Welcome to our first edition of the CDL Accident Benefits Newsletter!

Shirline Apiou, Dutton Brock LLP
Chair, CDL Accident Benefits Committee

It has been an exciting time for accident benefits practitioners and industry colleagues in this area. In the last year alone, we have seen the implementation of changes arising from amendments to the Insurance Act and the current Statutory Accident Benefits Schedule. Specifically, the transition to the License Appeals Tribunal (LAT) with respect to new applications disputing accident benefits and the winding down of existing applications and hearings at the Financial Services Commission (FSCO) and ADR Chambers.

While there was some question as to the precedential value of existing FSCO and Court jurisprudence, we have seen that LAT adjudicators will continue to apply, or at least consider as persuasive, the existing body of case law in determinations at the LAT, which had significant challenges on start up and continues to adapt to them in responding to the needs of both claimants and representatives. In the first year alone over 6500 applications were received, a record number of 4281 applications were withdrawn, over 3000 case conferences were conducted, 169 cases proceed to a hearing, 137 decisions have been released to date and more are pending. In response to industry concerns, the LAT has initiated another round of Automobile Accident Benefits Service (AABS) Feedback and Information Sessions in May 2017. Some of the changes we can expect going forward include the promised e-filing pilot project, enabling the submission of attachments electronically and new rules and practice directions. The current Rules of the LAT came into effect April 1, 2016 and the Safety Licensing Appeals and Standards Tribunals Ontario (SLASTO), under which the AABS operates, is now proposing to adopt a new set of common rules that would apply to the LAT and other tribunals under SLASTO.

The AB industry has also been affected by other trends in the industry. In response to concerns from the public, the Law Society of Upper Canada (LSUC) has reviewed the issue of referral fees and has now put an absolute cap of $25,000 on such arrangements to ensure fairness in the provision of legal services and has amended the LSUC Rules governing the advertising of legal services.[1] At this time, the LSUC continues to review the issue of contingency fee agreements. In April 2017, the Ontario government released a report on automobile insurance which recommends a major overhaul of the current system. In the report *Fair Benefits Fairly Delivered: A Review of the Auto Insurance System in Ontario*, David Marshall, former Workplace Safety Insurance Board President and CEO and an advisor on auto insurance appointed by the Minister of Finance, recommends changes to the automobile insurance system including significant changes to both existing tort and accident benefit regimes. The recent CDL audioconference on May 15, 2017 highlighted the recommendations in the Marshall report and provided critical analysis of the recommendations and practical shortfalls resulting from the proposed changes coming into effect. At this time, the Ontario government has indicated consultation on these proposed changes will be forthcoming. On May 31, 2017, the constitutional challenge regarding the legality of the amendments to the Insurance Act brought by Mr. Campisi, a prominent personal injury lawyer and professor at Osgoode Hall Law School, was dismissed by the Honourable Justice Belobaba of the Ontario Superior Court of Justice with the conclusion that section 280 of the *Insurance Act* did not

[1] http://www.lsuc.on.ca

breach sections 15(1) or 7 of the *Charter of Rights and Freedoms* and did not contravene section 96 of the *Constitution Act*.[2]

Looking ahead, the world of accident benefits continues to evolve quickly in response to competing interests from the government and the industry. The CDL Accident Benefits Committee is here to help you navigate the ongoing changes in this area by providing you with up to date news, trends, and alerts applicable to your defence practice. The AB committee is your resource and we hope you find us informative in the days to come.

