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A Tale of Two Cars

By: Daniel Strigberger of Miller Thomson LLP. © Daniel Strigberger. Reproduced with permission. This article originally appeared in the June/July 2011 issue of Claims Canada.

"I know a lot about cars, man. I can look at any car's headlights and tell you exactly which way it's coming." – Mitch Hedberg, comedian

The Financial Services Commission of Ontario (FSCO) has decided that 2011 will be the "Year of the Automobile." Herein is a tale of two incidents involving two very different types of machines on wheels. In both cases, people were injured while riding on such machines. They each applied to different automobile insurers for accident benefits. Their claims were denied, as accident benefits are meant for victims of automobile accidents. Both insurers decided that their respective claimants were not involved in automobile accidents – or so they thought.

How To Make an Automobile

The Ontario Court of Appeal held in *Adams v. Pineland Amusements* that the following three-part test must be used to determine whether a vehicle is an automobile:

(i) Is the vehicle an automobile in ordinary parlance?

(ii) If not, is the vehicle defined as an automobile in the wording of the insurance policy?

(iii) If not, does the vehicle fall within any enlarged definition of "automobile" in any relevant statute?

With respect to the third part, section 224(1) of the *Insurance Act* provides the following definition for the word automobile: "'automobile' includes, (a) a motor vehicle required under any Act to be insured under a motor vehicle liability policy, and (b) a vehicle prescribed by regulation to be an automobile."

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Therefore, where a vehicle isn't an automobile in ordinary parlance and is otherwise not defined as an automobile in the policy, it can become an automobile if it meets the criteria in section 224(1) of the *Insurance Act*: Either it is prescribed by regulation to be an automobile or it is a "motor vehicle" required under any other Act to be insured under an auto policy. Of course, the *Insurance Act* does not define motor vehicle, but the *Highway Traffic Act* does. With some exceptions, the definition of motor vehicle includes any vehicle propelled or driven otherwise than by muscular power.

So a motor vehicle that is required by law to be insured is considered to be an automobile for the purpose of automobile insurance in Ontario. With that in mind, our tale begins:

An Automobile by Any Other Name: *Buckle v. MVACF*

Wilhelmina Margaret Buckle was injured when she fell off a moving golf cart. By all accounts, at the time of the accident the golf cart was being operated on a public highway illegally: It was unlicensed, unregistered and uninsured. The parties agreed that the golf cart was neither an automobile in ordinary parlance nor defined as an automobile in the policy. The arbitrator found that the golf cart was a motor vehicle, as it was self-propelled. Therefore, the arbitrator had to decide whether the golf cart was required to be insured at the time of the accident.

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The arbitrator found that because the golf cart was a motor vehicle, under the *Compulsory Automobile Insurance Act* it was required to be insured at the time of the accident because it was travelling on a highway when the accident occurred. Therefore, pursuant to the definition of automobile under section 224(1) of the *Insurance Act*, the golf cart was an automobile at the time of the accident.

We can assume that the golf cart returned to being a non-automobile once it left the highway.

Arbitrator Pulls Automobile from Pocket: *Bouchard v. Motors*

Cassondra Bouchard had a friend named Kristin Stratton, who owned a couple of pocket bikes (described as gas powered miniature motorcycles). Stratton would ride the bikes on his own property and on a friend's property.

On Jan. 13, 2008, Bouchard was riding one of the pocket bikes on Kristin's property, when she collided with one of Kristin's other pocket bikes and sustained injuries.

Working with an agreed statement of facts, the arbitrator determined that the issue was whether the pocket bike was required to be insured under a motor vehicle liability policy. First, she found that the pocket bike was an off-road vehicle under the *Off Road Vehicles Act*. Next, she noted that pursuant to section 15 of the Act, the pocket bike was required to be insured under a motor vehicle liability policy unless it was driven on land occupied by the owner (Stratton) of the bike.

Even though the accident happened on Stratton's land, the arbitrator found that it was nevertheless required to be insured. Her decision apparently turned on the evidence that Stratton would drive his pocket bikes at a friend's house. She stated, "[c]learly the legislature intended that off-road vehicles be insured unless they were used *solely* on lands occupied by the owner." [emphasis added].

