

A photograph showing the front end of a blue car that has been involved in a collision. The car is parked on a snowy and icy surface. The front bumper is crumpled and partially detached, and the hood is bent upwards. A small, round, yellow object, possibly a light or a sensor, lies on the ground near the front wheel. The car's license plate is visible and reads "VAX 111".

What Are the Best Practices Insurers Should Follow When Seeking Repayment of Benefits Under the Statutory Accident Benefits Schedule?



While repayment is an indispensable tool in mitigating exposure, the procedural requirements can be complicated, with non-compliance potentially barring an insurer from recovery.

The purpose of this article is to provide a concise roadmap for all stages of the repayment claims handling process.

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Determining Whether the Insurer is Entitled to Seek Repayment

At the start of any repayment claim will be the question of whether an insurer can actually claim for repayment. Section 52 of the *Schedule* specifies the circumstances in which repayment can be sought.

Specifically, subsection 52(1) indicates that a person is liable to repay to an insurer:

“(a) any benefit described in this Regulation that is paid to the person as a result of an error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud;

(b) any income replacement or non-earner benefit under Part II that is paid to the person if he or she, or a person in respect of whom the payment was made, was disqualified from receiving the benefit under Part VII; or

(c) any income replacement, non-earner or caregiver benefit under Part II or any benefit under Part IV, to the extent of any payments received by the person that are deductible under this Regulation from the amount of the benefit.”



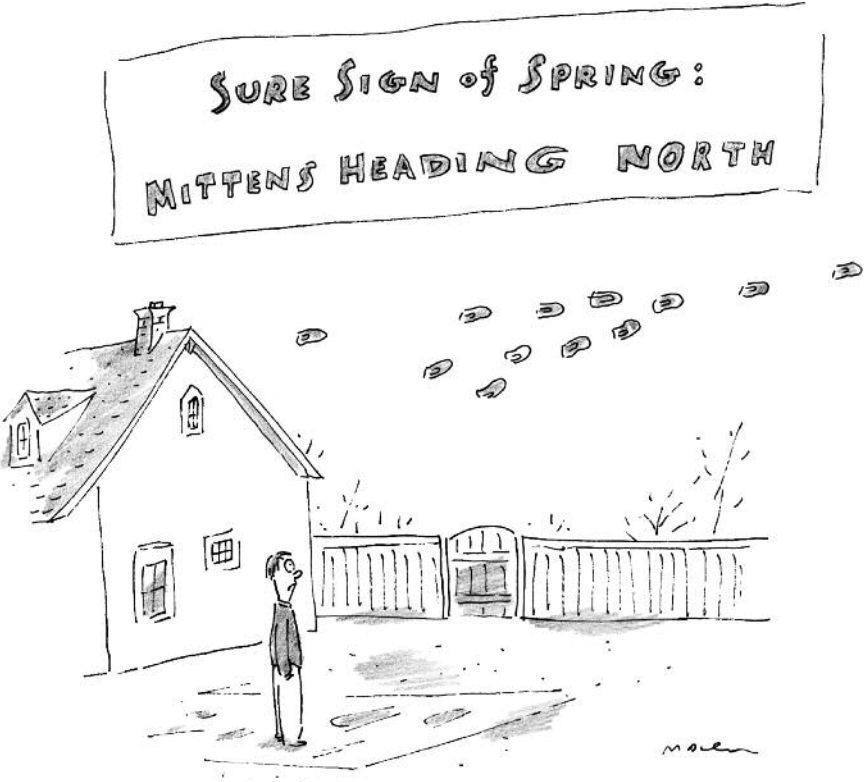
As per the above, an insurer is entitled to claim repayment of any benefit payable under the *Schedule* where payment of the benefit was due to error or was as a result of wilful misrepresentation or fraud.

With respect to income replacement and non-earner benefits, a repayment claim can arise where the insured person was disqualified from receiving the benefit under Part VII of the *Schedule*. The disqualification criteria under Part VII are numerous. Generally speaking, they relate to situations where a vehicle is uninsured, the driver is unlicensed or did not have consent from the owner to operate the vehicle, where the insured person was involved in a criminal act at the time of the accident, or where the insured person has made, or knows of, a material misrepresentation that induced the insurer to enter into the contract of automobile insurance or who intentionally failed to notify the insurer of a change in a risk material to the contract.


It is important to note that, in situations where an occupant of a vehicle knows or ought to reasonably know that the vehicle is being operated by an excluded driver, they are still permitted to recover accident benefits under a motor vehicle liability policy that lists them as a named insured. This exception extends to the excluded driver.

In situations where criminal charges have been laid, an insurer is entitled to hold amounts payable for income replacement and non-earner benefits in trust, until the final disposition of the criminal charge. In the event that the insured person is convicted, amounts held in trust will remit back to the insurer.

Finally, an insurer is entitled to seek repayment of lost educational expenses, visitor expenses, damage



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After determining that repayment can be claimed, an insurer must provide notice of its repayment demand to the person from whom repayment is being sought.

to clothing etc., and income replacement, non-earner, caregiver, house-keeping, and cost of examination benefits, where the insured person has received payment that is deductible from any of these benefits under the *Schedule*.

