

**COURT FILE NO.:** 04-CV-275318CM2

**DATE:** 20050407

**SUPERIOR COURT OF JUSTICE - ONTARIO**

**RE:** PRIMMUM INSURANCE COMPANY

(formerly Canada Life Casualty Insurance Company)

- Appellant

- and -

AVIVA INSURANCE COMPANY OF CANADA (formerly known as  
General Accident Assurance Company) and AVIVA CANADA INC.

- Respondent

**BEFORE:** T. Ducharme, J.

**COUNSEL:** J.R. Pollack and A.S. James for the Appellant

J.S. Bromley for the Respondent

MOTION

**HEARD:** March 22, 2005

**E N D O R S E M E N T**

I. NATURE OF THE APPEAL

[1] This is an appeal from the decision of Arbitrator Parnega, dated August 11, 2004, which held that the appellant Primmum Insurance Company ("Primmum"), having failed to serve a notice of dispute between insurers within 90 days of receiving the completed application for accident benefits as required by Regulation 283/95 pursuant to the [Insurance Act, R.S.O. 1990, c. I.8](#), had failed to bring itself within any of the exceptions provided for in s. 3(2) of the Regulation, and, as such, was prohibited from proceeding with an arbitration to determine responsibility for payment of statutory accident benefits to Kristen Puckett ("Ms. Puckett").

## II. THE FACTS

### (A) The Accident and the Ensuing Investigation by the Appellant

[2] Ms. Puckett, age 17, was catastrophically injured in a single vehicle accident on September 11, 1998 while an occupant of a stolen vehicle. At the time of the accident, she was living with her mother, Darlene Mitchell ("Ms. Mitchell"), and Ms. Mitchell's common law partner, Anthony Weiher ("Mr. Weiher") who was insured by Primmum.

[3] On October 19, 1998, the appellant was advised by correspondence that the claimant was involved in an automobile accident and that Statutory Accident Benefits would be claimed under a policy of automobile insurance issued by the appellant. On this same date, the appellant was advised by the counsel for the insured that the insured and his spouse were in a common-law relationship and that they were the mother and stepfather of the claimant.

[4] On October 22, 1998, Primmum retained the services of Jean Marion ("Mr. Marion"), an independent adjuster to investigate the claim and determine whether or not Primmum was responsible for payment of accident benefits. Mr. Marion knew that priority would be decided based on dependency. He advised counsel for the claimant by correspondence dated October 28, 1998 that further information was required in order to investigate the relationship alleged to exist between Primmum's named insured and the claimant. On October 29, 1998 Primmum was advised that Aviva (formerly General Accident) insured the vehicle in which Ms. Puckett had been a passenger.

[5] On November 4, 1998, Mr. Marion met with the insured, Mr. Weiher, his spouse and Ms. Puckett in the presence of the claimant's counsel. Prior to this meeting their counsel advised Mr. Marion that they were not very "sophisticated" and, as Mr. Marion later put it in his report to the appellant, it was apparent that they were having trouble coping with the situation emotionally, psychologically and intellectually. Apparently during this interview Mr. Marion did not ask questions of Ms. Puckett. The insured and his spouse confirmed that the claimant had resided with them at the time of the accident and that she had been financially dependent on them since 1993. Mr. Marion was told that both Mr. Weiher and Ms. Mitchell had not worked since the accident and were receiving social assistance. He did not ask them any further questions about their financial situation. Mr. Marion was also told that Ms. Puckett had had a part-time

job but he asked no further questions about what sources of income she had.

[6] On December 8, 1998 Mr. Marion met with Ms. Puckett's mother at her counsel's office, as she was having difficulty completing the application for accident benefits on behalf of her daughter. In order to complete the application Mr. Marion asked the questions, Ms. Mitchell provided answers to the questions asked, and Mr. Marion completed the application for accident benefits. Primmum had not received any prior claims or applications for Statutory Accident Benefits pertaining to the claimant.

