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• PRIORITY DISPUTES AMONGST INSURERS IN ONTARIO: REASONABLENESS IN AN IMPERFECT WORLD •

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Under the Ontario No-Fault automobile insurance provisions, if there is a dispute between insurance companies as to who is responsible to pay accident benefits, those disputes are settled under Ontario Regulation 283/95. Ontario is unique in Canadian jurisdictions as the only province with complicated priority provisions. Public insurance schemes in British Columbia, Saskatchewan and Manitoba are administered by government monopolies and in the vast majority of cases there is only one insurer. In the remaining jurisdictions, other than Ontario, it is clear which insurer is responsible. The responsible insurer is the insurer of the vehicle that is occupied by the victim, or, where the victim is a pedestrian, the insurer of the striking vehicle.[1]

Ontario has created a regime where the coverage that is most "proximate" to the insured person is liable to pay benefits to that insured. In other words, coverage follows the claimant as opposed to being based on the cars involved in the accident.[2] The main policy reason for coverage following the claimant, briefly stated, is that an injured party should receive benefits in accordance with what they arranged in their insurance contract with their insurer.[3] Thus, the basis for the coverage following the claimant appears sound. The result, however, has been an extremely complicated area of law in Ontario where litigation is common and the obligation to pay accident benefits as between different insurers uncertain. The reason for this uncertainty is two-fold. First, the uncertainty flows from the complexity of the "coverage follows the claimant" system. Secondly, the uncertainty flows from the unsettled nature of the test that applies to an insurer seeking to shift responsibility to pay benefits to another insurer, after the mandated 90-day notice period has passed.

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This article will address two issues. First, it will analyze the "coverage follows the claimant" scheme. Secondly, it will outline the law relating to when an insurer can shift the obligation to pay benefits to a second insurer after the 90-day period for notification has expired. The case law on this issue identifies a tension between the private arbitration decisions made under the priority scheme and the decisions of the courts that review those arbitration decisions. The arbitration decisions appear to apply a less stringent "reasonable" investigation test to an insurer applying for an extension of the 90-day notice period. The judicial pronouncements appear to impose a higher standard on the applying insurer that borders on a "perfect" investigation standard, although recent judgments may have watered-down that standard.

THE "COVERAGE FOLLOWS THE CLAIMANT" SCHEME

The obligation to pay accident benefits is governed by s. 268(2) of the *Insurance Act*[4] which states:

> **Liability to pay**
>
> **268.** (2) The following rules apply for determining who is liable to pay statutory accident benefits:
>
> 1. In respect of an occupant of an automobile,
>
> i. the occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured,
>
> ii. if recovery is unavailable under subparagraph i, the occupant has recourse against the insurer of the automobile in which he or she was an occupant,
>
> iii. if recovery is unavailable under subparagraph i or ii, the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to statutory accident benefits arose,
>
> iv. if recovery is unavailable under subparagraph i, ii or iii, the occupant has recourse against the Motor Vehicle Accident Claims Fund.
>
> 2. In respect of non-occupants,

i. the non-occupant has recourse against the insurer of an automobile in respect of which the non-occupant is an insured,

ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,

iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to statutory accident benefits arose,

iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund.

Thus, if you are an occupant in an automobile when you are struck, you have recourse against the insurer of an automobile in respect of which you are an "insured". If you are not an "insured", you have recourse against the insurer of the automobile in which you were an occupant. If there is no coverage under these scenarios, you have recourse against the insurer of any other automobile involved in the accident. If recovery is still unavailable, you have recourse against the Motor Vehicle Accident Claims Fund (the Fund).[5] Similar rules apply, with necessary modifications, if you are a pedestrian that is struck by a car.[6]

The Ontario priority of insurer scheme is further complicated by the rules relating to the determination of who is an "insured". As set out above, the first priority in any claim will be the accident victim's insurance company. Interestingly, even where an accident victim has no insurance in their name, they may still be an "insured". This flows from the definitions of "insured" and "insured person" under the *Insurance Act* and under Ontario Regulation 403/96 - *Statutory Accident Benefits Schedule/Accidents on or after November 1, 1996* ("SABS"). The *Insurance Act*, at s. 224(1), defines an insured as "a person insured by a contract whether named or not and includes every person who is entitled to statutory accident benefits under the contract whether or not described as an insured person". The term "insured person" is defined in s. 1 of the SABS as "the named insured, any person specified in the policy as a driver of the insured automobile, the spouse of the named insured, and any dependant of the named insured or spouse...". The practical effect of these definitions is that when you are in a car accident, you must ask yourself the following questions to determine who pays your accident benefits:

Question 1 – Are you a named insured on a policy?[7]

Question 2 – Are you a specified driver on a policy?[8]

Question 3 – Are you the spouse of a named insured?[9]

Question 4 – Are you dependent on either a named insured or the spouse of a named insured?[10]

If you answer yes to any of these questions, you are an "insured" even if you do not own an insurance policy and have never had any contact with your "insurer". Your recourse in respect of accident benefits is to claim them against the insurer identified in the first "yes" answer to these four questions.

