CITATION: Bradley Michael Mulhall v. The Wawanesa Mutual Insurance Company, 2015 ONSC 7495
LINDSAY COURT FILE NO.: 07/09
DATE: 20151218

SUPERIOR COURT OF JUSTICE - ONTARIO

RE: Bradley Michael Mulhall, Plaintiff

AND:

The Wawanesa Mutual Insurance Company, Defendant

BEFORE: D.S. Gunsolus J.

COUNSEL: David Zarek, Courtney Madison, Eric K. Grossman, Counsel, for the Plaintiff

Ian D. Kirby, Counsel, for the Defendant

HEARD: November 17, 18, 2015 and December 3, 2015

REASONS ON MOTION

Nature of the Motion

[1] The plaintiff brings this action against his insurer for attendant care benefits (ACBs) in relation to a motor vehicle accident that occurred on Victoria Street East, Whitby, in the Regional Municipality of Durham, on March 18, 2001. This action is to be tried by a judge and jury. A preliminary question of law arose as to when interest should begin to run in relation to attendant care benefits that may be found to be owed during a retrospective time period.

[2] Mr. Kirby, on the behalf of the defendant, insurer, has indicated that his client acknowledges:

1) the plaintiff is entitled to a declaration that he is an insured person under Ontario Standard Automobile Policy with the defendant, policy number 204014;

2) the plaintiff is entitled to a declaration that he is entitled to receive accident benefits pursuant to that policy;

3) the defendant is not raising a limitations defence nor a timely notice defence; and

4) the plaintiff has a right to seek retrospective benefits.

[3] As the issue in relation to interest is a question of law, counsel agreed that I should decide this question before putting the substantive portion of this case to a jury.

Background Facts

[4] Bradley Mulhall was catastrophically injured in a motor vehicle accident on March 18, 2001. He was 17 years of age at the time. The accident was reported to Wawanesa Mutual Insurance Company on March 21, 2001. Wawanesa hired and assigned a case manager on March 23, 2001. The plaintiff remained hospitalized until May 15, 2001 at St. Michael's Hospital in Toronto and immediately after was placed at Bloorview MacMillan Children's Centre in an overnight capacity. When he was discharged from Bloorview on July 27, 2001, the discharge summary noted:

> It was quite clear that throughout Brad's stay here, because of his problems with attention, concentration, and impulsivity, poor safety awareness and poor judgments, which he needed this constant supervision to maintain his safety. It was also important to help teach the family about the significant impacts this injury would have for him now and lifelong period.

[5] When the plaintiff was discharged, Wawanesa paid for service providers including, but not limited to, a Registered Social Worker (RSW), speech pathologist, child youth worker, case manager, and occupational therapists. Twenty-four hour attendant care service was not provided and it is the plaintiff's position that it should have been. The plaintiff's parents provided 24 hour attendant care. Since April 2006, Wawanesa has paid attendant care benefits. The critical period of time for which the plaintiff now claims attendant care benefits is from July 27, 2001 to December 6, 2006.

[6] On March 22, 2001, Wawanesa mailed to the plaintiff an application for accident benefits and pamphlets explaining the various statutory accident benefits available. On April 3, 2001, a representative of Wawanesa and the assigned case manager met with the plaintiff's parents at St. Michael's Hospital. The plaintiff was in a coma at the time and not expected to survive. It is the position of the defendant that at that time the plaintiff's parents were provided with an application for accident benefits and explanatory pamphlets in relation to various available statutory accident benefits. The defendant further takes the position that the available benefits were orally explained to the plaintiff's parents. An application for accident benefits was completed by someone other than the plaintiff's parents; however, the plaintiff's father signed the actual application. Attendant care benefits were not claimed.

[7] On December 7, 2006, an Assessment of Attendant Care Needs including a Form 1 was submitted on behalf of the plaintiff to the defendant. The report and Form 1 referenced the plaintiff's then current attendant care needs commencing December 7, 2006. It was not retrospective in application.

[8] As a result, Wawanesa began to pay attendant care benefits. A number of further attendant care assessments have taken place since then and while there may be a dispute as to the appropriate quantum of monthly attendant care benefits, Wawanesa has continued to pay for monthly attendant care to date.