In other words, according to this decision it appears that once the owner of an off-road vehicle uses the vehicle on lands not occupied by them, the off-road vehicle transforms into an automobile forever. There's no turning back.

Would You Insure My Three-Year-Old?

At this rate, it seems that the "ordinary parlance" test has gone out the window (of a moving automobile). Suppose my three-year-old drives his Power Wheel Diego Jeep Wrangler on the road. It would likely meet the definition of

motor vehicle under the *Highway Traffic Act* because it is a "vehicle propelled or driven otherwise than by muscular power." Therefore, while on the road it would also require auto insurance, pursuant to the *Compulsory Automobile Insurance Act*, and, accordingly, it would be considered to be an automobile under the Insurance Act. Go Diego Go!

RECENT CASES

Appeals

Arbitrator Did Not Rate All of Appellant's Impairments

The appellant appealed an arbitrator's decision that found she had not sustained a catastrophic impairment. The appellant raised 135 alleged errors of law. Much of her appeal focused on the arbitrator's weighing of the evidence and specific findings of fact. More specifically, the appellant submitted that her whole person impairment ("WPI") was 75% (the arbitrator had found 28%). The arbitrator had also found that the appellant's upper left extremity impairment and knee impairment were not assessable because they had not yet stabilized.

The appeal was allowed and the issue of catastrophic impairment was returned to arbitration for a new hearing. The Director's Delegate agreed with the appellant that all areas of impairment should be readdressed, as there was an overlap between impairments that were not rated and ones that were. The Director's Delegate noted that appeals from an arbitrator's order are limited to questions of law; therefore, the appellant's submissions about the evidence would be left to the arbitrator rehearing the matter. The Director's Delegate found that the arbitrator erred in law in not rating the appellant's left upper extremity and knee impairments. The Director's Delegate also held that a finding of catastrophic impairment does not by itself result in compensation; each benefit claim must still meet specific statutory requirements. He found that the two-year provision in subsection 2(2.1) of the *Statutory Accident Benefits Schedule* and the two-year non-catastrophic impairment limit on attendant care were not merely coincidence: the legislative intent is a timely catastrophic determination that allows for a continuity of benefits. Paragraph 2(1.2)(*f*) of the Schedule states that impairments are to be rated in accordance with the *Guides to the Evaluation of Permanent Impairment* (the "Guides"), but the timing of all assessments are determined by subsection 2(2.1), to which the Guides must defer. The arbitrator also erred in determining that neither a sleep disorder nor chronic pain could be rated separately.

Bains v. RBC General Insurance Company, Summary No. A-0976 (FSCO)

Counsel Refused To Sign Certification To Release

The appeal raised an important and novel question: if the parties settled a dispute with respect to accident benefits, what were the ramifications of a dispute over the execution of the release? The applicant's counsel refused to sign a certification that he properly advised his client of the legal ramifications of the release, and also refused to witness it personally. He did send an executed consent to dismissal and a draft order. Correspondence ensued and ultimately the applicant requested the matter be relisted for arbitration, with a preliminary issue hearing on the settlement issue. The applicant submitted he had provided everything required for a settlement. Arbitrator Killoran agreed with the applicant, and found the insurer was unreasonable to a flagrant degree, awarding a special award. The insurer appealed.

The appeal was allowed in part: the special award was rescinded; the insurer was required to pay the applicant $3,250 with interest; and the applicant was to provide a witnessed release. The Director's Delegate noted that both counsel submitted their personal beliefs as to the usual, standard, known, common, appropriate, and reasonable professional and business practice of the industry and bar regarding releases, but aside from those personal beliefs, the arbitrator had little or no proper evidence before her as to the common practice of releases generally, and the certification issue specifically. In that regard, the insurer conceded that a lawyer's certification regarding explaining the ramification of the release breached solicitor–client privilege. On the other hand, the Director's Delegate found that one could take judicial notice of the fact that having a witness to a contractual signature was reasonable and commonplace. With respect to the special award, the Director's Delegate found that the arbitrator ordered it on the principle that the insurer arbitrarily added an additional requirement that was not statutorily mandated. The Director's Delegate concluded that the arbitrator erred in this regard. If the documents were not accepted, then the parties were obliged to further discussion, keeping in mind the overriding legislative objective of resolving disputes fairly and efficiently. The Director's Delegate rescinded the arbitrator's special award.