Of course, an adjuster adjusting an accident should ask him or herself these questions, in respect of a claim for accident benefits, in order to ensure that the right insurer is paying the claim. If the claimant is not an insured, then the balance of s. 268(2) applies and the victim would then seek benefits from the insurer of the vehicles involved in the accident or the Fund. There will be cases where a person will be an "insured" with more than one company and scenarios where there is more than one vehicle involved in the accident. Sections 268(4) and (5) of the *Insurance Act* stipulate that in multiple insurer cases the accident victim, in his or her absolute discretion, may decide the insurer from which he or she will claim benefits.

The SABS contains a further provision under which a person may be "an insured" for priority purposes. Specifically, s. 66(1) of the SABS states that a person will be a named insured if at the time of the accident an insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or other entity or is being rented for a period of more than 30 days.[11]

THE 90-DAY NOTICE PERIOD AND SHIFTING RESPONSIBILITY FOR THE PAYMENT OF BENEFITS

OVERVIEW

Prior to the promulgation of Ontario Regulation 283/95, there was no provision to ensure that claim-

ants received payments while insurers disputed their obligation to pay. The matter went to arbitration under the relevant legislation and the issue of the obligation to pay would be litigated prior to the insured receiving any payments. The history of the priority regulation is aptly set out by Financial Services Commission of Ontario Director's Delegate David Draper in the case of *Mohamed v. State Farm Mutual Automobile Insurance Co.*[12] (at paras. 9-12):

> However, this system did not solve the problem of delayed payments. If the insurers disagreed about which one had priority, the insured person could be left waiting for benefits until that dispute was resolved. The Priorities Regulation was meant to address this problem. [Note 3: The Priorities Regulation was made under the authority of s. 121(1)10.4, allowing the Lieutenant Governor in Council to make regulations 'governing the procedure for determining who is liable to pay statutory accident benefits under section 268, including requiring insurers to resolve disputes about liability through an arbitration process established by the regulations and requiring interim payment of benefits pending the determination of liability.'] As the then Commissioner of Insurance explained, the 'new Regulation provides protection to injured accident victims who may be entitled to benefits and are caught in the middle of these disputes.' [Note 4: Bulletin No. A-5/95, 'Priority of Payments,' dated May 29, 1995.]
>
> Under the Priorities Regulation, disputes about insurer priority were moved from the dispute resolution system to private arbitration:
>
> 1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this regulation.
>
> 7. If the insurers cannot agree as to who is required to pay benefits or if the insured person disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the Arbitrations Act, 1991.
>
> Payment pending the resolution of any priorities dispute was addressed by making 'the first insurer that receives a completed application for benefits' responsible for paying:
>
> 2. 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.
>
> If that insurer believes it is not the priority insurer under s. 268 of the Act, it must give notice of its objection to every other insurer it claims is required to pay benefits and to the insured person [Note 5: The Priorities Regulation, s. 3(1) and s. 4]. This notice must be given within 90 days of receiving the application for benefits, or longer if 90 days was not sufficient time to determine that another insurer might be responsible. [Note 6: The Priorities Regulation, s. 3.] The insured person is given a chance to object to the transfer of the claim to another insurer. [Note 7: The Priorities Regulation, s. 5.] If the insured person objects, or the insurers cannot agree which company is responsible, the dispute is resolved by an arbitration under the Arbitrations Act, 1991, initiated within one year of the insurer's initial notice of objection. [Note 8: The Priorities Regulation, s. 7.]

As can be seen from the above, the legislation "contracted out" disputes between insurers regarding priority to be resolved by private arbitration under the *Arbitrations Act, 1991*. The new Ontario Regulation 283/95 ensured that claimants would receive payments even in scenarios where insurers disputed their obligation to pay. Moreover, under the new regulation a 90-day notice period within which to initiate priority disputes, with a legislated right to extend the 90 days, was installed to ensure that priority disputes were determined promptly. The notice and extension provisions are set out in s. 3 of the Regulation:[13]

> **3.** (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.
>
> (2) An insurer may give notice after the 90-day period if,
>
> (a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

The scheme operates reasonably well when there is only one potential insurer for the claim or the appropriate insurer for the claim has been located and notified within 90 days. Difficulties begin to emerge where an insurer begins making payments but that insurer, after 90 days of receiving a completed accidents benefits application, seeks to shift the obligation to pay benefits to another insurer. In these late notice cases there appears to be some tension between decisions of the private arbitrators appointed to hear s. 3 disputes and the decisions of the courts that sit in appeal from those arbitration decisions. Although the principle of *stare decisis* does apply in *Arbitrations Act* proceedings, there is sufficient interpretive room within the court's jurisprudence that the field remains somewhat open for arbitrators.