[9] On August 20, 2015, counsel for the plaintiff commissioned a report together with a retrospective Form 1 for the plaintiff's attendant care needs for the period July 27, 2001 to December 6, 2006. This report was received by Wawanesa on August 27, 2015. This was the first report and Form 1 assessing the plaintiff's attendant care needs for the period of July 27, 2001 to December 6, 2006.

[10] To date, Wawanesa has paid almost all medical and rehabilitation as well as visitor expense claims submitted by or on behalf of the plaintiff together with monthly attendant care benefits since first notified, on December 7, 2006, of an attendant care benefit claim.

[11] As stated above, the only substantive claim in the action is one for statutory accident benefits in relation to retrospective attendant care. The issue on this motion is for a determination as to what date interest should begin to accrue on the plaintiff's attendant care claim for the period of July 27, 2001 to December 6, 2006.

Party's Positions

[12] It is the plaintiff's position that he should receive the SABS[1] interest on the attendant care benefits commencing May 3, 2001 (effectively July 27, 2001 being the earliest date ACBs may be found to be owing). It is the defendant's position that there is no obligation on an insurer to pay attendant care benefits until such time as it receives a Form 1 Assessment. Payment, it is alleged, is not overdue and therefore interest should not accrue or begin to run on attendant care benefits until 10 business days after the receipt of the Form 1 Assessment which, in this case, in relation to the retrospective period would be 10 business days following August 27, 2015.

The Law

[13] Insurance law has been interpreted by the Supreme Court of Canada as being "geared towards protection of the consumer."[2] As such, an insurer is required to inform an insured in straight-forward and clear language, at the level of an unsophisticated person, the process that an insured must follow in order to obtain the benefits available to them.

[14] Our courts have repeatedly confirmed the proposition that interest payable under SABS is compensatory and not punitive. As stated in *Zacharias v. Zurich Insurance Company*, the intent of interest payable under the SABS is to "compensate insureds for the loss of the time value of money and to encourage insurers to pay accident benefits promptly."[3]

[15] The defendant in this case relied primarily on the case of *Grigoroff v. Wawanesa Mutual Insurance Co.*,[4] where the Divisional Court held that under the SABS, payment is not overdue until 10 business days have elapsed after a Form 1 Assessment of Attendant Care

---

[1] *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996*, O. Reg. 403/96.
[2] *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, at para. 16.
[3] 2013 ONCA 482, 116 O.R. (3d) 342, at para. 38.
[4] 2015 ONSC 3585, [2015] O.J. No. 3771 (Div. Ct.), rev'g 2012 ONSC 5313, [2012] O.J. No. 4497.

Needs is received by the insurer. Until such time as a Form 1 Assessment is received by an insurer, payment does not become due. Interest, therefore, cannot begin to accrue until attendant care benefits become due as a result of the submission of a Form 1.

[16] Counsel for the plaintiff argued that *Grigoroff* is factually distinct from the present case. Plaintiff's counsel submitted that *Grigoroff* was not a case dealing with the issue as to an insurer's obligation under s. 32 of the SABS based upon the knowledge that the insurer had early on as to the specific needs of an insured. Counsel also suggested that *Grigoroff* was decided on legislative wording that is distinctly different from that which applied in 2001 at the time of Mr. Mulhall's accident. In the 2001 SABS, s. 39(1) required that the insured submit "an application for attendant care benefits." Upon receiving such an application, the insurer was to do one of two things: a) notify the insured that the attendant care expenses were approved, or b) require that the insured's health practitioner furnish a certificate (a Form 1) confirming treatment reasonable and necessary for the insured's care. *Grigoroff* considered s. 39 of the SABS, amended in 2005,[5] that required that an application for attendant care benefits be in the form of an Assessment of Attendant Care Needs. "Under the SABS, Form 1 is the prescribed form for assessment of attendant care needs."[6] Counsel argued that there was no law that required an application for attendant care benefits to include a Form 1 under the version of the legislation that applied at the date of Mr. Mulhall's accident, unless the insurer requested it.

