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

Ontario

Tribunal File Number: 17-002496/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.

And in the matter of a motion brought by the respondent seeking an order staying the application for non-earner benefits and one medical and rehabilitation benefit.

Between:

J. L.

Applicant

And

Aviva Insurance Company of Canada

Respondent

PRELIMINARY ISSUE DECISION (AMENDED)

Adjudicator: **D. Gregory Flude**

APPEARANCES:

Counsel for the Applicant: **Jono Schnieder**

Counsel for the Respondent: **Gina Nardella and Surina Sud**

Heard in Toronto: **October 25, 2017**

INTRODUCTION:

[1] The applicant was injured in an automobile accident on February 29, 2012. She is seeking a number of benefits under the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "Schedule"), including a non-earner benefit and various medical and rehabilitation benefits. The respondent has denied the benefits and the applicant has applied to this Tribunal to determine her entitlement.

[2] At the outset of the hearing, the respondent brought a motion to determine two issues. The first issue relates to the applicant's entitlement to commence a proceeding for a non-earner benefit. The second relates to the application of the two year limitation period to one of the medical and rehabilitation benefits the applicant is seeking.

[3] The respondent has taken the position that the applicant has failed to complete all of the formal steps necessary to properly apply for a non-earner benefit prior to commencing her application for dispute resolution at the Tribunal. The consequence of that failure is that there is no dispute between the parties. Since a dispute is a prerequisite for an application to the Tribunal, the Tribunal has no jurisdiction to entertain this application.

[4] The respondent also argues that the claim for one of the medical benefits sought by the applicant was brought beyond the statutory two year limitation period set out in the Schedule.

PRELIMINARY ISSUES

[5] The case conference order defines the preliminary issues in this matter as:

(i) Whether the applicant is barred from proceeding with her claim for income replacement benefits or non-earner benefits because she failed to complete an election of benefits form (OCF 10) to make an election?

(ii) Whether the applicant is statute barred from proceeding with her claim for a medical benefit denied by the respondent on May 5, 2012 because it is out of time and is past the 2 year limitation period from the date of denial?

[6] The respondent asks to reframe the first issue concerning the election form as a jurisdictional issue. As stated above, in its submission, it has not yet made a decision on whether to accept or deny the claim for a non-earner benefit. It

argues that it is the denial of a benefit that creates the right of appeal. Absent a denial, there is no right of appeal.

[7] The applicant submits that I should address the question as stated in the case conference order and not consider the jurisdiction question. In her submission, the failure to file an election form does not remove jurisdiction from the Tribunal. The consequences of the failure are to be found in the Schedule.

[8] I do not consider the issue as reframed differs in substance from the issue as it is stated in the case conference order. While the question as framed does not specifically use the word "jurisdiction," but uses "barred," at issue is the question of whether the matter can proceed in the absence of a denial of the benefit. The respondent focussed its submissions on its inability to adjust the applicant's claim; the applicant focussed on the regulatory provisions surrounding the payment of a non-earner benefit. The submissions were simply two approaches to the question of the applicant's entitlement to a non-earner benefit in the absence of an election and a denial.

RESULTS

[9] I find that the applicant cannot proceed with her claim for a non-earner benefit. Her failure to identify the specific benefit she is seeking until after the commencement of this application denied the respondent the ability to consider her claim and make an informed decision on her entitlement to the benefit or give reasons why, in its view, she was not entitled to it. The respondent has not yet denied the benefit so there is no dispute upon which an application can be based.

[10] With respect to the lapse of the two year limitation period concerning the May 5, 2012 denial of a medical benefit, I find that the limitation period has not started to run. The May 5 letter does not clearly and unequivocally deny the benefit. It does not include an explanation of the appeal process for disputing the respondent's decision and fails to advise the applicant of the two year limitation period. It runs afoul of the minimum requirements set out by the Supreme Court of Canada in *Smith v. Co-Operators Insurance Company* [1]and is not effective to start the limitation clock. I verbally informed the parties of this decision and gave them reasons at the hearing and I will not expound my reasoning further.

ANALYSIS

[11] The dispute between the parties turns on the question of when the applicant filed a claim for benefits and if, when she did so, was it for a non-earner benefit. To

[1] *Smith v. Co-operators General Insurance Co.*, [2002] 2 SCR 129, 2002 SCC 30 (CanLII), 210 DLR (4th) 443; 36 CCLI (3d) 1; 286 NR 178; JE 2002-663; [2002] SCJ No 34 (QL); 112 ACWS (3d) 950; 158 OAC 1

resolve the dispute I must look at both the timing and content of the documents filed by the applicant and what obligations the filing imposed on the respondent.[2]

When did the Respondent first receive an Application for Benefits?