CASE LAW FROM THE COURTS

In the case of *Kingsway General Insurance Company v. West Wawanosh Insurance Company*,[14] the Ontario Court of Appeal dealt with a case where the insurer determined that it was liable to pay accident benefits and then the priority dispute common law changed. The insurer then applied to shift the obligation to pay benefits in accordance with the revised law. The arbitrator found that, on account of the change in the law, 90 days was not a sufficient period of time to make a determination that another insurer was liable to pay accident benefits and allowed the insurer's application. An appeal went to the Superior Court before Justice Nordheimer who allowed the appeal. A further appeal to the Court of Appeal was dismissed. On the 90-day issue, the Court of Appeal, per Justice Sharpe stated as follows (at para. 10):

> The Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assume and rely upon the requirement for compliance with those provisions. Insurers subject to this Regulation are sophisticated litigants who deal with these disputes on a daily basis. The scheme applies to a specific type of dispute involving a limited number of parties who find themselves regularly involved in disputes with each other. In this context, it seems to me that clarity and certainty of application are of primary concern. Insurers need to make appropriate decisions with respect to conducting investigations, establishing reserves and maintaining records. *Given this regulatory setting, there is little room for creative interpretations or for carving out judicial exceptions designed to deal with the equities of particular cases.* [Emphasis added.]

The point made by the Court of Appeal about "equities" is important. In almost every case under s. 3(2) there is a "well-healed" insurer who is technically the priority insurer but is attempting to escape its statutory and/or contractual obligation(s). Therefore, in almost every case the equities are with the applicant. The Court of Appeal considered this and made an express statement that arbitrators are to impose the 90-day rule strictly even if it is against what the arbitrator might think is inherently fair. The need for a clear direction and bright lines is further set out in para. 14 of the court's judgment:

> I also agree with the Superior Court judge that a change in the case law interpreting the liability of insurers does not constitute a factor justifying extension of the 90-day notice period under s. 3(2). As the Superior Court judge observed, this is an area in which there is a constant and steady flow of case law and arbitral decisions interpreting the law. Given the nature of these disputes and the disputants, as I have said, the dominant consideration must be clarity and certainty to ensure a predictable and efficient scheme of dispute resolution. In the present case, the appellant was able to conduct an investigation and make the determination that it was primarily liable. Having made that determination, it decided not to dispute liability. It follows, in my view, that the appellant cannot now argue that 90 days was not a sufficient period of time to make its determination.

Thus, it appears that in cases where the applicant makes a definitive determination that it is responsible to pay accident benefits it cannot, after the expiry of the 90-day period, say that it needed more time. Apparently, what is supposed to happen is that the insurer is to receive a completed application and continue its investigation until it has ruled out all possibilities of priority coverage. In all likelihood, if an insurer conducts an extensive investigation but it takes more than 90 days to locate the other insurer, it may well receive an indulgence under s. 3 of the Regulation. If the insurer closes its investigation, particularly if it has conducted only a cursory investigation, it appears that relief under s. 3 will not be afforded to the insurer.[15]

The Trial Court judgment of Nordheimer J. in *Kingsway*[16] pertained to two appeals from arbitrator decisions; the *Kingsway v. West Wawanosh* appeal and an appeal in a dispute between State Farm Mutual Automobile Insurance Company and the Motor Vehicle Accident Claims Fund. The facts pertaining to the State Farm dispute centred on whether notice from a lawyer for the insured person to an insurance company could constitute notice within s. 3 of the Regulation. Section 3(1) expressly stipulates that the notice must come from the applying insurer. The answer to this question was "yes" at the arbitration level and "no" at the Superior Court level. Justice Nordheimer's judgment in this regard was not appealed. Further, Nordheimer J. set out bright lines for arbitrators in respect of regulation 283/95 (at paras. 22 and 23):

> *I do not see any reason why the parties here should not be held to strict compliance with the requirements of the Regulation.* In both of these appeals, we are dealing with three large insurance companies and a branch of the Provincial Government. It goes without saying that these parties are sophisticated and experienced participants in the insurance industry. They have available to them all of the advisors of the highest quality that they could need in order to determine their rights and obligations under the prevailing statutory regime. There is, therefore, no unfairness visited upon them by insisting on strict compliance with the notice requirements. This situation is therefore distinguishable from cases such as Myshrall v. Toronto (City), 52 O.R. (3d) 686, [2001] O.J. No. 481 (C.A.) and Mattick v. Ontario (Minister of Health), 52 O.R. (3d) 221, [2001] O.J. No. 21 (C.A.) where individual citizens ran afoul of statutory notice requirements but relief from the strict application of the notice requirements was deemed warranted because the individual citizen was unfamiliar with his or her rights and obligations. Further, in cases involving disputes between insurers, strict compliance promotes certainty for the parties in terms of their handling of claims. *While it might redound to the detriment of State Farm in this case, it is just as likely that State Farm will be the beneficiary of the strict compliance in some other case.* [Emphasis added.]
>
> In my view, absent receipt by the Fund of a proper notice under s. 3(1) from State Farm within the 90-day notice period, the Fund was entitled to consider that any claim arising out of Mr. Greig's accident was no longer going to be advanced against it and the Fund was entitled to consider the matter closed. Consequently, State Farm was not, and should not be, entitled to proceed with its dispute with the Fund in the circumstances of this case.

In para. 22 above, Nordheimer J. sets out an argument as to why arbitrators need not get too caught up in the equities of a particular fact situation. What one insurance company loses in one instance it will likely gain at some other juncture.