[17] In *Grigoroff* the trial judge, relying on Laskin J.A.'s statement in *Attavar v. Allstate Insurance Co. of Canada*,[7] determined that interest ought to be paid from the time the payment is overdue even though the insurer had no way of knowing the amount to be paid. Interest should be attributable on attendant care benefits from the beginning of the period that ACBs should have been paid. In overturning the trial judge's decision, the Divisional Court determined that the central issue was when ACBs become due. The court found that "under s. 46(1) of the SABS, a payment is not overdue unless 'the insurer fails to pay the benefits within the time required' under s. 39, which is 10 business days after the receipt of an assessment of attendant care needs."[8]

[18] I agree with counsel for the plaintiff that this decision appears to stand for the proposition that a claim for attendant care benefits must be in the form of an Attendant Care Needs Assessment, a Form 1. Since s. 39(4) of the Regulation specifically provides that an insurer shall pay attendant care benefits within 10 business days of receiving such an assessment, interest begins to accrue at that point in time. In the case before me, the then applicable SABS, required an application and a Form 1 was not initially required, unless, the insurer did not accept the application and required that a Form 1 be completed by a designated medical care provider in addition to the application for attendant care benefits. In any event, I give little weight to the *Grigoroff* case given the very different fact situation of the case before me.

---

[5] O. Reg. 403/96, as amended by O. Reg. 546/05, s. 17.
[6] *Grigoroff*, at para. 16.
[7] 2003 CanLII 7430, 63 O.R. (3d) 199 (C.A.).
[8] *Grigoroff*, at para. 25.

[19] In *Grigoroff*, the Divisional Court did not consider the many cases that deal with the consumer protection aspect of insurance law nor did it deal with the issue as to when an insurer has sufficient information to properly adjust an insured's claim for attendant care benefits.

[20] A review of arbitration and court decisions reveals that these provisions have been interpreted with consistency. Interest is compensatory and not punitive; it is designed to compensate the insured for the time value of money and to encourage insurers to pay accident benefits promptly; no finding of fault against an insurer is required.[9]

[21] What the courts and arbitrators have not done is apply these provisions with consistency. This may be because each case is fact specific. It would appear that the underlying principle that courts have applied, yet have failed to clearly articulate, is that interest accrues from the date the insurer has sufficient information such that it is, or ought to be, aware that the benefit should be considered. Thus a payment is overdue once the insurer has sufficient knowledge to determine its obligation to pay the benefit or the insured's entitlement to the benefit.

[22] In *Attavar*, the trial judge concluded that "it is the insurer not the insured who must bear the consequences of a decision not to pay benefits that are later found to be owing".[10] The Court of Appeal upheld the trial judge's treatment of the law, reasoning that an amount payable to an insured is overdue if an insurer does not pay the full amount, ultimately determined by a trier of fact, to have been owed. Further the Court of Appeal pointed out that if the legislature had intended insurers who pay some of the benefit to which an insured is entitled to avoid interest on amounts still owing, it would have stated so in the Regulation.

[23] In *Van Galder v. Economical Mutual Insurance Co.*, the Ontario Superior Court followed the consumer protection policy of the regulation in order to grant interest on retroactive benefits at the full SABS rate. The court stated: "Once a benefit is applied for an insurer will become responsible for interest on amounts that are found to be overdue, despite any good faith payments made in the interim."[11] Given that the plaintiff in that case had suffered a catastrophic impairment, and other complicating factors, the court held that on the facts of the case it would be inequitable to deny the insured interest on the costs she incurred as a result of her delayed catastrophic injury determination.