[12] The Schedule sets out the manner in which injured persons may apply for and receive benefits. It places obligations on both insurers and on injured persons. It also defines the consequences of a failure of either of the injured person or the insurer to fulfill those obligations.

[13] The obvious first obligation is that an injured person must notify the insurer of an intention to apply for benefits. The Schedule states the notification must be within 7 days or as soon as practical after the accident.[3] The second obligation is to file an application for benefits. In the event there is a claim for an income replacement benefit or a non-earner benefit, as in this matter, the application must be accompanied by a disability certificate. The application for benefits is to be filed within 30 days. When the application and disability certificate indicate that an injured person may be entitled to two or more of an income replacement benefit, a non-earner benefit or a caregiver benefit, the insurer must send an election form and the insured must elect one of the benefits to the exclusion of the others.

[14] There is a dispute between the parties about when the applicant filed the disability certificate with the respondent. In the applicant's submission, the date of the filing of the disability certificate is the date that the respondent's obligation to pay the non-earner benefit was triggered. The applicant argues that that date was in and around June 7, 2012; the respondent argues it was January 2015. The respondent submits that, notwithstanding the date of the receipt of the disability certificate, the application remained incomplete until the applicant filed her election. I agree with the respondent's submission that there is no application for a non-earner benefit until the applicant makes her election so I do not need to address the question of when the disability certificate was actually filed in this preliminary issue hearing.

What Constitutes an "Application?"

[15] To answer the question of what constitutes an application, it is necessary to consider a number of interrelated provisions of the Schedule. The term "application" is not specifically defined in the definition section, s. 3. With respect to a claim for an income replacement or a non-earner benefit, s. 36 requires a disability certificate to accompany the application for benefits. Thus, it appears that a completed disability certificate is a prerequisite to apply for these benefits.

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[2] I have attached a more detailed Chronology as Schedule A.

[3] Section 32 of the Schedule

The applicant argues that the disability certificate is the application for a non-earner benefit in this case and receipt of it obliged the respondent to pay the benefit; give the applicant a notice explaining the medical and any other reasons why the insurer does not believe the applicant is entitled to the specified benefit and, if the insurer requires an examination under section 44 relating to the specified benefit, advising the applicant of the requirement for an examination; or send a request to the applicant under subsection 33 (1) or (2). I find this interpretation ignores other provisions of the Schedule, in particular, ss. 32(7) and 35.

[16] As stated above, s. 32 sets out the duties and obligations of the parties when applying for a benefit. Section 32(6) and (7) address the procedure when problems arise. Subsection (6) requires an insurer who has received an incomplete application to notify the applicant of the problem. Subsection (7)(a) states that an insurer shall not give a notice that an application is incomplete unless the insurer, after a reasonable review of the incomplete application, is unable to determine whether a benefit is payable without the missing information. An incomplete application, then, is one in which the insurer is unable to reasonably determine what benefit the applicant is seeking.

[17] Where the uncertainty over the benefit being sought arises out of a potential concurrent entitlement to two or more of an income replacement benefit, a non-earner benefit or a caregiver benefit, s. 35 requires that an insurer require the applicant to make an election. Except in the case of a catastrophically impaired claimant, the election is irrevocable once made.

[18] In considering the interpretation and interplay of the above sections of the Schedule, I have applied the modern approach to statutory interpretation. It requires that the words of a statute be read "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." This approach involves consideration of 3 factors:

- The language of the provision,
- The context in which the language is used, and
- The purpose of the legislation or statutory scheme in which the language is found.[4]

[19] Applying these principles, I find that the Schedule, while being consumer protection legislation that should be given a broad and liberal interpretation, nonetheless obliges applicants to provide sufficient information for insurers to understand the nature of the claim and the benefit sought. The term "application"

[4] Rizzo & Rizzo Shoes Ltd. (Re), [1998] 1 S.C.R. 27 citing *Driedger on the Construction of Statutes* (3rd ed. 1994) at page 87.

includes all the necessary documents for an insurer to make that determination. An insurer should have sufficient detail before it to be able to say that this applicant is seeking this benefit.

Was the Respondent able to determine the nature of the applicant's claim based on the information available to it?

[20] In assessing the applicant's claim, the respondent had two documents before it: the OCF-1 and the disability certificate. It argues that, when viewed together, they demonstrate that the applicant was potentially entitled to one of an income replacement benefit or a non-earner benefit. Pursuant to its obligations under s. 35, the respondent put the applicant to her election. Until the applicant filed her election, the respondent was unable to understand the nature of her claim and take steps to assess her entitlement. The applicant argues that the only benefit she was seeking was a non-earner benefit and that this fact was clearly identified to the insurer in the disability certificate that accompanied her application.