Justice Nordheimer's *Kingsway* judgment, where the Court of Appeal expressly endorsed his reasons, sets out a similarly high threshold for obtaining relief under s. 3. The question is whether His Honour went too far and imposed a standard of near perfection on the insurer seeking relief under s. 3. The key passage of the Nordheimer J. judgment in the *Kingsway* first-level appeal is found in para. 30 where His Honour states:

> ...There is nothing in [s. 3] that purports to require correctness as a part of the determination. It simply stipulates that the insurer must make a determination within 90 days *unless reasonable investigations undertaken within that time have made a determination impossible.* [Emphasis added.]

Has His Honour's choice of the word "impossible" created a standard of perfection or near-perfection in respect of the investigation required of an applicant insurer in a priority dispute hearing? Consider the practicalities of most applications under s. 3. The insurer will have missed the 90-day notice period but subsequently located the priority insurer. The applicant insurer's investigation will be scrutinized at the priority hearing, through the lens of hindsight. With the benefit of hindsight it will be exceedingly difficult to establish that the correct determination of priority was impossible to make within 90 days. Perhaps only perfect or near-perfect investigations will meet such a test. Is an impossibility/perfection standard the right standard to impose?

At present, the *Kingsway* judgments appear to stand for at least the following two general propositions: First, if you are able to complete your investigation within 90 days you are not in a position to argue later that you required more time. Secondly, to extend the 90-day requirement the insurer must prove that it conducted "reasonable investigations" within the 90-day time frame and that, these reasonable investigations notwithstanding, it was "impossible" to have

made a determination regarding another insurer within that time period. The insurer appears to be required to first conduct reasonable investigations and then prove impossibility. The key area of analysis in the decisions regarding priority, however, has been the reasonableness of the investigation.

How "reasonable" does the investigation in the 90-day period have to be? Not only is the investigation not to be a cursory one, it appears that the investigation also has to be proactive. In the case of *Axa v. Co-operators Insurance Company*,[17] Nordheimer J. was faced with an instance where prior to the first insurer receiving a completed application for benefits, the second insurer advised the first insurer that its policy had lapsed. Axa (the first insurer) took that assertion at face value until a year-and-a-half later when conflicting information was found. It then wrote to the second insurer and asked for its full file regarding coverage and disputed the priority issue. The arbitrator ruled that the first insurer could not obtain the benefit of the relief provision in s. 3. That decision was affirmed on appeal. The essence of Nordheimer J.'s judgment is that insurers have to be proactive. If there was a hint of alternative coverage, it has to be followed up within the 90-day period. At paras. 5 through 7 of the *Axa* judgment, His Honour stated:

> The fact is that in June 1996, the appellant accepted the representation of the respondent that its policy had lapsed at face value. It did not ask for any proof of that fact. This situation is to be contrasted with what happened in the Fall of 1997. On October 15, 1997 the appellant wrote a letter to the respondent in which it demanded complete disclosure on the policy including a copy of the agent's file and all notes to determine whether the respondent might be the primary insurer. There is no reason that appears from the record why such a letter could not have been written in June 1996.
>
> The appellant submits that to permit such a result to stand does not encourage insurers to be candid and forthright with each other although I note that it is not suggested here that the respondent was not so in communicating the information that it did in 1996. Indeed, the respondent maintains its position that its policy does not answer for these claims.
>
> While that may be the result of the arbitrator's decision, the converse is that by allowing the arbitrator's decision to stand, it encourages insurers to fully and completely investigate these issues promptly and expeditiously which has been said to be the fundamental purpose behind the requirements of s. 3 of the regulation. The appellant had the opportunity to do so but chose not to avail itself of that opportunity. Instead it took the information that it had regarding the respondent's policy and did nothing more. *In my view, s. 3 of the regulation places the burden on the insurer who intends to dispute its liability to take a more proactive approach to these issues and that the appellant, having failed to do so, cannot now invoke the exception provided for in s. 3(2) to extricate itself from the effect of that decision.* [Emphasis added.]

An arbitral decision of Arbitrator Malach, allowing an extension of the 90-day period, was upheld on appeal to the Superior Court in *CGU Insurance Company of Canada v. Federated Insurance*.[18] The judgment in this case appears inconsistent with Nordheimer J.'s judgment in *Axa*. In the *CGU* case the insurer was aware that the injured party had an ex-spouse, within the 90-day period, but relied on the injured party's insurer for the name of the spouse, (*i.e.*, a less than proactive approach). The information from the injured party's solicitor was not forthcoming until a failed mediation 82 days after the application for benefits was received. Notice was not provided until 60 days after the 90-day period. Justice Herman upheld the Arbitrator's findings in respect of the reasonableness of the investigations, noting that Federated had been persistent in its inquiries. In respect of the second branch of the test, whether 90 days was sufficient time, Herman J. appears to have applied a more lenient test for the applying insurer than that established in the *Kingsway* and *Axa* judgments (see para. 20 of the unreported judgment in *CGU*):

> While an insurer must satisfy both parts of the [s. 3(2)] test, the two parts are not, in my view, unrelated. They must be read together, so that they make sense. There will be instances in which an insurer makes reasonable investigations and the 90-day period is insufficient. In the *Canadian General Insurance Co.*[19] and *State Farm*[20] cases cited above, for example, the 90-day period was sufficient since the insurers had the information they needed to make the determination within 90 days. Had Federated, for example, made its investigations and found out the name and potential location of Mr. Young's spouse in August instead of in October, the 90-day period may well have been sufficient.