Dominion of Canada General Insurance Company v. Singh, Summary No. A-0977 (FSCO)

Fund Relied to Its Detriment on Prior Common Law

In May 2005, while driving an uninsured vehicle belonging to a friend, the claimant suffered serious injuries in a single-vehicle accident. An adjuster acting on behalf of the Motor Vehicle Accident Claims Fund (the "Fund") attempted to determine if the claimant was listed under his employer's automobile insurance policy. After several months, in November 2005, the employer finally sent a copy of its insurance policy to the Fund. A week later, the Fund adjuster sent the employer's insurer a Notice to Applicant of Dispute Between Insurers because this was typical practice. The insurer placed the file in abeyance pending the decision in *Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund*, 2007 ONCA 61, in which the Court of Appeal ultimately held that the Fund was an "insurer" and was bound by the notice provisions. At arbitration, the insurer argued that the Fund failed to deliver its notice within the 90-day period pursuant to O. Reg. 283/95 (the "Regulation"). However, the arbitrator found that the Fund was not bound by the notice provisions in the Regulation. The insurer appealed.

The appeal was dismissed. The Court noted that the dispute between the Fund and the insurer arose during various common law developments. In *Ontario (Minister of Finance) v. Progressive Casualty Insurance Co. of Canada*, 2009 ONCA 258, the Court of Appeal held that the decision in *Allstate* applied retrospectively except in cases where there is clear evidence of detrimental reliance on the prior common law rule. The Court concluded that the *Progressive* decision intended a party to be exempted from the new law in *Allstate* where it could show it clearly and detrimentally relied on the previous authority; any other interpretation of *Progressive* would be contrary to the scheme of the *Insurance Act*. The Court concluded the Fund did rely to its detriment on the existing common law authority at the time of its investigation, and the *Allstate* decision did not apply in the circumstances.

Ontario (Minister of Finance) v. Lombard General Insurance, Summary No. A-0979 (Ont. S.C.J.)

All Four Areas of Functioning To Be Considered When Making Assessment

The insurer applied for judicial review of a dismissal by the Director's Delegate of its appeal from an arbitrator's decision confirming a Designated Assessment Centre's ("DAC") assessment that the respondent suffered a catastrophic impairment due to mental/behavioural disorder. The respondent suffered a fractured ankle and had knee replacement surgeries. A DAC assessment determined that the respondent had a marked impairment in the activities of daily living due to mental or behavioural disorder, and moderate impairment in three remaining areas of functioning. The marked impairment in the activities of daily living was the basis for the finding of catastrophic impairment. The Director's Delegate, in response to the submission of the failure to attribute the limitations suffered by the respondent to physical impairment or associated pain, held that the arbitrator's determination that her behavioural and mental disorders resulted in a Class 4 impairment was a finding of fact. The Director's Delegate concluded it was not his role to second-guess the arbitrator's evaluation of the evidence.

The application for judicial review was granted and the decision of the Director's Delegate was set aside. The Court held that the assessment of mental/behavioural disorders requires consideration of all four areas of functioning. The Director's Delegate erred in not considering the effect of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the "Guides") on the *Statutory Accident Benefits Schedule*. The Court held that the Director's Delegate interpreted the Guides as if they had no relationship to the Schedule. The Court found that the cases relied on by the arbitrator and the Director's Delegate were informative, but not determinative of the issue. The Court also held that the Director's Delegate failed to consider the guidelines published by the province as external aids to understanding the Guides. The Court concluded that, while it was possible for a finding of catastrophic impairment to be dominated by one of the four areas of functioning, the requirement was that all four areas of functioning must be considered when making an assessment.

Matlow J., while agreeing with the result, dissented on the first issue, finding that nothing in the Guides required more than a single finding. Matlow J. also disagreed that the Guides were a part of the legislation.