[24] In coming to its decision the court relied on *Attavar* and *Grigoroff* (prior to the Divisional Court overturning the trial judge's decision) confirming that the intent of the legislation is compensatory. The trial judge went on to find that since the regime is compensatory "the intention of the legislation was not that insurers would avoid interest payments on amounts

---

[9] *Attavar*; *Grigoroff*; *Whyte v. State Farm Mutual Automobile Insurance Co.*, FSCO A12-005721 (24 July 2015), [2015] O.F.S.C.D. No. 217; and *Van Galder v. Economical Mutual Insurance Company*, 2015 ONSC 3261, [2015] O.J. No. 2650.
[10] *Attavar*, at para. 42.
[11] *Van Galder*, at para. 21.

that were overdue if they had in good faith paid a different amount or stopped payment in good faith".[12]

[25] In *Gill v. Royal and Sun Alliance Insurance Company*,[13] notwithstanding that the court found that the insured failed to provide the insurer with requested information, the court held that the insurer should have been able to make a determination with the information available to it and awarded interest to the insured from the date when the SABS benefits first became payable to the insured. The Financial Services Commission of Ontario (FSCO) has also had reason to consider this issue a number of times. In *Pastore v. Aviva Canada Inc.*[14] the Court of Appeal acknowledged FSCO's specialized expertise and experience and noted that deference is owed in relation to FSCO's interpretation of the statutory provision that it is authorized and obligated to interpret.

[26] In *T.N. v. Personal Insurance Company of Canada*[15] the commission noted that even though an insured did not submit a Form 1 on a timely basis, this delay did not relieve the insurer of its obligation to pay the insured attendant care benefits to which she might have been entitled on a retroactive basis. The insurer was found to have had ample information to commence the process of adjusting the claim and the insurer was deemed to have received an application for such benefits. In other words, the insurer had the information necessary to assess the insured's need for attendant care, and to inform the insured of the results of its own assessment. The commission ordered interest on a retrospective basis.

[27] In *L.F. v. State Farm Mutual Automobile Insurance Company*[16] and *Whyte v. State Farm Mutual Automobile Insurance Co.*, the insureds were awarded retroactive attendant care benefit claims. In *L.F.* and *Whyte*, the arbitrators found that there was nothing in the SABS which prohibited a claim for retroactive ACBs and further that a failure to file a Form 1 neither forfeited an insured's right to ACBs nor released the insurer from an obligation to pay. Whether or not the insured had a lawyer was deemed irrelevant given that the contractual relationship is between the insured and the insurer. Further, the fact that there had been no suggestion that ACBs should be paid did not prohibit a retroactive claim or interest on such a claim. In *L.F.*, the commission awarded the retroactive ACBs together with interest on a retroactive basis. In *Whyte*, the commission did not awarded interest on retroactive ACBs, using the same reasoning as the Divisional Court in *Grigoroff*.

[28] *L.F.* and *Whyte* acknowledged that interest is remedial and not punitive and designed not only to compensate applicants for the value of money withheld, but to further the system's fundamental goal of insuring prompt payment of benefits for an insured persons medical and vocational rehabilitation, their care, or their day to day financial support. The findings in both cases indicated that interest is mandatory, compensatory, and flows from late payment

---

[12] *Van Galder*, at para. 19.
[13] 2009 CanLII 10671, [2009] I.L.R. I-4835 (Ont. S.C.).
[14] 2012 ONCA 642, 112 O.R. (3d) 523.
[15] FSCO A06-000399 (26 July 2012), [2012] O.F.S.C.D. No. 101, further reasons at FSCO A06-000399 (20 Nov 2014), [2014] O.F.S.C.D. No. 265 (the SABS interest decision).
[16] FSCO P02-00026 (3 June 2004), [2004] O.F.S.C.D. No. 76.

of the overdue benefit such that there is no need for a finding of insurer misconduct. Accordingly, upon a finding of entitlement, interest should flow even in circumstances where an insurer has legitimate reasons for questioning the claim or requiring more information. In *L.F.* entitlement was determined upon the sufficiency of information the insurer had. In *Whyte* entitlement was determined upon the receipt of the then requisite assessment of attendant care benefits and Form 1.