The recent judgment of Justice Ducharme in *Primmum Insurance Co. v. Aviva Insurance Co. of Canada*,[21] has aspects that assist both an applicant and a respondent on a priority application. On the one hand, Ducharme J. appears to have lowered the applicant's duty to be "proactive" by holding that inaccurate information from an insured can found a basis for an extension of the 90-day period under s. 3. On the other hand, Ducharme J. ultimately dismissed the appeal from a failed application to extend the notice period. His Honour found that the investigation, on the facts before him, was not sufficiently thorough.

THE ARBITRAL JURISPRUDENCE

The arbitral jurisprudence appears less strict in terms of enforcing the 90-day rule than that of the Ontario courts, although not universally so. It is important to note, at the outset, that not all private arbitration decisions are available for review. Although s. 8(2) of Ontario Regulation 283/95 stipulates that decisions of an arbitrator made under this Regulation shall be public, the task of compiling all of these "public judgments" has not fallen on any particular body. Thus, to a large extent, these judgments reside in the filing cabinets of the arbitrators who are appointed to hear these applications and the counsel who argue them. Some arbitrators provide access to their judgments on Web sites. The Financial Services Commission of Ontario maintains a Web site containing some private arbitration judgments.

In *The Matter of an Arbitration between Unifund Insurance Company and Simcoe & Erie General Insurance Company*,[22] there remained ambiguity on two points regarding priority following the completion of the insurer Unifund's investigation. One point of uncertainty was the issue of whether the insured was a part-time cab driver or owner of the cabs. The second area of uncertainty related to whether a commercial policy was in priority to a personal policy. Unifund had assumed that the insured was a part-time driver and that a personal policy would have priority. Roughly a year later it occurred to Unifund that they were wrong on both counts and they notified Simcoe & Erie of a dispute to pay benefits. The insured had been injured in a cab and Unifund had been aware throughout that Simcoe & Erie insured the cab. The arbitrator also found that Unifund had closed its priority investigation in July 1995 and re-opened it in May 1996. The arbitrator dismissed the application and stated as follows (at p. 9):

> The onus under section 3(2) of Ontario Regulation [283/95] rests with the first insurer, in this case Unifund Assurance Company, who receives an application for accident benefits to establish that (a) the time period of ninety days is not a sufficient period of time to make a determination that another insurer is liable, and (b) that the first insurer has made reasonable investigations necessary to determine if another insurer [is liable]. The facts in each case will always determine this issue. I find that the evidence put forward by Unifund Assurance Company in this case does not meet the onus in either situation.
>
> I have found that all the relevant information was available in July 1995 had reasonable steps been taken by Unifund Assurance Company to do a full investigation. In order to shift the loss exposure to another insurer, the first insurer must proceed with due diligence and dispatch. *It is not sufficient nor reasonable to conduct a very circumspect investigation in the first instance and at a much later stage complete the investigation and then seek relief under section 3(2).* The legislation has a clear purpose. It enables injured persons to seek their accident benefits from an insurer without being caught up in any dispute between insurers as to which insurer must pay those benefits. It similarly sets out a specific course of action for insurers to sort out their priority disputes in a timely manner. [Emphasis added.]

There is also the judgment of Arbitrator Galligan in the case of *Canadian General Insurance Company v. Axa Insurance*.[23] In this case, a 17-year-old was injured in a car insured by Axa. Her father applied for benefits with CGI on the basis that the girl was dependent on him and he was insured with CGI. The application was made in December 1993. An audit, two years later, led CGI to doubt that the girl was a dependant and so in February 1996 CGI put Axa (the insurer of the striking vehicle) on notice. Again the cursory investigations conducted at the outset and the knowledge within 90 days of a potential other insurer were fatal to the application (see p. 5):

> My interpretation of Section 3 of the Regulation is made in the light of the fact that accident benefits can often amount to very substantial claims and that insurers, required to pay those benefits, are entitled

to have an early opportunity to investigate the claim and to manage the performance of the insurers' obligations to the injured person. It seems to me that when the regulatory authority chose a 90 day period for notice it did so in recognition of the importance of the right of the insurer, who will ultimately be responsible for payment, to have control of the claim from a very early stage.

As I read section 3, in order for an insurer to escape the rigours of subsection (1), it must comply with the provision of subsection (2). The plain words of subsection (2) lead me to the view that the insurer must *establish both of* two things:

1. that 90 days *was not a sufficient time* to make a determination that another insurer was liable and,

2. that it made reasonable investigations within the 90 day period to determine if another insurer was liable.

