CITATION: Unifund Assurance Company v. The Dominion of Canada General Insurance Company, 2016 ONSC 4337
COURT FILE NO.: CV-15-540663
DATE: 20160630

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
	)	
UNIFUND ASSURANCE COMPANY	)	
	)	*Eric K. Grossman*, for the Applicant
	)	
Applicant	)	
	)	
– and –	)	
	)	
THE DOMINION OF CANADA GENERAL INSURANCE COMPANY	)	
	)	*D'Arcy McGoey*, for the Respondent
	)	
	)	
Respondent	)	
	)	**HEARD:** June 10, 2016

M. D. FAIETA, J

REASONS FOR DECISION

INTRODUCTION

[1] This appeal raises the question of the proper interpretation of Regulation 283/95, made pursuant to the *Insurance Act*, R.S.O. 1990, c. I.8 ("*Insurance Act*"). The Regulation provides for the resolution of disputes between insurers with respect to which insurer is responsible to pay statutory accident benefits. The main issue on this appeal is whether an insurer to whom an insured person has applied for accident benefits, and who claims that another insurer is responsible for paying those benefits, is required to provide notice of its dispute to the insured within the same time period that it provides notice of its dispute to the other insurer.

[2] For the reasons described below, I have answered the above question in the affirmative and have granted Unifund's appeal from the decision of Arbitrator Shari L. Novick dated October 20, 2015.

BACKGROUND

[3] Mr. Jing Hua Fan (the "Insured") owns an automobile repair shop. On November 1, 2011, the Insured was an occupant of a customer's automobile that was involved in a collision.

[4] Dominion insured the automobile repair shop pursuant to the garage's insurance policy. As well, the Insured was also a named insured under a motor vehicle liability policy issued by Unifund Assurance Company.

[5] On January 4, 2012, Dominion received the Insured's Application for Accident Benefits (OCF-1). Dominion paid accident benefits to the Insured as a result of damages arising from the collision.

Notice of Dispute Delivered by Dominion to Unifund

[6] On January 24, 2012, Dominion delivered a Notice to Application of Dispute Between Insurer ("Notice") to Unifund. The Notice states:

> Notice to Applicant of Dispute Between Insurers:
>
> Name of Applicant: Mr. Fan, Jing Hua
> Street Address: Omitted
> City: Omitted
> Date of Accident: 29/11/2011
>
> This notice is to inform you that the insurer to whom you have applied for accident benefits claims that another insurer is responsible for paying these benefits. You may be required to assist the insurers in resolving their dispute by providing them with any information that may be needed to determine which insurer should be paying you accident benefits claim.
>
> You also have the right to object to your claim being transferred to another insurer. If you wish to object please complete Part 5 of this form and send it within 14 days to the insurer that is currently paying you accident benefits. If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer.
>
> If you have any questions about this notice, or about the process that insurers use to determine who is responsible for paying you claim, please contact the representative of the insurance company that is paying your accident benefits claim. The name and telephone number of the representative is listed in Part 1.
>
> Part 1: Insurer that you applied to for Accident Benefits
>
> Company Name: The Dominion of Canada General Insurance Company
> Mailing Address: Omitted
> City: Omitted
> Contact Person: Omitted
>
> Part 2: Insurer(s) Notified to Pay Benefits (By Insurer Listed in Part 1)
>
> First Company Name: Unifund Assurance Company
> Mailing Address: Omitted
> City: Omitted

Contact Person: Omitted

Part 3: Reasons

Details: The claimant was driving a vehicle that is insured with The Dominion and he is not a listed driver on our policy, but an ISB search reveals that he [is] a policyholder with Unifund Assurance Company, Policy# [Omitted]

Part 4: Signature of the Insurer Representative

Name: Omitted
Date: January 24, 2012

Part 5: Objection to Transfer of Claim (optional)

You can object to your claim being transferred to the insurer(s) referred to in Part 2 by completing this section and returning the form to the insurer that you applied to in Part 1 within 14 days. If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer. Please check the box below and return this form to the insurer listed in Part 1 within 14 days only if you wish to object to your claim being transferred to another insurance company.