Aviva Canada Inc. v. Pastore, Summary No. A-0980 (Ont. Div. Ct.)

IRBs Not Available to Plaintiff After He Elected for Caregiver Benefits

The plaintiff, who had been injured in an automobile accident, was entitled to two types of statutory benefits: income replacement benefits ("IRBs") and caregiver benefits ("CGBs"). He elected for the latter, and then commenced an action for, among other things, past income loss. Subsection 267.8(1) of the *Insurance Act* (the "Act") provides that statutory accident benefits are deductible from personal injury damages arising from the use of an

automobile. A pre-trial determination held that the IRBs were "available" to the plaintiff, despite his election for CGBs, and were therefore deductible from any potential damages award. The plaintiff appealed.

The appeal was allowed. The Court noted that the purpose of subsection 267.8(1) of the Act is to prevent double recovery, and that subsection 36(1) of the *Statutory Accidents Benefits Schedule* permits a person to receive only one of IRBs, CGBs, or non-earner benefits. The defendants argued that once the plaintiff chose not to apply for IRBs, despite the fact that they were available to him, he had to bear the consequences of that decision. The Court found that this argument ignored two issues. First, it ignored the fact that the legislation required the plaintiff to make a decision, and once he elected CGBs, IRBs were no longer available to him. Second, it ignored the "prevention of double recovery" purpose of subsection 267.8(1) and actually resulted in undercompensation to the defendants' windfall. To accept the defendants' argument would mean that they were entitled to the credit for both CGBs (which the plaintiff received) and IRBs (which he did not receive). The Court concluded that once the plaintiff elected CGBs, IRBs were no longer available to him.

Sutherland v. Singh, Summary No. A-0981 (Ont. C.A.)

Other Appeal Decisions

- Expenses

Piche v. Allstate Insurance Company of Canada, Summary No. A-0978 (FSCO)

- Request for Variation Order

Berger v. Gore Mutual Insurance Company, Summary No. A-0982 (FSCO)

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Determining Catastrophic Impairment

The issue before the arbitrator was whether the applicant sustained a catastrophic impairment. The applicant was in a horrific single-vehicle accident where all six occupants were ejected from the vehicle and only one was identified at the scene. The applicant maintained he was the person who was found imbedded in the hillside and that his Glascow Coma Scale ("GCS") score was 9 or less, which indicates catastrophic impairment according to the *Statutory Accident Benefits Schedule* (the "Schedule"). There was no written record of a GCS score of 9 or less for the applicant, except when he was sedated. The Ambulance Call Report, written by the paramedics who took the imbedded person from the scene, indicated a score of 13 for him. Two other paramedics who triaged the injured at the scene testified that they were not required to make a written record, but that they conducted a GCS test and assigned a score of 3 to the imbedded person.

The applicant was the passenger found imbedded in the hillside, but he did not sustain a catastrophic impairment within the meaning of subparagraph 2(1.1)(*e*)(i) of the Schedule. The arbitrator held that, based on statements, reports, and records, the applicant was the person imbedded in the hillside. The medical description of that patient was in accord with the paramedics' memory. However, with respect to the GCS score, the arbitrator concluded that the paramedics did not administer a GCS test on site; he did not accept their evidence in this regard. The arbitrator held that, while he did not doubt their sincerity, he did not accept that they had total recall of all the details nine years after the accident. In addition, the arbitrator noted that, as the standards did not require the triage unit to administer a GCS test, it was less likely that the paramedics did so. As such, there was no GCS score of 9 or less recorded for the applicant. The arbitrator concluded that there was no evidence upon which he could find that the applicant's brain impairment caused or contributed to the GCS scores upon which he relied in this arbitration.

