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Priority Disputes –
Step by Step Guide to Handling Claims

By: Laura Emmett and Matt Duffy

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Priority disputes are governed by Ontario Regulation 283/95 – *Disputes Between Insurers* (hereinafter "Regulation"). The Regulation was established in 1995 to ensure payment of Statutory Accident Benefits to injured persons while any disputes were resolved.

Prior to the enactment of the Regulation, there was no obligation on Insurers to pay benefits to a Claimant in circumstances where entitlement was disputed. Instead, where an Insurer denied entitlement, the Applicant was forced to proceed to Arbitration and argue that the Insurer had to pay. Until they were successful, the Insurer did not have to pay Statutory Accident Benefits.

The first priority dispute decision was *Cattrysse v. The Westminster Mutual Fire Insurance Company*[1] which was prior to the enactment of the Regulation. The Applicant had applied to both Westminster Mutual Fire Insurance Company and Anglo Canada General Insurance Company. Both Insurers claimed that they were not Mr. Cattrysse's insurer. Accordingly, the Applicant was forced to participate in an Arbitration against each in order to recover benefits owed to him. This was an expensive, cumbersome process and except for the good graces of the Insurers involved would have meant that Mr. Cattrysse would have gone without benefits until the completion of the Arbitration and subsequent appeal. It was cases like this one that led to the priority dispute regulation.

Mr. Cattrysse had been seriously injured in a motor vehicle accident on August 30, 1991. At the time, he was 22 years old. In September 1990, Mr. Cattrysse had enrolled in a law and security administration program at Niagara College but dropped out within two months to pursue a farming career. In the Winter of 1990, he worked at the Tobacco Marketing Board. He lived at home and helped out at his parents' tobacco farm during evenings and weekends. Until the time of the accident (with the exception of his time at Niagara College), he lived at home. The issues to be decided included whether Mr. Cattrysse had regular use of an automobile made available by a partnership or other entity and whether he was principally dependent on his parents (who were Insureds of Westminster).

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[1] Arbitrator Palmer, A-001618 and A-001789, Ontario Insurance Commission, Appeal dismissed [1998] O.I.C.D. No. 68 and Judicial Review denied [1998] O.J. No. 6558 (Gen. Div.).

While there was no obligation on either Insurer to pay Statutory Accident Benefits, the Insurers agreed that one of them was going to be responsible for paying the Statutory Accident Benefits to Mr. Cattrysse. Informally, they decided that they would each split the cost of the Statutory Accident Benefits so that Mr. Cattrysse could get the benefits that he desperately needed. Upon resolution of the Arbitration, the responsible Insurer would reimburse the other party.

The enactment of the Regulation resolved the issues faced by injured Applicants, such as Mr. Cattrysse. With the Regulation, the onus is no longer on the Applicant to proceed to Arbitration in priority dispute cases. Instead, the Regulation ensured that Applicants receive Statutory Accident Benefits in a timely fashion while priority disputes are resolved between Insurers.[2] The Regulation sets out the mandatory process for private Arbitrations to decide the issue of which Insurer is liable to pay Statutory Accident Benefits.

The general obligation to pay Statutory Accident Benefits is found at section 268 of the *Insurance Act* which provides that every motor vehicle liability policy is deemed to provide Statutory Accident benefits coverage. Pursuant to section 268(2), there is a hierarchy of Insurers who are obligated to pay Statutory Accident Benefits. Specifically, it provides:

> (2) The following rules apply for determining who is liable to pay statutory accident benefits:
>
> 1. In respect of an occupant of an automobile,
>
> i. the occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured,
>
> ii. if recovery is unavailable under subparagraph i, the occupant has recourse against the insurer of the automobile in which he or she was an occupant,
>
> iii. if recovery is unavailable under subparagraph i or ii, the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to statutory accident benefits arose,
>
> iv. if recovery is unavailable under subparagraph i, ii or iii, the occupant has recourse against the Motor Vehicle Accident Claims Fund.
>
> 2. In respect of non-occupants,

[2] Bulletin A-07/10, Changes to Ontario Regulation 283/95: Disputes Between Insurers, May 13, 2010.

