CITATION: Lefebvre v. Aviva Insurance Company of Canada, 2018 ONSC5676
DIVISIONAL COURT FILE NO.: DC-012/18
DATE: 20181002

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

SWINTON, THORBURN AND MATHESON JJ.

BETWEEN:	)	
	)	
JACLYN DANIELLE LEFEBVRE	)	*Jono Schneider*, for the Applicant/Appellant
	)	
Applicant/Appellant	)	
	)	
– and –	)	
	)	
AVIVA INSURANCE COMPANY OF CANADA	)	*Gina Nardella* and *Surina Sud*, for the Respondent
	)	
Respondent	)	
	)	
	)	
	)	**HEARD at Toronto:** September 13, 2018

W. MATHESON J.

[1] This is an appeal from the decision of the Licence Appeal Tribunal ("LAT") dated December 12, 2017, with amended reasons for decision released on January 2, 2018 (the "Decision").

[2] The appeal is on questions of law only: s. 11(6), *Licence Appeal Tribunal Act, 1999*, S.O. 1999, c. 12, Sch. G.

[3] The Decision relates to the *Statutory Accident Benefits Schedule — Effective September 1, 2010,* O. Reg. 34/10, s. 1 (the "SABS") and more specifically an election between non-earner benefits and income replacement benefits under s. 35 of the SABS.

[4] For the reasons set out below, the appeal is dismissed.

Brief background

[5] The Appellant was in a motor vehicle accident on February 29, 2012.

[6] On March 5, 2012, a physician prepared a treatment plan (OCF-18) for the Appellant, as well as completing a Disability Certificate (OCF-3). However, those documents were not provided to the Respondent at that time.

[7] On March 13, 2012, the Respondent sent the Appellant an Accident Benefits package and provided the name of an adjuster who was available to provide telephone assistance to help the Appellant fill out the enclosed forms.

[8] On May 9, 2012, the Appellant sent the Respondent the OCF-18 and OCF-3 that had been completed on March 5, 2012.

[9] On May 15, 2012, the Respondent wrote to the Appellant indicating that an OCF-1 must be submitted within 30 days of receipt of the Accident Benefits package. The Respondent requested that the Appellant's OCF-1 be submitted within 15 days of its letter.

[10] There is a dispute about when the Appellant provided her OCF-1. According to the Appellant, she completed that form on June 6, 2012 and left it with her physician's receptionist to submit to the Respondent. There is some evidence in the record that this was done. However, according to the Respondent, the OCF-1 was not received until January 2015, nearly three years after the accident. The Appellant acknowledges that the appeal does not turn on when that document was sent to the Respondent.

[11] Nothing happened in 2013. A paralegal was then retained by the Appellant, and wrote asking for a copy of the file in March, September and October 2014. It was sent in October 2014.

[12] Whether for the first or second time, the OCF-1 dated in June 2012 was sent to the Respondent on January 21, 2015.

[13] On the subject of the benefits now at issue, the OCF-1 indicated that Appellant was not employed at the time of the accident, but that she had been employed for 26 of the 52 weeks prior to the accident. In an Explanation of Benefits letter dated January 30, 2015, the Respondent notified the Appellant that it appeared that she may be entitled to an income replacement benefit and a non-earner benefit. The Respondent therefore gave notice to the Appellant under s. 35 of the SABS that she would have to complete and file an election form (OCF-10) indicating which of the two benefits she was seeking within 30 days.

[14] No election was forthcoming. On March 22, 2016, the Respondent wrote to the Appellant again indicating that she was required to file an election form electing between an income replacement benefit and a non-earner benefit before the Respondent could adjust her claim.

[15] The Appellant did not make an election. Instead, about two years later, the Appellant brought an application to the LAT.

LAT application

[16] The LAT application indicated that an income replacement benefit and a non-earner benefit were in dispute.

[17] A Case Conference regarding the LAT application was held on July 12, 2017, before Adjudicator Purdy. Adjudicator Purdy made certain orders regarding the conduct of the hearing of the application. Among other things, she determined that there were the following preliminary issues:

(i) whether the Appellant was barred from proceeding with her claim for an income replacement benefit or non-earner benefit because she failed to make an election between those benefits; and,

(ii) whether the Appellant's claim for a medical benefit was statute-barred due to the expiry of a two-year limitation period.

[18] After the Case Conference, but before the hearing, the Applicant provided a completed OCF-10, electing non-earner benefits.

[19] The hearing proceeded before Adjudicator Flude, commencing with the preliminary issues. Only the decision on the first preliminary issue is challenged on this appeal.

[20] The crux of the decision on the first issue was the Appellant's failure to make an election between the non-earner benefit and the income replacement benefit before commencing the LAT proceeding.