[ ] I object to the claim being transferred.

Name:
Date:
Signature

[7] There is no dispute that Unifund received the above Notice within the 90 day period prescribed by s. 3(1) of the Regulation. However, Dominion did not deliver this Notice to the Insured at the same time that it sent the Notice to Unifund even though the statements in the Notice are directed to the Insured. In fact, this Notice was not delivered by Dominion to the Insured until two years had passed.

[8] Dominion served a Notice of Commencement of Arbitration dated November 5, 2012 to determine whether Dominion or Unifund is obliged pursuant to section 268 of the *Insurance Act* to pay accident benefits to the Insured as a result of the motor vehicle accident.

Notice of Dispute Delivered by Dominion to the Insured

[9] About 17 months after it delivered its Notice to Unifund, Dominion delivered the Notice to the Insured by letter dated June 23, 2014. The covering letter states:

> We are enclosing the initial "Notice to Applicant of Dispute Between Insurers" dated January 24, 2012 for your review. Please read this notice, and if you have any questions please call me, and I will answer any questions you may have. If you object to your claim being transferred to Unifund Assurance Company, please complete Part 5 of this form and return it to the undersigned immediately.

[10] It is unclear when the Insured received the Notice; however, the parties agree that he had received the Notice by July 18, 2014.

[11] The Insured has not responded to the Notice. The Insured's accident benefits claim has not been settled with Dominion.

Arbitration and the Preliminary Question

[12] Dominion and Unifund entered an Arbitration Agreement, dated May 12, 2015, which provides:

> 1. The Applicant and the Respondent agree to submit to arbitration pursuant to Ontario Regulation 283/95, and pursuant to the *Arbitration Act, 1991*, the following question:
>
> (a) Is the applicant or the respondent higher in priority in respect of payment of statutory accident benefits to Mr. Jing Hua Fan ("the claimant");
>
> (b) If the respondent is higher in priority, what is the amount owed to the applicant and is interest owed? ...
>
> 9. The parties expressly reserve their right of automatic appeal to a single Judge of the Superior Court of Justice on questions of law or mixed fact and law. The parties agree that the standard of review on questions of law shall be correctness, and the standard of review on questions of mixed fact and law shall be reasonableness. ...
>
> 13. The parties agree that the arbitration ... herein shall proceed by way of written submissions.

[13] The parties submitted a preliminary question, which gives rise to this appeal, to the Arbitrator.

The Arbitrator's Decision

[14] The Arbitrator's decision states:

> Issue: Is Dominion precluded from pursuing this priority dispute against Unifund because it did not send a copy of the Notice of Application of Dispute Between Insurers to the Claimant, as required by section 4 of the Ontario Regulation 283/95, until after the arbitration proceeding was commenced?
>
> Result: No, Dominion's late delivery of notice to the Claimant does not preclude them from proceeding with this priority dispute. ...
>
> As I stated ... the words in section 4 of the regulation are clear, and create a mandatory obligation on the first insurer who receives a completed application to provide notice to the insured person of its intention to dispute its obligation to pay benefits. The section states that an insurer that provides notice to another insurer under section 3 "shall also" give notice to the insured person using the approved form. It is clear that the drafters of the regulation intended that claimants be

notified of an ongoing priority dispute between insurers regarding the obligation to pay their claims, and that they be provided with the opportunity to participate in it.

That said, it is difficult to understand the reason for permitting claimants to participate in these proceedings. After conducting numerous priority dispute arbitrations over the course of the last ten years, I have yet to preside over a case in which a claimant's participation in the process has affected the outcome. Claimants rarely resist the proposed transfer of their claim to another insurer, and if they do, it is often unrelated to the provisions of section 268(2) of the Act, which dictates the priority analysis. ...