[7] The completed Application for Accident Benefits specified that the claimant had been dependant upon the appellant's named insured and his spouse at the time of the accident and that the claimant resided with them. It further indicated that the claimant was only employed on a part time basis prior to the accident and that she was a student. Part 9 of the form has a question about receipt of social assistance it was left blank. Mr. Marion testified that if he had asked any questions about social assistance that it would have been checked off on the application.

[8] Mr. Marion conducted further investigations to confirm that Ms. Mitchell and Mr. Weiher were in a common law relationship, to confirm whether there was coverage available to Ms. Puckett through her birth father, and to confirm that Ms. Puckett was to return to high school in September had the accident not occurred. During his investigations Mr. Marion had no reason to doubt the information that Ms. Mitchell and Mr. Weiher gave him, and they did not refuse to provide any information requested by him. The completed application for accident benefits and Mr. Marion's report was submitted to Primmum and date stamped on January 12, 1999.

[9] On January 14, 1999, Mr. Luis De Sousa, a claims examiner for the appellant, advised counsel for the claimant that, based upon the information received to date, he was satisfied that Ms. Puckett was a dependant of her parents and that Primmum was therefore the primary insurer responsible for payment of accident benefits to Ms. Puckett. At the time that Mr. De Sousa made his determination on dependency he knew that there was information missing from the application for accident benefits. He also knew that both Ms. Mitchell and Mr. Weiher worked only part-time, that they were both on social assistance, that Ms. Puckett had been working part-time prior to the accident, and that she was due to return to work in the fall. However, he did not know their annual income, their sources of income, their expenditures, Ms. Puckett's salary, how long she had been working, how many hours a week she worked, whether she had other sources of income, whether she made more or

less than her mother, whether she contributed to the household expenses, whether she had attended school the year before, what grade Ms. Puckett was in, whether she had lived away from home for a period of time, or whether she had been on social assistance. After receiving the completed application for accident benefits, Mr. De Sousa took no steps to obtain any of the information on the issue of dependency that he did not have.

[10] A detailed statement from Ms. Puckett was ultimately obtained on or around June 29, 1999. In that statement, Ms. Puckett stated that she lived with the insured and his spouse for several months prior to the accident and that she had depended upon them for financial support. She further stated that she had been employed only on a part time basis at the time of the accident and that she was registered to attend school full time prior to the accident.

[11] Primmum later received a medical report that suggested the claimant had lived with her boyfriend, away from the home of its insured and his spouse, at the time of the accident. Another report suggested that the claimant may have been receiving social assistance at the time of the accident. As a result, Ms. Bedrossian, a claims examiner for the appellant, wrote to the claimant's solicitor dated July 28, 1999 asking whether the claimant had been in receipt of social assistance at the time of the accident. No response to that correspondence was ever received. In oral argument counsel for the respondent, while disputing that there had been any deliberate misrepresentation by the insureds, conceded that Ms. Puckett had in fact been receiving social assistance benefits.

[12] Ms. Bedrossian sent a letter dated September 8, 1999, to counsel for the claimant advising that the respondents are likely the primary carriers for Statutory Accident Benefits payable to and on behalf of the claimant. This correspondence enclosed a Notice to Applicant of Dispute Between Insurers and requested that certain fields on this form be completed if the claimant objected to her claims for Statutory Accident Benefits being transferred to the respondents. This correspondence, and enclosures thereto, was copied to the respondents.

#### (B) The Decision of the Arbitrator

[13] The issue before the Arbitrator was whether the appellant was barred by section 3(1) of Ontario Regulation 283/95 from proceeding to arbitration with respect to the accident benefits payable to Ms. Puckett. The only contested issue before the Arbitrator was whether Primmum, having failed to comply with the time limit in section 3(1), was entitled to rely on section 3(2) to extend the time for service of the notice of dispute.

The relevant provisions of Regulation 283/95 provide as follows:

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.

3(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.

[14] Relying on the decisions in *Kingsway General Insurance Company v. West Wawanoosh Insurance Company* per Nordheimer J. at trial (2001), 53 O.R. (3d) 436 (S.C.J.) and per Sharpe J.A. on the appeal (2002), 58 O.R. (3d) 251 (Ont. C.A.), Arbitrator Parnega ruled that Primmum could not rely on section 3(2)(a) of the Regulation. The *ratio* of his decision was that, having made a determination within 90 days, Primmum could not credibly argue that 90 days was not a sufficient time in which to make a determination. The Arbitrator did not address the appellant's argument that the 90 days was insufficient because they had not received complete and accurate information from the insured.