Discussion

[29] The defendant has relied primarily upon the Divisional Court decision in *Grigoroff*. In that case the defendant was ordered to pay retroactive attendant care benefits for a period from December 2001 to July 2003, after the plaintiff submitted a retroactive Form 1 in February 2009. Section 39(1) of the SABS requires attendant care benefit claims to be by way of an application together with a Form 1. Section 39(4) requires payment to be made within 10 business days of receiving such a Form 1 assessment. Since s. 39(3) provides the insurer does not have to pay expenses until receiving a compliant assessment, the Divisional Court ordered that interest did not commence until 10 business days after receiving the Form 1 Assessment. The SABS in effect at the time of Mr. Mulhall's motor vehicle accident, in 2001, required that to qualify for benefits under the SABS the plaintiff had to file an application for attendant care benefits. There was no requirement that the application for attendant care benefits be in Form 1 as *Grigoroff* seemed to suggest is a requirement of the amended language in s. 39. That modification included a definition of attendant care benefits requiring that such an application be in the form of a Form 1. Section 39(1) states:

> An application for attendant care benefits for an insured person must be in the form of an assessment of attendant care needs for the insured person that is prepared and submitted to the insurer by a member of a health profession who is authorized by law to treat the person's impairment. O. Reg. 546/05, s. 17.

[30] In 2001, s. 39(1) stated:

> Within 14 days after receiving an application for an attendant care benefit, an insurer shall,
> (a) give the insured person notice that it has approved the application, if the insurer determines that it is required to pay for the expenses described in the application; or
> (b) give the insured person notice that the insurer required the insured person to furnish a certificate from a member of a health profession who is authorized by law to treat the person's impairment stating that the expenses described in the application are reasonable and necessary for the person's care.

[31] Therefore, pursuant to s. 39(1), a claim for attendant care benefits must be in the prescribed form of an Assessment of Attendant Care Needs. As counsel for the plaintiff suggested, before the amendment an injured party had only to file an application in response to which the respondent insurer would either: a) agree to the payments, or b) take the further step of requiring the applicant to submit a form prepared by their health care professional (Form 1).

[32] *Grigoroff* was not a case involving the issue as to whether or not the insurer held sufficient information to determine an application for ACBs in circumstances where a Form 1 had not been tendered.

[33] A review of the case law discloses that a rule that a payment is overdue after an application is actually received, has not been consistently applied. Rather, many of the cases have deemed the payment to be due once the insurer has knowledge the insured may or may not be entitled to the benefit in question. In each case, the task is to determine the date when the insurer had sufficient information upon which to consider paying the disputed benefit. The unique facts of each case are determinative. The onus is on the insurer to identify the benefits to which the insured is entitled even absent an insured's application.

[34] In *Attavar* and *Van Galder* interest was retrospectively applied because the insurer was obligated to pay the benefit and the insurer should be the one to bear the consequences of its decision not to pay benefits that are found later to be owed. Interest was awarded from the beginning of the payment period, as it was within the insurer's knowledge that payments were owed to the insured at that time. As the court in *Van Galder* stated, "it is irrelevant that the insurer paid less on a good faith basis."[17] If the quantum of the benefit is in dispute and the trier of fact finds that more is owed to the insured, even though the insurer paid an amount toward the benefit in good faith, interest shall attach to the difference.

[35] If the trier of fact awards retroactive benefit payments, interest should begin accruing from the date that the insurer was, or should have been aware the benefits were owed, regardless of the amount and the retroactive date assigned. Our courts have consistently emphasized that interest is compensatory not punitive and therefore interest should be awarded once the insurer has knowledge the benefit is owed. *T.N.* and *Gill v. Royal and Sun Alliance* determined that interest should begin to accrue as of the date the insurer had sufficient information to assess whether or not a benefit was owed to the insured regardless of the amount.

[36] In *T.N.* it was found that even though the applicant did not submit an application for benefits, that had no bearing on the insurer's obligation to pay the applicant those benefits. The commissioner went on to state that the determination turns on whether the person provides the insurer with sufficient information to permit the insurer to commence the process of adjusting the claim.[18] Similar reasoning was applied in *Gill v. Royal Sun Alliance*

---

[17] *Van Galder*, at para. 17.
[18] *T.N.* (the SABS interest decision), at paras. 43, 47.

where the trial judge determined that the insurer had sufficient information in order to take a position on issues and make the appropriate decisions.[19] In *Michalski v. Wawanesa Mutual Insurance Company* the arbitrator determined that the onus is on the insurer to identify benefits to which the claimant is entitled even in circumstances where the claimant may never assert a claim for that benefit.[20]

[37] Following these underlying principles, I find that interest in this case should begin to accrue from the date that the insurer had sufficient information to be able to assess whether the benefit should have been paid regardless of whether or not the plaintiff or his parents specifically applied for attendant care expenses.