So, while I acknowledge that one of the underlying purposes of the priority regulation is to ensure that claimants receive benefits in a timely fashion, and that they are not affected by any dispute that may arise between the insurers as to which one is in higher priority to pay the claim, it seems clear that the rights provided to claimants to participate in the process are entirely procedural. No determination of priority between insurers will affect a claimant's entitlement to obtain benefits under the Schedule and in my view, questions regarding the nature of an insurer's obligation to provide notice to a claimant must be approached with that in mind. ...

While insurers should ideally provide notice to claimants at the same time as they do to the "target insurers", the fact remains that Mr. Fan was provided with the opportunity to participate in this process. I find that notice provided by Dominion, albeit very late, satisfies the requirement in section 4 of the regulation.

Counsel for Unifund argued that the ninety-day time limit in section 3 of regulation should also apply to an insurer's obligation to provide notice to an insured under section 4. I do not agree with this contention. Firstly, if the drafters of the regulation had intended this time line to apply, it would have been easy for them to have set that out. As contended by counsel for Dominion, in order to accept this submission I would be required to "read in" a specific time limit to the provision that is not spelled out explicitly. I am not prepared to do so in these circumstances.

Further, the ninety-day time frame within which a first insurer must provide notice to another insurer makes sense in the context of what an insurer who receives a completed application for benefits is required to do. Various steps and investigations must be undertaken by that insurer in order to determine whether another insurer may be in priority. This will often take some time. However, it is better for all concerned if the priority insurer begins adjusting the claim early in the process. The ninety-day time limit has been chosen as a "saw-off" point or compromise, in the recognition of these two competing interests. If a first insurer has not provided notice within the ninety-days specified, and wants to proceed with the dispute, it must meet the fairly onerous conditions set out in the "savings provisions" in section 3(2) of the regulation.

In contrast, no steps or investigation need be undertaken by a first insurer who receives a completed application to provide notice to a claimant that it intends to dispute its obligation to pay benefits for priority reasons. Given these circumstances, I do not see the rationale for applying a ninety-day time limit to the requirement to provide notice to a claimant under section 4 of the regulation.

Counsel for Unifund argued in the alternative that if I did not accept that Dominion had ninety days within which to provide notice to Mr. Fan, that the latest point at which notice could be provided to a claimant is one year after the provision of the notice to the other insurer(s) under section 3. In this case, that would have been January 25, 2013. The notice to Mr. Fan by

Unifund was provided in late June 2014, some 17 months later. Counsel noted that section 7(3) of the regulation provides that an insurer or an insured person may initiate arbitration "no later than one year after the day the insurer paying benefits first gives notice under section3", and claimed that if a first insurer could provide its notice to a claimant beyond this point, the claimant would be precluded from initiating arbitration.

I must reject this contention as well. A close review of section 5(3) of the regulation persuades me that allowing an insurer to provide late notice to a claimant does not preclude the claimant from availing themselves of the rights provided to initiate arbitration. While an insured initiating arbitration in the context of a priority dispute is extremely rare – if not unprecedented – the drafters of the regulation clearly intended to provide that right to insureds.

The right to initiate arbitration is referred to in both section 5(3) and section 7(3) of the regulation. Section 5(3) essentially provides that an insured who has provided notice of an objection to the proposed transfer of his or her claim, is entitled to participate in any subsequent proceeding. It then goes on to state that an agreement made between insurers regarding priority may only be binding if the insured person who has objected to the proposed transfer consents to it, or if 14 days have passed since the insured was provided written notice of the agreement and that person has not initiated arbitration. It is this fourteen day time line that dictates the insured's right to commence arbitration.

Presumably, if notice of an insurers' agreement is provided to an insured who has chosen to object to the proposed transfer, and the insured chooses to wait 60 or 90 days before initiating arbitration, they will not be permitted to do so. It is unclear how this clear directive fits together with the provision in section 7(3) of the regulation that an insured person may initiate arbitration no later than one year after the day the first insurer gives its notice to the "target insurer" under section 3.

