that there is no coverage, in a separate priority dispute with any insurers at the next rung on the priority ladder, commenced within the time frames set out in the priority regulation. To date, we have seen no such proof. Assuming such proof is furnished, each of The Personal, Zurich and Chubb would be at that next rung. It is not clear to us which insurer of the three would be obliged to respond in the circumstances, and if need be, suggest that a private arbitration deal with these issues.

In the interim, it is Royal & SunAlliance which is obliged to adjust Mrs. Vieira’s accident benefits claims in good faith.

Royal then wrote to Mrs. Vieira on November 1, 2001, stating that “pursuant to Regulation 283/95, we are responding to your application as this was received by our office first.” Although Royal agreed to respond to Mrs. Vieira’s claim, it took the position that she did not qualify for income replacement benefits and advised her of her right to dispute that decision through the dispute resolution process. Royal also made it clear that it felt one of the insurers covering the vehicles involved in the accident was the priority insurer and, therefore, would be following the process in the *Priorities Regulation*. To that end, Royal enclosed a *Notice of Dispute Between Insurers* form.

The *Notice of Dispute Between Insurers* form includes the following advice and instructions:

This notice is to inform you that the insurer to whom you have applied for accident benefits claims that another insurer is responsible for paying those benefits. You may be required to assist the insurers in resolving their dispute by providing them with any information that may be needed to determine which insurer should be paying your accident benefits claim.

You will continue to receive accident benefits that you are entitled to from the insurer that you applied to while the Insurers attempt to resolve their dispute.

You also have the right to object to your claim being transferred to another insurer. If you wish to object please complete Part 5 of this form and send it within 14 days to the insurer that is currently paying you accident benefits. If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer. [emphasis in the original]

Mrs. Vieira followed the instructions in this form, indicating that she objected to her claim being transferred to a company other than Royal. Royal did not pursue an order under s. 7 of the *Priorities Regulation*. Nor did Chubb or Mrs. Vieira, as they could have done under s. 7(2).

Mrs. Vieira applied for mediation with Royal, claiming entitlement to income replacement benefits. On January 22, 2002, after mediation started, Royal sent Mrs. Vieira a letter clarifying its previous correspondence — that she does not qualify as an insured person under the policy it issued to her son, Tony.

When the dispute was not resolved through mediation, Mrs. Vieira applied for arbitration. A number of preliminary issues were identified. The Arbitrator framed them as follows:

1. Is Royal obliged to respond to Mrs. Vieira's claim under Regulation 283/95 as the first insurer to which Mrs. Vieira submitted an application for accident benefits?
2. Is Mrs. Vieira an "insured person" under the Royal automobile insurance policy?

3. Did Mrs. Vieira suffer an impairment as a result of an “accident” within the meaning of subsection 2(1) of the *Schedule*?

The preliminary issues hearing started in October 2003, and resumed in January 2004.² The parties were Mrs. Vieira and Royal; Chubb was not involved. Royal argued that it was not obligated to respond to Mrs. Vieira’s claim because she was not an “insured person” under its policy. In its submission, the arbitrator was entitled to decide this issue because it was a question of coverage, not priority.

The Arbitrator released her decision on March 25, 2004. She found that Royal accepted that it was the first insurer to receive a completed application for accident benefits and, therefore, acted appropriately in responding to the claim and paying benefits. She accepted, however, that Royal could challenge its ongoing obligation to pay benefits on the basis that Mrs. Vieira was not an “insured person” under its policy because this was a question of coverage, not priority. Her order states as follows:

1. Royal accepts that it is the first insurer to which Mrs. Vieira submitted an application for accident benefits. Royal has responded to Mrs. Vieira’s application for accident benefits.
2. Mrs. Vieira is not an “insured person” under the Royal automobile insurance policy.

Mrs. Vieira’s appeal is from this order. She claims the Arbitrator erred in law in treating this as a coverage dispute, not a priorities dispute, and exceeded her jurisdiction in effectively deciding that another insurer is responsible for paying any benefits to which she is entitled.

