DEFENDING CLAIMS IN ONTARIO

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LAW SUITS IN CANADA

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WHICH PROVINCE?

Canada has ten provinces and three territories. The justice systems in all provinces except Quebec are quite similar. The Quebec legal system, however, is notably different and, like the legal system in Louisiana, is based on French civil law rather than British common law. As well, legal proceedings in Quebec are conducted in the French language.

Although the legal systems in all provinces except Quebec are relatively similar, the law with respect to motor vehicle accidents is quite different. Some provinces, including Quebec, Manitoba, Saskatchewan and British Columbia, have government insurance schemes and variations of no-fault motor vehicle schemes. The laws of the Atlantic Provinces (New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland) are more similar to those of Ontario.

AN AMERICAN / CANADIAN DICTIONARY

Our legal terminology is slightly different from American terms. Here is a short guide to some of the differences:

U.S. Lingo	**Canadian Lingo**
Attorney	Lawyer, barrister, solicitor, or counsel
Deposition	Examination for discovery
Complaint	Statement of Claim
Defence	Statement of Defence
PIP (Personal Injury Protection Benefits)	SABS (Statutory Accident Benefits), or A/Bs

ONTARIO COURT SYSTEM

Most motor vehicle litigation takes place in the Ontario Superior Court of Justice, before federally appointed Judges. These Judges are appointed for life, and are not elected.

Appeals from final decisions of the Superior Court of Justice go as of right to the Ontario Court of Appeal. A further appeal to the Supreme Court of Canada is available, but requires leave of the Supreme Court, which is very difficult to obtain. The Supreme Court of Canada only hears matters of national importance, or where there are conflicting decisions of appeal courts in different provinces on the same issue.

ONTARIO COURT PROCEDURES

Initial Procedures

Motor vehicle actions are started in Ontario by a Statement of Claim, which must be issued by the court within two years of the date of the accident. Extensions are available in certain circumstances. The Statement of Claim must be served personally on a defendant within six months of the date of issue, although extensions are readily available if the plaintiff has a reasonable excuse for failing to serve in a timely fashion.

Once the Statement of Claim is served, the defendant has 20 days to deliver a Statement of Defence, assuming the defendant was served in Ontario. If the defendant was served in the U.S. or another province of Canada, the time for defence is extended to 40 days.

Plaintiffs may waive strict compliance with the time limits for delivering a defence, and it is customary for plaintiff's counsel to do so on request as a professional courtesy.

Jury Notices

By default, civil actions are tried by a Judge alone in Ontario. However, either side may require trial by a six-person jury by delivering a "Jury Notice." A Jury Notice is typically delivered by the plaintiff with the Statement of Claim or by the defendant with the Statement of Defence. If either side delivers a Jury Notice, the case must be tried by a jury, with certain exceptions (for instance, jury trials are not available if the federal or provincial government or a municipality are parties to the action).

If neither side has delivered a Jury Notice within 10 days of delivery of the Statement of Defence, the matter will generally be tried without a jury. As a result, if the plaintiff has not delivered a Jury Notice, the defendant should decide at the time of delivering its defence whether to require a jury.

Should We Require a Jury?

Many of the major auto insurers in Ontario are of the opinion that, on average, juries assess damages lower than do Judges and, as a result, provide their defence counsel with standing instructions to issue a Jury Notice unless specifically instructed otherwise.

However, there are circumstances which mitigate against a jury:

- concerns about "homer" juries – there are concerns that juries might favour local plaintiffs over non-local defendants;
- if liability is an issue, you may not want a jury where the conduct of the defendant was particularly offensive – drunk driving or street racing for instance, as the jury may punish the defendant by inflating damages;

- jury trials are much more expensive; and
- jury results are less predictable.

Documentary Production

Following the close of pleadings, each side is required to deliver a sworn "Affidavit of Documents," listing in Schedule "A" all relevant and non-privileged documents, and in Schedule "B" all relevant but privileged documents. The parties are required to exchange all relevant and non-privileged documents. The rules of court require defendants to reveal their insurance policy limits and to include the insurance policies in Schedule "A".

Oral Discovery

Following documentary discovery, the parties arrange "examinations for discovery." Examinations for discovery are similar to U.S. depositions, but only the parties to the action may be deposed. Except in relatively rare situations, depositions of witnesses and experts are not permitted.

Examinations for discovery of the plaintiff can be quite thorough. Defendants are entitled to ask plaintiffs any question which is relevant to any matter at issue. Since plaintiffs often allege that the incident has had a serious impact on all of their activities of daily living, the scope of permissible examination is quite broad. A defendant can both examine and cross-examine a plaintiff during the discovery process, but may not ask questions relevant only to a witness' credibility.

If not produced in advance, a defendant may require the plaintiff to obtain and produce documentary evidence relevant to the liability and damages issues outlined in the pleadings, including: a copy of their SABS (PIP) insurer's file; a list of all treatments provided by the provincial health carrier (the Ontario Health Insurance Plan, or OHIP); files from short-term and long-term disability carriers; ambulance call reports; hospital records; physicians' clinical notes and records (CNRs); copies of prescription summaries from their pharmacies; employment files; income tax return documentation; and, other documents.

Independent Medical Examinations

Following completion of the examinations for discovery, defendants are entitled to have the plaintiff submit to one or more independent medical examinations by practitioners of the defendants' choice (but usually not more than one examination per medical specialty). However, the defence is required to obtain written reports of such examinations and to provide copies of them to the plaintiff on receipt.

Often the defence will delay in taking the opportunity to have a defence medical assessment until all of the plaintiff's documentary discovery has been completed, in order to make sure that the medical examiner has a complete picture of the plaintiff.

Initial expert reports must be served on the other parties at least 90 days prior to the pre-trial conference of the action and responding expert reports must be served at least 60 days prior the pre-trial conference. Any supplemental expert reports must then be served at least 45 days, with responding supplemental reports to be served at least 15 days, prior the actual start of the trial.

Mediation

Procedures may vary slightly from county to county within Ontario, but many courts require non-binding mediation to be held before trial. Payment of the professional mediator's fee is the parties' responsibility. In motor vehicle litigation, it is the defendant insurer's responsibility to pay for mediation, if mediation is sought pursuant to the *Insurance Act*. Written mediation briefs are exchanged prior to the mediation itself, which is usually scheduled for a full day.

Normally, the defendant claims handler is expected to attend the mediation, as is the plaintiff, so that a settlement can be completed at the mediation. In certain situations, we have been able to persuade the parties to allow the claims handler to be available by telephone, rather than be in attendance personally because of travel distance involved.

Mediations are strictly confidential and nothing said at a mediation can be used in court. Claims often settle at mediation.

Pre-Trial Conference

The final step before a trial is the pre-trial conference with a Judge. This is typically a one to two hour conference with counsel and their clients (or insurance representative). There are attempts by the Judge to bring the parties together to settle the matter. Like mediations, they are non-binding, but unlike mediations, most Judges will express a strong opinion as to the likely outcome of the case if it were to go to trial. If settlement is not brokered, the Pre-Trial Judge will deal with trial procedure issues and has the power to make various interim orders.

The Judge who hears a pre-trial is precluded from sitting as the Trial Judge, and the materials submitted by counsel to the Pre-Trial Judge are returned at the conclusion of the pre-trial conference and do not find their way into the court file. Although procedures vary across Ontario, in many counties the trial date is set at the pre-trial conference.

Trial

Trials in Ontario are much like trials in the U.S., except that both the Judges and the lawyers wear black gowns. We do not wear wigs.