DECISIONS OF INTEREST

Adjournments at the LAT

Shirline Apiou, Dutton Brock LLP
Chair, CDL AB Committee

A recent LAT decision released brings some hope for parties looking to adjourn a scheduled LAT hearing. In *16-003927* v. *Intact Insurance Company*, a reconsideration decision dated May 23, 2017, the parties requested an adjournment as a global mediation was scheduled one month after the hearing and this request was denied by the LAT without reasons. The Applicant sought reconsideration and provided an additional reason that one of the expert witnesses was not available for the hearing. Executive Chair Lamoureux granted the adjournment and relied on Rule 18.2(d) of the LAT Rules which allows a liberal interpretation and held that while reasons were not legally required, the interests of transparency and accountability dictates that the tribunal should have offered reasons to the parties.[3]

Liu v. Co-Operators

David Raposo, Dutton Brock LLP
Vice Chair, CDL AB Committee
Incoming Chair, 2017/2018

In Liu v. Co-Operators (16-000714/AABS) Adjudicator Sewrattan dismissed the Applicant's claim that his injuries fell outside the MIG and claim for non-earner benefits were dismissed in their entirety. The Adjudicator confirmed that in order to succeed, the Applicant must prove the accident directly caused the impairment(s) he submitted required treatment beyond the Minor Injury Guideline. The Applicant was alleging impairments of both a physical and psychological nature. Of interest, the Adjudicator spent some time in his decision articulating why the Applicant had lacked credibility including the fact that the Applicant withheld 'crucial' information from the IE assessors including failing to disclose

[2] Campisi v. Ontario, 2017 ONSC 2884.
[3] https://www.canlii.org/en/on/onlat/doc/2017/2017canlii31491/2017canlii31491.pdf

he had been involved in a separate accident wherein he alleged the same impairments. Additionally, the Applicant represented his employment situation differently to different parties, including the Tribunal. Of interest, the Adjudicator spent some time explaining why he chose to accept the IE's over the medical documentation submitted by the Applicant. More specifically, he stated that in medical reports he would like to see "more objective indicia of assessment" which he described as including "a description of the methods by which the Applicant was tested, the results of those tests, and an explanation for how the test results contributed to the medical practitioner's conclusion. The description of such analysis would better allow me to assess the soundness and reasonableness of the report created by the applicant's practitioners". This decision is a helpful one to point to when insurers are faced with medical reports alleging non-MIG which are often lacking in analysis and do not specifically outline the testing methods used to reach their conclusions. Of note, this decision is under appeal. The Divisional Court is scheduled to hear the appeal on June 9, 2017 and is the first appeal of a LAT decision.

CAT again

Lisa Pool, Sullivan Festeryga, LLP
AB Committee Member
Incoming Vice Chair, 2017/2018

The LAT released its first decision interpreting the issue of catastrophic impairment and GCS scores based on the Statutory Accident Benefits Schedule O. Reg. 34/10 prior to the amendments in June 1, 2016. In PFLR v. Intact, 2017 CanLii 9823, the tribunal held that the insured sustained a catastrophic impairment within the meaning of section 3 (2)(d)(i) of the *Schedule*. In coming to its decision the tribunal considered the requirements of the section and accepted GCS scores while the insured was intubated in accordance with existing FSCO and Court caselaw.[4]

MIG or not ?

Sven Mascarenhas, Gilbert Kirby Stringer LLP
AB Committee Member

Recent decisions on the issue of minor injury provides more insight on what is required to pursue a successful case for a case outside the minor injury guideline. In Patel v. TD Insurance FSCO A15-002293 decided April 10, 2017, the insured was diagnosed with chronic pain by his GP approximately 3 years post accident, had supporting reports from a chiropractor and orthopaedic specialist and relied on the Arruda v. Western case. The Insurer's physiatry expert did not diagnosed chronic pain given that the claimant had not tried a variety of prescription medications for pain or antidepressants. The arbitrator

[4] https://www.canlii.org/en/on/onlat/doc/2017/2017canlii9823/2017canlii9823.pdf

preferred the evidence of the Applicant, noted that his psychologist performed a more detailed examination compared with the Insurer's psychiatry expert and while the claimant was a poor historian he was nonetheless credible. This decision is similar to Peel v. Wawanesa, FSCO A15-006441 decided April 10, 2017 another arbitration decision where the claimant was found to be non-minor injury on the basis of a chronic pain diagnosis and support from medical evidence that there was compelling evidence to remove him from the minor injury guideline (x-rays showing degenerative condition, evidence of possible concussion, diagnosis of chronic pain). In contrast to these decisions, Nash v. Aviva FSCO A16-003609 decided April 24, 2017 shows that without medical support as to the cause of the pain and the accident the mere complaints of pain and mention of chronic pain was insufficient to escape the minor injury guideline.

