CITATION: R. v. Lombard Ins. Co. of Canada, 2010 ONSC 1770
COURT FILE NO.: 09-CV-390485
DATE: March 25, 2010

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

Her Majesty the Queen in Right of Ontario as Represented by the Minister of Finance

Applicant/Appellant

- and -

Lombard Insurance Company of Canada

Respondent/Appellant by Cross Appeal

Defendants

COUNSEL:

John Friendly for Her Majesty the Queen in Right of Ontario as Represented by the Minister of Finance
Linda M. Kiley for Lombard Insurance Company of Canada

HEARING DATE: March 15, 2010

REASONS FOR DECISION

PERELL, J.

[1] On June 30, 2007, Yohannes Berhe, a bicyclist, was injured in a motor vehicle accident. He received statutory benefits from the Motor Vehicle Accident Claims Fund (the "Fund"), which is the payor of last resort under the *Motor Vehicle Accident Claims Act,* R.S.O. 1990, c. M. 41 and the *Insurance Act*, R.S.O 1990, c. I.8, s. 268.

[2] Although Mr. Berhe received benefits paid by the Fund, those payments were payable under a policy of insurance issued by Lombard Insurance Company, and on June 5, 2008, almost a year after the accident, the Fund gave Lombard notice that it was responsible for paying the accident benefits. Lombard, however, refused to assume responsibility and submitted that the Fund had not provided it with timely notice as required by s. 3 of Ont. Reg. 283/95, which is a regulation that regulates disputes about which insurer should pay accident benefits under Ontario's no fault automobile insurance scheme.

[3] The Fund and Lombard now had a dispute about liability to pay statutory accident benefits, and the dispute went to arbitration on May 7 and 8, 2009 before Arbitrator Shari Novick, who decided that the 90-day period under s. 3 of Ont. Reg. 283 for giving notice began on February 11, 2008, when the Fund was "deemed" to have received a "completed application" for benefits. She concluded that the Fund's June notice was not timely, and she held further that the lateness could not be excused pursuant to s. 3 (2) of the regulation.

[4] The Fund now appeals Arbitrator Novick's decision on the grounds that: (a) she erred in concluding that the Fund had received a "completed application" for benefits that would trigger the running of the 90-day limitation period; (b) she erred in concluding that the Fund's notice to Lombard was late, and (c) she erred in concluding that if the Fund's notice was late, the time for giving notice was not extended pursuant to the provisions of s. 3(2) of the regulation.

[5] Lombard cross-appeals on the grounds that the Arbitrator erred by not concluding that the Fund had received a "completed application" in October 2007, with the result that the subsequent notice to Lombard was late and inexcusably late.

[6] For the reasons that follow, I allow the appeal and dismiss the cross-appeal.

Factual and Statutory Background

[7] The factual and statutory background is as follows:

[8] On June 30, 2007, in the parking lot of the Galleria Mall near Dufferin Street in the City of Toronto, while riding a bicycle and being pursued by a mall security guard, Mr. Berhe collided with a stationary BMW. The vehicle was insured by Lombard.

[9] The mall security guard apprehended Mr. Berhe at the scene of the collision, and the guard called the police, who investigated the incident because it was alleged that Mr. Berhe had been involved in a theft at the Price Chopper Grocery Store in the mall. The police questioned Mr. Berhe and also Ms. Narciso Lourenco, who owned the BMW. The mall security staff prepared a report that noted the licence number of Ms. Lourenco's vehicle.

[10] The police officer prepared an incident report on June 30, 2007. The report indicated that no further action would be taken. Notably, the standard MVA (Police Report) was not prepared, and a MVA (Police Report) was never prepared.

[11] On July 10, 2007, Mr. Berhe attended 14 Division to report that while driving his bicycle, he had been involved in a collision at the Galleria Mall and that he required a police report in order to process a claim for medical treatment.

[12] Around this time, Mr. Berhe retained a paralegal, Injury Claims Specialists, to prepare an application for insurance benefits, and Humberto Geova, a law clerk, prepared an Application for Benefits Form (OCF1), which is the standard form used to apply for

statutory accident benefits. In this instance, the application was made to the Fund as the insurer of last resort.