[21] The Adjudicator found that the OCF-1 confirmed that the Appellant "potentially qualified for both an income replacement benefit and a non-earner benefit." This gave rise to the notice of election under s. 35 of the SABS. The Appellant relied on the OCF-3 and the OCF-18 that had been submitted in 2012, both of which indicated that the Appellant was not employed at the time of the accident and one of which indicated "n/a" in response to her ability to carry on the essential tasks of her employment. However, those answers did not exclude a potential claim for an income replacement benefit since that benefit was also available if she had been employed 26 of the 52 weeks prior to the accident. On the OCF-1 submitted by the Appellant, that box had been ticked.

[22] The Adjudicator found that the application for benefits was not complete until the nature of the claim and the benefits being sought were identified. Section 35 of the SABS required the Respondent to give notice and required the Appellant to elect which benefit she wished to receive within 30 days after receiving the notice. As of the commencement of the LAT proceedings some two years later, the Appellant had not made an election. The Adjudicator found that "it cannot be said that there is a completed application" until the Appellant made her election. He therefore found that the Respondent's obligation to pay or take other steps under s. 36(4) of the SABS had not yet been triggered.

[23] The Adjudicator then addressed the question: "What is the impact on this proceeding of the failure to file an election?" The Adjudicator found that making the election after the commencement of the LAT application circumvented the claims adjustment process. The

Adjudicator found that the application for a non-earner benefit was "void from the start" for failure to make the election before commencing the LAT application. However, the order was worded differently. On the first issue, the Adjudicator ordered as follows:

> 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; [Emphasis added.]

[24] This appeal was then commenced, challenging the above order.

Analysis

[25] The Appellant raises three issues arising from the Decision, as follows:

(i) whether the LAT erred in law in its ruling on what constituted a sufficiently complete application for benefits, failing to find that there was an application in 2012;

(ii) whether the LAT erred in law in requiring that the Appellant make an election; and,

(iii) whether the LAT erred in law in its order requiring that the Appellant await the Respondent's "decision" before bringing another LAT application.

[26] It is agreed that the standard of review is reasonableness: *Melo v. Northbridge Personal Insurance Corporation*, 2017 ONSC 5885 (Div. Ct.), at para. 7.

[27] On the first issue, the Appellant relies upon *ING Insurance Company of Canada v. TD Insurance Meloche Monnex*, 2010 ONCA 559. In *ING*, the Court of Appeal addressed the question of whether the forms submitted in that case amounted to completed applications for accident benefits, triggering the insurer's obligation to pay, even though there was no OCF-1. *ING* was a dispute between two insurers that turned on the question of which insurer was the first to receive a completed application for accident benefits. The Court of Appeal ruled as follows, at para. 51:

> [A]n application for accident benefits need not be on a certain form in order to be valid - - it need only provide sufficient particulars to reasonably assist the insurer processing the application, identifying the benefits to which the applicant may be entitled, and assessing the claim: [citation omitted]. That is, the insurer only needs sufficient information to meaningfully move forward or commence the process of adjusting the claim [citations omitted]. [Emphasis added.]

[28] Relying on *ING*, the Appellant submits that an OCF-1 was not required and the Respondent ought to have proceeded based on one or both of the OCF-18 and OCF-3 that the Respondent received in 2012. The Appellant submits that OCF-18 and the OCF-3 contained sufficient information to know what benefits were sought, given the statements that the Appellant was

unemployed and the "n/a" in response to her ability to carry on the essential tasks of her employment.

[29] The Adjudicator did not reach his decision on the basis that an OCF-1 was required. The Adjudicator considered the above documents as well as the OCF-1 filed by the Appellant. He found as a fact that the OCF-1 confirmed the Appellant could have been entitled to both a non-earner benefit and an income replacement benefit. That finding gave rise to the need for an election under s. 35 of the SABS. He found that even if the Appellant had not worked for 26 of the 52 weeks prior to the accident, as put forward at the LAT hearing, there was nothing before him to suggest that information was before the Respondent at the relevant time. The OCF-1 signed by the Appellant said the opposite.

[30] In essence, the Appellant is asking us to re-examine the facts as set out on the various forms and reach a different factual conclusion. That is beyond the scope of this appeal, which is limited to questions of law.

[31] In the Decision, the Adjudicator ruled that "the application is not complete until the nature of the claim and the benefit being sought are identified." Taken in the context of the need for an election under s. 35, this is not materially different from the above ruling in *ING*. In accordance with s. 35, the insurer needed to know which of those alternative benefits the Appellant was electing in order to begin the process of adjusting the claim for that benefit.

[32] On both the first and second issues raised in this appeal, the Appellant also submits that the Adjudicator erred in law in requiring an election at all. The Appellant submits that there is no role for s. 35(1) even though it is in the SABS.

[33] Subsection 35(1) provides as follows:

> 35. (1) <u>If an application indicates that the applicant may qualify for two or more of the income replacement benefit, the non-earner benefit</u> and the caregiver benefit under Part II, the insurer shall, within 10 business days after receiving the application, give a notice to the applicant advising <u>the applicant that he or she must elect, within 30 days after receiving the notice, the benefit he or she wishes to receive</u>. [Emphasis added.]