In many cases, an agreement between insurers to transfer a claim that the objecting claimant has the right to dispute may take place a couple of years after the section 3 notice was provided, well along in the arbitration proceeding. It would not make sense if a claimant who had participated in the proceeding over the course of a few years, and then objected to an agreement reached by the insurers to transfer his or her claim within the 14 days permitted, would somehow be precluded from maintaining such an objection because it occurred, through no fault of his or her own, more than one year after the section 3 notice was provided to the other insurer.

I can only conclude that the language in section 7(3) would not prohibit a claimant, who is otherwise validly exercising his or her right to object to an agreement in accordance with section 5(3) of the regulation, from initiating arbitration. Accordingly, Unifund's submission on this point must fail.

For the reasons set out above, I find that Dominion is not precluded from proceeding with this priority dispute by virtue of having provided late notice to Mr. Fan under section 4 of the regulation. [Emphasis added.]

ISSUES

[15] This Application raises the following issues:

(1) Is an insurer required under s. 4(1) of the Regulation to serve its Notice on the Claimant within 90 days of receipt of a completed application from the Claimant or as otherwise provided by section 3 of the Regulation?

(2) If the answer to question 1 is yes, is relief from forfeiture available?

ANALYSIS

Standard of Review

[16] Dominion submits that the issue raised by this appeal is a question of mixed fact and law.

[17] In *Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 S.C.R. 748, at para. 35, the Supreme Court of Canada stated:

> Briefly stated, questions of law are questions about what the correct legal test is; questions of fact are questions about what actually took place between the parties; and questions of mixed law and fact are questions about whether the facts satisfy the legal tests. A simple example will illustrate these concepts. In the law of tort, the question what "negligence" means is a question of law. The question whether the defendant did this or that is a question of fact. And, once it has been decided that the applicable standard is one of negligence, the question whether the defendant satisfied the appropriate standard of care is a question of mixed law and fact.

[18] In my view, the question raised by this appeal is the proper interpretation of Regulation 283/95 and accordingly it is a question of law.

[19] The parties' arbitration agreement provides that a question of law is to be determined on a standard of correctness. Further, in *Wawanesa Mutual Insurance Co. v. Axa Insurance (Canada),* 2012 ONCA 592, 112 O.R. (3d) 354, at para. 32, the standard of correctness was applied by the Ontario Court of Appeal in interpreting the proper meaning of another phrase found in s. 275 of the *Insurance Act*. In my view, the question raised by this appeal is a question of law and must be determined applying a standard of correctness.

The *Insurance Act* and Regulation 283/95

[20] Section 268 of the *Insurance Act* requires that every motor vehicle policy provide coverage for statutory accident benefits. It also provides rules for determining which insurer is liable to pay statutory accident benefits when there is recourse against more than one insurer. Subsection 121(25.1) of the *Insurance Act* grants authority to the Lieutenant Governor in Council to make regulations governing agreements to settle claims and disputes governing statutory accident benefits.

[21] Regulation 283/95, entitled "Disputes Between Insurers", addresses how disputes between insurers regarding the application of the above rules are to be determined. It provides:

> 0.1 In this Regulation, ...

"benefits" means statutory accident benefits as defined in subsection 224 (1) of the Act; ...

"Schedule" means, in respect of an accident, the Statutory Accident Benefits Schedule as defined in subsection 224 (1) of the Act that applies in respect of the accident.

1. 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.

2. (1) The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act. ...

...

3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section. ...

(2) 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 under section 268 of the Act; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

...

(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7. ...

4. (1) An insurer that gives notice under section 3 shall also give notice to the insured person using a form approved by the Superintendent. ...

5. (1) An insured person who receives a notice under section 4 shall advise the insurer paying benefits in writing within 14 days whether he or she objects to the transfer of the claim to the insurers referred to in the notice.