> i. the non-occupant has recourse against the insurer of an automobile in respect of which the non-occupant is an insured,
>
> ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,
>
> iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to statutory accident benefits arose,
>
> iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund. R.S.O. 1990, c. I.8, s. 268 (2); 1993, c. 10, s. 1; 1996, c. 21, s. 30 (3, 4).

Under the *Insurance Act,* an Insured means "a person insured by a contract whether named or not and includes every person who is entitled to statutory accident benefits under the contract…" Priority disputes don't arise when an Applicant is the named Insured. Instead, these claims arise when someone other than the named Insured seeks benefits under an insurance policy. Priority disputes arise when an Insurer argues that there is another Insurer in higher priority. Generally, there are three instances where priority disputes arise:

1. Where there is a dispute about whether the Applicant is Dependent on a Named Insured;
2. Where there is a dispute about whether the Applicant is a Spouse of a Named Insured; and,
3. Where there is a dispute about whether the Applicant has Regular Use of an Automobile during the course of their employment.

The intention of this paper is to provide a brief overview of the relevant considerations to be given when adjusting claims that may involve priority disputes.

What to do when you get a claim that may involve a priority dispute

Step 1 – Don't deflect an Application for Benefits

As of September 1, 2010, there is a statutory obligation on all Insurers to adjust any accident benefits claim that they receive. It is inappropriate to advise an Applicant that they should apply to another Insurer. This ensures that people, like Mr. Cattrysse, get access to the Statutory Accident Benefits that they need while Insurers fight amongst themselves.

Section 2.1 of the Regulation provides that the first party to receive an Application for accident benefits is obligated to pay benefits pending an Arbitration. Section 2.1(5) states that the first Insurer shall not take any action intended to prevent or stop the Applicant from submitting a completed application to the Insurer and shall not refuse to accept the completed Application or redirect the Applicant to another Insurer.

There are now penalties contained in the Regulation where an Insurer attempts to deflect an Application for Benefits. Specifically, section 2.1(7) provides that the deflecting first Insurer shall reimburse the second Insurer for any legal fees, adjuster's fees, administrative costs and disbursements that are reasonably incurred as a result of non-compliance. Of significance, this remedial provision does not apply to the Fund.

There is no specific reference to the *Unfair or Deceptive Acts or Practices*[3] regulation ("*Unfair Act")* in the Regulation. Nevertheless, the failure to comply with section 2.1 of the Regulation would likely be considered an unfair or deceptive act or practice pursuant to section 1 of the *Unfair Act* on two grounds. First, because it is a commission of an act prohibited by the regulation and second, it could result in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims.

Prior to September 1, 2010, there were some limited instances where one Insurer was entitled to deflect. The leading case on deflection was the Court of Appeal's decision in *Kingsway General Insurance Co. v. Ontario (Minister of Finance).*[4] In that case, the Court recognized that Arbitrators and Courts had developed a nexus test for triggering an Insurer's obligation to respond. The Court explained that "as long as there is some nexus – some connection – between the insurer receiving an application for benefits and the insured, the insurer must pay pending the determination of its obligation to do so".[5] The Court of Appeal recognized that the nature of the nexus or connection would vary from case to case. Inherent in this recognition is the allowance that if there was no "nexus" the application could be deflected.

It remains to be seen whether any deflection at all, even in cases where there is no "nexus" is permitted under the new Regulation. There haven't been any cases which have considered same. The wording of section 2.1 would suggest that no nexus is required to trigger an obligation to pay. Given that deflection of an Application could be considered an unfair or deceptive act or

[3] O. Reg. 7/00.
[4] [2007] O.J. No. 290.
[5] *Ibid.* at para. 20.

practice, it is important that the claims processing be handled in the same manner as any other claim even where the Insurer does not believe that they are the priority Insurer.

