IN THE MATTER OF AN ARBITRATION under the Arbitration Act, 1991, S.O. 1991, c. 17 and in the matter of the Insurance Act, R.S.O. 1990, c. I.8 and s. 268 thereof and Regulation 283/95 made pursuant to the Insurance Act

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF FINANCE

Applicant

and

ROYAL & SUN ALLIANCE, THE ECONOMICAL INSURANCE GROUP, CGU INSURANCE COMPANY, AND ZURICH INSURANCE

Respondents

AWARD

COUNSEL:

W. Colin Empke for Royal & Sun Alliance

Brian C. Atherton for CGU Insurance Company

ISSUE:

Is Royal & Sun Alliance or CGU responsible for payment of statutory accident benefits to or on behalf of Mr. Rayan Clarke?

RESULT:

Royal & Sun Alliance is responsible for payment of accident benefits to or on behalf of Mr. Rayan Clarke.

HEARING:

The arbitration hearing was held in the City of Toronto, in the province of Ontario on November 25, 2002, with further submissions made by way of a teleconference call on December 16, 2002 before me, M. Guy Jones pursuant to the provision of Regulation 283/95 and the Arbitration Act, S.O. 1991.

THE FACTS:

Mr. Rayan Clarke was injured in a motor vehicle accident on August 11, 1999. Mr. Clarke was driving a motor vehicle owned by Mr. Michael Martens, which was believed at the time of the accident to be uninsured. Accordingly, on May 25, 2002 Mr. Clarke's representative submitted an application for accident benefits to Royal indicating that Royal was the insurer of the other motor vehicle in the accident, a 1992 International truck owned by Mr. Gurvinder Sidhu, and driven by Meletis Kell. The completed application for accident benefits referred to an insurance policy "Royal Ins. 32-R204852", which as it turns out, was taken from the police motor vehicle accident report prepared by the investigating police officer.

Upon receipt of the application, Royal did a computer search of its' files and determined that it had no such policy. On October 4, 2000, and on at least two subsequent occasions, Royal advised Mr. Clarke's representative that Royal could not locate such a policy and suggested that Mr. Clarke look to the Economical Insurance Group for accident benefits as the insurer of Mr. Kell. As a result, Mr. Clarke's representative sent an application for accident benefits to the Economical Insurance Group on June 19, 2000. It was subsequently learned that the Economical policy was in force only until June 17, 1999 or approximately seven weeks before the accident.

Having not received payment of accident benefits from either Royal or Economical, Mr. Clarke's representative submitted an application for accident benefits to the Motor Vehicle Accident Claims Fund (MVAC) on August 2, 2000. Further correspondence ensued amongst Royal, Economical, and MVAC as to who had a valid policy and who should respond to the policy. All three recipients of the application suggested that one of the other parties should respond to the application. On November 21, 2002 Mr. Clarke finally made an application to the Financial Services Commission of Ontario to mediate the issue and attempt to force one of the three to pay accident benefits. A mediation was held at FSCO, and on March 2, 2001 the mediator issued a Report indicating that the mediation had failed. Despite that failure, it would appear that shortly thereafter the Motor Vehicle Accidents Claims Fund commenced paying accident benefits to and on behalf of Mr. Clarke. The Fund subsequently served a Notice of Dispute and began an arbitration pursuant to Regulation 283/95 against Royal, the Economical Insurance Group, Zurich and CGU. CGU was added to the proceedings following a Ministry of

Transportation Motor Vehicle Search conducted by the Fund. At that time it was discovered that there was a potentially valid policy of insurance held by Mr. Martens, the owner of the vehicle driven by Mr. Clarke at the time of the accident. It would appear based on the evidence, that CGU's policy was the first in priority at the time of the accident and had they been served with the first application for accident benefits, they should have responded.

Subsequent to the filing of the Notice of Dispute between insurers, all the respondents with the exception of Royal and CGU were let out of the matter. The Motor Vehicle Accident Claims Fund did not appear at the hearing as there was agreement between CGU and Royal that one of them was responsible to pay accident benefits to or on behalf of Mr. Clarke.

