ING Insurance Company of Canada v. TD Insurance Meloche Monnex

[Indexed as: ING Insurance Co. of Canada v. TD Insurance Meloche Monnex]

103 O.R. (3d) 270

2010 ONCA 559

Court of Appeal for Ontario,
Gillese, Juriansz and LaForme JJ.A.
August 24, 2010

Insurance -- Automobile insurance -- Statutory accident benefits -- "Completed application for benefits" -- Application not required to be on particular form in order for insurer to have received completed application for accident benefits under s. 2 of O. Reg. 283/95 as long as application provides sufficient particulars to reasonably assist insurer with processing application, identifying benefits to which claimant may be entitled and assessing claim -- No requirement existing that application be submitted by injured person him or herself -- Claimants' chiropractor submitting OCF-23 forms to insurer containing names and addresses of each claimant and brief description of nature of their injuries -- Forms amounting to "completed application for benefits" -- O. Reg. 283/95, s. 2.

Four people were injured in a car accident and received treatment from a chiropractor. The chiropractor sent ING an OCF-23 form on behalf of each claimant, containing the claimants' names and addresses and a brief description of the nature of their injuries. The forms were signed by the

claimants. An arbitrator found that the forms amounted to "completed applications for benefits" for the purpose of s. 2 of O. Reg. 283/95, so that ING was responsible for the payment of benefits, pending determination of its priority dispute with TD. ING applied to the Superior Court to have the arbitrator's decision set aside. The application was dismissed. ING appealed.

Held, the appeal should be dismissed. [page271]

The standard of review of the arbitrator's decision was that of correctness.

An application for accident benefits need not be on a certain form in order to be valid. It need only provide sufficient particulars to reasonably assist the insurer with processing the application, identifying the benefits to which the claimant may be entitled and assessing the claim. In this case, when the ING adjuster received the forms, she had sufficient information to assist her with commencing the processing of the applications and assessing the claims. The arbitrator did not err in concluding that the forms amounted to completed applications for accident benefits. There is no requirement in the legislation that the completed application be submitted by the injured person. In any event, given that the claimants signed the forms and gave the chiropractor ING's information, including policy and claim numbers, as well as the date of the accident, it was open to the arbitrator to have found that the claimants intended to apply for accident benefits from ING and that the chiropractor submitted the forms on their behalf.

Cases referred to

Liberty Mutual Insurance Co. v. Commerce Insurance Co., [2001] O.J. No. 5479, [2001] O.T.C. 978, 36 C.C.L.I. (3d) 269, [2002] I.L.R. I-4049, 111 A.C.W.S. (3d) 812 (S.C.J.), apld

ING Insurance Co. of Canada v. State Farm Insurance Companies (2009), 97 O.R. (3d) 291, [2009] O.J. No. 3643, [2009] I.L.R. I-4887, 77 C.C.L.I. (4th) 198 (S.C.J.), affg (April 15, 2009) (Arbitrator L. Samis), distd

Other cases referred to
Andriano v. Wawanesa Mutual Insurance Co., 2007 CarswellOnt 5669 (FSCO Arb.); Kingsway General Insurance Co. v. West Wawanosh Insurance Co. (2002), 58 O.R. (3d) 251, [2002] O.J. No. 528, 155 O.A.C. 238, 35 C.C.L.I. (3d) 267, [2002] I.L.R. I-4087, 112 A.C.W.S. (3d) 145 (C.A.); McIntosh v. Allstate Insurance Co. of Canada, 2004 CarswellOnt 2467 (FSCO Arb.); Pooler v. Guardian Insurance Co. of Canada, [1999] O.F.S.C.I.D. No. 233 (Fin. Serv. Comm.)
Statutes referred to
Arbitration Act, 1991, S.O. 1991, c. 17, s. 49
Insurance Act, R.S.O. 1990, c. I.8 [as am.]
Rules and regulations referred to
O. Reg. 283/95 (Insurance Act), ss. 2, 3(1), 7(1)
O. Reg. 403/96
Statutory Accident Benefits Schedule -- Accidents on or after November 1, 1996, O. Reg. 403/96, ss. 2, 32, (1), (2), (a), 59

APPEAL from the order of D.M. Brown J., [2009] O.J. No. 1589, 73 C.C.L.I. (4th) 105 (S.C.J.) dismissing an application to set aside the decision of the arbitrator.