PRE-JUDGMENT INTEREST

In addition to damages, a plaintiff is entitled by statute to be paid "pre-judgment interest" on any award. Pre-judgment interest is also paid on settlement.

Before January 1, 2015, the default standard for pre-judgment interest on non-pecuniary general damages for pain and suffering was 5% per annum. However, the Ontario Court of Appeal in *Cobb v. Long Estate* [2017] O.J. No. 4830 (Ont. C.A.) and *El-Khodr v. Lackie* (2018), 140 O.R. (3d) 557 (Ont. C.A.) clarified that pre-judgment interest is subject to the overriding discretion of the court regardless of the rate set by the default rules. Currently, pre-judgement interest rates are governed by the *Courts of Justice Act*, which sets a figure consistent with prevailing bank rates of interest. These pre-judgement interest rate changes are retrospective, applying to all current and future actions, regardless of date of loss.

Pre-judgment interest is also payable on past pecuniary losses (e.g. wage loss and out-of-pocket expenses) from the date the losses were incurred. Pre-judgment interest for non-pecuniary losses and past pecuniary losses is paid at a rate governed by the *Courts of Justice Act*. The applicable rate is determined by the date on which the Statement of Claim was issued (currently 0.8%). No pre-judgment interest is payable on future pecuniary losses.

In motor vehicle cases, pre-judgment interest is calculated from the date on which the defendant was first given written notice of the claim to the date of judgment or settlement.

POST-JUDGMENT INTEREST

Interest is also payable on judgments from the date of judgment at a rate prescribed by the *Courts of Justice Act*, so there is some urgency to pay judgments quickly.

COSTS

Perhaps the biggest difference between the U.S. and Canadian court systems is the issue of "costs." In Ontario and most other Canadian jurisdictions, "costs follow the cause," meaning that the loser of a law suit has to pay a portion of the winner's legal fees and disbursements. The loser is also obliged to pay the Ontario Harmonized Sales Tax (HST) on the costs. The HST rate is currently 13%.

There are two scales of costs: partial indemnity costs and substantial indemnity costs. If partial indemnity costs are awarded, the loser has to pay approximately two-thirds of the winner's legal fees and all of the winner's attorney's "disbursements", which includes things such as expert fees (including medical experts' costs); photocopying and fax costs; costs of ordering transcripts; and court fees.

If substantial indemnity costs are awarded, then the winner's legal fees are paid more or less in full (approximately 85-90%).

The default scale is partial indemnity costs. The default costs consequences can be altered by settlement offers made by the parties. The rules are a little complicated and costs awards are always subject to the Judge's discretion, but, in general terms, they are as follows:

- If the defendant makes a written settlement offer and then at trial the plaintiff obtains judgment that is equal to or less than the amount of the defendant's written offer, the cost consequences are reversed.

The defendant would still have to pay the plaintiff partial indemnity costs up to the date of the offer, but the plaintiff would then have to pay the defendant's costs on a partial indemnity basis from the date of the offer to the conclusion of trial. A realistic written settlement offer by the defence can therefore be a powerful incentive to settlement, since the plaintiff runs the risk of paying the defence attorney's fees through trial if he/she is not successful in beating the offer at trial.

The other side of the coin is as follows:

- If the plaintiff makes an offer prior to trial and gets as much or more than his/her offer at trial, the obligation of the defence to pay costs is increased to substantial indemnity costs from the date of the offer.

These costs provisions substantially change the settlement dynamic from the U.S. practice. A realistic settlement offer by either party significantly increases the risk to the opposite side in taking the matter to trial.

Generally speaking, we gauge whether a party has won or lost at trial based on whether the party first beat the other side's offer to settle, and next whether the party beat its own offer to settle. If a defendant meets or beats its offer to settle, that is usually a 'win.'

Costs are Not Included in your Liability Policy Limits

In Ontario, the liability limits in an automobile insurance policy apply only to damages and pre-judgment interest. They do NOT apply to costs. Your obligation for costs is unlimited. For instance, if your policy limits are $200,000, then on a $200,000 claim you might be obliged to pay the plaintiff $30,000 for costs and a further $20,000 in

disbursements, in addition to the $200,000 in damages. So, on a $200,000 policy, your real exposure is probably more in the range of $250,000 (or more).

Typically, in negotiated settlements, costs are calculated at 15% of the first $100,000 of all damages (excluding pre-judgment interest) and then 10% of any further damages.

SOME USEFUL LINKS

- Rogers Partners LLP Publications and Resources:
  - http://www.rogerspartners.com/resources/

- Currency Convertors:
  - https://www.bankofcanada.ca/rates/exchange/?page_moved=1

  - https://online.royalbank.com/cgi-bin/tools/foreign-exchange-calculator/start.cgi

- Ontario Statutes:
  - https://www.ontario.ca/laws

- Ontario *Insurance Act*:
  - https://www.ontario.ca/laws/statute/90i08

- SABS Regulation:
  - https://www.ontario.ca/laws/regulation/100034

CROSS-BORDER ISSUES

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ONTARIO LAW SUITS FOR ACCIDENTS IN ONTARIO

Problems arise for foreign (out-of-province and U.S.) insurers when either their insured vehicle and/or their named or unnamed insureds are involved in a motor vehicle accident in Ontario.

What are the rights of these foreign insurers and their insureds, and what are the rights of the third parties in actions against those insureds?

What policy terms and laws govern in the circumstances?

Despite the difficulties posed by these questions, the answers have recently become clearer in Ontario jurisprudence, although the result may not be one which foreign insurers appreciate.

The Power of Attorney and Undertaking

A foreign insurer who is either licensed to write automobile insurance in Ontario (whether or not it actually does so) and/or files a Power of Attorney and Undertaking ("PAU") with the Canadian Council of Insurance Regulators ("CCIR"), provided it is in standard form, will (effectively) be required to treat its policy as an Ontario policy with all consequent coverages and benefits.

Similar provisions are in effect in most, if not all, jurisdictions in Canada, and a single PAU filed with the CCIR is effective for all applicable Canadian jurisdictions.

Any vehicle that enters Ontario is considered an uninsured vehicle if it is insured only by an insurer which is not a signatory to the PAU. The owner, lessee and operator of such a vehicle would be in breach of Ontario's *Compulsory Automobile Insurance Act* and subject to substantial penalties, including (in the case of the owner or lessee) the loss of the right to sue for damages sustained in an accident involving the vehicle.

Discussion

This interpretation of the PAU set out above has been almost uniformly adopted by all courts in Canada. In Ontario, it has received the endorsement of the Ontario Court of Appeal and the Divisional Court in two important cases:

- *Potts v. Gluckstein* (1992), 8 O.R. (3D) 556 (Ont. C.A.); and,
- *Schrader v. United States Fidelity & Guaranty Co. et al.* (1987), 59 O.R. (2nd) 178, additional reasons (1987), 59 O.R. (2d) 797 (Ont. Div. Ct.).

The practical effect of the case law rule is that foreign insurers may find themselves with far greater exposure with respect to a particular policy than was ever intended or considered possible under the terms of the policy as written in its place of origin.

This is true both with respect to first party and third party scenarios.

For instance, consider an example where a foreign insurer's insured travels to Ontario and drives a motor vehicle (whether the described motor vehicle in the policy or otherwise) and is involved in a motor vehicle accident for which he or she is totally at fault.

The foreign insurer will be responsible in the tort action to the third party and will be required to provide the statutory minimum liability limits in Ontario ($200,000, in Canadian funds), despite the fact that its policy may have contractual third party liability limits which are dramatically lower and/or geographic limitations applicable to the described vehicle(s).