Costs Recoverable by Insured from Tort Defendant

Bita Rajaee, Regan Desjardins LLP
Communications, CDL AB Committee

The new Rules that accompanied the incoming LAT removed the prima facie right of the winning party to recover costs in an accident benefits dispute. A party would have to prove that there was unreasonable, frivolous, or vexatious behaviour during the proceeding to be awarded costs (Rule 19.9 LAT). However, according to the case of *C**arr v. Modi*** 2016 ONSC 1300, as affirmed 2016 ONSC 7255, arbitration costs can be recovered by the claimant as part of their tort case. The reasoning for this is that the accident benefits arbitration may serves to benefit the tort defendant. For example, when income replacement benefits is awarded as part of the LAT dispute that reduces the financial exposure of the tort defendant.[5]

UPCOMING EVENTS

CDL AB Pub Night Series
July 6, 2017 - Speaker: David Raposo, Dutton Brock
Sept 21, 2017 – Location & Speaker TBA
November 16, 2017 – Location & Speaker TBA

ALL CDL Members Welcome! RSVP to maryellen@cdlawyers.org

AB Fall Seminar October 19, 2017
Chair Lisa Pool, Sullivan Festeryga LLP
(5-6 substantive and 1-2 professional CLE hours, to be confirmed)

Spring AB Symposium April 19, 2018

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5 ***Carr v. Modi*** 2016 ONSC 1300:
https://www.canlii.org/en/on/onsc/doc/2016/2016onsc1300/2016onsc1300.html?autocompleteStr=carr%2520v.%2520Mod&autocompletePos=1
*C**arr v. Modi*** 2016 ONSC 7255:
https://www.canlii.org/en/on/onsc/doc/2016/2016onsc7255/2016onsc7255.html?resultIndex=1

(5-6 substantive and 1-2 professional CLE hours, to be confirmed)

The CDL AB Committee

The CDL AB Committee supports the Canadian Defence Lawyers and provides resources and continuing legal education in the area of accident benefits for defence lawyers and industry professionals.

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Join the CDL AB Committee!

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CDL Accident Benefits Newsletter Volume 1, Issue 2, December 18, 2017

Second edition of the CDL Accident Benefits Newsletter

Shirline Apiou, Dutton Brock LLP
Editor in Chief, CDL Accident Benefits Committee

With the holidays upon us, we can now take a moment to reflect on the significant trends of the past year. Since our last issue, the case law continues to evolve in the area of statutory accident benefits. The Licence Appeal Tribunal (LAT) determines all Applications by an Injured Person for disputes on statutory accident benefits and decisions are released weekly. It would take a Justice League to cover all of the case law that has transpired in the last while, but we have included a sampling of the recent cases in this edition that we hope you will find relevant in your practice. Looking back on the last several months, notable decisions remind us that the incurred definition continues to remain contentious, catastrophic impairment on the basis of a "GCS score of 9 or less." must be as a result of brain impairment, an insurer's denial must be clear and unequivocal for any applicable limitation period defence, and claims for special awards continue to be fact specific. Also worth nothing are two recent developments in accident benefit litigation. In the FSCO appeal decision of ***Barnes***, Director Delegate Rogers held that the amendments to the ***Statutory Accident Benefits Schedule*** (O. Reg. 34/10, as amended) in February 2014 for attendant care applies to accidents that occurred before the amendment. The concept of economic loss continues to require further interpretation and we await the Judicial Review of this decision with anticipation. Recently, the Charter has become an area of interest for practitioners in this area. In the FSCO Decision on a Preliminary Issue in ***Abyan and Sovereign***, the constitutionality of the minor injury definition and the limits on medical benefits under the Schedule was challenged successfully. This decision has resulted in a multitude of Charter challenges raised by Applicants in relation to minor injury disputes currently before the LAT. Lastly, in addition to changes in the case law, external forces will have a role in the practice of both tort and accident benefits. Last week, the Ontario government release announced that it will be moving forward with the Fair Auto Insurance Plan which proposes significant structural reforms to address the issues and recommendations in the Marshall Report. As we head into the new year, it will be interesting to see what results from the anticipated changes to both the practice of statutory accident benefits and government reforms.

