IN THE MATTER OF THE *INSURANCE ACT,* R.S.O. 1990, c.I.8, AS AMENDED SECTION 268, AS AMENDED, AND ALL REGULATIONS THEREUNDER; AND INPARTICULAR ONT REGULATION 283/95, AS AMENDED;

AND IN THE MATTER OF THE *ARBITRATION ACT,* S.O. 1991, c.I.7 AS AMENDED;

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

AVIVA INSURANCE COMPANY OF CANADA

Applicant

- and -

PAFCO INSURANCE COMPANY, MOTOR VEHICLE ACCIDENT CLAIMS FUND, ALLSATE INSURANCE COMPANY OF CANADA, and BELAIR DIRECT INSURANCE

Respondents

DECISION

COUNSEL:

Frank Benedetto for Aviva Insurance Company of Canada
(Respondent on preliminary issue)

Tim Gillibrand for Pafco Insurance Company and Allstate Insurance Company of Canada
(Applicant on preliminary issue)

Daniel Fenwick for Motor Vehicle Accident Claims Fund

Stacey Morrow for Belair Direct Insurance Company

ISSUE:

Did Aviva Insurance Company of Canada initiate the arbitration within the 1-year limitation period as set out in Section 7(3) of Ontario Regulation 283/95, and if not, what are the consequences?

DECISION:

Aviva Insurance Company of Canada did not initiate this arbitration within the time limit as set out in Section 7(3) of Ontario Regulation 283/95 and accordingly Aviva is barred from proceeding with the arbitration.

HEARING:

The preliminary issue hearing was held in the city of Toronto, on November 8, 2017. The hearing proceeded on the basis of documentary evidence filed, and oral argument. No witnesses were called.

FACTS:

The facts in this matter are relatively straightforward. On November 28, 2014, Danielle Power was a passenger in a motor vehicle that was insured by Aviva Insurance Company of Canada ("Aviva").

On December 23, 2014 Ms. Power applied to Aviva for Statutory Accident Benefits by way of an application for accident benefit (OCF-1).

Aviva took the position that its policy on the vehicle in question had been cancelled prior to the accident for non-payment and therefore sent "Notice to Applicant of Dispute Between Insurers" ("Notice to Applicant"), to Pafco Insurance Company (also identified as Allstate Insurance Company of Canada "Allstate") on January 2, 2015 by fax. A further Notice to Applicant to Pafco/Allstate was sent by way of fax on January 13, 2015. Aviva also sent a Notice of Application to the Motor Vehicle Accident Claims Fund ("The Fund") on or about January 13, 2015. On January 13, 2016 counsel for Aviva sent a letter to Pafco/Allstate and The Fund enclosing a "Notice Demanding Arbitration".

On June 9, 2015 the Fund sent Notice of Application to Belair Direct Insurance Company ("Belair"), and on April 23, 2016, counsel for Aviva sent a Notice Demanding Arbitration to Belair by fax.

THE ISSUE AND THE LAW:

This matter is a priority dispute between insurers, and as such is governed by Ontario Regulation 283/95. Section 3 of the Regulation states:

> **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.

Once proper notice has been given, the insurer paying benefits may resort to arbitration to determine who the proper insurer to pay benefits should be, pursuant to Section 7(1) of the Regulation which states:

> **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.

Section 7(3) of the Regulation then sets out the time frame within which the arbitration must be initiated. It states:

> **7.** (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.

The Regulation then allows for second tier insurers to provide notice to other insurers pursuant to Section 10(1) which states:

> **10.** (1) If an insurer who receives notice under section 3 disputes its obligation to pay benefits on the basis that other insurers, excluding the insurer giving notice,

> have equal or higher priority under section 268 of the Act, it shall give notice to the other insurers.

Section 10(3) of the Regulation then provides that the dispute between insurers is to be resolved in one arbitration.

It is agreed by the parties that Aviva initiated the arbitration by way of a letter and "Notice Demanding Arbitration" on January 13, 2016. However, as noted above, Aviva gave two different Notices of Dispute Between Insurers (Notice of Dispute), the first notice being on January 2, 2015 and the second on January 13, 2015. If the first Notice of Dispute was valid then Aviva did not initiate the arbitration with the required time frame. Aviva however takes the position that the first Notice of Dispute was inadequate and did not provide sufficient reasons for the dispute and therefore the limitation period did not begin to run until the second notice was served on January 13, 2015.