Step 2 – Make sure you have a Completed Application

Prior to the amendment, there was a significant amount of case law on the issue of what constituted a "completed application." Arbitrators and Judges recognized that subject to "relatively rare cases", a completed application would mean an OCF-1.[6]

When the Regulation was amended in September 2010, the term "completed application" was defined. As outlined in the Regulation, a "completed application" means a "completed and signed application". Application is defined in the Regulation as an "Application for Accident Benefits (OCF-1)."

Step 3 – Make sure that you follow the timelines

For accidents prior to September 1, 2010, there are only two timelines that are of significance. Firstly, section 3(1) of the Regulation requires that the first Insurer to receive written notice give Notice, within 90 days of the receipt of a completed Application for Benefits, to every insurer it argues is required to pay.

Generally, the failure to do so means that a claim for priority can not be maintained. The only exception is contained in section 3(2) which provides that an Insurer may give notice after the 90-day period if (a) 90 days was not a sufficient period of time to make a determination that another Insurer or Insurers is liable and (b) the Insurer made the reasonable investigations necessary to determine if another Insurer was liable within the 90-day period.

While each case must be determined on its own facts, the "saving provisions" in subsection 3(2) are to be strictly applied and can only be invoked when both branches of the test are met.[7] The Insurer seeking to rely on these provisions faces a heavy onus.[8]

The saving provisions were considered by the Court in *Liberty Mutual Insurance Co. v. Zurich Insurance Co.*[9] The Court opined that section 3(2) "is to operate strictly, because an insurer is entitled to know at an early stage that it will be managing and responsible for the payment of

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[6] *ING Insurance Co. of Canada v. TD Insurance Meloche Monnex,* [2010] O.J. No. 3549 (C.A.).
[7] *Wawanesa, Ibid.*
[8] *Wawanesa, Ibid.*
[9] [2007] O.J. No. 4838 (S.C.J.).

benefits." The Court concluded that section 3(2) was designed to immediately engage the provision of benefits for the Insured and to encourage the first Insurer to promptly exercise due diligence to make a determination as to whether another insurer should be responsible to pay.

In determining whether the saving provisions ought to apply, the Court held that,

> an insurer seeking to deliver a notice after 90 days must show both that it exercised due diligence and also that there was something in all the circumstances that would justify requiring more than 90 days to make a determination about whether to issue a notice to a particular insurer.

Section 10 of the Regulation provides that where a second Insurer believes that another Insurer has equal or higher priority, the second Insurer can put a third Insurer on notice. Of significance, the 90 day timeline contained in section 3 of the Regulation does not apply in instances where a second Insurer claims that a third Insurer is the priority Insurer. The first case on this issue was Arbitrator Samis' decision in *Wawanesa v. Peel Mutual and Economical Mutual Insurance Company.*[10] Arbitrator Samis held that the procedural requirement did not apply to a second tier Insurer. Arbitrator Samis opined:

> To apply section 3 provisions to second tier insurers would give rise to an injustice, ultimately resulting in the payment of benefits by the wrong insurer. The regulation is designed to facilitate a process that will lead to the cost of a claim being visited upon the correct insurer, without burdening the insured person with prosecution of priority disputes issues. It would be abhorrent to interpret the regulation in a manner which has the opposite result unless that outcome is required by clear and specific language of the regulation. The language of the regulation does not have that clarity.

While Arbitrator Samis' decision was initially appealed, after supplementary reasons were released by him, the appeal did not proceed.

Arbitrator Bialkowski, in *Certas Direct Insurance Company (The Personal Insurance Company of Canada) v. Security National Insurance Company*[11] accepted and applied the holding of Arbitrator Samis. Arbitrator Bialkowski concluded "[s]imply stated, I do not find that a 2nd tier insurer is bound by the 90 day notice requirement imposed by s. 3 of [the Regulation]". This decision has not been appealed.

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[10] Arbitrator Samis, January 28, 2011 and June 21, 2011.
[11] Arbitrator Bialkowski, February 2, 2012.

The second, and ultimate timeline, is the deadline to commence an Arbitration by sending a Notice of Arbitration to the second Insurer. Section 7(3) provides that the Arbitration may be initiated no later than one year after the day the Insurer paying benefits first gives notice.