(2) If the insured person does not advise the insurer within 14 days that he or she objects to the transfer of the claim, the insured person is not entitled to object to any subsequent agreement or decision to transfer the claim to the insurers referred to in the notice.

(3) Subject to subsection 7 (5), an insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 14 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the Arbitration Act, 1991.

...

> 7. (1) If the insurers cannot agree as to who is required to pay benefits, the dispute shall be resolved through an arbitration under the Arbitration Act, 1991 initiated by the insurer paying benefits under section 2 or 2.1 or any other insurer against whom the obligation to pay benefits is claimed.
>
> (2) If an insured person was entitled to receive a notice under section 4, has given a notice of objection under section 5 and disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the Arbitration Act, 1991 initiated by the insured person.
>
> (3) The arbitration may be initiated by an insurer or by the insured person no later than one year after the day the insurer paying benefits first gives notice under section 3.

Principles of Statutory Interpretation

[22] In *Wawanesa,* the Ontario Court of Appeal stated that a purposive approach is to be applied when interpreting legislation. It stated at paras. 33-5:

> As Driedger explains, at p. 87 of his Construction of Statutes, 2d ed., (Toronto: Butterworths, 1983):
>
> > [T]he words of an Act are to read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.
>
> The purposive approach to statutory interpretation requires the court to take the following three steps: (1) it must examine the words of the provision in their ordinary and grammatical sense; (2) it must consider the entire context that the provision is located within; and (3) it must consider whether the proposed interpretation produces a just and reasonable result.
>
> The factors comprising the "entire context" include the history of the provision at issue, its place in the overall scheme of the Act, the object of the Act itself, and the legislature's intent in enacting the Act as a whole and the particular provision at issue...A just and reasonable result promotes applications of the Act that advance its purpose and avoids applications that are foolish and pointless. [Citation references omitted.]

[23] The above analytical framework includes the principle that legislation should be interpreted in a manner that does not result in absurd consequences: *Ontario v. Canadian Pacific Ltd.*, [1995] 2 S.C.R. 1031, at para. 65.

[24] I now turn to consider this question applying the above principles of statutory interpretation.

ISSUE #1: DOES SUBSECTION 4 (1) OF THE REGULATION REQUIRE THAT NOTICE TO THE INSURED PERSON BE GIVEN WITHIN THE 90 DAY PERIOD PRESCRIBED BY SECTION 3 OF THE REGULATION?

[25] On the issue of whether the 90 day period described in section 3 of the Regulation applies

to notice provided under section 4 of the Regulation as well, the Arbitrator found:

- If the drafters of the regulation had intended to require that an insurer provide notice to an insured within the 90 day period described in section 3 of the Regulation then it would have used express words;

- There is no rationale for applying a 90 day period to notice given under section 4 of the Regulation as an insured person may initiate arbitration beyond the one year period provided in s. 7(3) of the Regulation if it initiates an arbitration within 14 days after receipt of a proposed settlement of the dispute between the insurers.

[26] I respectfully disagree with the above analysis and conclusions. It is my view that a purposive interpretation leads to the conclusion that the time limits for notice under section 3 of the Regulation also apply to notice provided under section 4 of the Regulation. Further, the limits for filing for arbitration under subsection 7(3) of the Regulation are not extended by the late delivery of a notice under sections 3 or 4 of the Regulation. The time limit for the initiation of an arbitration found in s. 7(3) does not so provide. Further, that conclusion is inconsistent with the Ontario Court of Appeal's view in *Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund*, 2007 ONCA 61, 84 O.R. (3d) 401, at para 27:

> Arbitration and the time limits for initiating it are intended to ensure the prompt and cost-effective resolution of disputes over payment.

[27] I now turn to the application of the interpretive principles described above.

Ordinary and Grammatical Meaning

[28] Subsection 4(1) of the Regulation provides that ".... an insurer that gives notice under section 3 shall also give notice to the insured person ...". [Emphasis added]

[29] The Concise Oxford Dictionary, 12th Edition, defines "also" as follows:

"in addition, too"

"quite so, in that manner, similarly".