Essentially, this particular case comes down to what constitutes sufficient notice to another insurer that the first insurer disputes that it is in priority to the second insurer.

Counsel for Aviva submitted that one must look not just a Section 3(1) or the Regulation to determine what notice is required but at the entire Regulation as well as the Statutory Accident Benefits Schedule and the applicable sections of the Insurance Act to arrive at a conclusion. In support of this position counsel for Aviva submitted that the "modern principles of statutory interpretation" should apply citing the Supreme Court of Canada in *Teal Cedar Products Ltd. vs. British Columbia*, 2017, 32, citing E.A Dreiger, *Construction of Statues*, 2nd ed, Toronto: Butterworths, 1983.

> "Today there is only one principle or approach, namely, the words of an Act are to be 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."

Following this principle, counsel for Aviva points out that Ontario Regulation 283/95 requires all disputes as to which insurer is required to pay benefits under Section 268 of the Insurance Act

shall be settled in accordance with the Regulation. Incorporated by reference are the cascading priority rules set out in Section 268. Section 3 of the Regulation then says no insurer may dispute its obligation to pay benefits unless it gives written notice within 90 days of receipt of a completed Application for Benefits to every insurer which it claims is required to pay under Section 268. Aviva argues that by incorporating the reference to the cascading priority rules, and reference to a claim, supports the rationale that a reason must be provided for the Notice. It furthers argues that Section 7 of the Regulation addresses the sufficiency of notice because it says that the dispute shall be resolved through an arbitration if the insurers cannot agree as to who is required to pay benefits, which presumes adequate information forming part of the notice, so as to permit investigation and make a determination based on cascading priority rules.

In support of their position Aviva relies upon the case *Lombard Canada Ltd vs. Royal and Sun Alliance Insurance Co. 2008 Carswell ONT 7839, [2008] O.J. No. 5239,* wherein Justice Strathy noted the purpose which underlies the notice requirements sent by the first insurer to the second insurer. He stated:

> The seeming arbitrariness of making the first insurer initially responsible, despite the potential liability of another insurer, is compensated for by the system of notice and arbitration. The notice requirement allowing the second insurer to investigate the claim, to decide whether to accept responsibility and to take appropriate investigative and loss control measures.

Counsel for Aviva also points out that Section 4(1) of Regulation 283/95 requires that:

> **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.

Such a form has been approved by the Superintendent and is entitled "Notice of Applicant to Dispute Between Insurers". It was this form that was used by Aviva on both January 2nd and 13th, 2015 to give notice to Pafco/Allstate.

Part 3 of the form approved by the Superintendent has a section entitled "Reasons (why notice is given to other insurers)." In addition, in the box, it has the word "details". In the January 2, 2015

notice, the Aviva Senior Health Service advisor, Recovery Unit, simply filled in Part 3 with the words:

> Please be aware that you are priority on this motor vehicle accident under policy 558284043.

I was advised at the hearing that this refers to the Pafco/Allstate policy in question.

The January 13, 2015 notice from the Aviva representative contains considerable more detail in Part 3 of the form. It states:

> Please be aware that you are priority on this motor vehicle accident under policy 558284043.
>
> Our policy is cancelled. Attached, is the OCF-1 wherein the passenger is making a claim for injuries, Danielle Power. Our insured's policy was cancelled please find registered Notice of Cancellation, OCF-1 and the police report.

As indicated, Aviva included with the notice, a copy of the registered Notice of Cancellation and the police report. It is Aviva's position that the January 2, 2015 notice did not give sufficient particulars to constitute proper notice to Pafco/Allstate when taking into account the entire legislative scheme as well as Justice Strathy's comments cited above.

