CITATION: Varriano v. Allstate, 2021 ONSC 8242
COURT FILE NO.: DC-20-051
DATE: 2021 12 14

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT
Sachs, Backhouse and Mandhane JJ

B E T W E E N:	)	
	)	
NUNZIO VARRIANO	)	Ryan M. Naimark and Nergiz Sinjari, for the Appellant
	)	
Appellant	)	
	)	
- and -	)	
	)	
ALLSTATE INSURANCE COMPANY OF CANADA	)	Sophia Chaudri, for the Respondent
	)	
Respondent	)	
	)	
	)	**HEARD at Toronto by videoconference:** December 6, 2021

REASONS ON APPEAL

MANDHANE J.

OVERVIEW

[1] The Appellant, Nunzio Varriano, was injured in a motor vehicle accident on September 30, 2015. He was insured by the Respondent, Allstate Insurance Company of Canada.

[2] On December 2, 2015, pursuant to the *Statutory Accident Benefits Schedule—Effective September 1, 2010,* O. Reg. 34/10 ("*SABS*"), Mr. Varriano applied for income replacement benefits ("IRBs"). Allstate paid him IRBs between October 7, 2015 and December 2, 2015.

[3] In a December 30, 2015 Explanation of Benefits letter ("Benefits Letter") Allstate notified Mr. Varriano that: "Your Income Replacement Benefit has been stopped on December 2, 2015, as you returned to work full-time on December 2, 2015. No further Income Replacement will be paid after this date."

[4] On July 1, 2018, Mr. Varriano says that he was forced to stop working because of his injuries arising from the motor vehicle accident. He applied to Allstate to resume his IRBs and provided them with access to his personal employment and medical records to support his claim. Allstate eventually denied his claim for IRBs stating, "Please refer to our explanation of benefits dated December 30, 2015. Our position remains unchanged."

[5] On September 28, 2018, Mr. Varriano filed an application with the License Appeal Tribunal ("LAT") disputing Allstate's decision to stop his benefits. Allstate argued that his appeal was time-barred because the Benefits Letter was a refusal that triggered the two-year limitation period which expired prior to Mr. Varriano commencing his application on September 28, 2018.

[6] The LAT adjudicator Jesse A. Boyce (the "Adjudicator") agreed with Allstate. The narrow issue before him was whether the Benefits Letter complied with the statutory requirement in s. 37(4) of the *SABs* that Allstate advise Mr. Varriano of its determination to cease paying benefits "**and the medical and any other reasons** for its determination" (emphasis added).

[7] On January 6, 2020 and again on August 21, 2020, the Adjudicator found that Allstate was not required to provide medical reasons for its denial of IRBs under s. 37(4), Allstate's Benefits Letter was a proper refusal under s. 56 of the *SABS*, and the limitation period had expired. He ordered that Mr. Varriano was statute-barred from appealing Allstate's decision.

[8] Mr. Varriano asks this Court to overturn the LAT decisions. He says that the Adjudicator's interpretation of s. 37(4) of the *SABs* was incorrect because the statutory language is clear that insurers are required to provide medical reason when stopping insurance benefits, including IRBs. Allstate says that the adjudicator's interpretation of s. 37(4) was correct as it would be "absurd" to require insurers to provide medical reasons when terminating IRBs for the sole reason that the insured person resumed employment.

[9] I would allow the appeal. The Adjudicator's interpretation of s. 37(4) was incorrect. Allstate's Benefits Letter was not a valid refusal and did not trigger the

running of the limitation period under s. 56. Mr. Varriano's appeal to the LAT is not time-barred and shall proceed on its merits.

ANALYSIS

[10] Subsection 11(6) of the *Licence Appeal Tribunal Act, 1999,* S.O. 1999, c.12, Sched. G., permits appeals to the Divisional Court on questions of law in matters related to the proper application of the *Insurance Act,* R.S.O. 1990, c. I.8.

[11] Here, I must decide the following:

- Was Allstate required to provide medical reasons for discontinuing Mr. Varriano's IRBs?
- Was Allstate's notice a valid "refusal" such that his LAT application is time-barred?
- Should the appeal of the LAT's decisions be allowed?