While these timelines still exist, as of September 1, 2010, the Regulation was amended to include additional timelines to ensure that the Arbitration moves forward in a timely manner. These are outlined in section 8(2) of the Regulation.

First, when an Insurer serves a Notice of Arbitration, the Insurer must include a proposed Arbitrator. If the Insurer that receives the Notice does not respond within 30 days, the responding Insurer is deemed to have accepted the jurisdiction of the Arbitrator proposed in the Notice.

Second, the parties are obligated to have their first pre-arbitration hearing with the Arbitrator no later than 120 days after the appointment of the Arbitrator. Accordingly, the pre-arbitration hearing must be no later than 150 days after the Notice being sent.

Where an Insurer does not agree to the proposed Arbitrator, the parties can discuss other suitable Arbitrations. In the unlikely event that the parties cannot agree on an Arbitrator, the Insurers can bring an Application in the Superior Court of Justice to have the Court appoint an Arbitrator.

Finally, unless all the parties to the Arbitration have consented, the Arbitration hearing must be completed within two years after the commencement of the Arbitration. In addition, once a date for the Arbitration has been scheduled, the Arbitration must be conducted on that date. The only exception is where the Arbitrator finds that there is "cogent and compelling evidence of the reasons" why the hearing cannot proceed on the scheduled day.

Step 4- Is the Fund involved?

The amendments to the Regulation have also had an impact on the way in which the Motor Vehicle Accident Claims Fund ("Fund") is treated. Of significance, the Fund is not required to comply with the 90 day notice period in section 3(1) of the Regulation.

In addition, Insurers who seek to put the Fund on notice, have added obligations. Specifically, pursuant to section 3.1(1), before giving notice to the Fund, an insurer must (a) complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund and (b) provide particulars to the Fund of the investigation and the results of the investigation.

Step 5 – What to look for in determining whether you have a priority dispute

An Insurer should always be looking for opportunities to shift payment when possible. Opportunities to shift payment include both priority disputes and loss transfers. As the focus of the paper is priority disputes, the following provides an overview of the red flags that an adjuster should be on the lookout for which might mean you are not the proper Insurer and therefore able to shift payment. While each case turns on the specific facts and further investigation might mean that you are the proper Insurer, there are various indications which suggest that more information should be obtained to see if there is a priority dispute.

In assessing whether there is a dependency issue, it is important to keep the claim in context. What might be a red flag in one case could be perfectly normal in another. Keeping in mind the named Insured and his/her circumstances, some of the following facts, if unusual in those circumstances, might be red flags:

- The Applicant has a different address;
- The Applicant's age;
- The Applicant is residing with another parent or relative;
- The Applicant's employment status;
- The Applicant's school situation;
- The Applicant's income;
- The Applicant's expenses;
- The Applicant is receiving significant assistance from someone; and,
- The Applicant is receiving significant care from someone.

In assessing whether there is a spousal issue, key indicators include:

- The Applicant is residing with an individual they are in a relationship with; and,
- The Applicant has a child.

Finally, in assessing whether there is a priority dispute related to regular use of an automobile during the course of employment, key indicators include:

- The Applicant was working at the time of the accident;
- The Applicant was in a work vehicle at the time of the accident; and,

- The vehicle the Applicant was in was owned by the Applicant's employer.

Basis for Claiming Priority

As outlined above, there are generally three types of priority disputes. Each will be discussed in turn below.

Step 6 – Is the Applicant dependent on the Named Insured?

By far, this is the most common type of priority dispute. If an Applicant is dependent on the Named Insured, they will be considered an Insured under the policy and thus entitled to Statutory Accident Benefits.

A "dependent" is defined in the SABS as follows: "a person is a dependent of another person if the person is principally dependent for financial support or care on the other person or the other person's spouse."

While more will be discussed on the issue of spouse below, this is another instance where the meaning of spouse is relevant in the context of priority disputes.