Eric K. Grossman, for appellant.

Pamela L. Blaikie and Courtney Toomath-West, for respondent.

The judgment of the court was delivered by

[1] GILLESE J.A.: -- In Ontario, people injured in car accidents have immediate access to statutory accident benefits. To ensure [page272] this result, the first insurer to receive a "completed application for benefits" is responsible for paying the benefits. While that insurer may dispute its obligation to pay the benefits, such disputes are not to hold up benefit payments to the injured person. [See Note 1 below]

[2] In the present case, four people were injured in a car

accident. They went to a chiropractor for treatment. The chiropractor sent ING Insurance Company of Canada ("ING") certain forms. The question arose: did the forms amount to "completed applications for benefits", thereby triggering ING's obligation to pay benefits? This appeal answers that question.

The Background

[3] On July 23, 2006, Francisco Quintero was driving a car in which Susan Vasquez, Gema Aranciabia and Gema Orellanza Aranciabia were passengers. The Quintero car was in a collision with a car being driven by Neil Sheppard. All four people in the Quintero car (the "claimants") were injured.

[4] The Quintero car was allegedly insured by TD Insurance Meloche Monnex ("TD"). TD maintains that it had terminated the policy and was no longer the insurer of the vehicle at the time of the accident.

[5] The Sheppard car was insured by ING.

[6] Dr. R.F. Komeilinejad is a chiropractor who treated the claimants some time after the accident.

[7] On May 30, 2007 -- some ten months after the accident -- ING received four OCF-23 forms from Dr. Komeilinejad, one for each claimant (the "Form(s)"). The OCF-23 is entitled "Pre-approved Framework Treatment Confirmation Form". It is used by health practitioners to initiate pre-approved treatment for injuries.

[8] The Forms consist of four pages. All four of the Forms were filled out in a similar fashion. In the top left-hand corner of p. 1, there is a handwritten notation that reads: "Attn. AB Claims, ING Insurance". In the top right-hand corner, there is a claim number, policy number and the date of the accident.

[9] Below, in Part 1, each claimant's full name, address, telephone number, gender and birth date is set out. The Forms showed the same address (Fountainhead Drive in North York) for

Francisco Quintero and Susan Vasquez. The Forms showed the Aranciabias as having the same address as one another (Queens Drive in North York). The Forms indicated that all four claimants had the same phone number. [page273]

[10] In Part 2, ING is identified as the insurance company. The words "AB Claims" have been written in the boxes marked "Adjuster First Name" and "Adjuster Last Name".

[11] Part 3 indicates that there is no other insurance coverage for the pre-approved treatment. Part 4 is a section explaining the meaning of conflict of interest in relation to the provision of treatment under the pre-approved treatment regime.

[12] In Part 5 of the Forms, Dr. Komeilinejad is identified as the initiating health practitioner. Her office address, telephone number and fax number are set out and, at the foot of Part 5, Dr. Komeilinejad signed each Form and dated them November 25, 2006.

[13] Part 6 gives a brief description of the nature of the injuries that each claimant had sustained in the accident. Parts 7 and 8 address prior and current conditions and barriers to recovery.

[14] In Part 9 of each Form, the pre-approved services are identified, as well as the estimated fee for the services.

[15] All the claimants signed the Forms and dated them November 25, 2006.

[16] When asked why she sent the Forms to ING, Dr. Komeilinejad stated that she had seen ING's contact information in her file and wanted to receive payment for the services she had provided to the claimants.

[17] ING attempted to contact the claimants based on the information in the Forms. On June 5, 2007, ING tried calling the claimants using the telephone number provided on the Forms. That telephone number was out of service. ING then did a

Canada411 search on the claimants' names but the search yielded only the same information as that contained on the Forms.

[18] ING also called Dr. Komeilinejad and asked if she had any contact information for the claimants. Dr. Komeilinejad gave ING a telephone number for the cellphone of Gema Orellanza Aranciabia, a student. ING called the number and spoke briefly with Ms. Aranciabia, who said that she was leaving for a class and would call ING back later. Ms. Aranciabia never made the promised return phone call.