[38] A broad and liberal interpretation of when an application has been made for attendant care benefits in this fashion is consistent with the spirit of insurance law described by the Supreme Court in *Smith v. Co-operators* and the stated objective of consumer protection. Such a broad and liberal interpretation cannot be said to apply only to limitation defenses.

[39] In the circumstances of this case where Mr. Mulhall was left with severe brain injuries, I echo the comments of Arbitrator Wilson in *Kelly v. Guarantee Co. of North America*[21] where the suggestion was expressly rejected requiring an injured person, in every circumstance, to complete all paperwork, including a Form 1, before becoming eligible for attendant care benefits. As stated, "the folly of such an approach is demonstrated" in severe traumatic brain injury cases.[22] "It goes without saying that in an emergency situation, all attention is focused on treating the patient in danger and addressing the immediate care concerns of the injured person."[23] The insurer bears the obligation to provide sufficient information to enable the consumer to claim benefits and this applies even in circumstances where the insured person is represented by counsel. In *Kelly*, there was evidence that the claimant needed assistance bathing, grooming, dressing and undressing, walking, climbing stairs, sitting, standing, and finding words to express thoughts. This was determined sufficient to alert the adjuster to the need to provide the appropriate forms and additional information about attendant care benefits. Mr. Mulhall was in very similar circumstances after his accident.

[40] Counsel for Mr. Mulhall had urged that I should find some fault against the defendant insurer in this case. Fault does not enter into this exercise. In this case, "20/20 hindsight" has disclosed that this plaintiff may be successful in his claim for attendant care benefits for the period between 2001 and 2006 in an amount not yet agreed to or determined by the trier of fact. Both the plaintiff and defendant had counsel, doctors, occupational therapists, and no one suggested the payment of ACBs at the relevant time. The insurer in this case paid a number of benefits including for, but not limited to, a RSW, speech pathologist, child youth worker, case manager, and occupational therapists. The insurer paid and continues to pay

---

[19] *Gill v. Royal and Sun Alliance*, at para. 57.
[20] FSCO A03-001363 (13 December 2005), [2005] O.F.S.C.D. No. 150, at para. 118, aff'd FSCO Appeal P06-00003 (5 December 2007), [2007] O.F.S.C.D. No. 217, at para. 8.
[21] FSCO No. A12-006663 (7 August 2014), [2014] O.F.S.C.D. No. 155.
[22] *Kelly*, at para. 24.
[23] *Kelly*, at para. 26.

various statutory accident benefits. Fault is irrelevant as interest has been found to be a benefit payable commencing when the insurer had sufficient information by which it ought to have been able to consider to pay or deny attendant care benefits.

[41] A review of Mr. Mulhall's application for accident benefits and statement of activities of normal life provided to the defendant on or about April 3, 2001, would indicate that the plaintiff could not bathe, groom, dress, toilet, walk, climb stairs, relate to others without irritability or temper, participate in social activities, or "do any physical activities". Further, his discharge summary from the Bloorview MacMillan Children's Centre, dated May 15, 2001, stated,

> It was quite clear that throughout Brad's stay here, because of the problems with attention, concentration, impulsivity, poor safety awareness and poor judgments, which he needed this constant supervision to maintain his safety. It was also important to help teach the family about the significant impacts his injury would have on for his now and long life.

[42] And finally, the defendant was provided a letter from the Bloorview MacMillan Children's Centre, dated June 7, 2001. It was reported to the defendant, Wawanesa, that, "[a]though Brad is participating well in his therapy, he struggles significantly with his cognitive impairments … he has very poor insight in his impairments … he is considered to be at significant risk, because of his poor judgment and tendency to wander off when he is not attended." It could therefore be assumed that the defendant had, in 2001, sufficient information upon which it could have and should have assessed the need for attendant care benefits in relation to the plaintiff.