Based on the above definition, there are two types of dependency – financial dependency and dependency for care. Regardless of the type of dependency, the decision will be based on the specific facts of case.

The leading case on dependency remains the Court's decision in *Miller v. Safeco Insurance Co. of America*[12] which dealt with whether the Applicant was a dependent relative and thus entitled to accident benefits under his father's policy. In this case, the Court outlined the following specific criteria to be followed when considering the issue of dependency:

(a) the amount of dependency;

(b) the duration of the dependency;

(c) the financial and other needs of the alleged dependent; and,

(d) the ability of the alleged dependent to be self supporting.

[12] [1984] O.J. No. 3383 (H.C.J.), affirmed in part, [1985] O.J. No. 2742 (C.A.).

Financial Dependency

The financial dependency analysis is "numbers-based" and requires an Applicant's earnings or resources to be calculated and compared to their expenses.[13]

In the recent decision of *The Wawanesa Mutual Insurance Company v. Security National Insurance Co.,*[14] Arbitrator Robinson outlined the law with respect to dependency. Arbitrator Robinson noted that there have been many decisions, both by Courts and Arbitrators, with respect to "principally dependent" for financial support. Arbitrator Robinson confirmed that the decisions indicate that it is a question of fact to be determined upon the particular circumstances in each and every case.

In looking at financial dependency, the case law has held that to be principally dependent for financial support, a party must receive more than 50% of one's financial needs from someone other than themselves.[15] The test was articulated by Arbitrator Samis who considered the meaning of dependency in *Co-operators v. Halifax*:[16]

> The definition requires a dependent to be a "principal dependency" resulting in the determination that the person is only a dependent if they are "chiefly" or "for the most part" dependent on the other person. Mathematically, this suggests the person's reliance on the other person must be for more than 50% of their need in a 2-person relationship.

The relevant time period to review in determining dependency is not legislated. The period should not be a snapshot. Instead, Arbitrators and Judges have held that the analysis should be based on a time frame that fairly reflects the reality of the parties at the time.[17] It is necessary to look at the relationship as a whole, over a reasonable period of time to determine the nature of the relationship at the time of the accident.[18] Almost always, the analysis should not be forward looking. Generally, the analysis is retrospective and a good starting point is to look at the one year period preceding the accident. The appropriate time period varies with factors such as a significant change in the Applicant's employment, living situation or financial circumstances before the accident.

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[13] *Echelon General Insurance Company v. State Farm Mutual Automobile Insurance Company,* Arbitrator Novick, July 2011.
[14] April 30, 2012, Arbitrator Robinson.
[15] *CT Direct Insurance Company and Liberty Mutual Insurance Company,* Arbitrator Jones, December 2004.
[16] December 14, 2001, Arbitrator Samis, affirmed [2002] O.J. No. 2459 (S.C.J.).

In assessing the issues of financial dependency, the Insurer should be asking for the following information and documents to support same:

- Claimant's income (i.e. employment contracts, pay stubs, income tax returns);
- Household income (i.e. pay stubs and income tax returns);
- Household expenses (i.e. bills for utilities, rent, mortgage, property taxes, cable, internet, phone, groceries);
- Personal expenses (i.e. bills for clothing, meals, personal care, medical needs, schooling);
- Bank statements (which will be of assistance in assessing each of the above); and,
- In kind assistance (i.e. who was making meals, cleaning the house, doing outdoor work).

Dependency for Care

This is a much less common basis for arguing dependency. While the term "care" is used in the definition of dependency, it is not defined in the *SABS.* To date, there have been very few decisions that have considered the meaning of care.

An assessment for dependency for care cannot be determined with the same mathematical precision as financial dependency.[19] Similarly, it has been recognized that this assessment is more qualitative and should not take financial considerations into account.[20]

In *Echelon General Insurance Company v. State Farm Mutual Automobile Insurance Company,* Arbitrator Novick considered whether the Applicant was dependent for care. Arbitrator Novick held that an assessment of this issue "requires a consideration of the Claimant's physical, social and emotional needs, and the social and emotional support he or she receives from the person in question."