In further support of his position, counsel for Aviva cites the decision of arbitrator Bialkowsi in *Economical Insurance Group and State Farm Mutual Automobile Insurance Company*, 2014 Carswell ONT. 18693, 43 C.C.L. i (5th 292). In that case Economical received an application for accident benefits from the injured party and commenced payments. Economical than notified another insurer, State Farm, citing a policy number with State Farm and certain other particulars. State Farm responded, advising that the referred to State Farm policy had been cancelled prior to the accident. Economical then continued its investigation and sent a second notice to State Farm taking the position that a completely different person, the injured party's husband, had a policy with State Farm and cited a completely different policy than in the first notice. Arbitrator Bialkowski found that after State Farm had advised Economical that the first mentioned policy of the injured party was properly cancelled prior to the accident, Economical essentially abandoned

the notice and did not intend to pursue State Farm under that policy. Arbitrator Bialkowski further found that as a result of its further investigation it served a completely new notice alleging a different insured and different policy number of State Farm which thereby created priority. This amounted to an entirely new notice and he found that Economical's claim was therefore not statute barred by the earlier notice.

Counsel for Pafco/Allstate submits that I should take a "plain meaning interpretation" or alternatively the "purposive approach" to the statutory and regulatory provisions at issue in this matter. The "purposive approach" as set out in *Wawanesa Mutual Insurance vs. AXA*, 2012 ONCA, 592, sets out three steps to be followed:

> (1) Examine the words of the provision in their ordinary and grammatical sense;
> (2) consider the entire context that the provision is located within;
> (3) consider whether the proposed interpretation produces a just and reasonable result.

In my view, under any of the proposed approaches, the first notice given on January 2, 2015 constitutes the notice required and the second, more expansive notice, does not create a new base date from which to calculate the 1-year limitation period.

Section 7(3) of Regulation 283/95 simply states that the arbitration must be commenced no later than one year after the date the insurer paying benefits first gives notice under Section 3 of Ontario Regulation 283/95.

Section 3(1) requires that the paying insurer give written notice to every insurer within 90 days of receipt of a completed application to every insurer who it claims is required to pay. Nothing in regulation 283/95 sets out what particulars must be given by the paying insurer to the other insurers when giving notice of its intent to dispute priority.

It is worthwhile, at this point, to examine what information Aviva provided in its notice of January 2, 2015.

The Aviva representative sent a "Notice of Applicant to Dispute Between Insurers", a form which I have previously mentioned, was approved by the Superintendent of Insurance to be sent to the insured. While there is no requirement that the exact same form be sent to the insurers to constitute notice to them, I accept that it has become an industry practice to use the same form for both, and this seems reasonable to me. Further examination of the January 2, 2015 form reveals the name of the injured party, their address, what insurance company has received the application for accident benefits (Aviva) along with the name of the Aviva adjuster handling the matter with their address and phone number. It also states in Part 2 that the insurer being notified to pay benefits is Pafco. In Part 3 of the form, it provides the Pafco policy number under which Aviva is saying Pafo is in priority. The fact sheet sent to Pafco with the notice includes Aviva's handling adjuster's name, phone number, fax number, the injured party's name, her Aviva policy number as well as the Pafco policy holder's name and policy number in question.

The second notice of January 13, 2015 does give additional and useful information. It sets out the reasons why Aviva should not be in priority (cancellation) and some proof thereof.

While this additional information is useful, and is to be encouraged, it is not, in my view, essential to the giving of notice and the commencement of the running of the limitation period. What is required is notice of a claim, not the details of the claim or evidence to support it. This further information, if necessary, could be obtained by contacting the insurer giving notice and I note that in our case, the name, address, phone and fax numbers as well as the policy number were indicated. This, in my view, is all that was required to initiate the process.

While more information is generally better than less, when one considers the entire context of the provisions, both within the Regulation and the Statute, all that has been required is notice. The Regulation then goes on to specify that if the parties cannot resolve their differences in the following year, they shall proceed to arbitration. During that one year, presumably details will be obtained and evidence gathered.

When one considers whether this would create a just and reasonable result, we must again look at the entire scheme as set out in the Statute and Regulation 283/95. As has been pointed out by

numerous arbitrators and the courts, these are disputes between sophisticated insurers whose representatives deal with these issues on a daily basis. In this context clarity and certainty of application are a primary concern. As the Ontario Court of Appeal has noted in *State Farm Mutual Insurance Company vs. Ontario (Minister of Finance)* 2002, 58 O.R. (3rd) 251

> Given this regulatory setting there is little creative interpretation or for carving out judicial exceptions deigned to deal with the equities of particular cases.

It is not desirable, in my view, in these kinds of matters, to have arbitrators or the courts repeatedly review the details of the notice given. This would lead to uncertainty and unnecessary litigation.