[43] As stated by Boswell J. in *Sorokin v. The Wawanesa Mutual Insurance Company*, affirmed by the Court of Appeal for Ontario, "[t]he compensatory nature of the interest provided for in s. 46(2) of the SABS suggests to me that it is part of the overall scheme of benefits available to an insured under the Schedule."[24] Boswell J. went on to state that he thought a "liberal interpretation of the provisions of the SABS must be made, so as to achieve the object and intent of the legislation and to avoid results that create absurdity, injustice, and/or hardship."[25] In both *Sorokin* and *Gill v. Royal and Sun Alliance* the trial judges noted that the defendant insurer had use of funds that ultimately were ordered to be paid to the plaintiff such that the defendant insurers in those cases had the use of the plaintiff's funds and should compensate the plaintiff for the time value of that money.

[44] As stated in *L.F.*, "[t]he insurer is expected to adjust the claim and determine what benefits may be available based on the information received. The process is designed to ensure that an unsophisticated claimant receives the appropriate benefits."[26]

---

[24] 2008 CanLII 26265, 92 O.R. (3d) 314 (S.C.), at para. 28, aff'd 2009 ONCA 152, 94 O.R. (3d) 891.
[25] *Sorkin*, at para. 26.
[26] *L.F.*, at para. 67.

[45] I have no doubt that the insurer in this case had ample information, as in *T.N.*, to begin to address the issue of attendant care benefits especially in light of the fact that in this case, as in the *T.N.* case, the applicant had been catastrophically impaired as a result of the accident. Clearly the defendant insurer contemplated that the defendant might require attendant care. At paras. 298 and 299, of the Examination for Discovery transcript of the defendant's adjuster, Timothy Votskos, dated April 22, 2010, he acknowledged that from the very beginning the insurer realized Mr. Mulhall was probably going to require attendant care and even went so far as to set up reserves in the face of that prospect.

Relief From Forfeiture

[46] Given my reasons above, it is unnecessary for me to consider the plaintiff's alternate argument in relation to relief from forfeiture. However, I point out that in the recent case of *Dube v. RBC Life Insurance Company*[27] the Court of Appeal considered the provisions of s. 98 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, which states: "A court may grant relief against penalties and forfeitures, on such terms as to compensation or otherwise as are considered just." The Court of Appeal noted that the relief under s. 98 is both equitable and discretionary and the test that a court must consider has three components as follows:

1) the conduct of the insured applicant,

2) the gravity of the breach, and

3) the disparity between the value of the property forfeited and damage caused by the breach.

[47] In the matter before me, the plaintiff's conduct was not unreasonable given the fact that as result of the accident he suffered a severe brain injury. He provided, and complied with all requests to provide medical and other necessary information. In the circumstances of this case the defendant insurance company was provided all information necessary in order for it to ascertain what benefits might have been available to the plaintiff.

[48] Given the fact that the defendant set up a reserve within days of the plaintiff's accident, and given the unrestricted disclosure of medical evidence that the defendant received, the defendant suffered no actual prejudice.

[49] The attendant care benefits and applicable interest for the period 2001 to 2006 indicates that the disparity between the value of the property forfeited and the damage caused by the breach is indeed significant.

[50] Had it been necessary I would have granted relief from forfeiture in the circumstances of this case.

Order

---

[27] 2015 ONCA 641, 127 O.R. (3d) 161.

[51] Accordingly an order shall issue as follows:

1) Should the parties agree, or the trier of fact determine, that attendant care benefits are payable for the 2001 to 2006 time period, the plaintiff, Bradley Michael Mulhall, shall be entitled to SABS interest from May 3, 2001. (Effectively July 27, 2001 being the earliest date ACBs may be found to be owing.)

2) As to costs, the parties may arrange an appointment before me, if they are unable to agree as to same. If such an appointment in not arranged within the next 30 days, the issue of costs shall be deemed to have been resolved.

D.S. Gunsolus, J.

Date: 18 December 2015