[12] The proper standard of review is correctness: *Canada (Minister of Citizenship and Immigration) v. Vavilov,* 2019 SCC 65, 441 D.L.R. (4th) 1, at paras. 16-17.

Was Allstate required to provide medical reasons for discontinuing Mr. Varriano's IRBs?

[13] The short answer is, yes. The correct interpretation of s. 37(4) requires insurers to advise insured persons of the medical reasons for their determination to discontinue IRBs: *T.F. v. Peel Mutual Insurance Company*, 2018 CanLII 39373 (ON LAT) at para. 15; *M.B. v. Aviva Insurance Canada*, 2017 CanLII 87160 (ON LAT) at para. 26; *R.P. v Certas Home and Auto Insurance Company*, 2019 CanLII 72198 (ON LAT) at para. 21.

[14] In *Vavilov,* at paras. 117 to 118, the Supreme Court of Canada reiterated the "modern principle" of statutory interpretation: the decision-maker should read the words in a statute "in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament'": referring to *Rizzo & Rizzo Shoes Ltd. (Re),* [1998] 1 S.C.R. 27, at para. 21; and *Bell ExpressVu Limited Partnership v. Rex,* 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 26. I am to determine the legislative intention based on its legislative history and the context for the provision's enactment: *Rizzo*, at paras. 20-23.

[15] A plain reading of s. 37(4) supports a finding that the word "and" is to be read conjunctively rather than disjunctively. In general, it is presumed that the legislature avoids tautology, and superfluous or meaningless words": *Canada*

(Canadian Human Rights Commission) v. Canada (Attorney General), 2011 SCC 53 at para. 38.

[16] A contextual analysis also supports giving effect to the plain meaning of the statutory provision. The legislature amended s. 37(4) in 2010 specifically to require insurers to provide “medical and any other reasons” for their determination to discontinue IRBs. Prior to that, the *SABS* did not require insurers to provide any reasons for their determination to stop paying benefits if the insured person had resumed their pre-accident employment duties: s. 37(4), *Statutory Accident Benefits Schedule, O. Reg. 403/96 as amended by O. Reg. 281/03.*

[17] The amendment highlights the legislative intent behind s. 37(4): to require robust information sharing that allows the insured person to make an informed decision about whether to pursue their claims and file an appeal: *R.P.,* at para. 17.

[18] Given the eligibility criteria in s. 5(1) of the *SABS,* an insured person will not be able to assess the full impact of a stoppage decision if they are not provided with current and ongoing disclosure of the insurer’s position on their disability or medical “impairment.” The imperative for full and frank information sharing about “impairment” is accomplished within the statutory scheme by requiring insurers to provide “medical and any other reasons” in myriad situations where the insurer refuses or limits coverage: ss. 36(4)(b), 36(7)(b), 38(14), 43(2), 44(5). Regardless

of the situation, the legislature's presumption of consistent expression requires that the phrase be interpreted consistently and contextually: *M.B.,* at para. 24.

[19] Placed in its proper statutory context, the requirement in s. 37(4) to provide "medical and any other reasons" for terminating IRBs is not "absurd." Insurers are not required to manufacture medical reasons where they do not exist, but to be explicit as to whether or not such reasons support denying or limiting coverage. If they explicitly deny having medical reasons to support their determination, the Applicant will come to understand that their disability or "impairment" is not currently in issue. On the other hand, if the insurer states that they have medical reasons to support their decision, the Applicant will be on notice that their ongoing "impairment" may be in issue when it comes time to apply for future benefits.

[20] Here, Allstate did not provide Mr. Varriano with adequate information to allow him to assess whether to appeal their determination. The Benefits Letter left entirely unclear Allstate's position on Mr. Varriano's future eligibility for IRBs. Because Allstate's Benefits Letter did not address the "medical reasons" for their denial, Mr. Varriano was unable to assess the full impact of their denial on his future rights. This is because employment itself is not a bar to receipt of benefits under the *SABS*. The legislation contemplates and encourages insured persons to go back to work by maintaining their eligibility for both current and future benefits: s. 7(3)(a), s. 11. The ambiguity of Allstate's reasons for terminating Mr. Varriano's benefits is at the heart of the substantive dispute before the LAT.