This view was also affirmed by the Court in *Wawanesa Mutual Insurance Co. v. Underwriters, Lloyd's of London Insurance Co.* In that case, the Court held that the issue requires both a quantitative and qualitative analysis. Qualitative factors will include social and emotional support.

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[17] *Intact Insurance and Economical Mutual Insurance Company,* Arbitrator Novick, December 2011.
[18] *Ibid.*

In assessing this issue, the Insurer should be asking questions such as:

- What type of care or assistance was being provided;
- How much care or assistance was being provided;
- The duration that care or assistance was being provided; and,
- Why was care or assistance being provided.

Step 7 – Is the Applicant a Spouse of a Named Insured

If the Applicant is the spouse of a Named Insured, the Applicant will be entitled to coverage under the spouse's policy. Section 224(1) of the *Insurance Act* defines spouse as follows:

> "Spouse" means either of two persons who:
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> (a) are married to each other;
>
> (b) have together entered into a marriage that is voidable or void, in good faith on the part of the person asserting a right under this *Act;* or
>
> (c) have lived together in a conjugal relationship outside marriage;
>
> (i) continuously for a period of not less than three years; or,
>
> (ii) in a relationship of some permanence, if they are the natural or adoptive parents of a child.

While determining whether someone is legally married is relatively straightforward, the contentious issue is determining whether an Applicant satisfies subsection (c) of the above spousal definition. There is a fair amount of Arbitration and case law on this issue. Again, the result will turn on the specific facts of the case.

While both decisions were within the context of family law disputes, there are two cases which have been cited by Arbitrators in priority disputes involving an assessment of spousal relations. In

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[19] Wawanesa Mutual Insurance Co. v. Underwriters, Lloyd's of London Insurance Co., [2004] O.J. No. 3661 (S.C.J.); see also *Oxford Mutual Insurance Company v. Co-Operators General Insurance Company,* [2006] O.J. No. 4518 (C.A.).

[20] *Echelon, supra.*

M. v. H.,[21] the Supreme Court of Canada held that the leading authority on the "generally accepted characteristics of a conjugal relationship" was the Court's decision in *Molodowich v. Penttinen*[22]. In the latter case, the Court enumerated the following questions in assessing whether the parties are in a conjugal relationship:

(1) SHELTER:

(a) Did the parties live under the same roof?

(b) What were the sleeping arrangements?

(c) Did anyone else occupy or share the available accommodation?

(2) SEXUAL AND PERSONAL BEHAVIOUR:

(a) Did the parties have sexual relations? If not, why not?

(b) Did they maintain an attitude of fidelity to each other?

(c) What were their feelings toward each other?

(d) Did they communicate on a personal level?

(e) Did they eat their meals together?

(f) What, if anything, did they do to assist each other with problems or during illness?

(g) Did they buy gifts for each other on special occasions?

(3) SERVICES:

What was the conduct and habit of the parties in relation to:

(a) Preparation of meals;

(b) Washing and mending clothes;

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[21] [1999] 2 S.C.R. 3 (S.C.C.).
[22] [1980] O.J. No. 1904 (Dst. Ct.).

(c) Shopping;

(d) Household maintenance;

(e) Any other domestic services;

(4) SOCIAL:

(a) Did they participate together or separately in neighbourhood and community activities?

(b) What was the relationship and conduct of each of them towards members of their respective families and how did such families behave towards the parties?

(5) SOCIETAL:

What was the attitude and conduct of the community towards each of them and as a couple?

(6) CHILDREN:

What was the attitude and conduct of the parties concerning children?

Arbitrator Bialkowski referred and adopted the above analysis in *Intact Insurance v. Jevco Insurance Company.*[23] In addition to the above case, Arbitrator Bialkowski also cited the decision in *Wawanesa Mutual Insurance Company v. Kingsway General Insurance Company*[24] which identified further criteria to be considered. It included the following:

(a) duration of relationship;

(b) existence of children;

(c) stability of relationship;

(d) interdependence of the parties;

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[23] Arbitrator Bialkowski, October 13, 2011.
[24] Arbitrator Jones, April 2005.