Similarly, the foreign insurer will be responsible for paying the insured Statutory Accident Benefits (SABS) of the type and at the level available under an Ontario policy. Since Ontario, under its current regime, has a very comprehensive benefits scheme, it is likely that the insurer's exposure to its own insured is greater than would have been the case had the accident occurred in the foreign insurer's jurisdiction.

The Ontario Court of Appeal in *Healy v. Interboro Mutual Indemnity Insurance Company* (1999), 44 O.R. (3d) 404 (Ont. C.A.), has ruled that the obligation of a foreign insurer who has signed the PAU to pay SABS extends to its insureds who are involved in accidents in Ontario, even if they have not brought the insured vehicle into the jurisdiction.

Furthermore, where a vehicle insured by a foreign insurer (which is signatory to the PAU) is driven in Ontario and involved in an accident, the foreign insurer is potentially liable to pay Ontario-level SABS to its own insured, as well as all occupants of the insured vehicle and other individuals involved in the accident (subject to priority rules set out in the Ontario *Insurance Act*).

Although by signing the PAU, the foreign insurer makes itself liable to pay no-fault benefits on an Ontario scale, it also entitles the signing insurer to avail itself of the benefits of the Ontario Loss Transfer legislation (see *I.C.B.C. v. Royal Insurance,* [1999] I.L.R. I-3705 (Ont. C.A.)).

Broadly, this provision allows the insurer of an automobile to demand reimbursement from the insurer of a heavy commercial vehicle (essentially a truck weighing more than 4,500 kg/9,900 lbs) for all no-fault benefits the auto insurer has paid out to its insured, subject to apportionment for liability. There is a similar provision for motorcycle insurers to receive indemnity for benefits paid from the at-fault automobile insurers.

The Two FSCO Undertakings

In addition to the PAU (which applies across Canada), as of November 1, 1996, two other undertakings, **The Protected Defendant Undertaking** and **The Direct Compensation Property Damage Undertaking** were made available to foreign and out-of-province insurers. These undertakings apply only in Ontario and are filed with the Financial Services Commission of Ontario (FSCO). Details of these undertakings are set out in FSCO Bulletin No. A-9/96.

Foreign and out-of-province insurers who do not file the **Protected Defendant Undertaking** cannot avail themselves of certain protections of the Ontario *Insurance Act*, including the protection of the "permanent serious impairment" threshold, the statutory deductible applicable to non-pecuniary damages awards and protection from subrogation (in certain circumstances) by the provincial health insurer, OHIP.

Foreign and out-of-province insurers who do not file the **Direct Compensation Property Damage Undertaking** may not be able to assert a defence they might otherwise have against claims for property damage to other vehicles and cannot sue for property damage to their insured vehicle.

There is, however, appellate authority for the proposition that the **Protected Defendant Undertaking** has the same effect as the **Direct Compensation Property Damage Undertaking** (see *Clarendon National Insurance v. Candow*, 2007 ONCA 680). This reasoning may also extend to the impact of the PAU, such that filing it alone may be interpreted as affording all the protections (and, consequently, all the obligations) of both the **Protected Defendant Undertaking** and the **Direct Compensation Property Damage Undertaking**.

Most U.S. insurers are signatories to the PAU and both FSCO undertakings.

SOME USEFUL LINKS

Determining whether an insurer is a signatory to the undertakings can be done by visiting the Canadian Council of Insurance Regulators webpages at:

- Power of Attorney and Undertakings:
    - https://www.ccir-ccrra.org/PrivatePassengerAutomobiles

- List of Protected Defendant Undertaking Signatories:
    - http://undertaking.fsco.gov.on.ca/protected_defendant.aspx

- List of Direct Property Damage Undertaking Signatories:
    - http://undertaking.fsco.gov.on.ca/

ONTARIO LAW SUITS FOR ACCIDENTS IN THE U.S.

The situation where an Ontario resident plaintiff attempts to sue for damages occasioned by an accident that occurred in the U.S. is considerably more complicated. There are two primary issues to be considered – first, whether the Ontario court can or will hear the matter and second, if the matter is heard in Ontario, which laws are applicable in the law suit. The former issue is the "Choice of Forum" issue and the latter is the "Choice of Law" issue.

Choice of Forum

The choice of forum boils down to two issues: do the courts in Ontario even have jurisdiction to hear the matter; and, if so, should they exercise their discretion to decline jurisdiction on the grounds that another jurisdiction is more convenient. These two issues are referred to as the "*jurisdiction simpliciter*"and "*forum conveniens*".

Jurisdiction Simpliciter
The leading authority on these issues is *Club Resorts Ltd. v. Van Breda*, 2012 SCC 17 ("*Van Breda"*). The Supreme Court outlined that a court hearing a jurisdictional challenge must first determine if it even has the ability to hear the dispute.

To do so, the court must look at four factors which, if present, mean that there is a presumed connection between the incident(s) at issue in the law suit and the jurisdiction which is hearing the challenge. Those factors are:

- the defendant is domiciled or resident in the province[1];
- the defendant carries on business in the province;
- the tort was committed in the province; and
- a contract connected with the dispute was made in the province.

The court left the door open for new presumptive factors to be brought forward and incorporated into the above four.

If none of the presumptive factors are present, then the court will not move on to the next step as the court does not have the jurisdiction to hear the matter before it.

[1] However, caselaw has held that adding the plaintiff's underinsured motorist carrier as defendant does not satisfy this presumptive factor.

The fact that the defendant is insured by an insurer who has filed the PAU has been held to be insufficient to grant *jurisdiction simpliciter*.

The Ontario Court of Appeal in the case of *Tamminga v. Tamminga*, 2014 ONCA 478, found that the mere existence of a contract of insurance in Ontario is not a presumptive factor. Accordingly, even if a plaintiff has a contract for insurance in Ontario which includes underinsured or uninsured motorist coverage and gets into an accident in another jurisdiction, the mere fact of the insurance contract is not a presumptive factor for jurisdiction in Ontario.

The (Ontario made) contract "connected with the dispute" needs to include the foreign defendant as one of the contracting parties for the fourth presumptive factor to be engaged.

If one or more of the above presumptive factors are present, the court will move on to the next step – determining whether the court should decline jurisdiction in favour of a more convenient one.

Forum Conveniens

At this second stage of the analysis, Canadian courts will look at whether there is a substantial and compelling connection between the litigation and the jurisdiction in which the law suit was commenced. The burden is on the defendant challenging the choice of venue to show why the Canadian court should decline to exercise its jurisdiction, and why an alternative forum should be preferred. Generally speaking, a defendant will need to show that the alternative forum is clearly more convenient to successfully challenge jurisdiction on this ground.

The Supreme Court of Canada in *Van Breda* outlined a number of factors that the court will consider in determining whether a Canadian court should decline its jurisdiction, including:

1. the location of parties and witnesses;
2. the cost of transferring the case to another jurisdiction or of declining the stay;
3. the impact of the transfer on the conduct of the litigation or on related or parallel proceedings;
4. the possibility of conflicting judgments;
5. problems related to the recognition or enforcement of judgments;
6. the relative strengths of the connection of the parties;
7. loss of juridical advantage (although the Supreme Court of Canada notes that on this contextual analysis, a court should refrain from leaning too instinctively in favour of its own jurisdiction); and
8. existence of other parties/defendants with a connection to the jurisdiction.

If the above factors point toward a foreign jurisdiction being preferable, then the court has discretion to order a stay of proceedings in the 'home' jurisdiction.

Choice of Law

If the court determines that the matter is to be heard in Ontario, the next issue is what law is applicable.

