Q.: WHAT ARE THE EFFECTS OF A FAILURE TO MEDIATE, FAILURE TO APPLY FOR BENEFITS, AND A FAILURE TO PROVIDE PROOF OF INCURRED EXPENSES?

1. Failure to Mediate:

Section 281(2) of the *Insurance Act* limits litigation or arbitration proceedings stating that no person may commence a claim in court or arbitration unless:

1. Mediation was sought;

2. The mediation failed; and

3. Where the issues in dispute were referred for a neutral evaluation under section 280.1, the report of the evaluator has been given to the parties.

Section 51(1) of the *SABS* clarifies the provision in the *Insurance Act* stating that the limitation period in which a mediation proceeding or evaluation under section 280, 280.1 or 281 shall be commenced is within two years after the insurer's refusal to pay the amount claimed. **Section 51(2)** provides a further ninety-day grace period for commencement of a court proceeding or arbitration following the delivery of the report of the mediator.

The case law confirms that the failure to mediate a claim within the prescribed two year limitation period is a statutory bar to the commencement of arbitration proceedings. For example, in ***Murugappa v. Aviva*** (FSCO A05-000209, November 10, 2006), Arbitrator Wilson determined that the applicant's claim was statute barred since she failed to proceed to mediation within two years of the insurer's notice of stoppage. The Arbitrator considered and rejected the application of the recent Court of Appeal decision of ***State Farm v. Dominion*** ("*State Farm*"), which discusses the limitation period of a claim by one insurer to another, and which has been suggested to have resurrected the concept of rolling limitations in accident benefit cases. Arbitrator Wilson considered the comments in *State Farm* to be, at best, obiter dicta:

> *Given the long-standing nature of the rejection of rolling limitations in the accident benefit context, any decision changing such an approach should be explicit and deal directly with the issue rather than, at best, tangentially.*

Furthermore, effective March 1, 2006, non-attendance by an insured at an insurer examination is no longer a bar to filing for a mediation. Instead, such behaviour may result in cost sanctions at arbitration.

2. Failure to Apply for Benefits:

Section 32 of the *SABS* sets out a three step process for the application of benefits. First, the claimant must notify the insurer of the intention to apply for the benefit within 30 days from the date of an accident that occurred before October 1, 2003 and 7 days from the date of an accident that occurred after October 1, 2003, or as soon as practicable after that day (S.32(1)(1.1)). Second, the insurer must provide the insured with the appropriate application forms. Third, The claimant shall submit a signed application for the benefit to the insurer within 30 days after receiving the application forms from the insurer (S. 32(3)). Section 31(1) states that failure to apply for accident benefits within the prescribed time does not disentitle the claimant to a benefit, unless the claimant has a reasonable explanation.

In ***Paul v. Allstate*** (Appeal, P99-00033, May 18, 2000), Director's Delegate Draper concluded that the appellant s claim was statute barred where he received the proper forms from the insurer including an explanation of the time limitations but did not submit his application for accident benefits until almost one year later. However, more recent decisions indicate a trend toward focussing on the consumer protection nature of the *Schedule* in determining whether failure by an insured to apply for benefits within the prescribed time period(s) should bar his/her claim.

In ***Hunt v. Co-operators*** (FSCO A00-001308, May 17, 2002), Arbitrator Wacyk allowed the applicant to proceed to arbitration despite the fact that the specific benefits in dispute had not been claimed or denied prior to mediation. The Director's Delegate, in ***MacIntosh v. Allstate*** (FSCO P04-00019, March 15, 2005), confirmed that a completed Application for Accident Benefits is not necessary for a finding that the insured had complied with the requirements of section 32. In ***Najafi Far v. Echelon*** (FSCO A03001122, September 14, 2004), the Arbitrator held that where an insurer has been notified of the accident but has not been notified that the insured person intends to apply for a benefit, the obligation is on the insurer to:

1. Notify the insured of the time limit set out in section 32(1) and the potential consequences of non-compliance; and

2. Notify the insured of his or her right to provide a reasonable explanation for non-compliance.

> *The insurer should always have the prior obligation once it receives notice of the accident…an insured person...who does not want or intend to file a claim for benefits until he/she has tried to recover from the injuries sustained in the accident, may be assisted in applying for benefits by being informed that he/she risks losing his/her right to claim all accident benefits if he/she waits more than 30 days to notify the insurer of the fact that he/she intends to apply for a benefit...It is sufficient that this information* <u>*has the potential*</u> to "assist *[such an insured] person in applying for benefits." An insured person who is not provided with this information may, for that reason, see his/her claim dismissed, not on the merits, but because it is out of time, thus defeating the goal of consumer protection. It is not necessary to determine whether or not the insured person would have actually submitted a more timely claim had the required information been provided. In any event, there is no reliable basis in the present case (and probably in*

most cases) to make such a determination after the fact.

3. Incurred Expenses:

The *Schedule* requires the insurer to pay for expenses "incurred" by the insured in the context of caregiver benefits (section 13), medical/rehabilitation benefits (sections 14 & 15) and attendant care benefits (section 16). The case law set out below clarifies the nature of the insurer's obligation in relation to incurred expenses for the abovementioned benefits.

In the 2001 FSCO decision of ***Lombardi v. State Farm***, it was found that where there is no documentation confirming that attendant care expenses were incurred, there is no entitlement to indemnification.

However, FSCO case law has since taken an expansive view of the term "incurred." In the appeal FSCO decision of Director's Delegate Makepeace in ***Zurich v. Stargratt*** (March 31, 2003), it was found that the very fact of the insured person's need for assistance, and the provision of that assistance by the family member, creates the incurred obligation.

Recently, Director's Delegate Makepeace has again dealt with the issue of incurred expenses in the FSCO appeal decision of ***McMichael v. Belair***. In this decision, the insurer had refused attendant care. As a result, the applicant had not received attendant care, paid for it or incurred a debt or obligation for same. The arbitrator had nonetheless awarded the payment for PAF attendant care. In upholding the decision, Director's Delegate Makepeace reasoned that the accident benefits scheme is consumer protection legislation and that this sometimes requires "bright line boundaries" that produce anomalous results. The insurer should not be able to benefit from refusing the services that were reasonably required and accordingly an award of attendant care was warranted.

Thus, the "incurred" expenses requirements have been effectively erased from the *Schedule*. So long as the claimant "reasonably required" the services, payment will be awarded.

To discuss your case, please contact information@ztgh.com.