In addition to appealing, Mrs. Vieira reapplied for mediation with Chubb. Mediation Services accepted this application based on the Arbitrator’s decision that Mrs. Vieira was not an insured person under

² Mrs. Vieira applied for mediation with Chubb in October 2003, but this application was rejected on the basis that Mediation Services only accepts applications with respect to the first insurer that received the application for benefits — in this case, Royal.

Royal's policy. Chubb responded by filing an application for judicial review, seeking an order prohibiting the mediation from proceeding or, alternatively, staying the mediation pending Mrs. Vieira's appeal and any subsequent proceedings. Chubb also asked to intervene in the appeal, suggesting this might be a more expeditious approach than proceeding with the judicial review application. After hearing submissions from the parties and Chubb, I granted Chubb intervenor status on the following conditions:

- The mediation application filed by Ms. Vieira in respect of Chubb will be held in abeyance pending the outcome of this appeal.
- Chubb will not take any further steps in its application for judicial review pending the outcome of this appeal, subject to any requirement imposed by the Court.
- If the appeal is dismissed, Chubb agrees to participate in the mediation filed by Ms. Vieira, unless it challenges the appeal decision by way of judicial review.
- Chubb will not be entitled to or liable for appeal expenses.
- Chubb's intervenor status may be re-visited if its role becomes disruptive or impedes the fair, expeditious resolution of this matter.
- Chubb is entitled to the appeal record. Mr. Grossman should contact the Appeals Administrator, Ms. Sudesh Sharma, if he is not able to obtain copies of the relevant documents from the parties.
- None of the participants is entitled to lead any new evidence in the appeal without leave.

Mrs. Vieira, Royal and Chubb all filed written submissions and made oral submissions on November 18, 2004.

III. ANALYSIS

The *Priorities Regulation* was introduced to ensure that the payment of accident benefits is not delayed due to a dispute over which insurer should pay. Unfortunately, the legislation has left gaps. Five years ago, in *Mohamed and State Farm Mutual Automobile Insurance Company and American*

Home Assurance Company, (FSCO P99-00022, December 1, 1999), I commented on the irony that legislation meant to simplify matters for insured persons has created such confusion. This case is another example. Mrs. Vieira finds herself caught between two insurers, each claiming the other is responsible for paying her accident benefits — precisely the situation the *Priorities Regulation* was meant to eliminate.

The arbitration decisions attempt to find the line, identified by the Divisional Court in *Allstate Insurance Co. of Canada v. Brown*, (1998), 40 O.R. (3d) 610, between determining whether an insurer is an “insurer” for purposes of the *Insurance Act* and the priorities decision to be made under the *Priorities Regulation*.³ While the Arbitrator’s interpretation finds support in some of the earlier arbitration decisions, I conclude that she went too far. Distinguishing between coverage disputes and disputes over insurer priority is artificial and leads to the dead end at which Mrs. Vieira now finds herself — Royal is relieved from paying benefits because she is not an “insured person” under its policy and Chubb refuses to pay benefits on the basis that Royal was the first insurer to receive a completed application for benefits and did not challenge its obligation to pay under the *Priorities Regulation*.

The correct approach, in my opinion, is to treat the *Priorities Regulation* as part of the claims process. It establishes procedures, not substantive entitlements. Insurers are required to participate in a scheme designed to ensure that injured persons will get a prompt determination of their entitlement to the accident benefits, even if they have chosen the wrong insurer. It is inherent in this scheme that an insurer may have to pay benefits that another insurer should be paying, but only on an interim basis. If the first insurer to receive a completed application wants to shift responsibility to another insurer, it must follow