[30] The Shorter Oxford English Dictionary, Third Edition, defines "also" as follows:

1. Wholly or quite so; in this or that very manner; in like manner, likewise

2. Further, too

[31] Section 3 of the Regulation requires that written notice to an insurer be given within 90 days of receipt of a completed application for accident benefits. Thus, it specifies to how notice shall be provided (e.g., written) and when notice shall be provided. On the other hand, section 4 only specifies how notice shall be given (e.g., in a prescribed written form).

[32] In my view, the use of the word "also" in section 4 addresses when notice shall be given

to an insured person under section 4 for the following reasons.

[33] First, section 4 requires an insurer who has given notice under section 3 to an insurer to "also" give notice to an insured person using a prescribed form. The word "also" requires that notice be given in a like manner to the notice provided under section 3. In my view, this means that the notice under section 4 must also be provided within the 90 day period described in section 3.

[34] Second, "[i]t is presumed that the legislature avoids superfluous or meaningless words, that it does not pointlessly repeat itself or speak in vain": *McDiarmid Lumber Ltd. v. God's Lake First Nation*, 2006 SCC 58, [2006] 2 S.C.R. 846, at para. 36. In my view, if the word "also" does not reference and incorporate into section 4 of the Regulation the only matter addressed in the giving of notice under section 3 that is not otherwise specifically addressed in section 4 (namely, the 90 day time limit), then the word "also" would be meaningless and unnecessary.

Entire Context of the Provision

[35] An insured person is given three rights under s. 5(3) of Regulation 283/95: 1) the right to participate in any settlement discussions between the insurers regarding the transfer of his or her claim; 2) the right to veto any settlement arising from such discussions; and 3) the right to initiate arbitration. Section 5(3) states:

> Subject to subsection 7 (5), an insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 14 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the *Arbitration Act, 1991*. [Emphasis added.]

[36] However, a claimant must initiate arbitration within one year of the date that an insurer notifies a second insurer that the claimant's accident benefits application should be transferred to the second insurer. Section 7(3) states:

> The arbitration may be initiated by an insurer or by the insured person no later than one year after the day the insurer paying benefits first gives notice under section 3.

[37] Accordingly, the obligation to provide notice to a claimant under section 4 must be construed in a manner that does not nullify the rights given to a claimant under section 5(3).

[38] In my view, it is not a sufficient answer to say that the drafters of the Regulation did not intend for a time line to apply because none is expressly provided. In my view, that analysis leads to an absurd consequence in that the same drafters clearly gave claimants rights to participate and object in this dispute. Those rights are meaningless if the claimant is unaware of the dispute until after the one year time limit on initiating arbitration of the dispute has passed. In my view, the one year time limit imposed by s. 7(3) makes it clear that a claimant would have had to have been notified of the dispute at some earlier date. Given that the Regulation provides that a claimant has a right to participate in any proceeding to settle the dispute, it is my view that

the claimant be given the Notice within the same time period as applicable to the second insurer under section 3 of the Regulation.

[39] In my view, the Regulation must be interpreted in a manner that does not render ineffective the rights given to a claimant under the Regulation to object to any transfers of their claim to another insurer.

Does the Proposed Interpretation Produce a Just and Reasonable Result?

[40] One of the main objectives of automobile insurance is consumer protection: *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, at para. 11. This broader objective is reflected in the Regulation.