[19] As well, an ING adjuster sent letters dated June 5, 2007 to each of the claimants. In the letters, the claimants were asked to complete and return the standard form used to make an initial application for accident benefits (the "OCF-1") or to contact the adjuster if they had any questions. The OCF-1 form was not included with the letters.

[20] Unfortunately, all of the letters were mistakenly sent to the Fountainhead address. The Aranciabias had never lived at [page274] that address and apparently Mr. Quintero and Ms. Vasquez had moved from that address by the time that the letters were sent.

[21] None of the letters were returned to ING. None of the claimants contacted ING at any time or filed an OCF-1 with ING.

[22] On June 4, 2007, an ING adjuster wrote on each Form that ING was unable to respond as it could not confirm coverage.

[23] ING closed the files for the four claimants on July 20, 2007.

[24] TD opened accident-benefit claims files for the claimants on July 25, 2007. On October 10, 2007, TD received four OCF-1 forms from the claimants' authorized representative, GM Accident Claims & Dispute Resolution Specialists.

[25] Neither ING nor TD adjusted the files or paid benefits.

[26] Section 2 of O. Reg. 283/95 (the "Regulation") to the

Insurance Act, R.S.O. 1990, c. I.8 (the "Act") is the crucial legislative provision in the present case. It provides that

> 2(1) [T]he 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 section 268 of the Act.

[27] ING and TD disagreed about which had been the first insurer to receive a completed application for accident benefits within the meaning of s. 2 and, therefore, which had priority to respond to the Claimants' claims for statutory accident benefits. They went to arbitration to have the matter determined. [See Note 2 below]

[28] The arbitrator, Kenneth Bialkowski, found that ING's receipt of the Forms from the chiropractor constituted the receipt of a "completed application for benefits" within the meaning of s. 2. Based on this finding and in accordance with s. 2 of the Regulation, the arbitrator held that ING was responsible for the payment of benefits, pending determination of the priority dispute.

[29] ING applied to the Superior Court to have the arbitrator's decision set aside. The application was dismissed.

[30] ING now appeals to this court.

[31] For the reasons that follow, I would dismiss the appeal.
[page275]
The Arbitrator's Decision

[32] The arbitrator summarized the facts, noting that the ING contact information was in the chiropractor's file and that the Forms provided the names and addresses of each of the claimants, along with a brief description of the nature of the injuries each had sustained in the accident. He then set out the relevant legislative provisions.

[33] Next, the arbitrator considered the governing legal

principles. He stated that it is settled law that a person need not provide a formal application to an insurance company to be deemed to have provided a completed application for accident benefits. Relying on Liberty Mutual Insurance Co. v. Commerce Insurance Co., [2001] O.J. No. 5479, 36 C.C.L.I. (3d) 269 (S.C.J.), he opined that a person need only provide sufficient particulars to an insurance company so as to reasonably assist the insurer with the processing of the application and the assessment of the claim. Accordingly, the arbitrator viewed the real question to be whether the Forms "contained sufficient particulars to reasonably assist [ING] with the processing of the application and the assessment of the claim and whether ING took reasonable steps to obtain the necessary information from the information provided to [it]".

[34] The arbitrator concluded that the Forms met this test. In reaching this conclusion, he referred to several pieces of evidence from which the natural inference could be drawn that proper contact with one of the claimants would likely have provided timely contact information for all of them. Further, he found that had ING sent letters to the correct addresses for the Aranciabias or had it reasonably followed up with Gema Aranciabia once it had her cellphone number, it would have obtained sufficient contact information to enable it to process the claims. He observed that ING knew that Gema Aranciabia was a student and may not have had her phone activated during business hours and that there was no evidence that ING attempted to contact her outside of normal school hours. Moreover, ING made no attempt to personally contact any of the claimants at the addresses shown on the Forms. Documentation indicated that the Aranciabias continued to reside at the Queens Drive address throughout the relevant period.

[35] The arbitrator rejected ING's submission that the Forms were not a proper application because they had been submitted by an initiating health practitioner and not a "person" as set out [page276] in s. 32 of the Statutory Accident Benefits Schedule -- Accidents on or after November 1, 1996, O. Reg. 403/96 (the "Schedule"). [See Note 3 below] The arbitrator held that there was no requirement that the actual claimant provide the notice, noting that in many cases an injured claimant is incapable of

providing notice and that in Liberty Mutual, notice was provided by the injured party's lawyer.