Mr. Atherton, in his very capable argument, suggested that an interpretation of subsection (2) which requires a detailed investigation of the priority issues within 90 days would place an undue burden upon insurers. He contended that they do not have the resources sufficient to examine the priorities issue in detail in all of the many accident benefit claims which they receive. While I recognize the force of that contention it seems to me that it is, in effect, an argument that the 90 day period required in subsection (1) is itself unreasonable. I do not think an arbitrator is entitled to second guess the regulatory authority. I think that the case must be decided on the assumption that the regulatory authority considered and weighed the problem suggested by Mr. Atherton when it arrived at a 90 day period for notice.

It is my view that in order to obtain the benefit of subsection (2) the insurer must establish that, because of the peculiar circumstances of an individual case, the 90 day period was not sufficiently long for a determination of the issue. In this case Canadian General knew that Sandra Santos was injured while an occupant of a vehicle insured by Axa. It, therefore, knew immediately that there was another potential insurer who might be liable for Sandra Santos' accident benefits. It knew that there was the potential for a priority problem. It knew that its liability depended upon Sandra Santos' being "a dependant" of her father. Once Ms. Montaigne conducted her audit in December of 1995, she was able to have an investigation into the dependency completed within a period of two months. It therefore seems to me to be established that, in this case 90 days was a sufficient period of time to determine whether or not Sandra Santos was "a dependant" of her father. [Emphasis added.]

From these two judgments it appears that a cursory investigation raising "red flags" that are not followed up on will likely not be sufficient to shift liability under s. 3 of the Regulation after the 90-day notice period. The existence of "red flags" indicating alternative coverage was also determinative against applicant insurers in two cases decided by Arbitrator Malach: *ING Halifax Insurance Company v. Liberty Mutual Insurance Company*[24] and *Belair Insurance Group v. Old Republic Insurance Company.*[25] In *ING*, the insurer was immediately aware that the injured party lived with his parents and the insurer had a "hint" that the parents may have owned vehicles. ING took no steps to obtain further particulars in that regard. As stated by Arbitrator Malach (at p. 13): "If there is suspicion about other coverage, that must be checked out". In *Belair*, the injured party had been driving a U-Haul rental at the time of the accident but applied for accident benefits with Belair based on his belief that he was a listed driver on a car owned by his brother. Belair was able to rule out coverage within 21 days of receipt of the application for benefits but waited for a police report (which arrived after the 90-day period) to determine the insurer of the U-Haul rental rather than make proactive inquiries of U-Haul.

The "red flags", however, must be visible to the adjuster. Thus, in the case of *Ontario Municipal Insurance Exchange [OMEX] and Liberty Mutual Insurance Company*,[26] the investigation included the ordering of a police report, a review of an internal report, receipt of a completed accident benefits application (completed by a law firm), an interview with a law clerk retained by the injured party and a telephone interview with the injured party. Ultimately, after expiration of the 90-day period, it was discovered that the injured party was a listed driver on the policy of a divorced spouse. In other words, there were no red flags at the initial investigation; however, in the adjusting of the claim the information regarding the insured being a listed driver on the policy of his ex-spouse came to light. In these circumstances, Arbitrator Jones held (at p. 12): "It is

important to note that s. 3(2) requires a reasonable investigation, not perfection". Relief from the 90-day notice period requirement was granted.

In the case of *Coseco Insurance Company v. the Allstate Insurance Company*,[27] Coseco contacted the injured party and conducted a full intake. The injured party indicated that he was not a listed driver on an automobile insurance policy and had no automobile insurance of his own. Coseco requisitioned a police report. Coseco retained an independent adjuster who made numerous attempts to arrange the taking of a statement from the injured party. The injured party's solicitor refused to allow a statement to be taken. Coseco made further written requests for information; however, those requests were rejected until Coseco threatened to terminate benefits on the basis of non-cooperation. A letter from the insured's lawyer disclosing priority coverage with Allstate was delivered on February 23, 2000. Allstate was put on notice on February 29, 2000. Arbitrator Malach, applying the reasoning in his earlier judgments and that of Arbitrator Jones in the *OMEX* case ruled that Coseco could obtain the benefit of an extension of the 90-day period.[28]

An extension under s. 3(2) was granted in the case of *TTC Insurance Company and Gore Mutual Insurance Company*.[29] In that case, the applicant insurer received a comprehensive application for accident benefits that raised no "red flags". Arbitrator Robinson accepted the evidence of the applicant insurer's adjuster who had stated that there was absolutely nothing in the original application for accident benefits that raised "any flags" and nothing unusual on the application "that jumped out at him".[30]

Another example where reasonable investigations were conducted and relief from the 90-day period was granted is *Her Majesty the Queen in Right of Ontario as Represented by the Minister of Finance and The Co-operators General Insurance Company*.[31] In that case, the applicant had no insurance, was not aware of the date of her accident or with whom she had been in an accident. The application was made to the Motor Vehicle Accident Claims Fund. However, the inability to provide even rudimentary details of the accident hampered the investigation by the law firm retained by the claimant and the adjuster for the Fund. The information ultimately came to light as a result of communication with the insurer who had been contacted by the other person involved in the accident. The information about the existence of the Co-operators policy came to the Fund's attention after the 90-day period. Arbitrator Robinson allowed the application and found that the Fund had done all that it could do in circumstances where the information coming from the claimant was limited. The arbitrator was also persuaded that the nature of the Fund, insurer of last resort, could be taken into consideration in respect of an application under s. 3 of the Regulation. This judgment was upheld on appeal.[32]