(e) cohabitation;

(f) conjugal relationship;

(g) personal relations;

(h) responsibility for household services;

(i) interaction in a family and social context;

(j) financial arrangements and support;

(k) responsibility towards children;

(l) temporary interruptions in physical living arrangements;

(m) the expectations of the parties; and,

(n) the intention of the parties.

The trier of fact is obligated to weigh these considerations in determining whether the Applicant satisfies the definition of spouse. As recognized by Arbitrator Jones in *Wawanesa* and accepted by Arbitrator Bialkowski in *Intact,* not all of the components have to exist in order for there to be a spousal relationship and some individual components may be more important than others. As noted, each case must be determined on its facts.

In assessing whether the Applicant was a spouse, the above noted information should be obtained from the Applicant.

Step 8 – Does the Applicant have regular use of an automobile during the course of their employment?

Finally, if the Applicant has regular use of an automobile during the course of their employment, the Applicant could have coverage under the employer's policy. Section 66(1) of the *SABS – Accidents on or After November 1, 1996* states:

> An individual who is living and ordinarily present in Ontario shall be deemed for the purpose of this Regulation to be the named insured under the policy insuring an automobile at the time of an accident if, at the time of the accident,

> (a) the insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or other entity.

Under the new SABS, this same definition is contained in section 3(7).

The application of section 66(1) has been significantly limited by the Court's decision in *ACE INA Insurance v. Co-Operators General Insurance Company.*[25] Previously, a Claimant could have been found to be a Named Insured even if they weren't in the vehicle at the time of the loss.

In *ACE INA*, the Applicant was involved in an accident outside work hours and not involving a work vehicle. The Applicant was employed as a customer service representative at Enterprise Rent-A-Car. As a customer service representative, the Applicant had access to rental vehicles and could use them while at work to pick up/drop off customers. Once his work day was over, however, he could no longer drive the vehicles. In addition, he was not permitted to take the vehicles home.

The Applicant was involved in an accident on a Saturday night/early Sunday morning when he was going downtown in a friend's vehicle. He was not working at the time.

The Court considered the meaning of Section 66(1) and noted that the issue was what was meant by a vehicle being made available at the time of the accident. The Court opined that the question was not whether the company car would be available to the Applicant when he got back to work the next day. Instead, the question was whether it was being made available to the Applicant at the time of the accident, when he was off work and on his way downtown with a friend.

The Court concluded that Section 66 was not a "floating charge" and does not "confer portable status" that "remains" with the Insured – the status is only conferred at, and for a moment in time, namely the accident. The Court held that an employer's Insurer is liable to pay statutory accident benefits only if, at the time of the accident, a company insured vehicle was being made available to the employee.

Further, the Court noted that the previous wording under Bill 164 stated "…if an insured automobile is being made available for the regular use of an individual…"

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[25] [2009] O.J. No. 1276 (S.C.J.).

The wording had changed, however, to provide "…if, at the time of the accident…the insured automobile is being made available for the individual's regular use…".

The Court opined that the addition of the phrase "at the time of the accident" represented the legislature's intent to narrow the focus of the inquiry on vehicle availability "at the time of the accident". The Court concluded that because the Enterprise Rent-A-Car vehicle was not being made available for the Applicant's regular use at the time of the accident, the Applicant was not a named insured under the company policy.

The findings in this decision by Justice Belobaba were applied by Arbitrator Bialkowski in *The Personal Insurance Company v. Kingsway General Insurance Company*.[26] In addition, Justice Brown, in *Zurich Insurance Company v. The Personal Insurance Company*,[27] agreed with Justice Belobaba's decision but distinguished it as the Applicant was operating a work vehicle at the material time.

In assessing this issue, an Insurer should be asking the following:

- Who owned the vehicle at the time of the loss;
- Was the Applicant at work at the time of the accident;
- What was the frequency of use of the vehicle by the Applicant;
- Did the Applicant have regular access to the vehicle at the time of the accident; and,
- What was the Applicant's arrangement in using the vehicle.