[36] The arbitrator then held that as ING was the first insurer to have received a completed application for benefits, pursuant to s. 2 of the Regulation, it was responsible for the payment of accident benefits, pending determination of the priority dispute.

The Application Judge's Decision

[37] The application judge began by summarizing the facts and the reasons for decision of the arbitrator. In respect of the standard of review, he stated that the parties had agreed that the correctness standard applied to an appeal from the decision of a private arbitrator under the priority regulation.

[38] Next, the application judge noted that the policy of "pay now, dispute later" underpins s. 2 of the Regulation.

[39] The application judge then undertook a detailed consideration of Liberty Mutual. ING had argued that the arbitrator erred in applying the reasoning in Liberty Mutual because Liberty Mutual involved a claim for accident benefits under the predecessor regime, which did not include provisions for pre-approved framework claims. The application judge rejected this argument, stating [at para. 21] that he did

> . . . not see how the addition of a further benefit, such as [pre-approved frameworks], changes the over-arching "pay now, dispute later" policy informing the [statutory benefits] regime. The reasoning of Lissaman J. [in Liberty Mutual] fits as well with the current [statutory benefits] scheme as it did with the predecessor one. The Regulation seeks to start [statutory benefits] flowing to entitled claimants as quickly as possible, without awaiting the resolution of priority disputes amongst insurers. Liberty Mutual's functional, rather than formal, approach to interpreting what constitutes a "completed application" to commence the payment of benefits supports the policy underlying the [statutory benefits] regime.

[40] He concluded that the arbitrator was correct in accepting and applying the principle set out in Liberty Mutual. The application judge noted that in applying that principle, the arbitrator made a key finding of fact: had ING sent the letters to the correct address for the Aranciabias or made better efforts to reach [page277] Gema Aranciabia by telephone, sufficient contact information would have been obtained which would have allowed ING to process the claims. He noted that this finding was "amply supported" by the evidence and there was no reason to interfere with it.

[41] The application judge also queried why, at a minimum, ING did not treat the Forms as notice by the claimants of their intention to apply for benefits and send them the appropriate application forms as required by s. 32(2) of the Schedule.

[42] Finally, the application judge rejected ING's submission that the arbitrator had erred in holding that a benefits application could result from a communication made by a person, such as the chiropractor in the present case, on behalf of the injured claimant. He noted that this was exactly what had taken place in Pooler v. Guardian Insurance Co. of Canada, [1999] O.F.S.C.I.D. No. 233 (Fin. Serv. Comm.), where invoices submitted by a treating sports clinic had been held to constitute sufficient notice within the meaning of the former s. 59 of the Schedule, and that in Liberty Mutual it was the injured party's lawyer who provided notice of the claim.

The Issue

[43] This appeal raises a single issue: did the application judge err in upholding the arbitrator's decision that ING was the first insurer to receive a completed application for accident benefits within the meaning of s. 2 of the Regulation?

[44] In addition to addressing the issue as framed, ING asks the court to answer the following four questions.

(1) Did the arbitrator err (as upheld by the application judge) in finding that ING could have, through more extensive efforts, obtained the information necessary to adjust the potential claims of the claimants?

(2) Did the arbitrator err (as upheld by the application judge)

in implicitly accepting that a third-party service provider, Dr. Komeilinejad, was an agent authorized to bind the claimants in asserting claims with ING?

(3) What are the broader implications of the interpretation given by the arbitrator to the meaning of what constitutes a "completed application for benefits"?

(4) Of what significance is the inconsistent interpretation reached in ING Insurance Company of Canada v. State Farm Insurance Companies (April 15, 2009) (Arbitrator L. Samis) and [page278] upheld on appeal, as reported at (2009), 97 O.R. (3d) 291, [2009] O.J. No. 3643 (S.C.J.)?

[45] It bears noting that this is an appeal from the decision of the application judge. Thus, it is the decision of the application judge that is under consideration and the alleged errors should be those of the application judge. Nonetheless, when deciding the issue, I will briefly address these questions.

The Standard of Review

[46] ING submits that the standard of review to be applied by this court is that of correctness. [See Note 4 below] TD makes a number of arguments in favour of a reasonableness standard of review.