[15] With respect to section 3(2)(b) of the Regulation the Arbitrator considered both what Primmum had done and what they had failed to do in investigating the issue of Ms. Puckett's dependency on the insured:

The evidence showed that the Applicant's investigation determined that Kristin lived with her mother and her mother's common-law spouse. Confirmation was sought and obtained of that common-law relationship. It was also determined that Kristin was in full time attendance at a school or was about to attend. Confirmation was sought and obtained of Kristin's attendance at school. The Applicant also discovered that Kristin was employed on a part time basis and her parents both received social assistance. Confirmation of these facts, however, were not sought as the Applicant: (a) did not determine Kristin's hourly wage or (b) the number of hours per week that she worked (c) nor did it speak to her employer although it was authorized to do so. Furthermore: (d) no attempt was made to determine the level of benefits received by the parents, (e) the amount of expenses which the parents paid for on Kristin's behalf or (f) any contribution that Kristin may have made towards household expenses.

The Applicant was prepared to rely on the parents' statement that Kristen was principally dependant upon them for financial support without

seeking any confirmation.

The Arbitrator concluded that Primmum had simply relied on the statement from Mr. Weiher and Ms. Mitchell that Ms. Puckett was principally dependent upon them without conducting any further investigation or confirmation. As a result, the Arbitrator concluded that Primmum had not conducted the necessary reasonable investigations and therefore could not rely on section 3(2)(b) of the Regulation.

### III. THE LAW

#### (A) The Appropriate Standard of Review

[16] The arbitration agreement between the parties provides for a broad right of appeal with appeals being allowed based upon errors of law, mixed law and fact and fact alone. The standard of review on an appeal from a private arbitration (absent any specific provision to the contrary in the arbitration agreement) is one of correctness: *Liberty Mutual Insurance Co. v. Commerce Insurance Co.*, [2001] O.J. No. 5479 (S.C.J.); *National Ballet of Canada v. Glasco* (2000), 49 O.R. (3d) 230 (S.C.J.); *887574 Ontario Inc. v. Pizza Pizza Limited*, [1995] O.J. No 936 (Gen. Div.)

#### (B) The Purpose of the Regulation

[17] At the outset, the resolution of any issue under Regulation 283/95 should be informed by the comments made by Sharpe J.A. in *Kingsway General Insurance Company v. West Wawanoosh Insurance Company*, *supra*, at p. 255 about the purposes of the Regulation:

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 interpretations or for carving out judicial exceptions designed to deal with the equities of particular cases.

I find the following comments by Nordheimer J. at p. 443 of the trial decision equally compelling:

I do not see any reason why the parties here should not be held to strict

compliance with the requirements of the Regulation. In both of these appeals, we are dealing with three large insurance companies and a branch of the Provincial Government. It goes without saying that these parties are sophisticated and experienced participants in the insurance industry. They have available to them all of the advisors of the highest quality that they could need in order to determine their rights and obligations under the prevailing statutory regime. There is, therefore, no unfairness visited upon them by insisting on strict compliance with the notice requirements.

...

Further, in cases involving disputes between insurers, strict compliance promotes certainty for the parties in terms of their handling of claims. While it might rebound to the detriment of State Farm in this case, it is just as likely that State Farm will be the beneficiary of the strict compliance in some other case.

#### (C) Sufficiency of the 90-day Period

[18] The appellant submits that in this case the 90-day 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 argues that Primmum was intentionally misled by the insureds, something that is contested by the respondent. However, the appellant argues that, even if a misrepresentation or non-disclosure is 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 a sufficient time to make the determination.