³ For arbitration decisions considering the interaction between the *Priorities Regulation* and the dispute resolution process, see *Mariona and Canadian General Insurance Company*, (FSCO A96-000717, September 25, 1998); *Chen and Kingsway General Insurance Company*, (FSCO A97-000931, November 10, 1998); *Caicedo and State Farm Mutual Automobile Insurance Company*, (FSCO A99-000376, June 16, 2000); *Jimcaale and TTC Insurance Company Limited*, (FSCO A00-001311, August 16, 2001 and February 27, 2002); *Moore and Kingsway General Insurance Company*, (FSCO A01-000580, January 28, 2002); *Rozmerets and Wawanesa Mutual Insurance Company*, (FSCO A01-000579, July 22, 2002); *Panou and Zurich North America Canada*, (FSCO A01-000882, September 23, 2002); and *Bianca and Wawanesa Mutual Insurance Company*, (FSCO A03-001571, December 20, 2004).

the procedures in the *Priorities Regulation*. Although a FSCO arbitrator may need to determine whether the insurer before them was the first insurer to receive a completed application, if it was, that insurer can only resist the claim on the basis that the person is not entitled to the benefits provided under the *SABS*, not that he or she should be looking to another insurer to pay them. A more detailed analysis follows.

“Insurer” is broadly defined under the *Insurance Act* as “the person who undertakes or agrees or offers to take on a contract.” Insurers must be licenced and are subject to prosecution and other regulatory actions for breaching their obligations under the *Act*. For example, they may not engage in any “unfair or deceptive act or practice,” which includes “any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims.”⁴

Automobile insurance is specifically addressed in Part VI of the *Act*. Insurers are not free to structure their policies as they see fit. They must use forms approved by the Superintendent, including both policy and claims forms. Since 1990, every motor vehicle liability policy has been “deemed to provide for the statutory accident benefits set out in the *Schedule [SABS]*, subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule*.” In other words, whatever the wording of the policy when issued, the insurer is obliged to provide the benefits set out in *SABS* as it is amended from time to time.

The *SABS* are made under the regulation-making authority in s. 121 of the *Act*, primarily subsection (9). This subsection allows the Lieutenant Governor in Council to make regulations “establishing benefits for the purposes of Part VI that must be provided under contracts evidenced by motor vehicle liability policies and establishing terms, conditions, provisions, exclusions and limits related to such benefits.”

⁴ See *Insurance Act*, sections 1 and 40, and Parts XVII and XIX, and O. Reg. 7/00, *Unfair or Deceptive Acts or Practices*, s. 1.

In addition to establishing statutory accident benefits as part of every motor vehicle liability policy, s. 268 establishes priority rules. Subsection (2) sets out a cascading list of priorities designed to ensure that anyone injured in an automobile accident within the scope of the *Insurance Act* has access to accident benefits from some insurer or, as a last resort, the Motor Vehicle Accident Claims Fund (“MVAC”).⁵ Someone like Mrs. Vieira, who was not an occupant of an automobile at the time of the accident, is expected to look first to her own insurer, next to the insurer of the automobile that hit her, next to the insurer of any automobile involved in the incident, and, finally to MVAC.

The claims process supports these priority rules. The *SABS-1996*⁶ includes the following provisions, made under the authority of s. 121(4) of the *Insurance Act*, establishing procedures for claiming accident benefits:

32. (1) A person who wants to apply for a benefit under this Regulation shall notify the insurer within 30 days after the circumstances arose that gave rise to the entitlement to the benefit, or as soon as practicable thereafter.

(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.

(3) The person shall submit an application for the benefit to the insurer within 30 days after receiving the application forms.

⁵ See the discussion in *Griffiths and State Farm Mutual Automobile Insurance Company*, (FSCO P01-00018, March 25, 2002).

⁶ The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

I note that this section refers to “the person,” not “the insured person.” This suggests that insurers are expected to respond to inquiries without first determining whether the person making the inquiry is an “insured person” under one of their policies. Nor is “insurer” defined in the *SABS-1996*. This also favours a broader interpretation, not a narrow technical one.