Windsor v. Motor Vehicle Accident Claims Fund, Summary No. 11342 (FSCO)

Arbitrator To Decide Catastrophic Impairment

After the applicant was awarded various statutory accident benefits, he applied for a determination of catastrophic impairment. The parties were unable to resolve the precise scope of the issue to be put before the arbitrator and requested a preliminary ruling. The preliminary issue here was whether the issue of causation for the purpose of determining a catastrophic impairment had already been decided. The case had a long and complex procedural history. Technically, the issue in dispute was the procedural impact of Arbitrator Killoran's decision of July 7, 2005, in which she awarded the applicant benefits but did not deal with the issue of catastrophic impairment, as that issue was not before her. Prior to the applicant's death, a catastrophic impairment Designated Assessment Centre ("CAT DAC") assessment found 87% whole person impairment, but also opined 0% was related to the accident. The applicant argued the issue of causation was *res judicata*, as it was covered by the doctrine of estoppel.

The issue to be put before the arbitrator was: Was the applicant catastrophically impaired as a result of the accident on July 12, 2001? The arbitrator summed up the procedural quandary: on the one hand was an arbitrator's decision, confirmed by appeal and judicial review, that the applicant's impairments were accident-related and not simply the result of pre-existing conditions; but on the other hand were CAT DAC assessments that found the applicant met the test for catastrophic impairment, yet disagreed these impairments were accident-related. The arbitrator concluded that the issue of causation, solely as it related to whole person impairment, was not yet adjudicated. The arbitrator held that it was possible for an adjudicator to find someone with pre-existing conditions to be entitled to benefits but also not be catastrophically impaired as a result of the accident. While the general issue of causation was dealt with by Arbitrator Killoran, the catastrophic impairment definitions in the Schedule raised the issue of causation in a way not completely captured by a finding that a motor vehicle accident contributed to a person's disability or need for medical treatment so as to entitle the person to accident benefits. The arbitrator noted that the ultimate purpose of arbitration is to provide a fair hearing to both parties; the insurer was entitled to a fair hearing and to be allowed to argue its case.

Kanareitsev (Estate) v. TTC Insurance Company, Summary No. 11344 (FSCO)

Applicant Did Not Understand Arbitration Process

The preliminary issue before the arbitrator was whether the applicant was a party under disability pursuant to Rule 10 of the *Dispute Resolution Practice Code*. In addition to stating that he did not understand the proceedings, the applicant chose not to listen to medical testimony about him, saying he could not "be in the same room with two doctors who don't tell the truth".

The applicant was a party under a disability. The arbitrator found that the applicant was extremely confused and not able to focus on the proceeding. Despite repeated reminders as to the nature of the proceeding, it was never clear to the arbitrator that the applicant understood. The arbitrator noted that the applicant was continually interruptive, and seemed uncomfortable and apprehensive. The arbitrator noted that a medical professional found the applicant was unable to stay focused, and the inability to complete the mini mental status examination likely signified a hyperactive attention deficit disorder. The arbitrator found this evidence compelling and overrode the presumption that the applicant had the requisite capacity to proceed with the arbitration process. The arbitrator concluded that the applicant did not have the mental capacity to proceed in the dispute resolution process. After finding no suitable attorney or person to act on behalf of the applicant, the arbitrator stated he would forward a copy of this decision to the Public Guardian and Trustee.

Mr. S v. Aviva Canada Inc., Summary No. 11346 (FSCO)

Whether Daughter Was a Dependant and Entitled to Death Benefits

The applicant was the daughter of the deceased insured. The issue was whether she was entitled to a death benefit as a dependant of the insured. The applicant was enrolled in school. The accident occurred in August 2006, and the parties agreed to focus on the year preceding the accident in determining whether the applicant was financially dependent on her father.

The applicant was a dependant and was entitled to a death benefit. The arbitrator found the applicant credible; her testimony made sense and coincided with the oral evidence of other witnesses. The arbitrator concluded that the evidence as a whole established a relationship of financial dependence between the applicant and her father during the year in question. The arbitrator stated that her conclusion rested on an assessment of the applicant's expenses and income. For example, the applicant was only able to work part-time, which indicated an inability to be self-supporting. The arbitrator held that the student loan was not to be viewed as income, as the applicant's father intended to pay off the loan for her (he had put his car up for sale to help pay the student loan). The arbitrator also found that the insured made a car available to his daughter and paid her rent almost all of the time. The arbitrator concluded the applicant could only pay one-third of her expenses on her own.