[47] In my view, it is beyond debate that in this case, the standard of review is that of correctness. According to the reasons of the application judge, both parties agreed that he was to apply a correctness standard of review to the arbitrator's decision and it was that standard which he applied. The order of the application judge comes before this court by way of an appeal, albeit with leave. [See Note 5 below] As the application judge had to decide whether the arbitrator was correct in his determination that ING was the first insurer to receive a completed application for benefits and the application judge's decision comes to this court by way of appeal, this court must determine whether the application judge was correct in upholding the arbitrator's decision.

[48] I would simply add that all of the arguments that TD makes in favour of the reasonableness standard of review relate

to a review of arbitrators' decisions. Accordingly, those are arguments that apply to the standard of review that the application judge was to apply when reviewing the arbitrator's decision. Had TD wished to make these arguments, they should have been made below. As it stands, the application judge applied a correctness standard of review and, as no cross-appeal was taken on this matter, the propriety of the standard of review used by the application judge is not under scrutiny by this court.

Analysis

[49] ING's position is essentially this. It wrote to the claimants, asking them to send in completed application forms for [page279] benefits. No such forms were ever received. The claimants never communicated -- and may never have had -- an intention to assert a claim with ING. In contrast, it is clear that the claimants intended to seek accident benefits from TD because they submitted completed OCF-1 forms to TD on October 10, 2007. In the circumstances, ING submits it was an error for the arbitrator to have found that ING was the first insurer to receive a completed application for benefits and the application judge erred in refusing to overturn that decision.

[50] I disagree.

[51] I agree with the application judge, for the reasons that he gave, that the principle in Liberty Mutual applies. Accordingly, an application for accident benefits need not be on a certain form in order to be valid -- it need only provide sufficient particulars to reasonably assist the insurer with processing the application, identifying the benefits to which the applicant may be entitled, and assessing the claim: see paras. 41-42 of Liberty Mutual. That is, the insurer only needs sufficient information to meaningfully move forward or commence the process of adjusting the claim: see Andriano v. Wawanesa Mutual Insurance Co., 2007 CarswellOnt 5669 (FSCO Arb.), at para. 36; and McIntosh v. Allstate Insurance Co. of Canada, 2004 CarswellOnt 2467 (FSCO Arb.), at paras. 32-33, both relying on Liberty Mutual.

[52] The Forms contained significant information about the

claimants. The claimants had signed the Forms. They obtained chiropractic treatment and gave the chiropractor information about ING. This is evident from the fact that the Forms identified the ING claim and policy numbers. The Forms also set out the treatment that had been provided and requested payment for the same. When the adjuster at ING received the Forms on May 30, 2007, she had sufficient information to assist her with commencing the processing of the applications and assessing the claims. As discussed more fully below, the arbitrator was entitled to find that ING had failed to take reasonable steps to obtain the necessary further information from the claimants. Consequently, I see no error in the application judge upholding the arbitrator's determination that the Forms, in the circumstances of this case, amounted to completed applications for accident benefits.

Question 1 -- ING's efforts to obtain additional information

[53] ING argues that the application judge erred in failing to interfere with the arbitrator's finding that had ING taken reasonable steps, it could have obtained sufficient information to process the claims and pay benefits to the claimants. It contends [page280] that the only question was whether the information constituted a completed application and that ING's information gathering is irrelevant to that assessment.

[54] I see nothing in this argument. As I explained above, the principle in Liberty Mutual applies. Consequently it was relevant for the arbitrator to consider ING's conduct. As for the finding of the arbitrator, as the application judge stated, that finding was amply supported by the evidence and there is no reason to interfere with it. That is, it was open to the arbitrator to find that contact with one claimant would have led to contact with the others and, had ING sent letters to the correct address for the Aranciabias or made better efforts to contact Gema Aranciabia by phone, it would have obtained the information necessary to process their claims.

Question 2 -- Provision of the forms by a third party

[55] ING points to s. 32(1) of the Schedule, which provides

that a "person" shall notify the insurer of his or her intentions to apply for accident benefits. It then points to the definition of an "insured person" in s. 2 of the Schedule, which does not expressly include a third party. Consequently, ING contends, as a third-party service provider is not an "insured person" nor is it necessarily the injured person's agent, in the absence of evidence of any agency agreement between Dr. Komeilinejad and the claimants, it cannot be said that Dr. Komeilinejad notified ING of the claimants' intention to apply for accident benefits.