[19] The respondents make three points in reply. First, they argue that the possibility of incorrect information is the reason that insurers are permitted 90 days to make their determination of liability. Their second and third arguments are based on the following passages from the decision of Nordhemier J. in *Kingsway General Insurance Company v. West Wawanoosh Insurance Company*, *supra*, at p. 444:

Regretfully, I find myself again in disagreement with the analysis and conclusion of the arbitrator. First, the conclusion by Arbitrator Malach that the 90-day period was not a sufficient time for West Wawanoosh to make a determination seems to be directly at odds with the fact that West Wawanoosh made a determination within that period. It determined, after seeking legal advice, that it was responsible for paying the benefits to Mr. Verdonk. It is difficult to reconcile the fact that a determination was made

with the conclusion that there was insufficient time to make a determination.

In fact what Arbitrator Malach appears to have concluded is that the 90-day period was insufficient for West Wawanoosh to make the correct determination. However, that conclusion reads into s. 3 of the Regulation a significant requirement that is absent from the express language of the section. There is nothing in the section that purports to require correctness as a part of the determination. It simply stipulates that the insurer must make a determination within 90 days unless reasonable investigations undertaken within that time have made a determination impossible. The section is not intended, in my view, to deal with the issue of the correctness of the determination but simply the ability to make the determination. In that regard, the section is really directed toward the ability of the insurer to gather the necessary factual information to make a determination as to whether its policy or the policy of another insurer should answer for the benefits to be paid. It is not directed at ensuring that, armed with the factual information, the insurer will make the correct determination. Indeed, if there was uncertainty as to which insurer was liable, one would expect, as Arbitrator Malach himself pointed out, that the insurer would deliver a notice of dispute so that a ruling could be obtained.

...

What is clear is that West Wawanoosh had the necessary factual information to make a determination. It sought legal advice on the issue. West Wawanoosh concluded that it had to pay the benefits to Mr. Verdonk. The fact that arbitrators may have determined in subsequent cases that the insurer of the company vehicle, as Kingsway General was in this case, is the proper insurer to pay the benefits does not bring the matter within the parameters of s. 3(2) and I find that Arbitrator Malach erred in concluding that it did.

(emphasis added)

Thus, the respondent argues that the 90-day period was obviously sufficient in this case as Primmum were able to make a determination about their liability within that time period. They also submit that the sufficiency of the 90-day period is not affected by the accuracy of the information obtained by the insurer as there is no requirement that the determination mentioned in section 3(2)(a) be correct.

[20] The respondent submits that in order to establish the insufficiency of the 90-day period, the insurer seeking to rely on section 3(2) must demonstrate that the evidence was not available to them within the 90-

day period. In this case the respondent submits that the evidence was available to Primmum if only they had asked the correct questions.

[21] At the outset, it should be noted that insurance contracts have long been classified as contracts *uberrima fides*. That is, they are contracts in which the insurer and the insured owe a duty of utmost good faith to each other. The reason for this is straightforward:

The reason for this is that the insured alone knows the facts of material importance to the insurer in accepting, assessing, or continuing a risk or assessing and valuing a claim. Since it is difficult or impossible for the insurer to determine these facts, the obligation requires the insured to make full and accurate disclosure to the insurer: *Poersch v. Aetna*, [2000] O.J. No. 270 (S.C.J.) per Cameron J. at para 56

This duty imposes an ongoing obligation on the insured to provide the insurer with complete and accurate information. The appellant argues that Primmum was therefore entitled to rely on the accuracy of the information provided to it by its own insureds in determining whether or not its policy would be required to respond to the claims of the claimants.

[22] Of course, an insured or a claimant might dishonestly or fraudulently misrepresent or withhold facts during the course of an insurer's investigation. However, there are several other innocent reasons why an insured might not provide information to the insurer or might not provide it accurately. An insured might mistakenly believe that she had already provided the information to the insurer or that the insurer already has the information from another source. The insured might have intended to disclose the information and have simply failed to get around to doing so. The insured may have genuinely forgotten some or all of the material information. The insured might be mistaken as to the true state of affairs. Finally, the insured simply might not understand the significance of the issue and consequently fail to appreciate that she should convey the information to the insurer.