Subsection 52(1) has remained in place and unchanged since the introduction of the current version of the *Schedule* on September 1, 2010. It is important to note that while the prior version of the *Schedule* included similar provisions, there are important differences. The information outlined in this article should not be relied upon exclusively with respect to repayment claims where the date of loss pre-dates September 1, 2010.

It should also be noted that an insurer is entitled to receive interest on the amount to be repaid.

Practically speaking, the interest collectible is trivial, payable at the minimum rate at which the Bank of Canada makes short term advances to major financial institutions (currently 0.5% annually) and beginning to accrue from 15 days after valid notice of the repayment demand is given.

Providing Valid Notice of the Repayment Demand

After determining that repayment can be claimed, an insurer must provide notice of its repayment demand to the person from whom repayment is being sought. Such notice is required by subsection 52(2)(a) of the *Schedule* and without it, an insurer will not be able to receive repayment. As such, it is critical for any repayment claim that notice of the repayment demand be provided.



Of equal importance is that the notice of repayment demand be valid. In the event that such notice is considered invalid, subsection 52(2)(a) will be deemed not to have been satisfied, and the insurer will not be able to receive repayment.

In terms of what constitutes valid notice, subsection 52(2)(a) indicates that an insurer must provide notice of the amount that is required to be repaid. Unfortunately, and somewhat perplexingly, compliance with the requirements of subsection 52(2)(a) is not sufficient. A review of the decisions from the Licence Appeal Tribunal confirms that an insurer is required to provide the following information in its repayment demand letter:

1. That there has been overpayment of a benefit;
2. The nature of the benefit that has been overpaid;
3. The time period over which the benefit to be repaid was initially paid;
4. The amount of repayment sought;
5. That repayment of this amount is sought in accordance with section 52 of the *Schedule*; and,
6. Valid right to dispute notice.

While the amount sought to be repaid need not be “perfectly correct”, it should be “substantially correct”.

It is of paramount importance that an insurer provide notice compliant with the above noted requirements and not simply rely upon the wording of subsection 52(2)(a). Minor deviations may ultimately be forgiven by the Licence Appeal Tribunal, however a lax approach will only serve to create unnecessary and avoidable risk.

While a finding of invalid notice can constitute a costly error given the time and expense associated

with obtaining a decision from the Licence Appeal Tribunal, there are even more severe consequences that can result. In cases of repayment based on all criteria aside from wilful misrepresentation and fraud, subsection 52(3) requires that notice of the repayment demand be provided within 12 months of the date upon which the benefits to be repaid were originally paid. Effectively, subsection 52(3) states that if an insurer fails to provide notice of the repayment demand within 12 months of the payment, it will be barred from recovery unless it can establish that the benefit was paid due to misrepresentation or fraud.

An unfortunate and all too common example of the 12-month rule in action is as follows: An insurer believes it has overpaid benefits due

to error. It issues an invalid repayment demand letter within 12 months of the initial payment. At some point thereafter, the insurer realizes that the notice is invalid. It must now prepare a second notice letter. By this point, over 12 months have now passed from the date the benefit was paid. There has been no misrepresentation or fraud, and therefore, the insurer will be barred from seeking repayment.

In light of the above, when factoring in the litigation costs and delay associated with taking a disputed repayment claim to decision at the Licence Appeal Tribunal, as well as the prohibitive consequences for failure to comply with the 12-month rule, best practices dictate that an insurer always put its best foot forward through the provision of proper repayment demand notice.



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Commencing an Application for Repayment

In the event that valid notice of the repayment demand is made, with the person from whom repayment is sought either refusing to repay the benefit or simply not responding, the next substantive step will usually be for the insurer to commence a proceeding for repayment with the Licence Appeal Tribunal.

A repayment claim is subject to limitation rules, and as such, the proceeding must be commenced (through the issuance of an Application) within two years of sending the repayment demand letter.

While this step will necessitate the expense of retaining legal counsel, in cases where misrepresentation/fraud are not alleged, the proceedings are generally quite straight forward in nature, and should not involve excessive legal fees.