To fulfill their obligations under s. 32, insurers must use the application forms approved by the Superintendent.⁷ Part 4 of the application form is specifically designed to help the injured person determine where to make a claim. It starts by asking whether the person is covered under an automobile insurance policy personally, as a spouse, as a dependant, or as a listed driver. If so, details are requested. If not, the person is told that he or she “must send your application to the insurer of the automobile that you occupied at the time of the accident or the vehicle that struck you if you were a pedestrian or bicyclist. If this automobile was not insured or unidentified, describe any other vehicle involved in the accident.” Again, details are requested.

Once an insurer receives a completed application for accident benefits, it must respond according to rules set out in the *SABS-1996*. The details depend on the type of benefit claimed. For example, if the application is for income replacement benefits, the insurer must “promptly determine whether a benefit is payable” and, if so, pay the benefit within 14 days of receiving the application and at least once every second week thereafter.⁸ If the insurer refuses to pay a benefit, it must provide written notice to the person advising them of their right to contest the decision through the dispute resolution process.⁹

The dispute resolution process is established in sections 279 - 284 of the *Insurance Act* for “[d]isputes in respect of any insured person’s entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled.” As the Arbitrator points out,

⁷ See the *Insurance Act*, s. 121(4)(g) and the *SABS-1996*, s. 69(1).

⁸ *SABS-1996*, s. 35.

⁹ *SABS-1996*, s. 49 and the form approved by the Superintendent under s. 69 (*OCF - Explanation of Benefits Payable*).

arbitrators are given authority under s. 20 of the *Act* to determine all questions of fact and law that arise in any proceeding before them.

Before the *Priorities Regulation* came into effect, insurers could deny claims on the basis that another insurer should be paying, whether due to a lack of coverage or an assertion that the other insurer had priority. This raised a dispute in respect of the “insured person’s” entitlement to statutory accident benefits and, therefore, they could use the dispute resolution process.¹⁰ In these cases, however, the injured person often had to wait until the insurer dispute was resolved before receiving any benefits. As discussed in a number of decisions, including my appeal decision in *Mohamed*, this is the problem the *Priorities Regulation* was meant to address.

Authority for the *Priorities Regulation* was created through an amendment to s. 121 of the *Insurance Act*, allowing the Lieutenant Governor in Counsel to make regulations:

- 10.4 governing the procedure for determining who is liable to pay statutory accident benefits under section 268, including requiring insurers to resolve disputes about liability through an arbitration process established by the regulations and requiring the interim payment of benefits pending the determination of liability;

The key sections of the *Priorities Regulation* use the same term, “insurer,” without providing any specific definition for purposes of the regulation:

1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with the Regulation.
2. 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 s. 268 of the Act.

In my opinion, “insurer” in these provisions must be interpreted broadly based on the claim being asserted, not the ultimate determination. Where, as in this case, an insurance company licenced to write

¹⁰ *Insurance Act*, s. 279(1).

automobile insurance in the Province of Ontario receives a completed application for accident benefits under a specific policy that the applicant claims was in force at the time of the accident, that company must respond under s. 2 of the *Priorities Regulation*. Using the words in *Allstate v. Brown*, there is a sufficient nexus. Indeed, none of the arbitration decisions, including the one under review, suggests otherwise.

The question is whether, in determining the insured person's entitlement to benefits, a FSCO arbitrator can still consider coverage as part of the entitlement issue. The argument is reasonably compelling — how can an insurer be ordered to pay benefits without determining that it had an obligation to do so under a policy in force at the time of the accident? In my opinion, however, this question is answered by the legislation. All disputes about which insurer must pay the benefits — the *who pays* question — are decided under the *Priorities Regulation*. This leaves FSCO arbitrators and judges to determine entitlement — the *what, if any, benefits* question. In other words, if the insurer before a FSCO arbitrator was the first insurer to receive a completed application, the arbitrator's role is to determine what benefits that person is entitled to receive under the *SABS*, without regard to whether he or she is covered by that particular policy.