Payment of Accident Benefits Pending Dispute Resolution

[41] The objective is reflected in Regulation 283/95 as it: (1) requires an insurer to continue to pay accident benefits pending the resolution of its dispute that another insurer should be paying those benefits; and (2) provides the accident benefits with the right to object to the transfer of their claim to another insurer. The objectives of Regulation 283/95 were explained more fully by the former Ontario Insurance Commission as follows:

> The new Regulation provides protection to injured accident victims who may be entitled to benefits and are caught in the middle of these disputes. Insurers that first receive an application for accident benefits will now be required to pay benefits pending the resolution of these disputes.
> ...
>
> Section 268 of the Insurance Act sets out a priority ranking for determining which insurer is liable to pay for accident benefits where more than one insurer may be liable to pay for benefits. However, difficulties have emerged in resolving these disputes between companies: some claimants who have been entitled to benefits have been subject to delays in payments.
>
> The Regulation outlines a private arbitration process to resolve these inter-company disputes. ...
>
> Claimants will be notified of this process through the approved form entitled "Notice to Applicant of Dispute Between Insurers". In addition, claimants will also have the right to object to any transfers of their claim to another insurer."

[42] In *Zurich Insurance Co. v. Chubb Insurance Co. of Canada,* 2015 SCC 19, [2015] 2 S.C.R. 134; rev'd 2014 ONCA 400, 120 O.R. (3d) 161, at para. 40, the Supreme Court of Canada adopted the view of Juriansz J.A., who stated that the "overriding public policy of the Regulation is to provide timely delivery of benefits to all persons injured in car accidents in Ontario, despite the inconvenience to insurance companies who must provide benefits immediately and seek reimbursement from the correct insurance company later."

Resolution of Disputes by Arbitration

[43] In *Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund*, 2007 ONCA 61, 84 O.R. (3d) 401, at para. 25, the Ontario Court of Appeal found that a further objective of the Regulation is to provide for the resolution of insurer disputes by arbitration.

Right of an Insured to Object to the Transfer of a Claim

[44] A further objective of the Regulation is to provide a claimant with the right to object to a proposed transfer of his or her claim to another insurer.

[45] The Arbitrator stated that insured persons rarely resist the proposed transfer of their claim to another insurer and are not affected by any dispute between the insurers. Nevertheless, as is evident from the Arbitrator's statement, some insured persons object to the transfer of their claim. It is this interest that the rights afforded by the Regulation to insured persons, particularly ss. 4(1), 5(3) and 7(2), protect.

ISSUE #2: IS RELIEF FROM FORFEITURE AVAILABLE FOR FAILURE TO COMPLY WITH THE REGULATION?

[46] Dominion submits that the appropriate remedy, in the event that it is found to have failed to comply with section 4 of the Regulation, is to remit this matter back to Arbitrator Novick for a decision on whether relief from forfeiture ought to be granted.

[47] A court is granted authority to grant relief from forfeiture under section 98 of the *Courts of Justice Act* and section 129 of the *Insurance Act*. However, this authority only extends to imperfect compliance with a contractual obligation as opposed to a statutory obligation as in this case.

[48] Dominion submits that an arbitrator appointed under Regulation 283/95 has authority to grant relief from forfeiture under section 31 of the *Arbitrations Act, 1991* which states:

> 31. An arbitral tribunal shall decide a dispute in accordance with law, including equity, and may order specific performance, injunctions and other equitable remedies.

[49] No authority was provided by Dominion to support the view that relief from forfeiture is available under section 31 of the *Arbitrations Act*. I am not persuaded that relief from forfeiture is available under that provision for two reasons. First, section 1 of the Regulation provides that all disputes "shall be settled in accordance with this Regulation". There is nothing in either the *Insurance Act* or the Regulation that provides for relief from forfeiture in respect of a failure to comply with the time limits for the delivery of notice and the initiation of arbitration under the Regulation. Second, the Ontario Court of Appeal in *Kingsway General Insurance Co. v. West Wawanoosh Insurance Co.* (2002), 58 O.R. (3d) 251 (C.A.), at para 10:

> The Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assume and rely upon the requirement for compliance with those provisions. Insurers subject to this 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 each other. In this context, it seems to me that 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.