[21] A review of the documents shows that the applicant potentially qualified for both an income replacement benefit and a non-earner benefit. Section 35 obliged the respondent to put the applicant to her election and until she did so, it was unable to identify the nature of her claim or the benefit she was seeking. Indeed, that inability carried over beyond the filing of the application to the Tribunal where the applicant applied for both benefits.

[22] The information provided in the OCF-1 filed by the applicant confirms that the applicant could have been entitled to a non-earner benefit because she was not employed at the time of the accident but could have also been entitled to an income replacement benefit because she was employed for 26 of the 52 weeks prior to the accident. The OCF-1 form asked her if she had been employed for 26 out of the past 52 weeks. She answered "yes." This answer entitled her to claim an income replacement benefit. The applicant was not employed on the date of the accident so she was entitled to seek a non-earner benefit. The respondent notified her of her requirement to make an election on January 30, 2015. She finally filed that election in July 2017 after the case conference in this matter.

[23] The applicant points to the disability certificate as evidence that she submitted an application for non-earner benefits. In answer to a number of medical questions about the scope of her injuries, the healthcare professional who completed it answered as not applicable (n/a) questions relating the applicant's ability to carry out the essential tasks of her employment. She was not working at the time so this was the only possible answer. In and of themselves the answers do not exclude a potential claim for an income replacement benefit.

[24] Questions relating to the applicant's ability to carry on a normal life, that is, the test relating to entitlement to a non-earner benefit, were answered in the affirmative. The applicant argues that by virtue of s. 36(4) of the Schedule, these

answers obliged the respondent to take one of the three steps set out above: pay the benefit, deny the benefit and send the applicant for an independent medical examination or request further information under s. 33. I do not agree. I am of the view that s. 36 cannot be read in isolation. Despite this, even by its own terms it does not bear the applicant's interpretation.

[25] The obligation in s. 36 is to pay "the specified benefit." The failure of the applicant to specify the benefit does not trigger the obligations in s. 36(4). At best the disability certificate is equivocal because it does not exclude entitlement to an income replacement benefit; it merely states that given the applicant's lack of current employment, questions regarding her ability to complete the essential tasks of her employment are not applicable.

[26] The requirement to take the steps set out in s. 36(4) is triggered by the receipt of the application and the disability certificate. As I have found above, the application is not complete until the nature of the claim and the benefit being sought are identified. To accede to the applicant's argument is to render s. 35 of no effect. The effect of s. 35 is to require the applicant to identify what she seeks and it cannot be said that there is a completed application until she does so.

[27] The applicant further argues that she does not qualify for an income replacement benefit because she was not, in fact, employed for 26 out of the previous 52 weeks. While that may be true, there was nothing before me to suggest that this information was ever put before the respondent. Indeed, filing the election form would have cleared the point up entirely. In the absence of that information, it was totally proper and reasonable to require the applicant to file her election.

What is the impact on this proceeding of the failure to file an election?

[28] The respondent submits that the jurisdiction of the Tribunal is limited to adjudication of disputes. It further submits that there is no dispute until it has issued a denial of the non-earner benefit, something it has yet to do. It relies on a decision of this Tribunal, *D.B. and Cumis General Insurance*, for the proposition that the applicant cannot simply file the appropriate documents after applying to the Tribunal and make an application that was originally void, valid.

[29] In *D.B. and Cumis General Insurance*, the applicant, D.B. was seeking an attendant care benefit. The respondent, Cumis General Insurance, agreed that the applicant was entitled to the benefit in question but argued that he had not submitted any financial information in support of payment of the benefit. D. B. submitted the financial information as part of the documents he relied on at the hearing. He took the position that, since the respondent now had all of the information, it could make a decision to pay or not and the matter could proceed to a hearing. Adjudicator Johal held that since the respondent had been denied the ability to review the documents before the proceeding commenced, it had not denied the attendant care benefit. In the absence of a denial, the applicant had no

entitlement to apply to the Tribunal for the resolution of a dispute, as there was not, in fact, a dispute until the respondent had denied payment. Delivering the documents during the proceeding was improper as it completely circumvented the claims adjustment process.

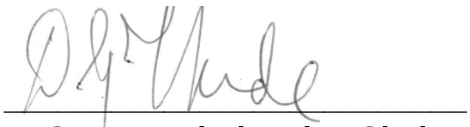
[30] I agree with the reasoning in *D.B. and Cumis General Insurance*. There is a very practical consideration to the reasoning in the current case. On the facts available to the respondent on receipt of the OCF-1 and the disability certificate, the applicant potentially qualified for two benefits, an income replacement benefit and a non-earner benefit. The statutory test for legal entitlement to each of these benefits is significantly different and would require the respondent to retain the services of professionals with very different skill sets to evaluate the claims. Until the applicant identified which benefit she was seeking, the respondent could not begin to review its file and organize any independent examinations it might require. By permitting the application to proceed, I would be denying the respondent its most fundamental right, the right to examine a claim. I find that the application for a non-earner benefit was void from the start and is, therefore, dismissed.