[34] In the Appellant's submission, this subsection has no role in this case. The Appellant submits that the caregiver benefit is not available, and the Appellant was never eligible for the income replacement benefit. The submission before us is that despite s. 35(1), no purpose was served by the Appellant making an election and to require an election was an error of law. This is contrary to both the factual findings made by the Adjudicator and the express words of the section.

[35] The Adjudicator made a finding that the Appellant may qualify for the income replacement benefits or the non-earner benefit based on the forms completed. Given that finding, s. 35(1), on its plain language, was invoked. There was not an error in law in requiring that the Appellant elect which benefit she wished to receive under s. 35(1).

[36] The third issue questions whether the Appellant must await a denial of benefits by the insurer before there is a "dispute" about the non-earner benefits that could be challenged at the LAT. If so, the Appellant submits that the Respondent can control access to the LAT and its mandatory dispute resolution, which is an error of law.

[37] Sections 280 of the *Insurance Act*, R.S.O. 1990, c. I.8, provides for the resolution of "disputes" by the LAT, not the court, as follows:

> 280 (1) This section applies with respect to the resolution of disputes in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled.
>
> (2) The insured person or the insurer may apply to the Licence Appeal Tribunal to resolve a dispute described in subsection (1).
>
> (3) No person may bring a proceeding in any court with respect to a dispute described in subsection (1), other than an appeal from a decision of the Licence Appeal Tribunal or an application for judicial review. [Emphasis added.]

[38] The Adjudicator posed the question: "What is the impact on this proceeding of the failure to file an election?" The Adjudicator focused on the Appellant's failure to make an election before she commenced her application to the LAT and the impact of the election that was made during the application.

[39] The Adjudicator followed *D.B. and Cumis General Insurance*, 16-002730/AABS, and found that an applicant cannot file the appropriate documents (here, the election) after the LAT application was commenced to make the application valid. The Adjudicator found that by permitting the LAT application to proceed in those circumstances, he would be denying the Respondent its right to examine the claim. The Adjudicator therefore concluded that the application was void from the start, and was therefore dismissed. In other words, there was no dispute when the LAT application was commenced because an election had not been made (let alone responded to), and that defect was not cured by the election made after the commencement of the LAT application. This is apparent from the reasons for decision.

[40] The Appellant does not challenge the Adjudicator's finding that the LAT application was void and not saved by the late election. It is the wording of the Adjudicator's order that is the focus of the Appellant's third issue on this appeal. The order provided that the application was dismissed without prejudice to the Appellant bringing another application "once the Respondent has issued its decision".

[41] The Appellant's issue arises if the reference to a "decision" means that there must be a denial of benefits before a claimant can go to the LAT. That is certainly the Respondent's position. However, that is not what the order says and to interpret it that way would be very problematic. It would place control over access to the LAT in the hands of the insurer and permit an insurer, through bad faith conduct such as deliberate delay, to prevent or wrongly delay access to the LAT.

[42] When asked what a claimant was to do where there was bad faith conduct such as deliberate delay by an insurer, the Respondent submitted that those problems must be pursued in court. This raises additional issues, which were not before the Adjudicator: see, e.g., the discussion in *Stegenga v. Economical Mutual Insurance Company,* 2018 ONSC 1512.

[43] The order must be read in context. The Adjudicator did not order that the Appellant had to wait until there was a denial of the non-earner benefits, despite being invited to do so by the Respondent. As for the meaning of "decision" in the order, the SABS specifically provide for the next steps, as set out in s. 36. That section provides different courses of action that an insurer must decide between. Many points of decision follow depending on the course of events. The Adjudicator did not discuss what could constitute a decision after an election, nor did he deal with delay, when delay would amount to a denial of benefits or how bad faith should be addressed. Bad faith was not at issue. The application before him turned, in his view, on whether the failure by the Appellant to make an election before commencing the LAT application meant that there was not yet a dispute.

[44] Read in context, the Adjudicator's order only required that there be some decision by the Respondent that was being challenged by the Appellant before there was a dispute. That would include a denial of benefits, but might also include all manner of decisions called for under the SABS and could include implied decisions through delay or other conduct. The order does not require that the decision be a formal denial of benefits. Whether subsequent events are sufficient to constitute a dispute can be addressed at the time, on the facts, as they may arise.

[45] In conclusion, the order in the Decision, properly interpreted, falls within the range of possible, acceptable outcomes on the facts of this case as found by the Adjudicator.

Orders

[46] The appeal is therefore dismissed.

[47] The Respondent, as the successful party, shall have its costs in the agreed upon amount of $6,000, all inclusive.

W. Matheson J.

I agree K. E. Swinton J.

I agree J.A. Thorburn J.

Released: October 2, 2018

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Applicant/Appellant

– and –

AVIVA INSURANCE COMPANY OF CANADA

Respondent

REASONS FOR DECISION

Released: October 2, 2018