The first and most important point to note is the PAU is not applicable to accidents occurring in the U.S., even if the case is tried in Ontario. Therefore, when accidents occur in the U.S., but are tried in Canada, your policy limits are not increased to the Ontario statutory minimum limits.

The choice of law rules are set out in the Supreme Court of Canada case of *Tolofson v. Jensen; Lucas (Litigation Guardian of) v. Gagnon,* [1994] 3 S.C.R. 1022. The rule is that the substantive issues are to be determined by the law of the place where the accident happened, but procedural issues are to be determined by the law of Ontario. The difficulties lie in determining which issues are substantive and which are procedural.

It has been held that laws which take away a right altogether are substantive, whereas laws which only serve to determine the quantum of damages or how the matter is to proceed are procedural.

As a result, the following issues have been held to be substantive and would be determined by the law of the place where the accident occurred:

1. any applicable threshold and deductibles of the state in which the accident occurred. The Ontario threshold and deductibles would not apply;
2. if there are any heads of damages taken away by the laws of the state where the accident happened, those laws would be applicable in that regard;
3. laws in the jurisdiction in which the accident happened, corresponding to or equivalent to the Ontario *Family Law Act* apply. The Ontario *Family Law Act* would not be applicable;
4. Ontario law with respect to pre-judgment interest would not be applicable; and
5. the limitation period which would be applicable is that of the state in which the accident happened.

The following issues are procedural and would be determined by the laws of Ontario:

1. the quantum of damages would be assessed as if it were an Ontario loss;
2. Ontario law with respect to legal costs would be applicable; and
3. the cap on general damages is procedural and, therefore, the law of Ontario would apply in that regard.

[See *Somers v. Fournier et al* (2002), 60 O.R. (3d) 225 (Ont. C.A.), *Britton v. O'Callaghan* (2002), 62 O.R. (3d) 95 (Ont. C.A.) and *Wong v. Lee* [2002] O.J. No. 885.]

We have been unable to find any case law that determines whether the deductibility of collateral benefits is procedural or substantive. It seems likely, however, that this issue is substantive and would be determined by the law of the place where the accident occurred.

Finally, it should be noted that an Ontario court will consider U.S. law to be an issue of fact to be proven. In a case tried in Ontario in which U.S. law is at issue, a U.S. attorney would have to be called as an expert witness to testify as to U.S. law.

ONTARIO AUTOMOBILE CLAIMS PRIMER

Rogers Partners LLP

INTRODUCTION

When a motor vehicle accident occurs in Ontario, an injured person may pursue two separate avenues of recovery:

- a tort action may be commenced against the at-fault driver, seeking recovery of damages; and
- an application for accident benefits may be submitted to the injured person's insurer, seeking payment of various accident benefits.

As a result of the undertakings signed by most U.S. insurers, for Ontario accidents the third party liability limits of the U.S. insurer's policy are automatically increased to CAD$200,000. In addition, the U.S. insurer will potentially have liability over and above the $200,000 limits for the plaintiff's legal costs and disbursements. Furthermore, U.S. insureds are entitled to accident benefits at the levels set out by the Ontario Statutory Accident Benefits Schedule (SABS).

Accidents Occurring on or after October 1, 2003

There were significant changes in the Ontario legislation pertaining to motor vehicle accidents in 2003, followed by a series of additional legislative changes modifying coverages and entitlements. This paper deals with the law as it applies to motor vehicle accidents in Ontario occurring on or after October 1, 2003 and outlines current damages and benefits entitlements.

TORT CLAIMS

Non-pecuniary general damages

Based on the provisions of the Ontario *Insurance Act*, claims for non-pecuniary general damages are subject to a verbal threshold and monetary deductible. The threshold for recovery of non-pecuniary damages is defined in s.267.1 of the *Insurance Act* as:

(a) permanent serious disfigurement; or

(b) permanent serious impairment of an important physical, mental or psychological function.

The serious and permanent threshold is further defined by regulation which also sets out evidence that must be adduced to prove entitlement. "Serious" requires: "substantial interference with ability to continue with regular or usual employment despite

reasonable accommodation…; or substantial interference with most of the usual activities of daily living considering the person's age". "Permanent" is of a nature that is expected to continue without substantial improvement when sustained by persons in similar circumstances.

In Canada, there is a cap on non-pecuniary general damages, which is approximately $390,313 (as of July 2019 - it is indexed monthly).

FLA Claims

In addition to claims by injured persons, dependent relatives of persons injured or killed in accidents are entitled to claim for pecuniary losses and damages resulting from a loss of care, guidance and companionship of the injured or deceased persons. *Family Law Act* claims are reduced for contributory negligence attributable to the injured or deceased person.

Section 61 of the *Family Law Act* sets out the rights of dependants to sue in tort. It states, in part:

> If a person is injured or killed by the fault or neglect of another under circumstances where the person is entitled to recover damages, or would have been entitled if not killed, the spouse, as defined in Part III (Support Obligations), children, grandchildren, parents, grandparents, brothers and sisters of the person are entitled to recover their pecuniary loss resulting from the injury or death from the person from whom the person injured or killed is entitled to recover or would have been entitled if not killed, and to maintain an action for the purpose in a court of competent jurisdiction.

The damages recoverable by FLA claimants include:

(a) compensation for the loss of guidance, care and companionship that the claimant might reasonably have expected to receive from the person if the injury or death had not occurred
(b) actual expenses;
(c) actual funeral expenses;
(d) travel expenses in visiting the person during his or her treatment or recovery; and
(e) loss of income or the value of the nursing, housekeeping or other services provided for the person.

In certain dependency circumstances, FLA claimants may also be entitled to claim loss of financial support which would have been received from the injured or deceased person. FLA claimants may also be able to claim for their own income losses suffered because of the grief or upset sustained as a result of the death or serious injury of the main plaintiff (or estate).

Non-Pecuniary Damages - Statutory Deductible

The statutory deductible applies only to non-pecuniary losses and is to be applied to the award of damages before any split in liability. Unlike pre-judgment interest which begins to accrue from the date the plaintiff first gave the defendant notice of the claim, the statutory deductible amount is set as of the date of trial.

There is no deductible for wrongful death claims arising from accidents which occurred after August 31, 2010.

As a result of a statutory amendment effective August 1, 2015, the statutory deductibles are increased yearly for inflation. Currently, the applicable deductibles are: $38,818.97 for the main plaintiff and no deductible if non-pecuniary damages exceed $129,395.49; and $19,409.49 for FLA claimants and no deductible if non-pecuniary damages for FLA claimants exceed $64,697.21.

The inflated deductibles have been held to apply retrospectively for all judgments/ settlements after August 1, 2015.

Pecuniary Losses

Health care claims are permitted, but only if the plaintiff's injuries meet the serious and permanent threshold. This can be a significant source of exposure in serious injury cases, where the actual health care costs exceed available funding through collateral benefits (including SABS or private health care plans).

Neither the threshold nor the deductible applies to other pecuniary loss claims.

There can be no claim for income losses suffered in the first seven days after the accident. Claims for pre-trial income loss are restricted to 70% of gross income loss. Claims for post-trial income loss are assessed at 100% of gross income loss.

Claims for housekeeping and home maintenance/handyman expenses are common. Various other claims for special damages are permitted subject to remoteness.

Collateral Benefits

Collateral benefits are statutorily required to be deducted from non-economic losses in the context of a tort award, but are not to be deducted from non-pecuniary damage awards.