This interpretation is reflected in Practice Note 10 to the *Dispute Resolution Practice Code* and, while not binding, I believe it accurately summarizes the law:

If the first insurer has a number of reasons for denying the claim, some of which are based on lack of entitlement, and others based on a liability question, it should dispute the claim in the normal manner before the Commission on the entitlement dispute. It should also issue a notice under the Regulation to the insurer that it believes would be required to pay, in the event it is unsuccessful on the entitlement issues. The second insurer may seek permission to join the proceeding concerning entitlement to accident benefits started by the first insurer at the Commission.

I also find support for this interpretation in the decision of the Court of Appeal in *Kingsway General Insurance Co. v. West Wawanosh Insurance Co.* (2002), 58 O.R. (3d) 251. In that case, Mr. Verdonk was driving a vehicle owned by a company and insured by Kingsway. He also had his own personal automobile policy, issued by West Wawanosh. Mr. Verdonk applied first to West

Wawanosh for accident benefits, but a few days later, he also applied to Kingsway. West Wawanosh considered its obligation to pay, including obtaining a legal opinion, and decided that it should be paying. Roughly six months later, West Wawanosh delivered a *Notice of Dispute Between Insurers* to Kingsway under the *Priorities Regulation* after discovering a small body of unreported decisions suggesting that Kingsway might be the responsible insurer.

In *Kingsway*, both insurers accepted that they had policies in force that covered the incident; the issue was the time requirement for starting the process under the *Priorities Regulation*. While this makes the case distinguishable from the situation before me, the Court's approach to the legislation is instructive. In concluding that West Wawanosh could not challenge its obligation to pay because it has waited too long, the Court made the following comments:

The Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assume and rely upon the requirement for compliance with those provisions. Insurers subject to this Regulation are sophisticated litigants who deal with these disputes on a daily basis. The scheme applies to a specific type of dispute involving a limited number of parties who find themselves regularly involved in disputes with each other. In this context, it seems to me that clarity and certainty of application are of primary concern. Insurers need to make appropriate decisions with respect to conducting investigations, establishing reserves and maintaining records. Given this regulatory setting, there is little room for creative interpretation or for carving out judicial exceptions designed to deal with the equities of particular cases.

I agree that clear rules are needed to make the legislative scheme work. Unless the obligations imposed on insurers are clear and insurers follow them, the purpose of the *Priorities Regulation* will not be achieved.

In this case, Mrs. Vieira filed a completed application for accident benefits with Royal. She referred to a policy issued to her son and explained her understanding that this policy covered a vehicle that the two of them co-owned. This was far from a random choice of insurer. Perhaps most strikingly, Royal's agent sent a letter to Mrs. Vieira and her son on July 4, 2001, less than a month before the accident, thanking them for their business and enclosing "your new policy documentation." In the circumstances, Royal was obligated to respond under s. 2 of the *Priorities Regulation* as the first insurer to receive a

completed application. As Chubb correctly stated in its October 2001 letter, Royal's recourse was to follow the procedures in the *Priorities Regulation* if it wanted to claim that some other insurer was responsible for paying the benefits. It was not entitled to make that same argument through the backdoor of an arbitration hearing.

For these reasons, the appeal is allowed.

Mrs. Vieira argued that Royal should be ordered to pay a special award under s. 282(10) of the *Insurance Act* for unreasonably withholding or delaying the payment of benefits. While the delays in this case are unfortunate, there was support for Royal's position. Therefore, I am not prepared to order a special award.

IV. APPEAL EXPENSES

According to my intervention order, Chubb is not eligible for expenses or liable to pay expenses. If the parties are unable to resolve the issue of appeal expenses, they should follow the procedures in Rule 79 of the *Dispute Resolution Practice Code*.

David R. Draper
Director of Arbitrations

February 15, 2005

Date