Poutney v. Economical Mutual Insurance, Summary No. 11356 (FSCO)

Representative Awarded Expenses Due to Insurer's Conduct

The applicant was injured in an accident, and the arbitrator ruled on his claims for statutory accident benefits, reserving on the expenses issue. The insurer sought an order that Alon Rooz be made a party to the proceedings and that he personally pay all or part of the expenses awarded to the insurer. Rooz consented, but then moved for summary judgment to dismiss the insurer's claim regarding his personal liability. In the meantime, the Director's Delegate dismissed the applicant's appeal of the

arbitration order. The arbitrator granted Rooz's motion for summary judgment and dismissed the insurer's motion. At issue was which party was entitled to expenses in relation to both the arbitration hearing and the motion for summary judgment.

The applicant was to pay the insurer's expenses of the arbitration hearing. The insurer was to pay $500 to Rooz for the motion for summary judgment. The insurer was not permitted to set off its expenses award against the expenses it was to pay to Rooz. In applying the criteria set out in what is commonly known as the Expense Regulation, the arbitrator found that the insurer was entirely successful at arbitration, and that none of the other factors were particularly relevant. As such, the insurer was entitled to expenses. However, given the overall simplicity of the hearing, the amount of preparation time sought by the insurer was not reasonable, nor did the insurer require double legal representation. The arbitrator concluded that the insurer was entitled to $4,509.22 of the approximately $28,000 it claimed. With respect to the summary judgment motion, the arbitrator noted the insurer presented no evidence to support its claim to have a representative made personally liable. The arbitrator found the insurer's conduct unreasonable and, given Rooz's success, awarded him expenses. However, the arbitrator found that Rooz's claim for legal fees was excessive, especially since much of the argument presented resembled *Seyed v. Federated Insurance Company of Canada*, where an order for expenses was sought against another member of Rooz's firm. The arbitrator fixed Rooz's expenses at $500 and awarded this amount. Finally, the arbitrator found that the possibility the insurer would be unable to recover from the applicant did not justify an offset of Rooz's award, who was a distinct and different party.

Abbas v. Security National Insurance Co./Monnex Insurance Mgmt., Summary No. 11364 (FSCO)

Insurer Required To Produce File Beyond Date of Application for Mediation

The insurer and the applicant disputed her entitlement to housekeeping and home maintenance benefits. In this motion, the issue was whether the insurer was required to produce its file beyond the date of the application for mediation and, if so, whether production was limited to the portion of the file related to housekeeping and home maintenance benefits or whether the entire file was required. The insurer had agreed to produce its file up to the application for mediation. The date stamp on the application for mediation was October 6, 2008, but FSCO notified the insurer by letter dated January 2, 2009.

The insurer's entire file was relevant, and it was required to produce the file, subject to any privilege, to the date of FSCO's letter. The arbitrator found that there was either a one-step or a two-step approach to determining if litigation privilege arose, depending on the issue. The one-step approach was used if there was only one issue in dispute or if all the benefits claimed were in dispute. The two-step approach applied where there were numerous benefit claims, but with only one of those issues being subject to a reasonable apprehension of litigation, such that the party seeking privilege bore the burden in the second step of showing that the documents were prepared in anticipation of litigation. Applying the first step, the arbitrator found it likely that in the circumstances of the significant delay by FSCO in notifying the insurer, the insurer did not anticipate litigation until it received notice that the applicant applied for mediation. The second step, following receipt of the application for mediation, meant that documents in the insurer's file were dual-purposed: for settlement and defence/litigation. The aforementioned significant delay by the FSCO was the distinguishing feature for the arbitrator's departure from previous FSCO arbitrator's decisions that privilege commenced on the date of the application for mediation.

