COURT FILE NO.: CV-08-367189
DATE: 20090421

SUPERIOR COURT OF JUSTICE - ONTARIO

RE: ING Insurance Company of Canada v. TD Insurance Meloche Monnex

BEFORE: Justice D. M. Brown

COUNSEL: E. Grossman, for the Appellant/Applicant

P. Blakie, for the Respondent

DATE HEARD: March 19, 2009

E N D O R S E M E N T

I. Overview

[1] Did the receipt by the appellant, ING Insurance Company of Canada, of four treatment plans on OCF-23 forms from a chiropractor treating the claimants constitute the receipt of a "completed application for benefits" by ING, for the purposes of section 2 of the Statutory Accident Benefits priority dispute regulation (O. Reg. 283/95), thereby making ING responsible for the payment of benefits pending determination of the priority dispute? Arbitrator Kenneth Bialkowski held that it did. ING appeals his order, by way of application, and seeks to set it aside and replace it with a finding that the respondent, TD Insurance Meloche Monnex, was the first insurer to receive completed applications for accident benefits from the claimants.

[2] For the reasons set out below, I dismiss the appeal.

II. Facts

[3] On July 23, 2006, the four claimants, Francisco Quintero, Susan Vasquez, Gema Aranciabia, and Gema Orellanza Aranciaba, were passengers in a car driven by Francisco Quinterio. That car was involved in a collision with one driven by Neil Sheppard. The claimants were injured. The Quintero car was insured by TD; the Sheppard car by ING.

[4] Dr. R.F. Komeilinejad is a chiropractor. On May 30, 2007, she faxed to ING four Pre-Approved Framework Treatment Confirmation forms, known as OCF-23s or PAF Treatment Plans, one for each claimant.

[5] Each PAF Treatment Plan bore a handwritten notation in the top left-hand corner which read: "Attn. AB Claims, ING Insurance". ING was identified as the insurance company in Part 2 of the form, and in the box marked "Adjuster Last Name", the words "AB Claims" was filled in. Part 6 of each form recorded the injury and sequelae information, and Part 9 specified the PAF services for which approval was sought, as well as the estimated fee for the service.

[6] The completed forms also identified the policy number and the name of each applicant. The same address and telephone number was provided for Francisco Quintero and Susan Vasquez; a different address and telephone number were recorded on the PAF Treatment Plans for the Aranciabias.

[7] Dr. Komeilinejad signed each form and they were dated November 25, 2006. When asked why she had sent the four 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.

[8] ING made some efforts to contact the claimants. The evidence before the Arbitrator was as follows:

(i) All the phone numbers listed on the forms were out of service;

(ii) A Canada 411 search did not disclose any other telephone numbers;

(iii) The address for Quintero and Vasquez (Fountainhead Drive) was either out of date or incorrect; that for the Aranciabias (Queen St.) was accurate;

(iv) On June 5, 2007, an ING adjuster wrote separate letters to all four claimants, but mistakenly mailed them all to the same the address – the one which appeared on the Quintero/Vasquez forms, Fountainhead Drive. ING requested that the claimants file an *OCF 1 – Application for Accident Benefits*; no response was received from them;

(v) ING contacted the chiropractor's office for additional information and obtained a cell phone number for one claimant, Gema Orellanza Aranciaba, who was a student. ING called the number, spoke briefly with the claimant, who advised that she would call ING back at a later time, after class. She never did.

[9] On three of the forms an ING adjuster wrote: "We are unable to respond as we cannot confirm coverages", and inserted the date, June 4, 2007.

[10] The claimants did not file an application for accident benefits with ING, which closed its file on July 20, 2007.

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

[12] A priority dispute ensued between ING and TD. Neither insurer adjusted the file; no SAB benefits have been paid. The parties selected Kenneth Bialkowski as arbitrator, and their arbitration agreement provided that each party could appeal to a single judge of this Court on a question of law, fact, or mixed law and fact.

III. Decision of the Arbitrator

[13] In his reasons released November 4, 2008, the Arbitrator accepted that:

> [I]t 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. A person need only provide sufficient particulars to an insurance company to reasonably assist the insurer with the processing of the application and the assessment of the claim.

The Arbitrator framed the issues before him as whether the OCF-23s contained sufficient particulars to reasonably assist the insurer with the processing of the application and the assessment of the claim, and whether ING took reasonable steps to obtain the necessary information from that provided to it.