Enforcing Repayment

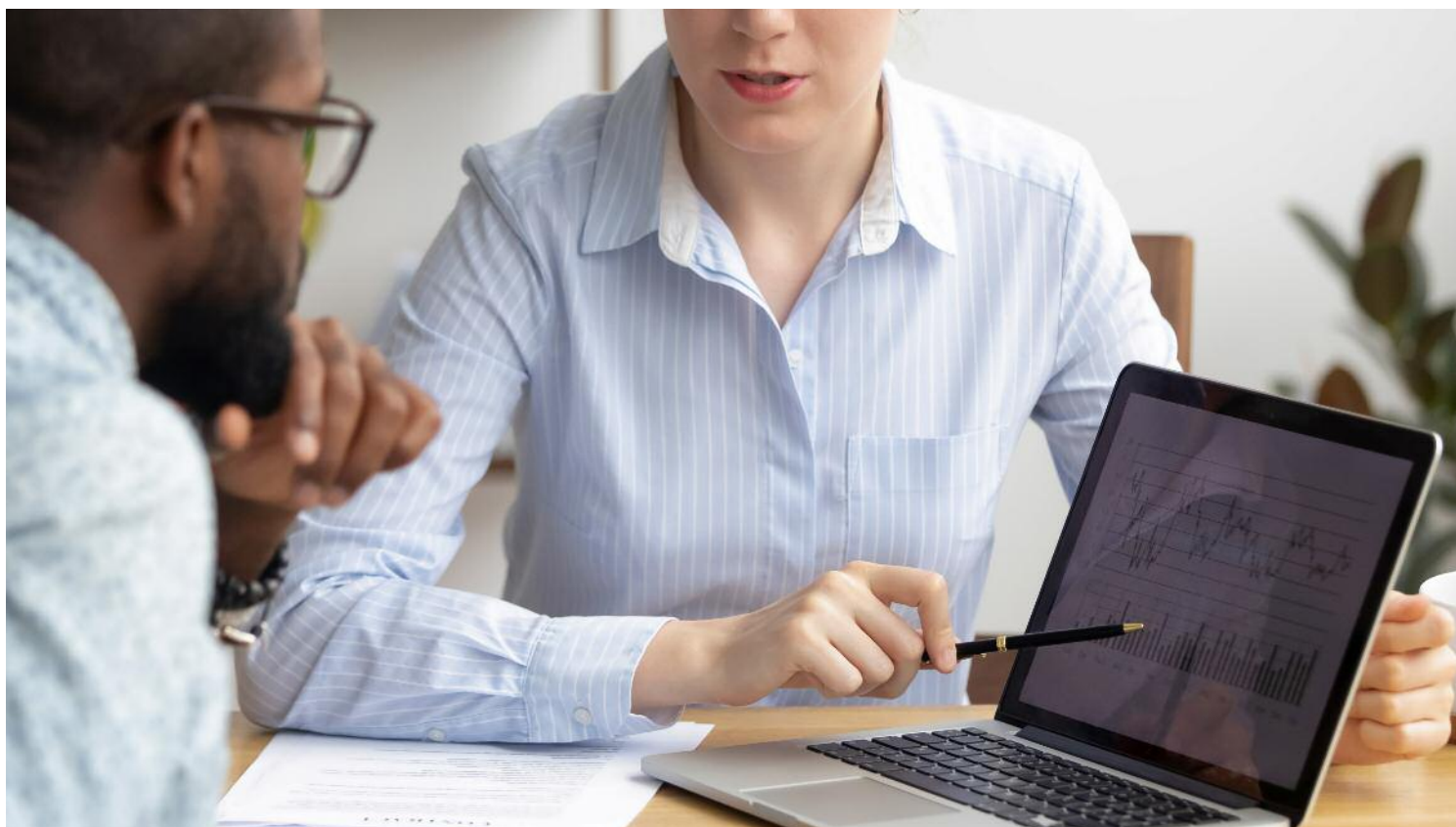
Even in the event that an order for repayment is successfully obtained, an insurer will still often need to take steps to compel actual repayment.

Under section 19 of the *Statutory Powers and Procedures Act*, an order from the Licence Appeal Tribunal may be filed with the Superior Court of Justice by the insurer, and when it is, it shall be deemed to be an order of the Court and may be enforced as such. Once the order is filed, the insurer can access the enforcement provisions under the *Rules of Civil Litigation*, including, but not limited to, writ of seizure and sale, and garnishment.

Exploring Alternatives to Commencing an Application and Enforcing an Order

The above noted methods of enforcement, while effective, do involve additional expense and delay.

Even in the event that an order for repayment is successfully obtained, an insurer will still often need to take steps to compel actual repayment.



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As such, best practices dictate that an insurer consider alternative methods to obtain repayment.

In cases where the benefit for which repayment is being sought is an income replacement or caregiver benefit that continues to be paid to an insured person, an insurer may, upon providing notice, reduce each subsequent payment of the benefit by up to 20% in order to claw back the repayment.

This claw back repayment method is preferable for two reasons. Firstly, it permits an insurer to begin collecting money owed without having to seek a Tribunal order or pursue enforcement. Secondly, it provides a method of collection from persons who do not own any assets and who do not earn income. An insurer should always consider it a primary means of collection when it is available.

In circumstances where an insurer is attempting to settle an accident benefits claim with an outstanding repayment owed, proceeding to the Licence Appeal Tribunal is often unnecessary. The insurer can instead use the outstanding repayment as a negotiating tool to bridge the gap towards settlement. Almost all insured persons would prefer to take a discount on money payable to them by an insurer, rather than making payment to the insurer while holding out for a larger settlement figure. Before formally issuing a repayment application and/or exploring enforcement options available, insurers should always explore the possibility of making repayment work for them in settlement.



Geoff Keating is a partner with the firm of Kostyniuk & Greenside Lawyers, practicing in the area of insurance defence and specializing in the area of no-fault statutory accident benefits. He has proudly acted as lead Counsel in numerous accident benefits dispute hearings since his call to the bar in 2013. When not working, Geoff enjoys spending time with his wife, Lidia, and training in Muay Thai.

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