For income losses, based on the *Insurance Act* provisions, the plaintiff's damages are reduced by: all SABS benefits received or available for income loss or loss of earning capacity up to date of trial; all payments received or available under a legislated income continuation plan or an income continuation benefit plan up to the date of trial (e.g. Canada Pension Plan Disability Benefits); and all payments received under a sick leave plan up to the date of trial.

Similar statutory provisions require that health care and other economic loss claim awards be reduced by collateral benefits received or available up to the date of trial. Claims are to be presented in three broad categories or "silos" of income loss, health care and other pecuniary losses. The claims advanced in each "silo" are reduced by all benefits received or available in that silo. A benefit is deemed not available if the plaintiff has made an application for the benefit in good faith and the benefit has been denied.

However, after a trial, plaintiffs are entitled to recover future pecuniary losses from the tortfeasor without regard to future collateral benefits. Future benefits will be subject to a statutorily codified *Cox* v. *Carter* Order which requires the plaintiff to hold all future benefits received (from collateral payors) in trust for the tortfeasor. Alternatively, a court may order that the plaintiff assign future rights to collateral benefits over to the tortfeasor and to co-operate with the tortfeasor in the future collection of benefits from collateral payors.

Direct Compensation Property Damage

Section 263 of the Ontario *Insurance Act*, in essence provides that, in the event of a collision between two insured vehicles, each vehicle's insurer pays its own insured the property damage that would ordinarily be the obligation of the other party's insurer.

As an example, if a U.S. vehicle were to collide with a vehicle, "X", insured by another insurer, and X was 75% at fault for the accident, the U.S. insurer would pay its insured 75% of the insured's property damage claim under the Direct Compensation Property Damage coverage.

If the U.S. insurer's insured carried collision coverage, the U.S. insurer would pay the remaining 25% under the collision coverage. Fault is determined by a Fault Chart in R.R.O. 1990, Reg.668. These rules can be found at:

- https://www.ontario.ca/laws/regulation/900668

ACCIDENT BENEFITS CLAIMS

An insured person may claim SABS benefits from his/her own personal insurer, employer's insurer, insurer of the vehicle in which he/she is an occupant at the time of the accident, or insurer of other vehicles involved in the accident. Numerous different types of SABS benefits are available as part of the standard Ontario automobile policy depending on nature and severity of the claimant's injuries.

There is, generally speaking, no ability for an insurer to subrogate to recover SABS payments made to its insureds. There is an exception, however, in claims involving certain classes of automobiles, including heavy commercial vehicles and motorcycles (loss transfer).

In addition to changing the rate for pre-judgment interest on non-pecuniary damages, there has been a recent change to the dispute resolution process for accident benefits claims. Previously, a claimant could apply to the Financial Services Commission of Ontario ("FSCO") for mediation and proceed to arbitration or litigation in court. However, FSCO has now been replaced with a body called the Licence Appeal Tribunal ("LAT") with exclusive jurisdiction over SABS disputes and a completely new set of procedural rules. These new procedural provisions for resolution of SABS disputes by the LAT were implemented as of April 1, 2016.

Due to legislative changes over time, the benefits available under the SABS vary depending on the date of the accident. The following is a summary of benefits currently available (September 2019).

Weekly Benefits

Income Replacement Benefits
IRBs compensate for lost income if the claimant suffers a substantial inability to perform the essential tasks of his/her pre-accident job and will continue beyond two years post-accident if the claimant suffers a complete inability to engage in any employment for which he/she is reasonably suited by education, training or experience.

The benefit is calculated at 70% of gross income before the accident, up to a maximum weekly benefit of $400.

Non-Earner Benefits
NEBs compensate if the claimant is completely unable to carry on a normal life and does not qualify for an Income Replacement Benefit or Caregiver Benefit. The benefit is $185 per week beginning four weeks after the complete inability arose and is available for 104 weeks after the accident.

Caregiver Benefits
CGs compensate the claimant for expenses incurred if he/she cannot continue as the main caregiver for a person (such as child under age 16) who needs care. The benefit pays expenses up to $250 per week for the first person in need of care, plus $50 for each additional person. For accidents occurring after September 1, 2010, Caregiver Benefits are only available for claimants deemed to be catastrophically impaired.

Health Care Benefits

Medical Benefit
Medical benefits pay for reasonable and necessary medical expenses incurred as a result of the claimant's injuries, which are not covered by any other medical plan, such as the Ontario Health Insurance Plan, or any private healthcare benefit plans (such as those available through the claimant's workplace).

Rehabilitation Benefit
Rehabilitation benefits pay for reasonable and necessary rehabilitation expenses incurred as a result of the claimant's injuries, which are not covered by any other public or private healthcare benefits plan.

Attendant Care Benefit
AC compensates for the expense of an aide or attendant or services provided by a long-term care facility at prescribed rates.

For automobile insurance policies issued *after* June 1, 2016, the maximum amount available for medical, rehabilitation and attendant care (combined) for non-catastrophic claimants is $65,000, with a five year limit. The combined limit for medical, rehabilitation and attendant care benefits for catastrophically impaired claimants is $1,000,000, with no time limit.

Other Expenses
There is also coverage available for expenses of family members in visiting injured claimants during treatment or recovery; housekeeping and home maintenance, payable at a maximum of $100 per week (but for accidents occurring after September 1, 2010 only if the claimant is found to be catastrophically impaired); repair or replacement of items lost or damaged in the accident such as clothing, prescription eyewear, dentures, hearing aids, prostheses and medical or dental devices; lost educational expenses; and the reasonable cost of examinations obtained for the purposes of the SABS.

Catastrophic Impairment
If the claimant meets the definition of "catastrophic impairment", he/she is entitled to significantly increased accident benefits (monetary and temporal limits). For accidents occurring after June 1, 2016, "Catastrophic impairment" is defined at s.3.1 in O.Reg. 34/10 and generally includes an impairment resulting in any of the following:

- paraplegia or tetraplegia;
- severe impairment of ambulatory mobility or use of an arm, or amputation;
- loss of vision of both eyes;
- traumatic brain injury;
- a physical impairment or combination of physical impairments that results in 55% or more physical impairment of the whole person;
- a mental or behavioural impairment, excluding traumatic brain injury, that, when combined with a physical impairment (or combination of physical impairments) results in 55% or more impairment of the whole person; or
- an impairment that results in a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning or a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder.

Death and Funeral Benefits
Death and funeral benefits are available to pay family members of a person killed in an automobile accident ($25,000 is paid to a surviving spouse, $10,000 to each surviving dependant, and $10,000 to a person on whom the deceased was a dependant) and up to $6,000 to cover funeral expenses.

Optional Benefits
Optional benefits are available for purchase from Ontario insurers, which could dramatically increase the limit of many of the benefits above.

Accident Benefits Procedures

The SABS provides for a complicated procedural system for claiming and responding to claims for accident benefits, including numerous forms (OCFs) created by FSCO. The system involves strict timelines for responses to various forms submitted to insurers and involves the determination of entitlement based on the severity of the initial injury, followed by ongoing assessments. If treatment modalities or benefits are sought which are not approved, entitlement may be determined by way of medical examinations and insurer's assessments.

Various SABS sections require compliance by the insured with requests for information and documentation. Non-compliance (without a reasonable explanation) can result in suspension and/or forfeiture of benefits. Insurers are permitted to terminate Income Replacement Benefits, Non-Earner Benefits and Caregiver Benefits if the insured fails to participate in treatment or seek reasonable employment. In addition to medical examinations, insurers may conduct an Examination under Oath of the claimant (with limitations).