[14] After reviewing the evidence of the efforts by ING to contact the claimants, the Arbitrator held:

> On the evidence overall, I am satisfied that if the letters to Gema Aranciabia and Gema Orellanza Aranciabia had been sent to the correct address, or better efforts made to make voice contact with Gema Aranciabia, sufficient contact information would have been obtained so as to allow ING to process these claims. ING knew that Gema Aranciabia was a student and may not have had her phone activated during business hours. There is no evidence that attempts were made to contact Gema Aranciabia outside of normal school hours. ING made no attempt to personally contact any of the claimants at the addresses shown on the original OCF-23s. Documentation would indicate that the Aranciabias continued to reside at 298 Queens Drive through out the entire period. Overall, I am of the view that sufficient information would have been available if ING had written to the Aranciabias at the correct address, or would have reasonably followed up with Gema Aranciabia once her cell phone number was identified.

[15] The Arbitrator also held that an application for accident benefits could be made by a person on behalf of the injured claimant, such as was done by Dr. Komeilinejad. In the result, the Arbitrator found that ING was the first insurer to receive a completed application for accident benefits for the claimants arising from the motor vehicle accident of July 23, 2006.

IV. Standard of Review

[16] Both parties agreed that the standard of review on an appeal from the decision of a private arbitrator under the priority regulation is one of correctness: *State Farm Mutual Automobile Insurance Co. v. Ontario (Minister of Finance)*, [2001] O.J. No. 1115 (S.C.J.), at para. 13.

V. Issue: Did the Arbitrator err in holding that the four OCF-23 forms received by ING on May 30, 2007 were completed applications for benefits within the meaning of section 2 of the Statutory Accident Benefits priority dispute regulation (O. Reg. 283/95)?

A. The priority dispute Regulation

[17] Disputes as to which insurer is required to pay for statutory accident benefits must be resolved in accordance with the priority dispute Regulation, O. Reg. 283/95. Section 2 of the Regulation provides:

> 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 section 268 of the Act.

This requirement reflects the "pay now, dispute later" policy underlying the SAB regime, a policy designed to secure the prompt payment of SABs to injured persons. The Regulation does not define the term, "completed application for benefits".

B. "Completed Application for Benefits"

[18] In *Liberty Mutual Insurance Co. v. Commerce Insurance Co.*, [2001] O.J. No. 5479 (S.C.J.), Lissaman J. considered what communications to an insurer constituted a "completed application for benefits" in a priority dispute between Ontario and out-of-province insurers. He first considered the jurisprudence regarding what makes up an application for a benefit under what is now s. 32(3) of the Schedule. Under section 32, a person must notify the insurer of his intention to apply for a benefit, whereupon the insurer must promptly provide the person with "appropriate application forms" and other information: s. 32(1) and (2). The person then must submit "a signed application for the benefit" to the insurer within 30 days of receiving the application form: s. 32(3). Lissaman J. wrote:

> 42 In order to meet the requirements of the legislation, an application for accident benefits must provide sufficient particulars to reasonably assist the insurer with the processing of the application and the assessment of the claim. See *Lopez v. Canadian General Insurance Group*, [1997] O.I.C.D. No. 83 at paragraph 24. It has been held that the receipt of an invoice from a treatment provider including the name of the injured party, the date of the accident and the insurance policy number should provide sufficient information to an insurer to know that a claim for accident benefits is being made. See *Pooler v. Guardian Insurance Company of Canada* [1999] O.I.C.D. No. 233.
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> *H'Ng v. Allstate Insurance Co.*, [1997] O.I.C.D. No. 34 upheld on judicial review by the Divisional Court on September 28, 2000, [2000] O.J. No. 3589 (Div. Ct.) set out that an "application for benefits" under subsection 59(3):
>
> > ... must identify the particular benefit sought, or, at minimum, provide sufficient particulars to enable the Insurer to reasonably identify the benefit in question.

> ...
>
> An application is not limited to a particular form. It may include additional information contained in a covering letter, and documentation enclosed or appended.
> ...
>
> The Forms do not require the applicant to choose a benefit category. However, the forms should provide the essential information required by the insurer to allow it to determine whether an applicant may be entitled to a benefit under the Schedule.
> [emphasis added]

(A more recent arbitration decision, *McIntosh v. Allstate Insurance Co. of Canada*, [2004] O.F.S.C.D. No. 58, followed this approach of focusing the analysis not on the form in which the information was provided to the insurer, but on the adequacy of that information, and whether it was sufficient to allow the insurer to process and assess the claim: para. 32.)