Arbitral jurisprudence points to an additional basis upon which s. 3 may be successfully invoked by an insurer. In *Saskatchewan Government Insurance and Lombard Canada Inc.*,[33] the first insurer to receive a completed application for accident benefits re-directed that application to another insurer. The Regulation, however, mandates that the insurer who first receives a completed application for benefits must pay those benefits and dispute the obligation, not simply re-direct the applicant.[34] Thus, even though this insurer was ultimately not technically the priority insurer, it was estopped from relying on the 90-day period as a basis to avoid the obligation to pay benefits.[35] In the *Lombard* case, as in the *Co-operators* case discussed above, an additional factor included the fact that the Fund, the insurer of last resort, was the applicant insurer.

CONCLUSION

It is not easy to reconcile the case law on s. 3 of Regulation 283/95. The courts appear to have a strict approach to granting extensions of the 90-day notice period (*Kingsway* and *Axa*). However, in some circumstances a more lenient approach may be applied (*CGU*). Leading arbitration decisions fall into both the strict application test (*Unifund* and *CGI*) and a more lenient test (*OMEX* and *Coseco*). Common threads that run through the jurisprudence from the courts and the arbitrators appear to be the following:

- A thorough investigation by the insurer must be conducted forthwith after receiving a completed application (*Kingsway*, *Axa*, *Unifund* and *CGI*).

- A determination as to liability to pay benefits should not be made until all possible sources of coverage have been ruled out (*Kingsway*, especially the trial court judgment of Nordheimer J.).

- Thus, the four questions regarding whether the injured party is an "insured" must be carefully explored and followed up on a timely and proactive basis. If the injured party is not an "insured", the details of insurance coverage regarding the other cars involved in the accident must be followed up on and those insurers must be notified promptly of their obligation to pay benefits (*Axa*, *ING*, *Belair*).

- The insurer is not to simply accept the claimant's word or the word of another insurer at face value but must affirmatively investigate all reasonable possibilities (*Axa*).

- If, on account of the particular facts in a particular case, a thorough and diligent investigation does not yield the identity of the priority insurer within 90 days, the insurer which has made payment may be granted an extension under s. 3 when it does locate alternative coverage (*CGU*, *Omex*, *Coseco* and *TTC*, *HMQ and Saskatchewan Government*).

- An insurer that conducts an investigation which is merely cursory or which identified the eventual priority insurer but failed to promptly notify that insurer will likely not be granted relief under s. 3 (*Axa*, *Unifund*). Reasonable and persistent investigations that yield results soon after the expiration of the 90-day period may obtain an extension (*CGI*).

Like any other area of law, the equities of a particular fact situation cannot be ignored. Thus, while the courts appear to be signaling a need for a strict approach to interpreting s. 3, the strict judicial decisions in *Axa* and *Kingsway* could be understood as a specific example and an analogous example, respectively, of cases falling into the final category above, where relief is less likely to be granted. It can be argued that these judgments do not lay down a rule that equities are not a relevant consideration. From an equities perspective, if an insurer has conducted an exhaustive and diligent investigation but required more than 90 days to discern the identity of the priority insurer, relief under s. 3 should be considered even though it was not "impossible" to have obtained that identity within the 90-day period. Arbitrators Jones and Malach are correct when they note that s. 3 mandates reasonable investigations and not perfection. Indeed, perfection has never been the standard imposed on drafters of legislation, insurance companies, their lawyers or judicial officers.

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1 See Brown and Menezes, *Insurance Law in Canada* (Toronto: Carswell, 2002-looseleaf), pp. 17-55 to 17-56.

2 In other words, if you have an insurance policy but you are driving in your friend's car when the accident occurs, your insurer would pay benefits and in the other provinces where private insurers are involved, the friend's insurer would be liable.

3 See *CGU Insurance Group (Canada) Ltd. v. Lombard Insurance Company* (Private Arbitration Decision, Arbitrator Jones, January 7, 2000), at pp.14-15; rev'd on other grounds *CGU Group Ltd. v. Lombard Canada Insurance Company*, [2000] O.J. No. 3805 (S.C.J.) (QL) (October 16, 2000); appeal to Court of Appeal for Ontario dismissed, May 3, 2001, [2001] O.J. No. 1738 (C.A.) (QL).

4 R.S.O. 1990, c. I.8, as amended.

5 See s. 268(2)1. of the *Insurance Act, ibid.*

6 See s. 268(2)2. of the *Insurance Act, ibid.*

7 Named insured has been defined as "the person or entity in whose name the policy is issued", "the person named in the certificate of insurance as the insured" and "the person or entity with whom the contract of insurance has been made". See *Goos v. Non-Marine Underwriters*, [1998] O.F.S.C.J.D. No. 36 (QL) (September 25, 1998, Appeal P96-00038), at p. 7.