Accident Benefits Litigation

If a dispute arises regarding payment of accident benefits, the claimant or insurer may make an application to the Licence Appeal Tribunal ("LAT"). As of April 1, 2016, a claimant is no longer permitted to apply to FSCO or to commence a court action to dispute accident benefits issues.

LAT proceedings deal with specified benefits in dispute and declarations for entitlement to ongoing benefits. An insured cannot sue for a lump sum settlement of a SABS claim, but an insurer may negotiate a full and final resolution of the claim with the insured claimant.

There can be no lump sum settlements until one year after an accident, unless there have already been Licence Appeals Tribunal proceedings. There are strict requirements with which insurers must comply regarding disclosure and settlement documentation when a claim is fully and finally settled.

Accident Benefits Claims Handling

Due to the overly technical nature of Ontario SABS claims handling and the onerous timing restrictions, we highly recommend that a foreign insurer retain a qualified Ontario adjuster to administer its first party accident benefits claims

PRIORITY AND LOSS TRANSFER DISPUTES

Disputes between insurers regarding payment of accident benefits may arise in two different contexts and result in two distinct categories of disputes which must be resolved by way of private arbitration under the *Arbitrations Act*, *1991.*

Priority Disputes arise in situations where an insurer disputes its obligation to pay accident benefits to a claimant and alleges that there is another insurer which stands in higher priority such that it is responsible to pay those benefits.

Loss Transfer is a mechanism to re-allocate the burden of paying accident benefits in the context of accidents involving heavy loss causers (heavy commercial vehicles) and most vulnerable vehicles (motorcycles).

The parties generally sign an Arbitration Agreement appointing a private arbitrator and outlining certain rules which govern the dispute, failing which they are governed by the default provisions in the *Insurance Act* and the *Arbitrations Act, 1991.*

Recourse to the courts for Priority and Loss Transfer Disputes is only with respect to "initiating" an Arbitration (in order to force the appointment of an arbitrator and force the respondent to submit to arbitration) or with respect to appeals from private arbitrators' awards.

Priority Disputes

Priority disputes are disputes between insurers regarding the responsibility to pay accident benefits to a claimant. The dispute mechanism is set out in Regulation 283/95 of the *Insurance Act*. This mechanism provides an insurer with the ability to permanently transfer an accident benefits claimant to another insurer.

The priority scheme detailing the responsibility to pay is in s.268 of the *Insurance Act*. Simply put, the hierarchy of priority for payment of accident benefits is as follows:

1. The insurer of an automobile in respect of which the claimant is a named insured or a spouse or dependant of a named insured.
2. The insurer of an automobile in respect of which the claimant is an insured.
3. The insurer of an automobile in respect of which the claimant is an occupant.
4. The insurer of an automobile involved in the incident from which entitlement to benefits arose.

This hierarchy is complicated by certain definitions in the SABS and certain provisions in the SABS which can deem an individual to be a named insured in situations where a company vehicle is made available for his/her regular use or where there is a long-term rental. Specific priority issues arise in situations involving "dependency", "marital status", "regular use provided by a corporation", "occupancy", etc.

Generally, the first insurer to receive a completed application for accident benefits must begin paying benefits pursuant to the SABS, subject to a priority dispute.

Within 90 days of receiving a completed application for accident benefits, an insurer must put other potential insurers on notice of a priority dispute. The 90 day notice period may be extended only in certain narrow circumstances. Failure to satisfy the 90 day notice period is fatal to the dispute, so early and thorough investigation of priority issues is essential.

Within one year of the first notice of priority dispute, a private arbitration proceeding must be initiated.

If another insurer is found to be the priority insurer, the claimant's accident benefits claim is transferred to the priority insurer for ongoing handling and the priority insurer is responsible to indemnify the initial handling insurer for benefits and expenses incurred in the preliminary administration of the claim.

Loss Transfer Disputes

Loss transfer disputes are a different type of dispute between insurers. The loss transfer mechanism provides an insurer with the ability to seek indemnity for benefits paid in connection with an accident benefits claim. However, the accident benefits claim will continue to be administered by the same insurer.

The loss transfer mechanism is set out in s.275 of the *Insurance Act* and parts of Regulations 664 and 668. The insurer seeking the loss transfer is the "first party insurer" and the insurer against whom the claim is brought is the "second party insurer." Loss transfer is generally available:

- to the insurer of a motorcycle from the insurer of <u>any other</u> class of automobile; and
- to the insurer of <u>any other</u> class of automobile from the insurer of a heavy commercial vehicle.

The rationale is that under a no-fault system, a shifting of the burden is required when greater loss causing and more vulnerable vehicles are involved in accidents.

It has been held by the Ontario Court of Appeal that, where a foreign insurer is a signatory of the Power of Attorney Undertaking, it may be a target of a loss transfer claim and is entitled to bring a loss transfer claim with respect to an accident in Ontario.

"Heavy commercial vehicle" is defined in s.9(1) of Regulation 664 as: a commercial vehicle with gross vehicle weight greater than 4,500 kg (or approximately 9,900 lbs). According to the *Insurance Act* a "commercial vehicle" is an automobile used primarily to transport materials, goods, tools or equipment in connection with the insured's occupation.

Loss transfer indemnification is made according to the respective degree of fault of each insurer's insured. In an attempt to achieve expediency over exactitude, fault for the purpose of loss transfer is determined under the Fault Determination Rules found in Regulation 668 (generally either 0%, 50% or 100%). If the accident is not described in any of the rules or there is insufficient information about the accident, fault is determined according to the "ordinary rules of law". Indemnity is paid only to the extent that the second party insurer's insured was at fault for the accident

In situations where loss transfer indemnity is available, the first party insurer continues to administer the accident benefits claim – it is never transferred to the second party insurer for handling.

Section 275(2) provides the first party insurer with a right of indemnification "in relation to such benefits paid by it." In the loss transfer context, administrative expenses such as

adjusting fees, investigations, costs of insurer's examinations and other "loss control measures" are not recoverable from the second party insurer. Section 275(3) stipulates that there is no indemnity available in respect of the first $2,000.00 of accident benefits paid to a claimant (the deductible).

The second party insurer may also challenge the reasonableness of the payments made by the first party insurer, including whether the insured was reasonably entitled to payment of the benefits delivered by the first party insurer. Generally, however, a second party insurer must prove gross negligence or bad faith on the part of the first party insurer for benefit payments to be considered unreasonable. There is arguably no indemnity payable for overpayments of benefits and interest paid on overdue benefits.

It has been held that a lump sum settlement of the insured's past, present and future accident benefits constitutes the "payment of statutory accident benefits" and is, therefore, subject to loss transfer.

The Ontario Court of Appeal has held that the limitation period for loss transfer claims only arises once the first party insurer demands indemnity from the second party insurer (which demand is deemed to be refused one day after the demand). The first party insurer must commence arbitration proceedings within 2 years plus 1 day following its demand for loss transfer reimbursement to comply with the limitation period. A new two-year limitation period begins to run for each indemnity demand.

THIRD PARTY LIABILITY COVERAGE IN AUTOMOBILE INSURANCE CONTEXT: Key Concepts and Practical Strategies

Rogers Partners LLP

INTRODUCTION

Automobile coverage issues in Ontario include principles extending coverage (such as consent), and principles limiting coverage (such as breach of statutory conditions).

This article serves to explore a number of issues, including:

- when coverage will extend beyond the named insured;
- the concept of a breach of a condition;
- the relatively newly imposed concept of honest but mistaken belief; and
- resurfacing of the relief from forfeiture doctrine.

We will also consider practical strategies for insurers, such as reservation of rights letters and non-waiver agreements, and consider the related strategy of the insurer adding itself as a statutory third party to the litigation.