Walker v. The Co-Operators

David Raposo, Dutton Brock LLP
Chair, CDL AB Committee 2017/2018

Section 36 of the SABS is clear in stating that when applying for a specified benefit, "an Applicant for a specified benefit shall submit a completed Disability Certificate with his or her Application under Section 32". Subsection (3) states: "an Applicant who fails to submit

a completed Disability Certificate is not entitled to a specified benefit for any period before the completed Disability Certificate is submitted".

In the decision of ***Walker* v.** ***The Co-Operators General Insurance Company*** (Tribunal No. 17-000388\AABS), the Applicant was involved in an accident on September 17, 2013. The initial Application package indicated the Applicant may qualify for an income replacement benefit and Co-Op had requested an OCF-3 Disability Certificate on a variety of occasions in order to determine entitlement. The Applicant ultimately submitted two Disability Certificates dated October 10, 2013 and a second one dated February 13, 2017. The first Disability Certificate dated October 10, 2013 did not confirm entitlement to Income Replacement Benefits but indicated that the test for IRB was "N/A". The second Disability Certificate, submitted approximately 3.5 years later on February 13, 2017 did confirm entitlement to the Income Replacement Benefit. Co-Op took the position that because the Applicant failed to submit a "positive" Disability Certificate confirming entitlement within 104 weeks following the accident that he was precluded from proceeding with the said Claim. Adjudicator Paluch concluded that the word "completed" in Section 36 cannot be equated to mean "positive". In other words, he concluded that all that is required is the submission of a completed Disability Certificate. He noted that a document can be completed if all the fields are filled in and even if it does not confirm entitlement to a particular benefit that does not render the Certificate incomplete. He noted that the doctor who issued the first Disability Certificate chose one of the three options available to him being "not applicable" and therefore he completed the Disability Certificate properly.

The Adjudicator found the insurer's position "very restrictive" and too much weight being placed on one question. He stated that the insurer's position "leaves the Applicant's health practitioner complete power to effectively negate a claim simply by means of checking the "No" box, or as in this case, the "N/A" box". He noted this type of restraining approach is not in keeping with the overall objectives of the *Insurance Act* which emphasizes consumer protection and that Section 36 must be interpreted in a "fair, liberal and purposive" manner to achieve the objectives of protecting an insured's rights to Statutory Accident Benefits". Adjudicator Paluch also noted the Disability Certificate is not the sole factor to consider when determining whether a Claimant meets the disability test for an Income Replacement Benefit although it is a "integral part" of the analysis. He states that paragraph 30:

"In summary, I find the state of the law to be that a "completed Disability Certificate" need not be a "positive Certificate" or a Certificate that has to absolutely confirm entitlement to IRB's. It merely has to be a "completed Disability Certificate" that conforms to the formalities required by Section 67 of the Schedule and the completion instructions on the actual OCF-3 form".

Adjudicator Paluch also made a distinction between applying and qualifying for IRB and notes there is no requirement in the SABS which specifically dictates that in order to receive an IRB an insured person must apply within a 104 weeks of the accident. He notes that the schedule only dictates that the Claimant suffer a substantial inability to perform the essential tasks of that employment within 104 weeks. However, in the end the Adjudicator went on to provide an analysis with respect to entitlement and still found that in accordance with Section 5 of the SABS to be eligible for an IRB an insured person must as a result of and within a 104 weeks after the accident suffer a substantial inability to perform the essential tasks of their pre-accident employment. He found as a fact that the medical documentation relied upon was all commissioned post 104 weeks, including the second Disability Certificate which confirmed entitlement, and as there were no medical reports produced within 104 weeks of the accident to positively answer the specific question as to whether he met the test he was precluded from receiving Income Replacement Benefit and the Application was dismissed.