While CGU was the insurer who held a policy with the highest in priority at the time of the accident and would therefore have been responsible for paying the accident benefits, they have submitted that Royal received the first completed application for accident benefits and that pursuant to section 2 of Regulation 283/95 Royal should have paid the benefits and then served CGU with a Notice of Dispute between insurers. They argue that since Royal received the first completed application for accident benefits, they are not entitled to dispute their obligation to pay benefits under section 268 of the Insurance Act, as they have not complied with section 3 (1) of Regulation 283/95 which states that:

> no insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within ninety days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

Royal has raised a number of defences to this argument. I will deal with each separately. To begin with, Royal submits that I do not have the jurisdiction to deal with this matter. It argues that while a private arbitrator has the authority under Regulation 283/95 to determine which insurer has the obligation to pay accident benefits pursuant to section 7 of the Regulation, I do not have the jurisdiction to determine the issue of who received the first completed application for accident benefits (section 2). Royal points to the case of Brown & Allstate Insurance Company of Canada [O.I.C A97-000579,(1998) 40 O.R. (3rd) 610 (DIV Ct.) in support of this proposition.

I am unable to agree with this proposition. In Brown, the insured brought the application forward to arbitration. In our case, while the insured brought the issue to mediation, the question of paying the insured was resolved after the mediation but before any arbitration proceeding was commenced. The only way that an insurer can then proceed to determine who received the first application is by way of Regulation 283/95. I am reinforced in this view by section 1 of the Regulation which states:

> all disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation.

When one reads section 1, in conjunction with section 2 and section 7, it is clear that the legislature created the Regulation to ensure a quick and efficient way to resolve disputes not only between insureds and insurers, but also between insurers. To put section 2 disputes between the insurers in the Financial Services Commission of Ontario forum would defeat that purpose.

Royal also submitted that the application which they received was not complete as required by section 2 of the Regulation. Briefly put, Royal argues that the application that they received was incomplete and that it referred to a policy of insurance with Royal which did not exist. The application referred to "Royal Ins. 32-R204852". It is certainly true that no such policy under that number existed. While it is unclear from the evidence at the hearing exactly what searches were done by Royal after receiving the application, it is clear that a number of combinations by various names and numbers were searched without success.

As a result of investigations by Royal & Sun Alliance in or about February 2001, Royal knew that a Mr. Gurvinder Sidhu had owned a 1988 international truck which he had insured with Royal commencing in 1994 but which Mr. Sidhu cancelled on July 1, 1995. The policy number covering that vehicle was RZ-052304 which is far different from policy number R2-04852 given by Mr. Clarke's representative. The policy also covered a 1988 truck rather than the 1992 international truck involved in the accident. The only connection seems to have been that Mr. Sidhu owned the 1988 truck and was listed in the police report as owning the 1992 International truck.

At the hearing Royal filed an affidavit sworn by Mr. Terry Clarke, the Royal claims representative that handled the file for Royal, stating that he had conducted a computer search of both Mr. Sidhu and Mr. Kell but could not locate a policy for either individual. Despite this, subsequent to the hearing of this matter, but prior to writing this decision, I was advised by

counsel for Royal that they had just spoken to Mr. Sidhu's former employer who was also aware of Mr. Kell's employment. They advised that they were aware of a policy number RZ-046852. When one compares this with the number given in the application, being R2-04852, one can see that a "2" was used rather than "Z" which was on the police report and the number "6" had been missing from the police report and the application for accident benefits. Royal, after the hearing, determined that it did have such a policy issued to Meletis Kell between June 8, 1994 and December 30, 1994 for a 1981 GMC Truck which was cancelled by Mr. Kell. Thus, it would appear that the police officer who investigated the accident was given an expired certificate of insurance by Mr. Kell which covered a different vehicle. In addition it would appear that the investigating police officer dropped the number "6" from the policy insurance provided by Mr. Kell at the time of the accident and Mr. Clarke's representative used a "2" rather than a "Z" when submitting the application. It should be noted, however, that Royal policies begin with RZ and therefore the "2" and the "Z" error should not have caused Royal much difficulty. The representative at Royal who testified also indicated that Royal policies contained six numbers rather than the five given.