Lastly, we will consider the absolute liability provisions of the Ontario *Insurance Act*, including an indication of the coverage related circumstances when such liability will be imposed and when it will not.

THIRD PARTY LIABILITY CONCEPTS: DRIVER

Third party liability coverage under an automobile policy may extend beyond coverage to the named insured, and may include coverage to another 'driver.' This extension of coverage, however, has limits, typically defined by the scope of 'consent.'

Consent

The Ontario *Insurance Act* provides that a driver (who is not the named insured on a motor vehicle policy) is only an insured on a policy if the driver had consent of the named insured to drive or be an occupant of, or be in possession of, or use, or operate the insured vehicle.

Generally speaking, where the owner of the vehicle has, either expressly or by implication, expressed confidence in a driver to be in charge of his/her vehicle on a roadway, even for a limited purpose, that owner will be deemed to have provided consent to drive the vehicle. This is so even if the vehicle is being used for some other purpose when an accident takes place.

Once even limited consent is granted (e.g. consent to use the vehicle only to go to and from work, or to only drive during the daytime), the onus then shifts to the owner to prove that the driver did not have consent at the time of the accident. Controversies can arise, however, about whether the driver had consent, in instances where the owner had previously expressed clear limits on the driver's use of the vehicle, such as not driving on highways.

The proper approach is a subjective one from the point of view of the driver, namely whether the driver, under all the circumstances, would be justified in thinking that he or she had the implied consent to drive (or operate, possess, occupy, or use) the insured automobile.

AUTHORITY TO DRIVE AND HONEST BUT MISTAKEN BELIEF

In Ontario, many drivers have restrictions in place on their driver's licence. This is especially true in the context of new drivers, who are subject to the province's "graduated licencing scheme", designed to delay receipt of a full driver's licence.

Drivers with restrictions may be found not to have been in compliance with the terms and conditions of their licence. Generally speaking, when an insured drives in contravention of a term of his/her licence, this is considered a breach of the insuring agreement, requiring an insured to have the proper 'authority to drive' the automobile.

The inquiry for insurers considering whether such violations negate coverage under a policy of insurance, however, does not end with proving that a violation took place.

As discussed below, once coverage is extended it may prove difficult, absent the clearest of cases, for an insurer to successfully deny coverage. This is so even in circumstances where the insured has committed a clear breach of the policy.

In *Tut v. RBC Insurance*, 2011 ONSC 823 (upheld on Appeal, 2011 ONCA 644), a young driver drove his mother's vehicle the morning after a night of alcohol consumption. The mother consented to her child driving the vehicle in order to take some of his friends home after the party.

Under his G2 licence, the young driver was to have zero alcohol in his blood at all times while driving. The Ontario Court of Appeal held that since the son (driver) was found to have had a reasonable belief that he had zero blood alcohol content, his onus was discharged such that he believed himself to be driving under the conditions of his licence. The court concluded that the son held an <u>honest but mistaken belief</u> that he had zero alcohol in his blood.

He was found not to have been in contravention of his licence restrictions, and he thus had the appropriate authority to drive.

This is clearly a problematic doctrine, as it is difficult to imagine how an insurer would, in certain circumstances, put forward evidence to rebut an allegation on the part of a driver that he had an honest but mistaken belief. The focus in instances such as this will be on the extent of the due diligence undertaken by the driver to satisfy himself/herself that he/she was in compliance with the terms of his/her licence.

Interestingly, even if it is found that the insured was in fact in breach of the terms of his licence, and did not have a reasonable but mistaken belief regarding his conformity with the conditions of his licence, that does not end the coverage analysis.

RELIEF FROM FORFEITURE

Recently, the Ontario Court of Appeal decided that relief from forfeiture can be applied to automobile insurance contracts where the exclusion is due to imperfect compliance with a statutory condition, rather than non-compliance with a condition precedent (e.g. failure to renew driver's licence vs. never having had a licence). The court indicated that relief may be available for both pre-accident conduct as well as post-accident failures in procedures (i.e. filing a proper proof of loss).

In *Kozel v. Personal Insurance Co,* 2014 ONCA 130, a 77 year old woman was involved in a serious motor vehicle accident while driving with a licence that had expired four months previously. The woman did not realize her licence was expired, because she mistakenly believed the renewal form sent to her only pertained to her vehicle licence plate renewal.

Despite concluding that the insured did not have a 'reasonable' but mistaken belief regarding her licencing status, the court granted relief from forfeiture to the insured.

The court reiterated that, if a breach is substantial and prejudices the insurer, however, relief from forfeiture is not an available remedy for an insured. Where relief from forfeiture is available, the following factors will be considered by the court to determine if it should be granted:

- The conduct of the insured (in totality, before and after the incident):
    - In *Kozel*, breach had never happened before; the insured renewed her licence without difficulty; the insured had always paid premiums in a timely manner and acted in good faith on all occasions.

- The gravity of the breach (nature and impact):
    - The Court of Appeal found that the breach in *Kozel* was minor in nature and had no impact on the insured's ability to drive safely, and no impact on the contractual rights of the insurer.

- The disparity between the value of the property forfeited and the damage caused by the breach (i.e. prejudice to the insurer caused by the breach)
    - The Court of Appeal, in *Kozel*, found that the insured stood to lose $1 Million in coverage, whereas the breach caused no prejudice to the insurer.

As a result, insurers will need to consider much more than whether an insured has breached a condition of his/her driver's licence. An insurer must also consider whether an insured may be found to have an 'honest but mistaken belief' regarding compliance and/or whether the insured may be entitled to relief from forfeiture for any such breach of the policy.

PRACTICAL STEPS FOR THE INSURER

Ongoing Further Investigation

When a potential policy breach is found to exist, the insurer is put to an election of either:

- refusing to defend the insured, thereby repudiating the contract; or
- defending the insured in spite of the breach, thereby waiving the insurer's right to deny coverage under the policy.

The insurer's election can be made expressly or implicitly. An act or correspondence that suggests that a defence is being granted to the insured can be taken later by the court to have implied an election on the part of the insurer to affirm the contract. Accordingly, an insurer may be obligated to defend an insured, even where no explicit election to do so was communicated.

Advising Insured of Potential Off-Coverage Position

Non-Waiver Agreements
The usual approach is for an insurer to send to the insured a non-waiver agreement or a reservation of rights letter. A non-waiver agreement is preferable insofar as it is a signed agreement between the insurer and the insured. However, there are certain difficulties in completing a non-waiver agreement that must be considered as well.

A non-waiver agreement stipulates that the insured agrees that the insurer does not waive its rights to deny coverage when further steps, including investigation into details of the claim, are undertaken.

Reservation of Rights Letters
A reservation of rights letter is essentially a "Dear John" letter to the insured that states that the insurer will proceed with the defence, but reserves the right to deny coverage to the insured because of a potential policy breach. Such a letter can be sent before any consultation so that the insured is aware of the coverage situation. Fairness and

transparency are key concepts when dealing with the insured and potential coverage problems. However, despite the foregoing, no reservation of rights letter is foolproof.

The courts in Ontario have held that where an insurer is aware of coverage issues and sends a reservation of rights letter, but then later sends a letter confirming that the insured is covered up to the third party liability limits, but not beyond (an "excess letter"), the insurer is deemed to have elected to defend the insured, at least up to the limits of the policy.

Practical Steps to Take when Coverage Issues Arise

Once an insurer becomes aware of a coverage issue, it must communicate clearly with the insured and continue to investigate until the facts are clear enough to make a coverage decision. It would be prudent to send a reservation of rights letter or non-waiver agreement.

