LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Citation: **Ruth Patzan vs. Certas Home and Auto Insurance Company, 2019** ONLAT **18-004441/AABS**

Date: June 14, 2019
File Number: 18-004441/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

Ruth Patzan

Appellant(s)

and

Certas Home and Auto Insurance Company

Respondent

PRELIMINARY ISSUE DECISION

PANEL: Cezary Paluch**, Adjudicator**

APPEARANCES:

For the Applicant: Luis Quail

For the Respondent: Kayley Richardson

HEARD: **In Writing on: December 3, 2018**

OVERVIEW

[1] The applicant was injured in an automobile accident on March 16, 2015 and sought benefits pursuant to the *Statutory Accident Benefits Schedule* – Effective September 1, 2010 *(the "Schedule").*

[2] The applicant applied for benefits that were denied by the respondent including non-earner benefits. The applicant disagreed with these denials and submitted an Application to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal") which was received on May 15, 2018.

[3] The respondent raised a limitation issue that the applicant is precluded from filing an application with the Tribunal with respect to non-earner and other benefits as the applicant did not commence the application within two years of the denial.

[4] The parties agreed to hold a preliminary hearing in writing scheduled for December 3, 2018 to address the limitation period but only as to the non-earner benefits.

PRELIMINARY ISSUE

[5] The preliminary issue to be decided as per the case conference order of Adjudicator Norris dated November 19, 2018 is:

i. Is the applicant precluded from disputing entitlement to a non-earner benefit (NEBs) pursuant to section 56 of the Schedule?

RESULT

[6] The applicant's claim for the NEBs is not out of time. I find that the respondent's notice was insufficient and did not comply with s. 37(4) of the *Schedule*. Accordingly, the respondent's preliminary issue is dismissed. The appeal should proceed to a hearing as soon as possible.

ANALYSIS

[7] Under s. 56 of the *Schedule*, an appeal of an insurer's denial of a benefit must be commenced within two years after the insurer's refusal to pay the amount claimed. The two years is called the "limitation period".

[8] If an appeal is not filed within the two-year limitation period prescribed by s.56, then the Tribunal cannot hear it and the appeal is effectively dismissed without a hearing. In other words, the appeal is said to be "statute barred."

[9] As noted by the applicant and uncontested by the respondent in their submissions, the limitation period does not begin until the insurer has issued a clear, straightforward and unequivocal denial or refusal of the benefits.[1]

[10] In this way, it makes sense, that the respondent cannot raise the limitation period as a bar to an appeal of its denial if its own conduct led the insured person to delay his or her appeal beyond the limitation period.[2]

[11] Further, it is well accepted jurisprudence that the onus is on the respondent insurer to establish that the applicant has received the proper notice of denial and that the denial was clear and unequivocal.

Parties' Positions

[12] The applicant acknowledges that the respondent denied the applicant NEBs on September 29, 2015, but submits that this denial was not proper because it failed to comply with s. 37(4) of the *Schedule* by not providing a "*medical and other reasons*" and therefore the limitation period never commenced to run.

[13] In the alternative, the applicant submits that the limitation period should be extended in these circumstances pursuant to section 7 of the *Licence Appeal Tribunal Act*.

[14] The respondent submits the applicant is statute barred from proceeding to a hearing for NEB's because the applicant failed to commence the dispute resolution process (commenced on May 15, 2018), under subsection 280(2) of the *Insurance Act*, within two years of the limitation period established by the *Schedule* based on its Explanation of Benefits (EOB) letter sent to the applicant on September 29, 2015. They further maintain that the denial satisfies s. 37(4) of the *Schedule*.

[15] I first address the applicant's position that the notice of denial was deficient.

Was the respondent's notice of the denial insufficient or improper?