[56] This argument appears to be misconceived. An insurer's obligation arises if it is the first insurer to receive a completed application for accident benefits. There is no requirement in the legislation that the completed application be submitted by the injured person and I see no reason for reading in such a requirement. As the arbitrator noted, the claimant may be physically incapable of submitting the claim due to his or her injuries. As well, one can conceive of language and disability challenges that might lead to someone other than the injured person submitting an application. Given that there is no requirement that the completed application be submitted by the injured person him or herself, there was no need for the arbitrator or the application judge to have determined whether Dr. Komeilinejad was acting as agent for the claimants in sending in the Forms to ING. Even if I am wrong on this matter, given that the claimants signed the Forms and gave the chiropractor ING's information, including policy and claim numbers, as well as the date of the accident, it was open to the arbitrator to have found that the claimants intended to apply [page281] for accident benefits from ING and that Dr. Komeilinejad submitted the Forms on behalf of the claimants.

Question 3 -- The broader implications of this decision

[57] ING makes essentially two arguments on this matter.

[58] First, it says that the goal of the Regulation is to ensure that insured persons are not left without benefits in the event of a priority dispute. It submits that this goal is not served by broadening the concept of a "completed

application for benefits" to include a single, stale-dated PAF treatment plan or invoice from a service provider in the absence of any indication that the injured person intended to pursue a claim for accident benefits.

[59] Second, ING says that ambiguity and uncertainty about what constitutes a completed application for accident benefits renders it difficult for an insurer to comply with this court's decision in Kingsway General Insurance Co. v. West Wawanosh Insurance Co. (2002), 58 O.R. (3d) 251, [2002] O.J. No. 528 (C.A.), in which it emphasized the importance of providing timely notice of a dispute, where priority to pay the benefits is challenged by an insurer.

[60] I do not accept either of these submissions. The goal of the Regulation is to "pay now, dispute later". By adopting a flexible -- rather than a formalistic -- approach to deciding what documents amount to a completed application for benefits, the courts have encouraged insurers to do just that. Once an insurer has received sufficient information that it can obtain any further necessary information, it must obtain that additional information and begin to pay benefits. This interpretation furthers the goal of "pay now" as the insurer cannot rely on shortcomings in written documentation as a ground for refusing to pay benefits. Furthermore, in my view, there is nothing inconsistent with such an approach to this court's admonition in Kingsway General Insurance that insurers must give timely notice of a priority dispute. If an insurer takes steps to obtain any additional information that may be required to pay benefits and then pays such benefits, the insurer will have the opportunity to get the information necessary to give timely notice if it disputes its obligation to pay such benefits.

Question 4 -- Reconciling this decision with ING v. State Farm

[61] In ING v. State Farm, ING became aware of an accident. It met with the claimant and took a statement that described the accident circumstances, the claimant's injuries, her employment status and her access to benefits. The statement did not include

a request for accident benefits. Twelve days later, the [page282] claimant filed an OCF-1 form with ING. Just under 90 days later, ING commenced a priority dispute with State Farm. State Farm argued that the statement that ING had taken amounted to a completed application for the purposes of commencing the 90-day limitation period within which an insurer may dispute its obligation to pay benefits. [See Note 6 below]

[62] ING says that ING v. State Farm stands for the proposition that the claimants' failure to submit OCF-1s to ING and their submission of such forms to TD makes it clear that TD was the first insurer to receive a completed application for accident benefits. It submits that the decision in the present case is inconsistent with that rendered in ING v. State Farm.

[63] I disagree.

[64] ING v. State Farm can be distinguished from the present case on two factual bases. First, the statement in ING v. State Farm did not notify ING of the claimant's intention to apply for accident benefits nor did it include a request for the payment of benefits. By way of contrast, in the present case each Form was signed by the claimant, sets out the treatment for that claimant and requests payment for those treatments.

[65] Second, ING's conduct in the two cases was very different. In ING v. State Farm, at p. 3, the arbitrator praised ING, saying that it displayed a "high caliber of claims handling which is appropriately responsible to notification of a claim". At p. 2, he said that

> . . . ING's course of conduct in [respect of the statement] is entirely appropriate, and indeed is to be encouraged. They moved expeditiously to respond to a potential claim. They have been thorough in their investigation. They have been careful to deal with all of the rather complicated requirements of the insurance regime. On December 5, 2006, they sent a letter to the claimant providing an accident benefits package of various documents and enclosing descriptions of the various benefits that would potentially be available to the claimant.