A non-waiver agreement or reservation of rights letter should not be indefinite. A sophisticated insured may demand that an insurer make an election right away.

To the extent possible, keep defence and coverage issues separate.

Even an excess letter can be deemed to be evidence of an election to affirm the contract, despite a clear policy breach. Accordingly, such a coverage limiting communication should be sent along with, or at least expressly subject to, all other coverage issues. If defence counsel sends an excess letter, it may paper over any and all coverage issues and defences raised in previous correspondence sent by the insurer.

It is best that the insurer sends all coverage limiting communications to the insured, including the standard 'excess letters' as it relates to claims in excess of the policy limits.

When and why an Insurer should add itself as a Statutory Third Party

An insurer may wish to deny coverage to an insured defendant in a law suit, but may still wish to participate in the defence of the law suit in order to defend and limit the damages being claimed by the plaintiff, as well as defend liability, all "in the best interests" of the putative insured.

In such instances, Ontario law permits an insurer to add itself as a party to the litigation. The insurer would then be considered a "statutory third party" in the proceedings.

An insurer may want to add itself as a statutory third party when it is taking an off-coverage position with respect to its insured for a breach of statutory condition, failure to cooperate, or a material misrepresentation or fraud. By alleging a policy violation and adding itself as a statutory third party, the insurer who takes an off-coverage position

merely preserves its position. The coverage dispute will then be an issue to be determined in any subsequent litigation as between the insurer and its putative insured.

CONSEQUENCES OF COVERAGE BREACH

The Absolute Liability Provisions

Section 258 of the Ontario *Insurance Act* enables injured parties to recover damages in an action, and not be deprived of a remedy based solely on the conduct of the defendant insured. Accordingly, if a defendant insured is in breach of an expressed or implied term of the insuring agreement, the insurer is still 'absolutely liable' to the plaintiff. The insured, however, may forfeit entirely his/her right of indemnity with the insurer.

Indemnity can be denied by an insurer based on a finding that the insured breached a statutory condition, or made a material misrepresentation to the insurer.

When the absolute liability provision applies, an insurer may only raise policy defences to claims in excess of the minimum limit for coverage in Ontario (CAD$200,000). Hence, an insurer is considered to be 'absolutely liable' to the plaintiff upon judgment against its putative insured for amounts up to CAD$200,000 (inclusive of interest, plus costs and disbursements).

For amounts in excess of CAD$200,000, the insurer may avail itself of any defence it is entitled to set up against the insured.

In cases where an insurer is required to pay a plaintiff based on the absolute liability provisions, the insurer may then pursue the insured for reimbursement of any amounts that it was required to pay to the plaintiff, as a result of s.258(13).

When do Absolute Liability Provisions Apply?

Given the consequences associated with the application of s.258, of particular importance is the question of which coverage related circumstances give risk to 'absolute liability' and which do not. There appears to be no clear demarcation at law. However, appellate level authority in Ontario has determined the outcome with respect to a number of common situations.

Section 258 has been held to apply in the following cases:

- Breach of Condition
- Intentional (Criminal) Act
- Material Misrepresentation

Section 258 has been held NOT to apply in the following cases:

- Breach of "Other Automobile" Coverage
- No Consent
- Excluded Driver

As a result, it will be important to be aware of the nature of the coverage limiting conduct of the putative insured, and whether such conduct will negate entirely the coverage under the policy, or whether the insurer will remain 'absolutely liable' to the plaintiff up to the minimum limits.

CONCLUSION

In sum, we have canvassed a number of coverage concepts under the automobile policy, including common breaches and coverage exclusions, and court created exceptions to those exclusions.

Automobile Coverage Issues

This paper has canvassed coverage issues which typically arise with respect to drivers and owners, particularly as they relate to issues of consent and breach of statutory conditions. Further, it also has considered when an insurer is made aware of potential breaches of the policy or other coverage issues. Those include communications with the insured.

Fairness and transparency emerge as the key concepts so that insurers make their insureds aware of the situation, and the insurer's position and decision regarding coverage.

Non-Waiver Agreements and Reservation of Rights Letter

The insurer often knows early on that there is a coverage issue, but does not have enough information and is not ready to make a firm and final decision on coverage. In those situations, strategies such as a non-waiver agreement and reservation of rights letter can be employed. This paper canvassed the difference between the two, when to use which, and common pitfalls to avoid when utilizing either.

Statutory Third Parties

Once the insurer has decided what should be communicated to the insured, the insurer should consider whether to add itself as a statutory third party. This paper discussed this mechanism and the corresponding issue of the nature and applicability of the absolute liability provisions, including an indication of which coverage related circumstances give rise to 'absolute liability' and which do not.

BILL 18: PRIORITY AND LIABILITY OF RENTAL COMPANIES' INSURANCE POLICIES

Rogers Partners LLP

THE SCHEME FOR ACCIDENTS AFTER MARCH 1, 2006

In motor vehicle accidents involving rented or leased vehicles, the law in Ontario sets out the following priority for third party liability coverage:

1. The first level of insurance is any motor vehicle liability policy in which the lessee/renter is the named insured. [RENTER]
2. The second level of insurance is any motor vehicle liability policy in which the driver is a named insured; or is the spouse of a named insured (if driver resides with spouse); or in which the driver is listed as a driver in the contract. [DRIVER]
3. The third level or layer of excess insurance is any motor vehicle liability policy in which the owner of the automobile is a named insured. [OWNER]

The Ontario *Highway Traffic Act* makes the lessee (or renter) of a vehicle vicariously liable for the driving activities of the driver. A lessee's insurer is first-loss insurance in the event of a motor vehicle accident. A lessee is defined as a person who is leasing or renting the automobile for any period of time.

Section 267.12 of the *Insurance Act* creates a limit on the liability of rental companies and lessors to the greatest of:

a) $1,000,000;
b) the amount of third party liability insurance required by law; or
c) the amount determined by regulations that are to determine the maximum amounts for this clause.

This $1,000,000 cap covers all lessors (except taxi cabs or limousines). However, it only covers vicarious liability as independent negligence remains unrestricted.

Importantly, this $1,000,000 maximum is reduced by any amounts recovered under any third party liability provisions of the lessee, renter, or any other persons with respect to the accident. Accordingly, if the lessee has in place a policy of insurance with $1,000,000 in third party liability limits, the rental company or lessor likely has no exposure for vicarious liability.

WHO COVERS WHOM

The coverages at play can become complicated, particularly when there is a driver operating a rental vehicle and where the driver is not the person who rented the vehicle. Various scenarios are summarized in the following chart:

Person seeking coverage	**Is the person covered?**
Driver seeking coverage under a renter's policy	No, coverage probably not extended to driver unless the driver is an insured under the renter's policy
Renter seeking coverage under a driver's policy	No, coverage not extended to renter unless the renter is insured under the driver's policy
Driver and renter seeking coverage under the vehicle owner's policy	Yes, but limits are $1 Million, less renter's/driver's own third party liability limits
Driver and renter seeking coverage under owner's excess policy	Debatable, but recent case law says 'no.' There is now also a specific endorsement (OEF 110), however, which, if attached to the owner's excess policy, results in limits of $1 Million less renter's/driver's own third party liability limits
Vehicle owner seeking coverage under renter's or driver's policy	No

CONCLUSION

This short paper provides the key concepts and practical implications of the Bill 18 legislation with respect to the priority scheme for third party liability insurance coverage applicable to leased and rented vehicles in Ontario. However, it is a general summary only and may overlook or oversimplify some of the complex issues surrounding the priority of coverage issues.

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