Loss Transfer Disputes
Not So “quick and dirty”

Aruba Mustafa,
Bertschi Orth Solicitors and Barrister LLP

A Divisional Court decision by Justice Corthorn dealt with a loss transfer claim where a claimant’s choice between two available policies was put to the test. Only one of the available policies entitled the insurer to loss transfer indemnity.

The facts of this case are unique. The Respondent, Primmum’s, insured was involved in an accident as a pedestrian; the Appellant, L’Unique’s, insured struck the pedestrian with his vehicle. Two policies of equal ranking were available to the insured (as a dependant of his father and his step-mother). Both policies were issued by Primmum. One policy insured a motorcycle and the other policy insured an SUV and a pick up truck. Primmum paid accident benefits under the motorcycle policy and claimed indemnity from L’Unique, pursuant to the loss transfer scheme.

L’Unique argued that a relevant issue in the arbitration was how and/or why the benefits were paid under the motorcycle policy rather than the second policy available to the insured. Justice Corthorn found evidence is required to support a claimant’s choice of a policy and that the evidence must show that the claimant:

(a) was aware of the choice of policies, and
(b) made a conscious choice with that awareness.

Ultimately, the decision finds that the insured’s choice of policy is relevant to the loss transfer dispute and that Primmum must produce evidence with respect to its adjustment of the insured’s claim under one policy as opposed to another available insurance policy.

Primmum Insurance Company v. L’Unique Assurances Generales Inc*, , 2017* ONSC 5235:

Costs at the LAT

Bita Rajaee, Regan Desjardins LLP
Communications, CDL AB Committee

In ***17-000043 (M.O.) v Unifund Assurance Company***, 2017 CanLII 35317 (ON LAT), the Applicant withdrew her LAT Arbitration Application at the Case Conference (“CC”), as she had not attended the required Insurer’s Examination (“IE”). A few hours later, she brought a second LAT Application citing one of the same issues listed on the first Application. A CC took place for the second Application. By the time of the second CC, the Responded had

rescheduled the IE, but the Applicant failed to attend yet again. At the second CC, the Applicant again withdrew her LAT Application as she still had not attended the IE.

At that second CC, the Respondent brought a motion for costs, which proceeded subsequently in writing. Costs were awarded in the amount of $500. The Arbitrator relied on Rule 19.1 and found that the Applicant's second Application was frivolous, vexatious, and unreasonable.
This decision also provides some guidance on how the quantum of Costs may be determined. The Respondent had requested $5,000 in Costs. However, the Arbitrator stated at paragraphs 13-14,
"Given an award of costs is not meant to be an assessment of the actual costs a party has had to incur as a result of defending a claim, an award of $5,000 would be inappropriate in this circumstance…As a consequence of the applicant's conduct, the respondent only had to incur extra costs in defending the second application. Given that the issue in dispute in the second application was included in the first application, the respondent had already incurred the bulk of its costs defending the issue in the first application. "

Prior to this decision, it appeared that Applicants could apply or withdraw their Application at will without apparent consequences. However, this decision indicates otherwise. It further provides guidance on what measure is used when determining the amount of costs that are awarded, namely a calculation of the amount that the Applicant's frivolous Application has cost the Respondent and the Tribunal.