[23] In assessing the sufficiency of the 90-day period under section 3(2)(a) what, if any, relevance does a material misrepresentation by the insured have? In my view, the utmost duty of good faith entitles an insurer to rely upon information provided to it by its own insureds in determining whether or not its policy would be required to respond to the claims of the claimants. Where an insured dishonestly or fraudulently withholds or misrepresents facts to the insurer this duty is obviously violated. At the same time, the requirement in s. 3(2)(b) of a reasonable investigation by the purported insurer constitutes a recognition that the insurer may well need to investigate any information provided to it by the insured. In my view, these two factors can be balanced by recognizing that, where an

insurer can demonstrate that they were intentionally misled in a material way by an insured, the 90-day limit in section 3(2)(a) might be insufficient in the circumstances.

[24] The question admittedly becomes somewhat more difficult when assessing the relevance of innocent misrepresentations to the 90-day period in section 3(2)(a). However, in my view, the result must be the same. That is, where an insurer can demonstrate that they were innocently misled in a material way by an insured, then the 90-day limit in section 3(2)(a) may be shown to be insufficient in the circumstances. I reach this conclusion for two reasons. First, Regulation 283/95 should not be interpreted in a vacuum. As the Regulation addresses insurers, who are parties to a contract *uberrima fides*, the assessment of the sufficiency of time must be premised on the accurate and complete reporting of material information by the insured to the insurer. Second, contrary to the respondent's submission, this conclusion is actually supported by the decision of Nordheimer J. in *Kingsway General Insurance Company v. West Wawanoosh Insurance Company*, *supra*. As Justice Nordheimer observed there is nothing in section 3(2)(a) that purports to require correctness as a part of the determination of the sufficiency of the 90-day period. But that case also had nothing to do with the time required to gather the necessary facts. There West Wawanoosh carried out an investigation into priority and decided that it was the liable insurer based upon its understanding of the law. When it ultimately reversed its position, it did not do so due to inaccurate information from the insured but rather because of a subsequent change in the jurisprudence. Thus, when Nordheimer J. refers to there being no requirement of "correctness," he is referring to the legal correctness of their conclusion not its factual underpinnings. Importantly, at page 445 of his decision, he underscores that the question of the sufficiency of the 90-day period is tied to the ability to gather the necessary facts:

The section is not intended, in my view, to deal with the issue of the correctness of the determination but simply the ability to make the determination. In that regard, the section is really directed toward the ability of the insurer to gather the necessary factual information to make a determination as to whether its policy or the policy of another insurer should answer for the benefits to be paid.

...

What is clear is that West Wawanoosh had the necessary factual information to make a determination.

(emphasis added)

Obviously incomplete or inaccurate reporting of material facts by an insured may adversely impact the ability of an insurer to gather the requisite facts needed to assess the liability of the various potentially involved insurance policies rendering the 90-day period insufficient. The fact that a determination was made within the 90 days should not be determinative. The Arbitrator erred in concluding that this fact precluded Primmum from satisfying s. 3(2)(1). However, I would not reverse his decision on this ground, for the reasons set out in paragraph 27, *infra*.

[25] The respondent argues that the 90-day period in s. 3(2)(a) is only insufficient where the insurer can demonstrate that the evidence was not available to them within the 90-day period. In support of this they refer to two arbitration cases: *Ontario Municipal Insurance Exchange v. Liberty Mutual Insurance Company* (October 2000), Arbitrator Jones (hereinafter "OMEX"); *T.T.C. Insurance Company Limited v. Gore Mutual Insurance Company* (September 18, 2003), Arbitrator Robinson (hereinafter "*T.T.C. Insurance Company*"). In *OMEX*, the claimant had been divorced for several years prior to being involved in an accident. The applicant in that case accepted liability and then later determined that, unbeknownst to the claimant, he was a named insured under his ex-wife's policy of automobile insurance and that her insurer therefore had priority. In *T.T.C. Insurance Company* the applicant was involved in an accident on a T.T.C. streetcar and the T.T.C. accepted liability. Only later, when the claimant was involved in another separate accident, was it discovered that she was included as a named insured on her mother's motor vehicle insurance policy.