Having set out the facts of this case, the question becomes what constitutes a completed application as required by section 2 of the Regulation. Arbitrator Seife in Lopez vs. Canadian General Insurance Group [1997] O.I.C.D. No. 83 held that an application for accident benefits meets the requirements of the legislation if it provides sufficient particulars to reasonably assist the insurer to process the application and assess the claim fairly and expeditiously.

I also note that Arbitrator Joachim, in Pooler vs. Guardian Insurance Company of Canada [1999] O.I.C.D No. 233 found that merely receiving an invoice from a treatment provider containing the name of the injured policy, the date of the accident and the insurance policy number should provide sufficient information to allow the insurer to be aware that a claim was being made.

While each case must be decided on its own set of facts, these cases do provide some guidance. It is clear from the case law that one need not look at just the application itself when deciding whether an application is complete. One may also look at what other information has been supplied or is available. In my view, Royal did have sufficient information to process the claim. It had the name of the injured party, details of the injuries, treatment required etc. While it may well vary from case to case, it is not always necessary to have a complete policy number. There was some information provided, while incorrect, that did tie the matter to Royal. One must distinguish between an incorrect and incomplete application. In this instance the policy number was incorrect, but the application nonetheless was complete. As such I find that it was sufficient to constitute a complete application for the purposes of section 2 of the Regulation.

The next issue raised by Royal was whether Royal was an "insurer" at the time of the accident such that it should have responded to the application for accident benefits that it received. It is not sufficient for an insurer when it receives an application for accident benefits to simply say that it is not the proper insurer because the policy was cancelled before the accident or that another insurer was higher in priority.

The leading case with regard to this issue is Brown vs. Allstate, cited above. In that case, the applicant, Mark Brown, was seriously injured in a motor vehicle accident. He applied for accident benefits from Allstate Insurance Company but the company refused to pay on the basis that there was no valid policy of insurance in existence at the time of the accident. While Allstate was the first company to receive the application for accident benefits, it maintained that Mr. Brown's policy of insurance with Allstate expired approximately four months before the accident and was therefore not an "insurer" of Mr. Brown at the time of the accident. Senior Arbitrator Rotter found that there was a sufficient connection or nexus between the parties to create the obligation for Allstate to respond to the application if it felt that it was not the correct party to pay benefits, it could pursue any other insurer by way of Regulation 283/95.

In upholding Senior Arbitrator Rotter's decision, the Divisional Court held that there was a sufficient nexus between the injured party and Allstate for the company to make the accident benefit payments even though that it might subsequently be found that Allstate was indeed not the insurer at the time of the accident. The court went on to note that:

> this Regulation ensures that the accident victim will not be denied statutory accident benefits simply because the first insurer applied to for benefits thinks another insurer should pay. Section 2 of the Regulation requires that the first insurer that receives an application to adjust the claim and to pay benefits to which the insured person in entitled, pending resolution of any dispute as to which insurer is required to pay benefits.[1]

The question therefore becomes was there a sufficient nexus between Royal and Mr. Kell or Mr. Clarke such that Royal should have paid the benefits. While section 2 of the Regulation makes it

very clear that the first recipient of an application for benefits is to pay the benefits and dispute the matter with another insurer if it believes that it is not the appropriate insurer to be paying, the Court made it clear in Brown that there must be some nexus between the injured party and the company. In that case the nexus was that Allstate had a valid policy of insurance up to four months before the accident.

In our case the facts are quite different than in Brown. Here, it would appear that the only connection with Royal was that the investigating officer was given a certificate of insurance by the other driver which had expired some four years before the accident and applied to another motor vehicle. To compound the problem it would appear that the investigating police officer dropped one digit from the policy number when putting it on the police report and Mr. Clarke's legal representative changed the "Z" to a "2" when preparing the application for accident benefits.