[19] Lissaman J. then turned to consider the application of this jurisprudence to the question of what documents could form a “completed application” within the meaning of the Regulation:

> 48 I have reviewed Arbitrator Jones' analysis and the cases cited in support of his finding regarding a "completed application for benefits." I do not accept the Appellant's suggestion that the Arbitrator's reliance on these decisions was misplaced. While the cases refer to the SABS, the SABS is directly applicable to the case at bar, and clearly sets out the obligations of the various parties with regard to statutory claims for accident benefits. The cases set out what is required for an insurer to know that a claim is being made and to proceed with the processing of that claim.
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> 49 Further, I reject the Appellant's claim that an "ordinary meaning" interpretation necessarily leads to the conclusion that a "completed application" is the equivalent of a formal application. *A "completed application" is not limited to a specific form, and as long as the insured provides the essential information with sufficient particulars required by the insurer to allow it to process and assess the claim, an application for accident benefits can meet the requirements of the legislation.* (emphasis added)

[20] In *Liberty Mutual* the court concluded that correspondence from the insured’s lawyer asserting a claim for benefits and the submission of a claims form used in another jurisdiction provided “the requisite information and sufficient particulars to constitute a completed application” within the meaning of the Regulation so as to make the recipient insurer responsible for paying SABs, pending the resolution of any insurer’s dispute: *Liberty Mutual*, para. 51.

[21] ING attempted to distinguish the reasoning in *Liberty Mutual* on the basis that it involved a claim for SABs under the predecessor regime, O. Reg. 776/93, which did not include provisions for Pre-Approved Framework claims. With respect, I do not see how the addition of a further benefit, such as PAFs, changes the over-arching "pay now, dispute later" policy informing the SABs regime. The reasoning of Lissaman J. fits just as well with the current SABs scheme, as it did with the precedessor one. The Regulation seeks to start SABs 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 SABs regime.

[22] Moreover, I do not accept ING's argument that section 37.1 of the Schedule creates, as a pre-condition for a PAF claim, the need to file a section 32 benefit claim. Section 37.1 the Schedule reads:

> 37.1(1) This section applies if an insured person
>
> (a) *submits or intends to submit* an application for a benefit in accordance with section 32; and,
>
> (b) claims medical or rehabilitation benefits in respect of an impairment that comes within a Pre-approved Framework Guideline. (emphasis added)

The section refers not only to the submission of an application for a benefit, but also to the expression of *an intention* to submit an application. The filing of an OCF-1 is not a statutory pre-requisite to making a PAF benefit claim, whatever might be the ordinary practice in filing such claims.

[23] For these reasons, I conclude that the Arbitrator was correct in accepting and applying the principle set out in the *Liberty Mutual* case.

[24] In applying that principle to the present case the Arbitrator reviewed the evidence and made this key finding of fact:

> On the evidence overall, I am satisfied that if the letters to Gema Aranciabia and Gema Orellanza Aranciabia had been sent to the correct address, or better efforts made to make voice contact with Gema Aranciabia, sufficient contact information would have been obtained so as to allow ING to process these claims.

This finding was amply supported by the evidence, and there is no reason to interfere with it. Moreover, given the information contained on the four PAF Treatment Forms, including the notations, "Attn. AB Claims", one must query why ING, at a minimum, did not treat the forms as notice by the claimants of their intention to apply for a benefit and send to them "the appropriate application forms" as required by section 32(2) of the Schedule.

[25] As a final point, ING submitted the Arbitrator erred in holding that a benefits application could result from a communication made by a person, such as chiropractor, on behalf of the injured claimant. I disagree. That is precisely what took place in *Pooler v. Guardian Insurance Co. of Canada*, [1999] O.F.S.C.I.D. No. 233 where the arbitrator recognized invoices submitted by a treating sports clinic as sufficient notice within the meaning of the former section 59 of the Schedule. And, as the Arbitrator pointed out in his reasons, in *Liberty Mutual* it was the injured party's lawyer who provided notice of the claim.

VI. Conclusion and costs

[26] For these reasons, I conclude that the Arbitrator did not err in holding that ING was the first insurer to receive completed application forms for statutory accident benefits on behalf of the claimants. I therefore dismiss the appeal by way of application.

[27] I would encourage the parties to try to settle the costs of this motion. If they cannot, TD may serve and file with my office written cost submissions, together with a Bill of Costs, by Friday, May 1, 2009. ING may serve and file with my office responding written cost submissions by Friday, May 15, 2009. The costs submissions shall not exceed three pages in length, excluding the Bill of Costs.

D. M. Brown J.

DATE: April 21, 2009