[26] Neither of these cases assists the respondent. First, they are clear examples where an initial determination of liability within the 90-day period does not preclude the insurer from later challenging the sufficiency of the 90 period under section 3(2)(a). Second, they are not cases where the evidence was not available to the insurer. The evidence was there, but the insurer was unaware of it because of innocent non-disclosure on the part of the claimant. Thus, these two decisions actually support the approach I have articulated above. They also demonstrate that the test proposed by the respondent for s. 3(2)(a) is ultimately unworkable. If evidence exists that points to the priority of a second insurer, that evidence can always be said to be available to the first insurer if only it had asked the right questions or had looked in the right place. However, considerations of this sort are more appropriately dealt with in the context of the inquiry under s. 3(2)(b).

[27] Having reached the conclusion I have with respect to s. 3(2)(a), it should be clear that 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 s. 3(2)(a)

is whether the receipt of the inaccurate information renders the 90-day period insufficient for the investigation of the particular case. It is for the insurer who seeks to rely on s. 3(2) to demonstrate why, in the particular case, the non-disclosure or misrepresentation made the 90-day period inadequate. The Arbitrator erred in failing to consider this argument although it was advanced before him. However, I would not reverse the Arbitrator's decision on this basis as the evidence led by Primmum falls far short of that required to establish that the 90-day period was insufficient. The testimony of Mr. Marion demonstrates that he conducted only a superficial investigation into the issue of dependency. He accepted the statements of the unsophisticated insureds because the living situation they described was "common" and "he had no reason to disbelieve them." The issue under section 3(2)(a) is not whether the investigation was done properly within the 90 days. The issue is whether the investigation could be done properly within the 90 days. In this case, the 90-day period was more than enough time to conduct an investigation.<sup>[1]</sup> The appellant's problem is that they did not do so.

#### (D) Whether The Appellant Conducted the Reasonable Investigations Necessary

[28] While the foregoing conclusion ends the matter, as the Arbitrator dealt with s. 3(2)(b) I will address it as well. For the appellant to rely on section 3(2) of the Regulation it must also satisfy the requirements of section 3(2)(b), i.e. it must have made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

[29] Here the appellant argues that the Arbitrator erred in failing to consider the evidence of three witnesses with extensive experience in the area of statutory accident benefits who testified that the investigations carried out by the appellant were thorough and reasonable in the circumstances. It also argues that there was no reason to suspect the information provided by the insured and therefore no reason to investigate it further.

[30] The determination of reasonableness in the context of section 3(2)(b) is very much a fact driven process and must be determined on a case-by-case basis. Opinion evidence such as that led by the appellant is not required to establish the reasonableness of the investigation. Indeed, I am of the view that the opinion evidence led by the appellant was of extremely dubious value. Most seriously, it did not meet the necessity requirement for the reception of expert evidence identified in [R. v. Mohan, \[1994\] 2 S.C.R. 9](#) (S.C.C.). The assessment of the

reasonableness of the investigation dealt with non-technical facts and common sense inferences. It cannot be said that the Arbitrator needed the assistance of a person with special knowledge in order to appreciate the facts or that, without such assistance, he was unlikely to form a correct judgment on the matter.<sup>[2]</sup> On this basis alone it should not have been admitted. Second, while in oral submissions Primmum's counsel referred to these individuals as "experts", no effort was made to qualify these witnesses as such and I have significant doubt about whether they could be so qualified. Third, contrary to the submissions of the appellant, none of the three witnesses actually articulated in any reasoned way an appropriate standard of care for investigations of this sort. Fourth, Ms. Bedrossian was quite argumentative and partisan as a witness and the probative value of Mr. Marion's evidence was significantly undercut by the fact that he was unaware that in Ontario a 17 year old could receive social assistance benefits. Consequently, while it would have been preferable for the Arbitrator to have adverted to this evidence, I do not think it would have affected the outcome.