With respect to the decision of arbitrator Bialkowski, without commenting on the correctness of the decision, I note that he was dealing with completely different set of facts than are before me. In that case the two notices referred to both different insureds and different policy numbers. That is not the case before me and I find that the first notice in our case was sufficient and not abandoned.

The issue whether there was separate limitation periods as against other insurers was also raised. For example, the original notice in the case before me was sent only to Pafco/Allstate whereas the second notice was sent to the Motor Vehicle Accident Claims Fund on January 13, 2015 and Belair on April 13, 2016.

Some assistance in resolving this issue may be obtained by examining Regulation 28/95. Section 7(3) of that regulation states:

> (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. (emphasis mine)

A literal reading of this section would suggest the limitation period for all those that the original insurer's claimed against would be begin to run when the original notice went out – in our case, January 2, 2015.

Those insurers receiving notice from the insurer who receives the first application to pay benefits are, of course, entitled to give notice to other insurers pursuant to Section 10 of the Regulation. Thus, upon receipt of a Notice of Dispute, in our case, Pafco/Allstate could then serve notice on other potentially responsible insurers, in this case Belair.

I do not believe, however, that Aviva, haven given notice on January 2nd 2015, can then give later notice Belair and commence an arbitration against Belair outside the one year anniversary of the first notice to Pafco/Allstate.

While this may, in some cases, seem harsh, one must remember yet again that we are dealing with sophisticated insurers who handle these matters on a daily basis. There is a need for certainty predictability and a fairly expeditious resolution of the matters dealt with by this regulation. As one can see by reviewing the regulation there are numerous tight timelines designed to ensure that the disputes are resolved expeditiously. If one were to allow multiple limitation periods it would be contrary to this objective. To allow multiple limitations periods would also make it difficult, at best, to have the dispute among insurers resolved in one arbitration as required my Section 10(3) of the regulation, without potentially inordinate delays.

In our particular case if there were more than one limitation period it would allow Aviva to proceed against the other insurers, who could then make a claim against Pafco/Allstate, which has a valid limitation defense against Aviva. This would allow Aviva to pursue a claim indirectly, which it cannot do directly, which is clearly not desirable.

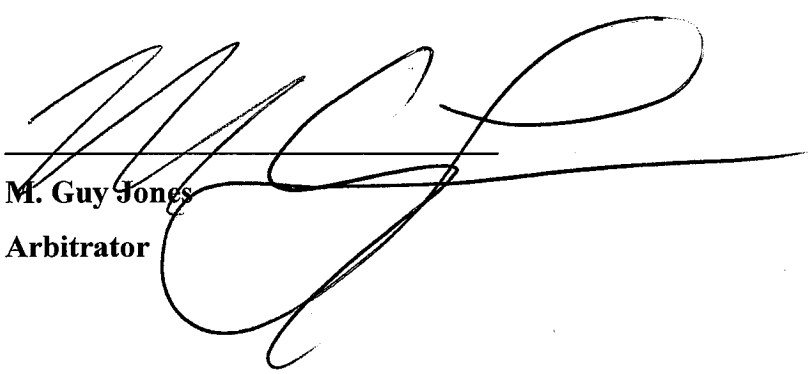
Counsel for Aviva also submitted that as arbitrator, I should exercise my power to grant equitable relied against the running of the limitation period. As an arbitrator, I have equitable jurisdiction pursuant to Section 31 of the Arbitration Act S.O. 1991 c 17. Despite the very able submissions of counsel for Aviva on this point, I do not think that this is an appropriate case for

the exercise of my equitable jurisdiction. Even if one were to accept that I could, in effect, over rule the Regulation, of which I have some doubts, I do not think that factually this is an appropriate case to exercise that power. In this case Aviva was truly the author of their own misfortune. I have found that the notice of January 2, 2015 was valid notice and regrettably the arbitration was not commenced within one year of that date.

For the reasons expressed above, I find that the arbitration was commenced outside the limitation period and the arbitration is therefore barred.

In the event the parties are not able to agree with regard to the issue of costs I may be spoken to.

DATED at TORONTO, ONTARIO this 18th DAY OF JANUARY, 2018.



M. Guy Jones
Arbitrator