[16] The procedure for terminating NEBs is found in s. 37(4) of the *Schedule*, which provides that: "If the Insurer determines that an insured person is…no longer entitled to receive [the NEB], the insurer **shall** advise the insured person of its determination **and the medical and any other reasons for its determination**." [emphasis added]

[17] The purpose of s. 37(4) is to require an insurer to notify the insured person of its decision to stop the NEB supported by the medical and any other reasons for its stoppage. To that end, the insured person is entitled to make an informed

[1] *Smith v. Co-Operators General Insurance Co*., 2002 SCC 30, at para. 14 and 15 cited by the applicant.
[2] *Zeppieri v. Royal Insurance Co. of Canada* 1994 CarswellOnt 7389, [1994] OICD No.13, at para. 44 and 50.

decision about whether they wish to pursue their claims and file an appeal, or not. Most importantly, they need to understand the reason for the denial.

[18] As well, it is trite to say that given the serious consequences to an insured person of barring them from commencing an application to the Tribunal to dispute an insurer's denial of the NEBs - the notice requirements set out in s. 37(4) should be strictly construed and the insurer's notice should be closely examined to ensure it complies.

[19] Here, in reviewing the respondent's denial of the NEBs, the EOB of September 29, 2015, contains the following statement as follows:

> *Non-Earner Benefits*
>
> *No further Non-Earner benefit is payable because you no longer suffer a complete inability to engage in your normal life. We are in receipt of the ocf-3 [Disability Certificate] dated 2015/09/24 completed by Gerald Gayah. According to the ocf-3 you do not meet the test of a complete inability and as such you are not eligible to receive this benefit effective 2015/09/24. Thank you.*

[20] It appears that no enclosure letter was ever provided with the EOB form by the respondent to the applicant which could have included additional information or more detailed and plain reasons for the stoppage.

[21] Words in legislation or regulation are important. The use of the word "shall" in section 37(4) means that this information (medical and other reasons) are mandatory and an insurer has no discretion whatsoever in this regard. Thus, the insurer must provide to the insured the medical and any other reason for reaching its determination in their denial.

[22] The sufficiency of notice and meaning of "medical and other reasons" in the *Schedule* was addressed by the Tribunal in *T.F. v. Peel Mutual Insurance Company* (in the context notice requirements under s. 38(8) re reason for denying treatment plans), and also in *M.B. v. Aviva Insurance Canada*[3] (in the context notice requirements under s. 44(5)(a) re IE examinations) and I find the following principles persuasive and worth highlighting:

i. an insurer satisfies its obligation to provide its "medical and any other reasons," by explaining its decision with reference to the insured's medical condition and any other applicable rationale. That explanation will turn on the unique facts at hand;

[3] *T.F. v. Peel Mutual Insurance Company*, 2018 CarswellOnt 7165 (Ont. LAT), at paras. 20-21
M.B. v. Aviva Insurance Canada, 2018 CarswellOnt 20635 (Ont. LAT), at para. 26 and M.B. v. Aviva Insurance Canada, 2017 CanLII 87160 (ON LAT) ("M.B.").

ii. an insurer's "medical and any other reasons" should, at the very least, include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires;

iii. an insurer should also refer to the specific benefit or determination at issue, along with any section of the *Schedule* upon which it relies; and

iv. an insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue.

[23] I am supported in my view that the above four principles equally apply to this case by the Executive Chair's clarification in *M.B.* that regardless of the situation, the legislature's presumption of consistent expression requires that the phrase "medical and any other reasons", which is used in several different places in the *Schedule* (including the applicable s. 37(4) which is specifically cited in footnote # 7 of this decision*)*, be interpreted consistently.[4]

[24] In addition to the above principles which I accept as applicable. I also consider it essential that any a notice should be written in ordinary plain and easy to read language and not overly rely on legal terminology. It is only by using plain easy to read language without any legalese that an average person can understand a denial notice. This standard goes to the very heart of administrative law and embraces procedural fairness - for a person to be heard they must have a right of adequate notice. In other words, to have adequate notice one must first be able to understand the notice – a person will not be heard if they do not have such notice.

[25] This approach is also in keeping with the primary interpretative principle in *Smith v. Co-Operators General Insurance Co*. that denials be clear and unequivocal. I note that the *Schedule* does not spell out the exact wording for EOBs or require particular language to be included. In my view, to better accomplish this goal, and satisfy the insurer's obligation.