[13] Here, it may be noted that s. 6 of Ont. Reg. 283/95 provides that "the insured person shall provide the insurers with all relevant information needed to determine who is required to pay benefits under s. 268 of the Act."

[14] For the processing of claims for statutory accident benefits under the *Insurance Act*, Form OCF-1, Application for Accident Benefits, is the form used for all accidents that occurred after November 1, 1996. The top of the form includes the following alert:

> *Completion of ALL sections is mandatory. Your application may be denied if information is incomplete or incorrect.*

[15] Part 11 of the Form is the part of the form that addresses claims to the Fund. The template for this part of the form is as follows:

> DO NOT FILL OUT UNLESS ITEMS (1) TO (5) ON PAGE 2 DO NOT APPLY AND YOU ARE APPLYING TO THE MOTOR VEHICLE ACCIDENT CLAIMS FUND
>
> You and your representative acknowledge that you have the responsibility to investigate and apply to all potential insurers to which the applicant may have recourse BEFORE submitting an application to the Motor Vehicle Accident Claims Fund (MVACF).
>
> You and your representative acknowledge that the application MUST INCLUDE a completed:
>
> □ NOTICE OF COLLECTION OF PERSONAL INFORMATION FORM, signed and attached
>
> □ Form 3 – Section 6 MVACF Application for Statutory Accident Benefits, signed and attached
>
> □ Motor Vehicle Accident (Police) Report, attached
>
> before the applicant can make an application for the payment of accident benefits from MVACF.
>
> I certify that I have read this part and understand that this application for accident benefits is not complete until the required forms are completed, signed and provided to the MVAC Fund.

[16] On October 26, 2007, the Fund received Mr. Berhe's Form OCF1 application, signed by him. The form indicated falsely that: Mr. Berhe was a cyclist travelling on Dufferin Street when he was struck by a vehicle; that the accident had been reported to

the police; that the police officer's name and badge number would follow; and that a MVA (Police) Report had been requested.

[17] After receiving the application from Mr. Behre, the Fund retained CGI Adjusters Inc. to adjust the claim, and Ms. Komal Shellikeri was assigned to the file. On October 29, 2007, she sent a series of letters to Mr. Berhe and to Mr. Geova at Injury Claims Specialists advising them that the Fund would require a signed statement, various authorizations, and a police report. The letters indicated that the application form was not complete without a complete police report and that Mr. Berhe's claim could not be determined unless a police report was provided.

[18] On November 1, 2007, Ms. Shellikeri asked her assistant to obtain a copy of the police report.

[19] On November 13, 2007, Mr. Geova wrote and acknowledged Ms. Shellikeri's letter and stated that the police report had been requested and would be forwarded. Around this time, Ms. Shellikeri's assistant reported to Ms. Shellikeri that they needed the police officer's name, badge and the plate number of the vehicle before the police could respond to their request for a MVA (Police) Report.

[20] On January 2, 2008, Ms. Shellikeri's involvement in the matter ended.

[21] On February 11, 2008, John Scott of CGI Adjusters Inc. took over adjusting Mr. Berhe's claim, and Mr. Scott and Mr. Berhe spoke on February 11, 2007, at which time Mr. Scott received a copy of the police incident report of June 30, 2007. The report indicated that no action would be taken about the incident and included the following occurrence synopsis:

> On 2007-07-10 at approximately 1500 hours, the reportee [Mr. Berhe] attended 14 Division to report that he had been involved in an incident involving his bicycle and a motor vehicle at the Galleria Mall on June 30, 2007.
>
> The reportee claimed that he had sustained injuries as a result of a collision with the motor vehicle and he needed a police report in order to seek treatment from a physiotherapist.
>
> Investigation revealed that the reportee in fact was fleeing from security at the time as he had been involved in a theft at the Price Chopper Grocery Store and was attempting to ride away on his bicycle when he struck a stationary vehicle in the parking lot.
>
> Mall security apprehended the reportee at the scene and turned him over to police. He was subsequently released without any charge being laid.
>
> The vehicle that the reportee ran into sustained some damage.