ORDER

[31] Having considered the evidence and submissions of the parties, I order that:

(i) The application for a non-earner benefit is dismissed without prejudice to the applicant bringing the application before the Tribunal once the respondent has issued its decision; and
(ii) The claim for a medical benefit purportedly denied on May 5, 2012 is not barred by virtue of the two year limitation period and may proceed to a hearing.

RELEASE DATE: January 2, 2018



D. Gregory Flude, Vice-Chair

SCHEDULE A

Chronology

[32] I have two affidavits before me from which I have determined the course of events. The first is sworn by Andrew Ferguson, the respondent's Accident Benefits Claims Advisor who dealt with the applicant in this matter until April 2017. The second is a one page hand-written affidavit from, Ingrid Kehler, the medical secretary at the offices of Dr. Kevin Grant. The second affidavit addresses the question of when the Application for Benefits form was sent to the respondent. It is superficially at odds with Mr. Ferguson's evidence and I will address that inconsistency as I go through the chronology.

[33] Both affidavits were sworn a number of years after the events to which they refer. Ms Kehler's affidavit was sworn three years after the event it refers to and Mr. Ferguson's recital of events starts five and a half years after the events initially described. I do not doubt that each affiant referred to some form of note or record. In the case of Mr. Ferguson, he details telephone conversations but does not provide me with contemporaneous notes or log entries. Ms. Kehler provides no supporting correspondence. Despite these shortcomings, I believe the affiants were giving their best recollection of the events in question. Since Ms. Kehler's affidavit deals only with events in and around June 6 and 7, 2012, I rely on Mr. Ferguson's affidavit for the broader picture.

[34] The chronology is as follows:

2012 Events

- Accident occurred on February 29, 2012
- On March 13 Andrew Ferguson sent an Accident Benefits Package to the applicant and offered telephone assistance to help the applicant fill out the forms
- On May 9 the applicant submitted a treatment plan for chiropractic services dated March 5. Mr. Ferguson reviewed the file and determined that the applicant had still not filed an application for benefits form (this form is referred to as an OCF-1)
- On May 15, Mr. Ferguson wrote to the applicant to advise of the need for her to submit an OCF-1 within 15 days of receipt of his letter
- According to the applicant's interpretation of Ms. Kehler's affidavit, she sent in a completed OCF-1 to the respondent in and around June 7. The respondent states that it never received the OCF-1 from Ms. Kehler
- Mr. Ferguson spoke to the applicant by telephone on July 18 and advised her that he had not yet received the OCF-1. On the same date, Mr. Ferguson forwarded another copy of the Accident Benefits Package to the applicant

- On August 8, during a telephone conversation, the applicant advised Mr. Ferguson that the OCF-1 form had been completed but she was waiting for approval of treatment from her surgeon, Dr. Grant, before mailing it. Mr. Ferguson asked the applicant to include a note from the surgeon explaining the delay in treatment. He informed the applicant that the respondent would pay any charges related to the preparation of the note.
- On October 29, when nothing was forthcoming from the applicant, Mr. Ferguson wrote to the applicant denying payment of the treatment plan because the applicant had failed to submit the OCF-1

2013

- There was no action on the file in 2013

2014

- On March 14, again on September 25 and finally on October 20, Elio Laraia a paralegal retained by the applicant, wrote the respondent and asked for a copy of the respondent's file. Mr. Ferguson sent the file on October 20.

2015

- On January 21, the respondent received a completed OCF-1. The OCF-1 indicated at box 5 that the applicant had worked for 26 weeks in the last 52 indicating that the applicant may be eligible for either of an income replacement benefit or a non-earner benefit.
- On January 30, Mr. Ferguson wrote to the applicant, copied to her legal representative, that she would have to complete and file an election form indicating which of the two benefits she was seeking.

2016

- Nothing happened in the file from January 2015 until March 22 when Mr. Ferguson wrote to the applicant advising that she was required to file an election form for the respondent to be able to adjust her claim for benefits

2017

- On April 21 the Tribunal received the Application by an Injured Person dated March 30. The application seeks both an income replacement benefit in the amount of $185/week or a non-earner benefit in the amount of $185/week.
- On July 17 the applicant filed an election to seek a non-earner benefit rather than an income replacement benefit.