[26] Against this backdrop, I now turn to applying these principles to s. 37(4) and the facts at hand, and find that the respondent's notice was not sufficient.

[27] As mentioned above, the respondent's EOB of September 25, 2015, explained that the NEBs were no longer payable because "you no longer suffered a complete inability to engage in your normal life….[and] you do not meet the test of complete inability." This language is inaccurate and misleading in at least two respects. First, it does not adequately explain what is meant by "complete inability" or reference the applicable section number of the *Schedule*. Subsection 3(7)(a) of the *Schedule* is critically important in advancing an NEB claim because it explains that a person suffers from a complete inability to carry

[4] *M.B. v. Aviva Insurance Canada,* 2017 CanLII 87160 (ON LAT) at para. 24.

on a normal life as a result of an accident if the person sustains an impairment that continuously prevents the person from engaging in substantially all of the **activities** in which the person ordinarily engaged before the accident. Unfortunately, this definition of "complete inability" and in particular the reference to "activities" is not included anywhere in the EOB.

[28] Further, the reference to "activities" should have been referred to in the EOB because it is the individual "activities" themselves that govern, and that an adjudicator will examine, if the denial is contested, to determine if a person's post-accident activities are so significantly restricted compared to their pre-accident activities that they prevent him/her from engaging in substantially all of his/her pre-accident activities. In other words, this is how one qualifies for NEBs, plainly said, by showing that they are unable to do the same activities they were engaged in prior to the accident (as opposed to saying "you do not meet the test of complete inability")

[29] Related to this is that we do have a leading and widely accepted decision of *Heath v Economical Mutual Insurance Company,*[5] where the Court of Appeal clarified that the starting point for the analysis of whether a claimant suffers from a complete inability to carry on a normal life will be to compare the claimant's activities and life circumstances before the accident to his or her activities and life circumstances after the accident. Merely stating that "you do meet the test of complete inability" without explaining what is meant by this term is not helpful and very ambiguous.

[30] Moreover, the EOB did not provide any specific details about the insured's condition that formed the basis for its decision or reference any further information it required. It was not in plain language and used legalese by using such words as "complete inability" or "test of complete inability." Again, "complete inability" is a defined legal term in s. 3(7)(a). Also, strictly speaking, there is no "test of complete inability" in the *Schedule* – there is only determination of entitlement to a non-earner benefit in s. 12 of the *Schedule* by complying with the required conditions. It also referred to a form called an "ocf-3" without identifying or explaining in any way what this form was. I would be surprised if any average individual knows what an ocf-3 is.

[31] As a result, I find the EOB was not in compliance with the principles as set out in *Smith v Co-operators General Insurance Company* and the *Schedule*. It also violates the basic principles of procedural fairness by denying the applicant the right to be heard as they did not have adequate notice of the denial.

[5] *Heath v Economical Mutual Insurance Company*, 2009 ONCA 391 (CanLII), 2009 95 OR (3d) 785 ("*Heath*")

Should the limitation period be extended pursuant to section 7 of the License Appeal Tribunal Act?

[32] Under s.7 of the *Licence Appeal Tribunal Act*,[6] the Tribunal may extend the time for filing an appeal of a denial of benefits beyond the legislated limitation period if it is satisfied that there are reasonable grounds for doing so.

[33] As I have found that the respondent's notice was insufficient and did not comply with s. 37(4) of the *Schedule* and the limitation period did not begin to run on September 29, 2015, and dismissed the respondent's preliminary issue on this basis alone, I do not need to address the applicant's alternative argument that the limitation period should be extended pursuant to s. 7 of the *LATA*.

ORDER

[34] The application related to the NEBs is not statute-barred. The appeal should proceed to a hearing or a case conference as required.[7]

Released: June 14, 2019

Cezary Paluch
Adjudicator

[6] *Licence Appeal Tribunal Act*, 1999, SO 1999, c 12 ("*LATA*").

[7] Para. 11 of the Order of Adj. Norris dated November 20, 2018 requires a case conference to be schedule to address the remaining substantive issues in dispute which shall take place within 3 weeks of the release of this decision. I would encourage parties to contact the Tribunal with mutually convenient dates for the case conference.