[50] In any event, I agree with the views expressed by Nordheimer J. in *State Farm Mutual Automobile Insurance Co. v. Ontario (Minister of Finance)* (2001), 53 O.R. (3d) 436:

> 37 I am prepared for the purposes of this appeal to assume that arbitrators under the *Arbitration Act, 1991* have jurisdiction to grant equitable relief. In my view, however, that jurisdiction in the circumstances of this case has been ousted by the provisions of section 3(2) of the Regulation. The government has "occupied the field" by including a provision which allows for relief from the imposition of the 90 day notice period in the particular circumstances set out in section 3(2). Having done so, there is no jurisdiction to invoke other grounds for granting such relief.
>
> 38 In any event, it is questionable whether the Court has any jurisdiction to relieve against a penalty or forfeiture that is decreed by statute. This principle is stated in Story on Equity, 3rd edition, (1920) at para. 1326:
>
> > "When any penalty or forfeiture is imposed by statute upon the doing or omission of a certain act, then courts of equity will not interfere to mitigate the penalty or forfeiture, if incurred, for it would be in contravention of the direct expression of the legislative will."
>
> 39 The same principle is set forth in the Court of Appeal's decision in *McBride v. Comfort Living Housing Co-operative Inc.* (1992), 7 O.R. (3d) 394 where Finlayson J.A. said, at p. 402:
>
> > "Section 111 (now s. 98) of the CJA now sets out the equitable power of the court in much the same fashion:
> >
> > 111. A court may grant relief against penalties and forfeitures, on such terms as to compensation or otherwise as are considered just.
>
> This section apparently does not empower a court to relieve against penalties and forfeitures imposed by statute: *Webb v. Box* (1909), 19 O.L.R. 540 (Div. Ct.) (leave to appeal refused (1909), 20 O.L.R. 220 (C.A.))."
>
> 40 However, even assuming there is some residual jurisdiction in the Court to relieve against penalties and forfeitures imposed by statute, I cannot see how the jurisdiction could arise in a situation where, as here, the statute has already stipulated for relief to be given in certain defined conditions and the party seeking the relief has been unable to bring itself within those defined conditions. [Emphasis added]

[51] This decision was upheld by the Ontario Court of Appeal in *Kingsway General Insurance Co. v. West Wawanoosh Insurance Co.* (2002), 58 O.R. (3d) 251 (C.A.), which stated, at para. 13:

> I would also reject the submission that a court should exercise any general discretion it might have to grant the appellant relief from forfeiture for its failure to provide the required 90-day notice. Despite Mr. Samis' skilful and forceful argument that the respondent was aware of the appellant's intention to dispute liability, had conducted the required investigation and would suffer no prejudice if required to engage in the arbitration, I do not think that this is a case in which the court's discretion comes into play. I agree with the conclusion of the Superior Court judge that the Regulation provides a scheme that contemplates extensions of the 90-day notice period in certain circumstances, and that, by implication, any general discretion a court might have to grant extensions in other circumstances is excluded. [Emphasis added.]

CONCLUSIONS

[52] For the reasons given, I allow Unifund's appeal. The Arbitrator committed an error in law in finding that the 90 day time limit provided by section 3 of the Regulation does not apply to notices given to an insured under section 4 of the Regulation. I also reject the submission that the Arbitrator has authority to relieve Dominion from the consequences of having failed to comply with section 4 of the Regulation. Accordingly, Dominion's dispute is barred.

[53] I encourage the parties to resolve the issue of costs failing which I direct that Unifund deliver its costs submissions within seven days of today's date and that Dominion deliver its submissions within fourteen days of today's date. Costs submissions shall be a maximum of three pages long exclusive of an outline of costs and any offers to settle.

Mr. Justice M. D. Faieta

Released: June 30, 2016

CITATION: Unifund Assurance Company v. The Dominion of Canada General Insurance Company, 2016 ONSC 4337
COURT FILE NO.: CV-15-540663
DATE: 20160630

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

UNIFUND ASSURANCE COMPANY

Applicant

– and –

THE DOMINION OF CANADA GENERAL INSURANCE COMPANY

Respondent

REASONS FOR DECISION

Mr. Justice M. D. Faieta

Released: June 30, 2016