> The reportee advised the reporting officer that he attended hospital on his own and now needed a police report to process his claim for treatment. Given the reportee's past history of involvement with the police, including/ being charged with public mischief, the reporting officer submits this incident report.

[22] Mr. Scott and Mr. Berhe met on February 12, 2008 when Mr. Scott was able to obtain a partial statement from Mr. Berhe.

[23] I pause here to note that in Arbitrator Novick's decision she regarded February 11, 2008 as the date the Fund had received a "complete application," because it was on that date when Mr. Scott would have realized that no MVA (Police) Report would be forthcoming. As will appear, the February 11, 2008 date is the crucial date for the Arbitrator's analysis of the situation under Ont. Reg. 283/95.

[24] On February 12, 2008, Mr. Scott and Mr. Berhe went to the Galleria Mall where Mr. Scott spoke with a security guard, who advised that the mall's property manager had an incident report.

[25] On February 18, 2008 and March 4, 2008, Mr. Scott wrote the property manager and requested the property manager of the Galleria Mall's notes or information about the incident.

[26] On March 31, 2008, Mr. Scott was advised that the property manager refused to provide any information, and on April 2, 2008, Mr. Scott requested that the Fund appoint counsel to pursue the matter.

[27] On April 4, 2008, Mr. Scott wrote the "Access & Privacy" department of the police to request information.

[28] On April 8, 2008, Ms. Devyn Pawley, a claims administrator at the Fund, assigned counsel, who, on May 29, 2008, 51 days later, wrote the mall property manager and the security supervisor requesting information about the June 30, 2007 incident. In particular, counsel requested information about the licence plate number or insurance information for the vehicle involved in the collision with Mr. Berhe.

[29] On June 3, 2008, the head of security at the mall contacted a law clerk at the Fund's legal branch, and the security officer advised the clerk of the licence number of the vehicle that had been involved in the collision.

[30] The information about the licence number was then used to complete a licence plate search, and the vehicle was identified as being insured by Lombard at the time of the incident at the mall.

[31] Pursuant to s. 3 (1) of Ont. Reg. 283/95, the Fund sent out a notice to Lombard on June 4, 2008, and the notice was received at Lombard's offices on June 5, 2008. Subsections 3 (1) of Ont. Reg. 283/95 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.

[32] I pause again in the factual narrative to note that Arbitrator Novick held that the Fund's notice to Lombard was out of time. She calculated the 90-day period as commencing on February 11, 2008 and as having expired on May 11, 2008, some three and half weeks before the notice was received by Lombard. She found that the lateness of giving notice could not be excused under s. 3 (2) of the regulation.

[33] On October 10, 2008, the police forwarded to Mr. Scott another copy of the incident report of June 7, 2007.

Decision of Arbitrator Novick

[34] With the above factual background, Arbitrator Novick held that the requirements of OCF1 were clear and that when a claimant submits an application, he or she must include the MVA (Police) Report. The absence of the MVA (Police) Report meant that the application form was not a "completed application" when it was originally received on October 2007. It followed that time to give notice to another insurer under s. 3 (1) had not yet begun to run.

[35] However, Arbitrator Novick concluded that with the receipt of the incident report from the police on February 11, 2008 that the application form was deemed to be complete. She stated:

> In my view, the requirements of the OCF1 form are clear – when a claimant submits an application for benefits to the Fund, he or she must provide the two extra forms listed in Part II, as well as the police MVA report. If the police report is not submitted with the OCF 1, I find the Fund is correct in maintaining that they have not received a completed application for benefits. I appreciate that there will be circumstances in which a police report may not be easily obtained, and it would be unfair to penalize a claimant by not requiring the Fund to pay benefits to them pending its receipt of the report. That is not the issue before me in this case, however, and I will not comment on the Fund's obligation on that context. ....
>
> ... I find that the receipt of Mr. Berhe's application by the Fund on October 26, 2007, which did not attach a police report, did not constitute a "completed application for benefits". As such the 90-day clock cannot be said to have started on that date. ....
>
> While the Incident Report generated from that visit contains some useful information about what transpired on June 30, 2007, it is clearly not a Motor Vehicle Accident (Police) Report as contemplated in Part 11 of the OCF1 form. Notably, it does not contain any information about the car that Mr. Berhe collided with. It would have been clear to Mr. Scott, however, and