Clear and Unequivocal Denial

Bita Rajaee, Regan Desjardins LLP
Communications, CDL AB Committee

In ***Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company),*** 2017 ONCA 395**,** the Appellant fell from a roof and suffered serious injuries. He was paid benefits until those were terminated by way of letter dated January 12, 2012. In the letter, he was advised that, if he disagreed with the decision, he could provide additional medical records. He was not advised about the limitation period for bringing an action against the Insurer. In 2015, he took steps to bring an action against the Insurer, but was advised that he was too late. He commenced an action anyway. The Insurer then successfully brought a motion for summary judgment relying on the Appellant having missed the limitation period. The Appellant appealed the decision, arguing that it was within the Insurer's duty of good faith to have advised him of the limitation period, but the Insurer had failed to discharge that duty, and that, as a result, the Insurer could not rely on the limitation period. The Court of Appeal agreed with the motion judge, saying that the Insurer does not have a positive obligation to advise the Insured of the limitation period.

However, the relevance of this decision to SABS claims is that the Court of Appeal specifically cited accident benefits cases as an exception to this finding. In paragraph 43, it is noted:

“The appellant relies on ***Smith v. Co-operators*** in support of his argument for imposing a duty on an insurer to advise the insured of the limitation period when the claim is denied. In that case, the Ontario regulation pertaining to the Statutory Accident Benefits Schedule required the insurer to inform the insured, in writing, at the time a claim was denied, of the statutory procedure for the resolution of disputes. That statutory procedure specified a two-year limitation period. The Supreme Court held that the effect of the regulation was to require the insurer to inform the insured “of the most important points of the process, such as the right to seek mediation, the right to arbitrate or litigate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process” (at para. 14; emphasis added). Without providing that information to the insured, it could not be said that the insurer had given a valid refusal and the time limit did not begin to run.”

Thus, if an accident benefits issue is to be denied, the points noted above must be included in the denial letter for the limitation period to commence.

Expanding view on "Ordinarily Engaged In" for Attendant Care Providers

Shelby Chung, Dutton Brock LLP
AB Committee

In ***A.P. v. Coseco,*** 2017 CanLII 76917, the issue in dispute was whether the Applicant’s mother qualified as a professional service provider to provide attendant care under the SABS, or whether she had to prove economic loss.

Section 3(7)(e)(iii) sets out the two categories of service providers and the requirements of proof of incurred expenses in claiming attendant care benefits as follows:

(iii) the person who provided the goods or services,

(A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or

(B) sustained an economic loss as a result of providing the goods or services to the insured person.

Adjudicator Truong read section 3(7)(e)(iii) as creating two classes of service providers. Those under clause (A) as being trained providers, and those under clause (B) as untrained. Adjudicator Truong also found that professional service providers under s. 3(7)(e)(iii)(A) of the SABS, while normally arms-length providers, did not exclude family members.

At the time of the accident, the Applicant’s mother had a Diploma in the Personal Support Worker Program at CJ Health Care College obtained in 2012, and had obtained her PSW Certificate in 2013. However, the Insurer took the position that the Applicant’s mother was not a professional service provider as she had not worked in that capacity pre-accident, and in fact did not do so until 10 months post-accident.

In reviewing section 3 of the SABS, Adjudicator Truong agreed that the Applicant's mother was not "employed" at the time of the accident, but that this did not disentitle her, given the inclusion of "profession" in the statute. Adjudicator Truong held at paras. 27-29,

With respect to the term "profession", I find the plain meaning of that word is a vocation with specialized training and/or certification. One does not necessarily need to be employed in order to have a profession.

...

An individual's profession is not dependent on whether or not they are employed. It is dependent on whether or not the individual has the training, competency, any required professional/regulatory certification and whether or not they are actively trying to obtain employment in that profession. Practically speaking, can they do the job? Actively seeking employment is important, because if the individual stops seeking employment in their profession, they are no longer "ordinarily engaged in" that profession.

Adjudicator Truong concluded that while "ordinarily engaged in" could include employment, it could also include training, the professional licensing or regulatory certification process and actively seeking employment.

Adjudicator Truong found the mother was trained and certified as a PSW at the time of the accident, had not yet obtained her first position as a PSW, and was actively seeking work; the mother was found to be a professional service provider as defined by the SABS and not required to prove an economic loss.