There are some situations where there will be an insufficient nexus so that a company need not respond to the application. As arbitrator Rotter noted in Brown:

> Allstate's argument may have some merit in a situation where an applicant candidly admits that he or she has simply applied for accident benefits from a randomly selected insurance company, without asserting any contractual relationship or nexus. In that situation, it may be that the company need not respond to the application.[2]

In our case the nexus is far less than in the Brown case and yet there is still some connection. This is not a situation where the injured party simply randomly picked an insurance company and applied for benefits. The injured party, in good faith, took the information from the police

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[1] Allstate Insurance Company of Canada vs. Brown [40 O.R. (3rd 610 @ 622)]

report, as many injured parties do, in order to determine to what insurer he should apply to for accident benefits. While it is unfortunate that this turned out to be the wrong insurer, there was nonetheless some connection.

In order to determine if this was a sufficient nexus or connection, one is assisted by looking at the purpose of Regulation 283/95. Prior to the creation of the Regulation situations had developed whereby an injured party was shuffled between insurers, with each insurer claiming that the other insurer was responsible for paying benefits. As a result, the injured party often went without benefits while the insurers argued as to who should pay.

In response to this problem Regulation 283/95 was created. Section 2 of that Regulation made it very clear that the first insurer that receives a completed application is responsible for paying the accident benefits pending resolution of any dispute as to which insurer is required to pay in accordance with section 268 of the Insurance Act. The originally paying insurer's recourse is, of course, to serve a Notice of Intent to Dispute upon any other insurer it believes should be paying, within ninety days of receiving the application for accident benefits.

What happened in Mr. Clarke's case is exactly what the Regulation, in my view, was designed to deal with. Mr. Clarke was injured in a motor vehicle accident and was entitled to receive accident benefits. He relied, not unreasonably, upon the police report to provide him with the name of an insurer to provide those benefits and he applied to that company. While his legal representative may have compounded the problem by mistakenly changing a "Z" to a "2", this

[2] Brown vs. Allstate Insurance Company of Canada O.I.C.A 97-000579

was not a fatal error, in my view. The insurer knew that its policies began with the reference RZ and it does not require a great effort to realize that a "Z" and a "2" are very similar.

While I am sympathetic to Royal's position in that they were faced with an erroneous policy number to a policy which had expired some four years or so prior to the accident, the fact remains that there was a sufficient nexus present and in accordance with section 2 of the Regulation they should have paid the accident benefits. If they felt that another company was responsible, they should have sent a Notice of Intent to Dispute within ninety days of receiving the application for accident benefits and proceeded to arbitration by way of Regulation 283/95. Instead what happened in this case was that the various potential insurers shuffled the matter between themselves and Mr. Clarke went approximately nine months without receiving the appropriate accident benefits.

CGU has taken the position that because Royal was the first insurer to receive the application and it did not give written notice to any other insurer within ninety days of receiving the application for accident benefits it cannot now dispute its obligation to pay the benefits. Section 3 (1) of the Regulation states:

> no insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within ninety of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

The courts have consistently held that the Regulation is to be strictly complied with .Norheimer J. in Kingsway General Insurance Company vs. West Wawanosh Insurance Company 58 O.R. (3rd) 251 stated:

> the Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assurance and rely upon the requirements for compliance with those provisions. Insurers subject to the Regulation are sophisticated litigants who deal with these disputes on a daily basis. The scheme applies to a specific type of dispute involving a limited number of parties who find themselves regularly involved in disputes with one another. In this context, clarity and certainty of application are of primary concern. Insurers need to make appropriate decisions with respect to conducting investigations, establishing reserves and maintaining records. Given this regulatory setting there is little room for creative interpretations or for carving out judicial exceptions designed to deal with the equities of particular cases.

While I am not unmindful of the equities of this particular case in that Royal will end up paying benefits in a case where CGU was clearly the priority insurer, it is important for the insurers to understand that once they have received the first application for accident benefits, they must make the payments and dispute the issue later, pursuant to Regulation 283/95. Only in the most extreme cases, where the connection with the insurers is totally arbitrary should the insurer refuse to pay.

Counsel for Royal submitted that this would be an appropriate case for the "saving provisions" of section 3 (2) to apply. That section states:

> an insurer may give notice after the ninety-day period if,
> (a) ninety days was not a sufficient period of time to make determination that another insurer or insurers is liable under section 268 of the Act; and
> (b) the insurer made reasonable investigations necessary to determine if another insurer was liable within the ninety-day period.