Vaitheeswaran v. State Farm Mutual Automobile Insurance Company, Summary No. 11365 (FSCO)

Insurer's Motion for Third-Party Documents Was Blatant Fishing Expedition

In a dispute over benefits, the insurer moved for an order that the Children's Aid Society of Toronto ("CAS") produce an unredacted copy of its records in respect of the applicant's children. The applicant, who continued to receive income replacement benefits as a result of his accident, had been hospitalized with suicidal ideation. The CAS became involved and investigated. The insurer argued this information related to the family dynamics and, therefore, the applicant's functionality. The insurer also relied on a letter from the applicant's counsel implying that late productions would be acceptable and on the fact that the applicant also made late productions. The applicant opposed the motion, submitting, among other things, that the insurer's CAS record request was made the night before the hearing and such lateness was prejudicial to him. In addition, the applicant raised confidentiality concerns in respect of his wife and children. With respect to his counsel's letter, the applicant argued its purpose was not to permit an "ambush" on the eve of the hearing with previously unraised issues.

The motion was dismissed. The arbitrator scheduled what she thought was a valid motion for third-party pro-

duction and assumed that the insurer had adhered to the requirements of Rule 67 of the *Dispute Resolution Practice Code*. Instead, at the hearing, counsel made submissions without tendering any evidence in respect of the criteria required by Rule 67. The arbitrator stated that administrative law is based on two principles: the duty to be fair and the duty to be heard. The arbitrator held that the insurer ignored both. In addition to its failure to comply with Rule 67, the arbitrator found that the insurer provided no valid basis or extraordinary circumstances for the late request pursuant to Rule 39.2 of the Code. The arbitrator concluded that all of the insurer's reasons were spurious and made up after the fact, and that its request was a "blatant, last minute 'fishing expedition'". The arbitrator concluded that the motion was frivolous, vexatious, and unnecessary.

Mr. C. v. Coachman Insurance Company, Summary No. 11367 (FSCO)

Applicant Not Malingering, But Bulk of Claims Dismissed

The applicant was a self-employed bagel maker who claimed he lost his business as a result of the physical and mental impairments sustained in an accident. He did not seek treatment until 10 months after the accident, at which point various insurer medical examinations found the applicant's behaviour so bizarre and unusual that he was referred for immediate psychological/psychiatric evaluation. Four years after the accident, the applicant applied for a determination of catastrophic impairment due to mental/behavioural disorder pursuant to paragraph 2(1.1)(*g*) of the *Statutory Accident Benefits Schedule* ("SABS"). He submitted that the highly traumatic nature of the accident caused his psychological impairment. The insurer submitted that while the applicant suffered some soft tissue injuries, they had resolved. The insurer argued the applicant was malingering. Despite numerous evaluations, the applicant's condition had not been definitively diagnosed.

The claim was allowed in part. The applicant was not entitled to income replacement benefits, housekeeping expenses, or attendant care benefits. He did not suffer a catastrophic impairment in the accident, but he was entitled to the treatment costs he actually incurred. With respect to the varying medical opinions and the applicant and his family's lack of credibility, the arbitrator stated that neither the applicant's possible malingering nor his lack of diagnosis precluded an inquiry into whether he genuinely suffered from psychological symptoms that amounted to an impairment under SABS. Starting from the premise that an inquiry was necessary, the arbitrator noted there was no dispute that the applicant suffered soft tissue injuries, but found they had resolved by August 2004. One of the experts opined that the applicant suffered from "motor vehicle accident syndrome", but the arbitrator noted this was not a recognized disorder of diagnostic category to date. The arbitrator made the following factual conclusions on the evidence: the applicant's business was failing; and he had difficult dealings with customers, health inspectors, and the Canada Revenue Agency, as well as a strained relationship with his wife, all before the accident. The arbitrator concluded that there was no question in her mind that the applicant was a genuinely psychologically troubled and dysfunctional person, disagreeing with the insurer that he was malingering. However, the applicant failed to establish that the accident was a significant cause of his psychological impairment; the impairment predated the accident and was caused by the aforementioned unrelated factors.

R.P. v. Allstate Insurance Company of Canada, Summary No. 11369 (FSCO)

Other Cases

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Emburgh v. Co-operators General Insurance Company, Summary No. 11343 (FSCO)

- Non-Earner Benefits

Tam v. Wawanesa Mutual Insurance Company, Summary No. 11345 (FSCO)

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