[66] In the present case, however, the arbitrator was justifiably critical of ING. As has already been noted, ING did not move expeditiously to respond to a potential claim nor was it thorough in its investigation. After receiving the Forms, ING failed to take reasonable steps to obtain any additional information that it required. It never sent letters to the Aranciabias' correct address. It failed to reasonably follow up with Gema Aranciabia [page283] by phone and it made no attempt to personally contact any of the claimants at the addresses shown on the Forms. Further, ING did not carefully deal with the requirements of the insurance regime. Section 32(2) of the Schedule requires an insurer to promptly provide a claimant with the appropriate application forms. [See Note 7 below] ING failed to send the appropriate forms to the claimants in this case, whereas in ING v. State Farm, it did so promptly.

[67] These factual differences fully explain the different results in the two cases, thus, I do not view them as inconsistent. Moreover, it is significant that in ING v. State Farm, at p. 6, the arbitrator opined that there might be circumstances relating to the conduct of the insurer that would justify holding the insurer as having received a completed application in the absence of receipt of the prescribed form. He noted that in the case before him, there was no documentation submitted in lieu of a form and there were no communications in which the claimant had, in writing, requested benefits.

[68] The present case falls within the circumstances described by the arbitrator in ING v. State Farm as justifying a finding that the insurer had received a completed application form. The Forms are written documents submitted in lieu of the OCF-1 form, in the sense that they were a request for the payment of benefits. The claimants had each signed the Forms; thus, there were written request for benefits. These facts, coupled with ING's failure to take reasonable steps to obtain additional information, justify the arbitrator's conclusion that ING received a completed application for accident benefits within the meaning of s. 2 of the Regulation.

[69] While ING argues that the reasoning of Strathy J. in the appeal decision in ING v. State Farm supports its position, I disagree. It is correct to say that Strathy J. indicated that the plain meaning of the words in s. 3(1) of the Regulation contemplated an OCF-1 form; however, he went on to say that there are cases -- distinguishable from the one before him -- in which an insurer that has not received a completed OCF-1 form should be treated as being the first insurer to have received a completed application for accident benefits. He expressly referred to the decisions of the arbitrator and application judge in the present case as one such case: see para. 35. At para. 37, he described ING's conduct in the present case as "unsatisfactory claims [page284] handling" that resulted "in prejudice or potential prejudice to the injured party". He went on to state that "The insurer was not permitted to avoid its responsibilities by sticking its head in the sand and hoping that the claim would disappear or that the claimant would pursue another insurer."

[70] I share Strathy J.'s view, expressed at para. 44 of his reasons, that the interests of the insurance industry favour certainty in the meaning of a "completed application" as it is that which triggers the commencement of the limitation period. However, I also agree with Strathy J. when he says that while normally a completed application will mean an application in the OCF-1 form, there will be those "relatively rare cases" in which because of "waiver, estoppel, delay or deflection", an insurer who has not received an OCF-1 form is to be treated as the first insurer for the purposes of s. 2. As I have already explained, the findings of the arbitrator, as affirmed on appeal in the present case, justify treating ING as the first insurer in the present case.

Disposition

[71] Accordingly, I would dismiss the appeal with costs to the respondent fixed at $8,000, inclusive of disbursements and applicable taxes.

Appeal dismissed.

Notes

Note 1: The legislative provisions underlying these statements are set out below.

Note 2: Section 7(1) of the Regulation provides, among other things, that if insurers cannot agree on who is required to pay benefits, the dispute shall be resolved through an arbitration under the Arbitration Act, 1991, S.O. 1991, c. 17.

Note 3: Section 32(2)(a) reads as follows: "The insurer shall promptly provide the person with, (a) the appropriate application forms".

Note 4: In oral argument, ING resiled somewhat from this position but argued that standard of review was not of particular importance in this case.

Note 5: Arbitration Act, 1991, s. 49.

Note 6: Section 3(1) of the Regulation provides: "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."

Note 7: In ING v. State Farm, at p. 5, the arbitrator described this as the insurer's "unequivocal" obligation.