Step 9 – Do you have enough information to make a decision

There are two ways that an Insurer can obtain information – by requesting documentation and by obtaining statements.

Documentation

Pursuant to section 33 of the *SABS,* an Applicant is required to provide any information reasonably required to assist the Insurer in determining the Applicant's entitlement to benefits, which includes priority disputes. In the event that an Applicant fails to co-operate, section 33(2)

[26] Arbitrator Bialkowski, June 19, 2009.
[27] [2009[O.J. No. 2157 (S.C.J.).

provides that an Insurer is not liable to pay a benefit for the period in which the party fails to comply.

In addition, section 6 of the Regulation provides that an Insured shall provide the Insurers with all relevant information needed to determine who is required to pay benefits under section 268 of the *Insurance Act.* There are no specific enforcement mechanisms outlined in the Regulation if the Insured does not comply. However, section 25(6) of the *Arbitration Act, 1991* permits Arbitrators to order the production of documentation. Where an Applicant fails to comply with the Arbitrator's order, section 25(7) is of assistance. It provides that a Court may enforce the direction of an Arbitrator as if it were similar to a direction made by the Court in an action.

Requests for relevant documentation should be made once the Claim is received by the Insurer. Depending on the issues in dispute, the request could be for financial documentation, employment information and insurance policy documentation.

One difficulty in the production of documentation arises where the Insurers involved in a priority dispute wish to share documentation that they have obtained during the course of their investigation. Without the express consent of the Applicant or an Order by an Arbitrator, the Insurer cannot disclose the documentation they obtained.

Generally, a consent can be obtained without issue from the Applicant or the Applicant's representative. In the event that consent cannot be obtained, it may be necessary to commence an Arbitration. The Insurer, or their representative, can then seek an Order from the Arbitrator requiring the production of the documentation.

Statements

The Insurer should also consider obtaining a written statement from the Insured. Generally, these Statements should be obtained early as they can be sufficient to obtain the information necessary to resolve the priority dispute.

If the Applicant does not co-operate and the Insurer is not able to obtain a statement, an Examination Under Oath may be warranted. Section 33(1.2) of the *SABS* could be used to obtain an Examination Under Oath. This section provides that if requested, an Applicant shall submit to an Examination Under Oath. Again, if the Applicant fails to co-operate, section 33(2) prohibits entitlement to benefits during the period where they are non-compliant.

Further, as the priority dispute is governed by the *Arbitrations Act, 1991,* section 25(6) is of importance. This section provides that an Arbitrator can order that a party submit to an Examination Under Oath with respect to the dispute.

In practice, where an Applicant does not attend an Examination, Arbitrators have convened an Arbitration hearing for the sole purpose of getting the Applicant to attend under subpoena which can be issued under the *Arbitrations Act*. The Arbitrator then immediately adjourns the hearing, leaves the room and Counsel proceeds with the Examination. If the Applicant still does not attend or co-operate, section 25(7) of the *Arbitrations Act, 1991,* can also be used. As outlined above, the Insurers can go to Court to get the Arbitrator's Order enforced in the same manner as direction by the Court in an action.

Consideration should be given as to whether the Examination should be arranged in conjunction with the other Insurer. In some instances, a joint Examination is appropriate. Usually, this is where there is already an Arbitration and the parties intend to use the transcript at the Arbitration. In other cases, an Insurer may wish to proceed with an Examination Under Oath prior to commencing any priority dispute to clarify the issues. While there can only be one Examination Under Oath pursuant to the *SABS*, if the matter proceeds to an Arbitration, another Examination can be arranged pursuant to the *Arbitration Act, 1991.*

Conclusion

As outlined above, Insurers should always be mindful of opportunities to shift payment of Statutory Accident Benefits where appropriate. Priority disputes present Insurers such an opportunity. By being mindful of the key indicators suggestive of a priority dispute, an Insurer may find an opportunity to save a significant amount of money.