[21] Finally, I note that my interpretation of s. 37(4) is consistent with the general principle that "insurance coverage provisions are to be interpreted broadly, while coverage exclusions or restrictions are to be construed narrowly, in favour of the insured": *Monks v. ING Insurance Company of Canada*, 2008 ONCA 269 , 90 O.R. (3d) 689, at paras. 49-52. This is especially the case in relation to the *SABS* which establish a no-fault insurance regime for accident survivors who forego their right to civil damages and who may not have access to other resources to support their rehabilitation.

Was Allstate's notice sufficient such that Mr. Varianno's LAT application is time-barred?

[22] The parties agree that the two-year limitation period in s. 56 is only triggered after the insurer provides a valid notice terminating benefits pursuant to s. 37(4). The LAT addressed the sufficiency of notice and meaning of "medical and other reasons" in *T.F. v. Peel Mutual Insurance Company, supra,* and *M.B. v. Aviva Insurance Canada, supra*.

[23] In those cases, the then-Executive Chair of the LAT held that, in general, the insurer should:

- explain its decision with reference to the insured's medical condition and any other applicable rationale;

- 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;

- refer to the specific benefit or determination at issue, along with any section of the *SABs* upon which it relies; and

- be clear and sufficient to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue.

[24] Allstate's Benefits Letter fell short of these imminently reasonable baseline standards. It did not refer at all to Mr. Varriano's medical condition or the specific provision of the *SABS* that it relied upon to deny benefits. Overall, it was insufficient to allow Mr. Varriano to assess his future eligibility for benefits under s. 11.

[25] I reject Allstate's argument that Mr. Varriano should have assumed that Allstate's decision to deny benefits effectively meant that they no longer accepted that he was suffering from "impairment as a result of the accident." This makes no sense considering that the statutory regime allowed him to work and resume benefits in the future, so long as he was suffering from an "impairment as a result of the accident." Allstate's argument also does not accord with the lived experiences of people who suffer impairment because of a motor vehicle accident. Their disabilities can be singular or multi-faceted; physiological or psychological; temporary or permanent; transient or chronic. It follows then that some accident

survivors will be intermittently employed based on the state of their functional impairment at the time.

[26] Allstate argues that, even if the reasons in the Benefits Letter were deficient, the denial itself was unequivocal such that the limitation period began to run. In *Sietzema v. Economical Mutual Insurance Company,* 2014 ONCA 111, 118 O.R. (3d) 713, at paras. 12-13, the Court of Appeal held that it was sufficient for the insurer to give clear and unequivocal notice that it was cancelling benefits to trigger the limitation period, even if their reasons for stopping the benefit were incorrect. In *Bonaccorso v. Optimum Insurance Company Inc*, 2016 ONCA 34*,* 129 O.R. (3d) 544, at para. 19, the Court of Appeal clarified that an unequivocal denial of benefits was sufficient to trigger the limitation period, even if the insured person's eligibility for future benefits under s. 11 was left unclear.

[27] In my view, *Seitzema* and *Bonaccorso* are of limited assistance because the Court was considering the proper interpretation of the pre-2010 *SABS*, which did not explicitly require "medical and any other reasons" as part of the insurer's decision to deny IRBs. The Court of Appeal's narrow focus on the clarity of the insurer's ultimate decision to deny benefits cannot be justified in the face of the legislature's 2010 amendments that clearly and explicitly require insurers to provide adequate reasons for their determination, including medical reasons.

[28] Allstate's Benefits Letter was not a valid refusal and did not trigger the running of the limitation period.

Should the appeal of the LAT's decision be allowed?

[29] The appeal is allowed. Adjudicator Boyce erred in law in his interpretation of s. 37(4) of the *SABS.*

[30] The matter shall be remitted back to the LAT for a hearing on its merits.

[31] The parties have agreed on the matter of costs. Allstate shall pay Mr. Varriano $7,500 in costs.

Mandhane J.

I agree Sachs J.

I agree Backhouse J.

Released: December 14, 2021

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Appellant

- and -

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