I think that this argument fails for two reasons. To begin with, in my view, an insurer can only invoke this section if it has complied with section 2 and commenced paying benefits. Even if

this were not the case, Royal can still not bring itself within the requirements of section 3 (2) in that it would appear that it was neither difficult nor time consuming for Royal to determine that CGU was potentially the proper insurer to pay accident benefits. In this regard, I note that the Motor Vehicle Accident Claims Fund was able to conduct a Ministry of Transportation Motor Vehicle search very quickly and determine that the vehicle in which Mr. Clarke was an occupant was insured by CGU. Accordingly, Royal cannot rely on the saving provisions of section 3 (2).

While the question of the applicability of the equitable remedy of relief from forfeiture was raised briefly during the hearing, I am of the view that it has no applicability in light of section 3 (2). See: Kingway General Insurance Company vs. West Wawanosh Insurance Company 58 O.R. (3rd) 281 (C.A.)

Counsel for Royal also submitted that CGU itself failed to give Notice of Intent to Dispute to Royal and that they therefore ought not to have the benefit of section 3 of Regulation 283/95. In order to deal with this issue it is important to understand the chronology of events in this matter.

After the Fund decided to pay benefits, it served a Notice of Dispute upon, among others, Royal and CGU. In order for Royal's argument to succeed, there must be an obligation on CGU then to file a subsequent Notice of Dispute upon Royal.

This issue was dealt with in Saskatchewan Government Insurance Company vs. Lombard Canada Insurance and Her Majesty the Queen in right of Ontario as represented by the Minister

of Finance, unreported decision of Arbitrator Robinson, dated November 15, 2001 and upheld by Speigel J., unreported decision, dated November 4, 2002. In that case a Mr. Timothy Mullen was a passenger in a car driven by a Mr. Hall. Mr. Mullen was not insured but his mother was insured with Lombard Canada. Lombard refused to pay and the Motor Vehicle Accident Claims Fund then began paying accident benefits while it conducted its' own investigation. Subsequently the Saskatchewan Government Insurance Company (SGI), which insured the vehicle in which Mr. Mullen was an occupant, took over payments from the Fund. The Fund had served a Notice of Dispute upon both Lombard and SGI. At the hearing of the priority dispute, Lombard argued that SGI had failed to serve Lombard with a Notice of Dispute and therefore could not dispute its obligation to pay in accordance with section 3 of Regulation 283/95. Arbitrator Robinson held that there had been compliance with section 3 of the Regulation due to the actions of the Fund in putting both Lombard and SGI on notice and that it was not necessary for SGI, once having been served with a notice along with Lombard, to also serve Lombard.

Judge Seagel upheld the arbitrator, noting that:

> I conclude that the purpose of the legislation is to provide a quick, uncomplicated and efficient process for resolving insurer's disputes for the protection of the insured . . . given that the purpose of the legislation is a timely resolution of these disputes, it seems counter intuitive to suggest that a subsequent notice as between SGI and Lombard would also be required. This would needlessly complicate and likely delay the resolution of the dispute. In addition, any subsequent notice would be redundant in the sense that the first notice from the Motor Vehicle Accident Claims Fund had already notified Lombard that, as between all three parties, there was a dispute with respect to liability.

I am in agreement with Speigel, J. in this regard. In our case, the Fund put both CGU and Royal on notice and this is sufficient on the facts of this particular case. In so deciding, I wish to make it clear that this situation is different from a case arising out of section 10 of the Regulation where one insurer, having received a notice from a company that is paying benefits, is required to serve a Notice on a third insurer. Notice provisions under section 10 apply, in my view, when the insurer receives the Notice of Dispute from the original paying insurer, claiming that a third insurer, not yet served by the original insurer, should pay. That is to be distinguished from our case, where the Fund has put both insurers on notice.

In conclusion, I find that Royal is precluded from disputing its obligation to pay benefits under section 268 of the Act. While this may appear to be a severe result in the circumstances, it must be fully understood by insurers that if they receive an application for accident benefits, unless there is no nexus, they must pay the benefits and dispute their obligations pursuant to Regulation 283/95.

Dated this _____ day of January, 2003.

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M. Guy Jones

Arbitrator