> therefore to the Fund that as of February 11, 2008 when this report was forwarded by Mr. Berhe that there would be no MVA police report forthcoming. I find that the application was deemed to be "completed" at this point in time and that the 90-day period should begin on February 11, 2008.

[36] Having concluded that the application form was deemed complete as of February 11, 2008, Arbitrator Novick reasoned that under s. 3 (1) of Ont. Reg. 283/95, the Fund now had 90 days to give written notice to dispute its obligation to pay statutory benefits, unless s. 3(2) of the Act was available to extend the time for giving notice. Section 3 (2) states:

> 3 (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

[37] From her review of the evidence, Arbitrator Novick concluded that the Fund had not satisfied the onus of proving that 90 days was insufficient to make a determination that another insurer was liable to pay the statutory insurance benefits, and she concluded that s. 3 (2) was not available to permit the Fund to give notice after the 90-day period.

Nature of the Appeal

[38] Pursuant to their arbitration agreement, the parties agreed that there was a right of appeal on questions of law and mixed fact and law.

[39] The Funds' position is that the time to give notice to Lombard never began to run because a completed application was never received, or alternatively, the Fund submits that the time to give notice began to run when the Fund was informed about the licence plate of the motor vehicle involved in the collision and that the subsequent notice was timely. The Fund says that it is entitled to be reimbursed for the benefits paid and that it is also entitled to be reimbursed for the costs it incurred to investigate Mr. Behre's claim for benefits.

[40] Lombard appeals the Arbitrator's failure to find that the application form was completed as of October 23, 2007 and that the 90-day period for giving notice ran from that day and accordingly, the notice given in June 2008 was very late.

[41] The standard of review for this appeal is correctness on an issue of law and reasonableness on a question of mixed fact and law: *Personal Insurance Co. v. Allstate Insurance Co.*, [2009] O.J. No. 5021 (S.C.J.); *Oxford Mutual Insurance Co. v. Cooperators General Insurance Co.*, [2006] O.J. No. 4518 (C.A.).

[42] In my opinion, the case at bar raises the question of what are the appropriate legal principles to apply. This is a question of law. This is not a case of mixed fact and law, where it could be said that the Arbitrator identified the correct legal principles but arguably misapplied them. In such a case, the standard of appellate review would be the deferential standard of reasonableness. The case at bar is about the legal principles to apply in determining the meaning and operation of the concept of a "complete application" in ss. 2 and 3 of Ont. Reg. 283/95. Therefore, the standard of appellate review for this appeal is that of correctness.

[43] Based on the analysis that follows, I am allowing the appeal and dismissing the cross-appeal because, in my opinion, the Arbitrator erred in law in her interpretation of s. 3 of Ont. Reg. 283/95 in the circumstances of this case.

Analysis

[44] In my opinion, Arbitrator Novick was correct in her approach to the case and in her reasoning with respect to the period between October 26, 2007 and February 11, 2008, at which time the Fund received a copy of the police incident report but not a MVA (Police) Report. For this period, she held that the Fund had not received a "completed application" because the application submitted on Mr. Berhe's behalf had not included a MVA (Police) Report, and she reasoned, therefore, that the 90 day period stipulated in s. 3(1) of Ont. Reg. 283/95 had not begun to run.

[45] For the period up until February 11, 2008, as I will explain, her reasoning is correct, both as a matter of the policy, as a matter of interpreting Ont. Reg. 283/95, and as a matter of the case law. However, for the period after February 11, 2008, Arbitrator Novick decided that Fund had received a "completed application" as of February 11, 2008. In my opinion, this decision is not correct as a matter of policy, interpretation, or the case law.