[31] In considering the adequacy of the investigation it is important to stress that section 3(2)(b) requires that the investigation be "reasonable," not that it be perfect. This could not be otherwise since, when viewed through the often omniscient lens of hindsight, it would be the rare investigation that could not be improved upon. In making this assessment of reasonableness, it is appropriate to consider both what was done to investigate the claim as well as what was not done. As is evident, from the passage of his reasons quoted at paragraph 15, *supra*, this is precisely the approach taken by the Arbitrator. I see no error in either his approach or his conclusion.

[32] In addition to the factors discussed by the Arbitrator, there were other inadequacies with the investigation. At the November 4, 1998 meeting, Mr. Marion did not ask Ms. Puckett any questions and no explanation was offered for this omission. Moreover, Ms. Puckett was never asked to account for all her sources of income and no investigation was done with respect to her place of residence. The appellant's submission that the information about Ms. Puckett's income and place of residence was "not reasonably available to it when it conducted the investigations" is simply untenable. Having failed to ask Ms. Puckett or her parents the appropriate questions, the appellant cannot now claim that the insureds would have lied in any event. In this regard, I would note that, within 90 days of the submission of her application for accident benefits, Ms. Puckett had told her occupational therapist that she had co-habited with her boyfriend.<sup>[3]</sup> Shortly thereafter, she told a medical consultant that she had been receiving social assistance.<sup>[4]</sup> While Primmum did not receive these reports within the 90 days, they suggest that, if Ms. Puckett had been interviewed, she would have answered

questions honestly. At the very least, having been told that the insureds were not particularly sophisticated, the insurer should have taken greater pains to ensure that it got the information it required.

[33] While the duty of utmost good faith means that the 90-day period in section 3(2)(a) may not be sufficient for an investigation where an insurer has been misled as to material facts, it does not preclude a searching assessment of the investigation conducted by the insurer. To hold otherwise would render section 3(2)(b) meaningless. This would substantially reduce the incentives for the insured to conduct a thorough investigation and be contrary to the purpose of section 3 of the Regulation, i.e. to place "the burden on the insurer who intends to dispute its liability to take a more proactive approach to these issues."<sup>[5]</sup> A thorough investigation is required precisely to detect non-disclosure or misrepresentation no matter what its cause. The resulting early detection of inaccuracy will benefit everyone by ensuring that decisions are made based on a proper understanding of the facts. This will reduce the number of disputes between insurers and their related costs and increase certainty for all.

[34] For all these reasons, I would conclude that the Arbitrator did not err in concluding that the appellant had failed to satisfy the requirements of section 3(2)(b) of Regulation 283/95. As a result, the appellant is not entitled to proceed with an arbitration concerning the priority dispute between itself and the respondents.

#### ORDER

[35] It is ordered that the appeal of the decision of the Arbitrator be dismissed.

#### COSTS

[36] The respondent is entitled to its costs. If the parties are unable to agree as to the scale and quantum of costs, the respondent shall provide brief written submissions with respect to costs within seven days of the release of this judgment and the appellant shall provide written submissions within seven days of the receipt of the respondent's written submissions.

---

T. Ducharme J.

**Released:** April 7, 2005

---

[1] This is especially true where, as here, the investigation actually begins before the commencement of the 90-day period. Mr. Marion interviewed the parents on November 4, 1998, more than two months before the receipt of the SABS application on January 12, 1999. Thus, by the end of the 90-day period set out in s 3(1) of the Regulation, Primmum had had over 5 months to investigate this claim.

[2] Indeed, one would expect that parties such as these would choose arbitrators with expertise in the area.

[3] The report of Ms. Swanson, the occupational therapist, was dated April 23, 1999 and was based on evaluations conducted on March 24 and 31 and April 14, 1999. Ms. Swanson does not indicate when Ms. Puckett spoke of co-habiting with her boyfriend. It is not clear exactly when this report came to the attention of the insurer although it clearly would have been outside the 90-day period.

[4] The report of Crawford Healthcare Management is dated July 20, 1999 and does not indicate when Ms. Puckett revealed she had been "receiving welfare."

[5] *Axa Insurance Company v. Co-operators Insurance Company*, (unreported, 3 May 2001), Toronto, 00-CV-191314 (S.C.J.) per Nordheimer J. at p. 7.