8 Specified driver means an alternate driver listed on a policy.

9 Spouse has its definition at various places in the scheme. See s. 2(1) of the SABS which takes the reader to Part VI of the *Insurance Act* where spouse is defined as including persons married to each other and the standard common law definition — see s. 224(1). An additional complication in this area is the case law which stipulates that an insured is a spouse of a person when separated and remains a spouse until the couple obtain a formal divorce (see *Allstate Insurance Company of Canada v. State Farm Mutual Automobile Insurance Company*

(Private Arbitration Decision, Arbitrator Rudolph, October 30, 1996), at p. 18, *Macartney v. Dominion of Canada General Insurance Co*, [1994] O.J. No. 1976 at para. 19 (Gen. Div.) (QL); *McLean v. Wellington Insurance Co.*, [1996] O.I.C.D. No. 102 (QL) (O.I.C. No. A-006649: June 24, 1996) (Arbitrator Naylor – Appeal), at p. 9.

10 Dependant is defined in the SABS at s. 2(6) where it states that a person is a dependant of another person if the person is principally dependent for financial support or care on the other person or that person's spouse.

11 See *Lombard General Insurance Co. of Canada v. Allstate Insurance Company of Canada*, [2000] O.J. No. 3805 (S.C.J.) (QL); appeal dismissed, [2001] O.J. No. 1738 (C.A., May 3, 2001) (QL). But see *Monnette v. Old Republic Insurance Company*, [2001] O.J. No. 2245 (QL), 54 O.R. (3d) 559 (S.C.J.).

12 [1999] O.F.S.C.I.D. No. 228 (QL) (Appeal P99-00022, December 1, 1999).

13 O. Reg. 283/95.

14 [2002] O.J. No. 528 (QL), 58 O.R. (3d) 251 (C.A.).

15 The Ontario Court of Appeal in the *Kingsway v. West Wawanosh* case has finally settled the debate as to whether arbitrators can extend the 90-day period in circumstances other than those set out in s. 3(2) of the Regulation, *e.g.*, relief from forfeiture. The Court of Appeal ruled that Regulation 283/95 provides a scheme that contemplates extensions of the 90-day notice period in certain circumstances and that by implication any general discretion the court might have to grant extensions in other circumstances has been removed.

16 *Kingsway v. West Wawanoosh*, [2001] O.J. No. 1115 (QL), 53 O.R. (3d) 436 (S.C.J.).

17 Unreported: May 3, 2001 (Ont. S.C.J.).

18 Unreported: January 16, 2004 (Ont. S.C.J.).

19 *Canadian General Insurance Co. v. AXA* (Private Arbitration Decision, Arbitrator Galligan, December 19, 1996).

20 *State Farm Mutual Automobile Insurance Co. v. Ontario (Minister of Finance)*, [2001] O.J. No. 1115 (QL), 53 O.R. (3d) 436 (S.C.J.).

21 [2005] O.J. No. 1477 (S.C.J.) (QL)

22 Private Arbitration Decision, Arbitrator Robinson, May 1, 1997.

23 Private Arbitration Decision, Arbitrator Galligan, December 17, 1996.

24 Private Arbitration Decision, Arbitrator Malach, January 2, 2002.

25 Private Arbitration Decision, Arbitrator Malach, June 29, 2005.

26 Private Arbitration Decision, Arbitrator Jones, October 10, 2000.

27 Private Arbitration Decision, Arbitrator Malach, November 15, 2001.

28 Both the *Coseco* and the *OMEX* judgments are of note in that both arbitrators rejected arguments by the responding insurer that vehicle searches or Autoplus searches were a necessary component of an adjuster's investigation and that a failure to conduct an Autoplus search was fatal to the applicant insurer's application. Autoplus is a private service that allows insurers to identify whether an injured party is a named insured or a listed driver on an Ontario policy. Thus, while an Autoplus search is an important investigative tool it does not appear to be a mandatory aspect of an adjuster's investigations into the priority issue. With the passage of time, and the notice to insurers embodied in these two judgments, however, it may be that in the future an insurer who attempts to invoke s. 3 in respect of an injured party that was ultimately found to be a listed driver on another policy may have to have conducted an Autoplus investigation within the 90-day period.

29 Private Arbitration Decision, Arbitrator Robinson, September 18, 2003.

30 See p. 14. Arbitrator Robinson thus ordered that the applicant insurer could shift the obligation to pay benefits to the respondent insurer.

31 Private Arbitration Decision, Arbitrator Robinson, February 22, 2002.

32 See *Ontario (Minister of Finance) v. Co-operators General Insurance Company*, [2002] O.J. No. 4933 (QL), 62 O.R. (3d) 755 (S.C.J.).

33 Private Arbitration Decision, Arbitrator Robinson, November 15, 2001.

34 See s. 2 of the Regulation.

35 *Lombard v. Saskatchewan Government Insurance*, [2002] O.J. No. 4257 (S.C.J.) (QL).