We note that Adjudicator Truong distinguished the Ontario SCJ decision of *Shawnoo v. Certas Home Direct Insurance* (2014 ONSC 7014) on its facts, noting that the provider in *Shawnoo* was retired for three years pre-accident, and the Judge found that the provider was not actively seeking employment or likely to receive an offer of employment. In this case, the Applicant's mother gave evidence that she was looking for employment as a PSW at the time of the accident and did in fact employment after the accident. We look to see whether the Tribunal will narrow the scope in later decisions considering factors such as the length of time an individual may be without employment as a service provider, or other intervening employment, etc.

The Right of the Insurer to Request Documentation

Shirline Apiou, Dutton Brock LLP
Past-Chair, CDL AB Committee

In 2 recent decisions, the LAT has affirmed the right of the insurer to request documentation relevant to determine a benefit under section 33 of the Schedule O. Reg. 34/10, as amended and raises the bar for what constitutes "a reasonable explanation for the delay". A section 33 request and denial of the benefit in relation to non compliance to the insurer's request for information can also trigger the running of the 2 limitation period to dispute the benefit.

In ***F.F.* v. *Aviva***, 2017 CanLII 77381 (ON LAT), the adjudicator at the first instance found the claimant entitled to an income replacement benefit as he met the test for entitlement, a

substantial inability to perform the essential tasks of his preaccident employment. On Reconsideration, Executive Chair Lamoureux found that while there was a section 33 breach by the claimant, the adjudicator erred in finding that the claimant had a reasonable explanation for the delay in providing the financial documentation requested by the Insurer. Specifically, it was found that "simply a bald, after-the-fact assertion" and "explanations he now offers for his delay, for example his age, injuries, and pre-existing conditions, are undocumented assertions" unsupported by the evidentiary record and the "Tribunal's conclusions must be based on evidence, not speculation or conjecture". On reconsideration, the insurer was found not liable to pay for income replacement benefits during the period where there was no response to the insurer's accountant for documentation and reduced the adjudicator's finding that he was entitled to two years of IRBs down to one year.

In ***S.K.*** **v.** ***Allstate***, 2017 CanLII 77394 (ON LAT), the adjudicator found that the insurer's request for information under section 33 and notice that benefits would not be payable as a result of non compliance was sufficient to trigger the running of the limitation period. In that case, the adjudicator found that the letter from the insurer requesting financial documentation to calculate the IRB and the statement that "if the applicant does not comply with the request then the insurer has the right to withhold payment of the benefits" was a "clear and unequivocal way to say the insurer is refusing the pay the amount claimed". The insurer then sent a later Explanation of Benefits OCF 9 stating he was not eligible for the income replacement benefit with the standard wording on the claimant's rights to dispute under the dispute resolution process and the 2 year limitation period. The adjudicator found that the claimant was statute barred from proceeding with the IRB claim. With respect to the section 33 non compliance, on the facts, the adjudicator found the claimant's explanations for the delay in providing documents did not satisfy the requirement of a reasonable explanation. Specifically, the assertions that he was responsible for putting together the tax documentation for his company and he could not provide the documentation by the deadline because he was injured were not supported by the evidence. The adjudicator found that the claimant did not provide a reasonable explanation for the 4 year delay in producing the requested documentation to the insurer.

UPCOMING EVENTS

AB Committee Pub Night – January 31, 2017
"Upcoming Trends in Accident Benefits"
Location & Speaker TBA

ALL CDL Members Welcome! RSVP to maryellen@cdlawyers.org

Spring AB Symposium April 19, 2018
Chairs: Maura Thompson Shillingtons LLP & Maia Bent, Lerners LLP
Hyatt Regency, 370 King St W, Toronto, ON
Register now!

PAST EVENTS

Constitutional Challenges to the MIG, CDL Audioconference, December 6, 2017,
Audio recording available to access: **HERE**

The CDL AB Committee

The CDL AB Committee supports the Canadian Defence Lawyers and provides resources and continuing legal education in the area of accident benefits for defence lawyers and industry professionals.

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