[46] As a matter of policy, the legislative purpose of requiring a "completed application" is to ensure that the insurer who receives the application form has the information it needs: (1) to perform its legislated obligations and (2) to exercise its legislated rights.

[47] The insurer's legislated obligations begin in s. 2 of the regulation which requires a "completed application." Section 2 states:

> 2. 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.

[48] As I read the case law about the interpretation of the requirement in s. 2 of a "completed application," the first insurer must carry out its legislated obligations if it receives: (1) a genuinely completed application; or (2) an application, which although inaccurate or incomplete in some particulars, is nevertheless functionally adequate.

Further, pursuant to the doctrines of waiver or estoppel, by its conduct a first insurer may be treated as if it had received a completed application.

[49] From a policy perspective, the goal of s. 2 of the regulation is to have the first insurer promptly assume the obligation of paying benefits, and this purpose is facilitated by interpreting a "completed application" to be a genuinely completed application, a functionally adequate application, or an application that as a result of the first insurer's conduct should be treated as a "completed application."

[50] The first insurer, however, also has rights associated with a "completed application." Under s. 3 of the regulation, the first insurer has the right to dispute its obligation to pay benefits if it gives written notice within 90 days of receipt of a completed application.

[51] In this context of exercising its rights, a completed application is needed not for the purposes of performing the first insurer's obligations to pay benefits but rather it is needed for the first insurer to exercise its right to dispute its obligation to pay benefits. In this context, a first insurer would be able to exercise its rights if it receives: (1) a genuinely completed application; or (2) an application, which although inaccurate or incomplete in some particulars, is nevertheless functionally adequate. Further, once again, under the doctrines of waiver or estoppels, there are situations where a first insurer by its conduct might be treated as if it had received a completed application.

[52] Turning to the case law, the following propositions have been established:

- A "completed application" need not be compliant with a particular form provided that the insured provides the essential information with sufficient particulars to allow the insurer to process and access the claim: *Liberty Mutual Insurance Co. v. Commerce Insurance Co.*, [2001] O.J. No. 5479 (S.C.J.); *ING Insurance Co of Canada v. TD Insurance Meloch Monnex*, [2009] O.J. No. 1589 (S.C.J.).

- In determining whether an application is completed, it is appropriate to look beyond the form itself to determine if the required information has been provided to the insurer: *Primmum Insurance Company and Allstate Insurance Co.* (March 23,2007, Arbitrator M. Guy Jones), appeal dismissed *(Allstate Insurance Co. v. Primmum Insurance Company)* November 26, 2007; *State Farm Mutual Insurance Company and Lloyd's of London Insurance Company, the Toronto Transit Commission and Economical Mutual Insurance* (January, 2002, Arbitrator M. Guy Jones).

- A "completed application" may contain incorrect information provided that the insured provides the essential information with sufficient particulars to allow the insurer to process and access the claim: *Ontario (Min. of Finance) v. Royal & SunAlliance* (January, 2003: Arbitrator M. Guy Jones).

- A "completed application" may by missing administrative details or have minor technical deficiencies and nevertheless be a completed application: *Allianz*

Insurance Company of Canada and Dominion of Canada General Insurance Company (June 2006, Arbitrator M. Guy Jones.).

[53] In *ING Insurance Co. of Canada v. State Farm Insurance Companies* (2009), 97 O.R. (3d) 291 (S.C.J.), Justice Strathy stated at para. 44 [emphasis added]:

> The introduction of a judge-made exception, crafted for another purpose, into the interpretation of "completed application" in s. 3 of the Regulation would not benefit either the motoring public or the insurance industry. Surely it is in the interests of the insurance industry to have certainty regarding the commencement of a limitation period. This is achieved by saying that "completed application" in s. 3 means an application in the OCF-1 form, except in those relatively rare cases where -- whether because of waiver, estoppel, delay or deflection -- an insurer who has not received the form has been treated as being the "first insurer" for the purposes of s. 2. For the reasons expressed by the Arbitrator, this is manifestly not one of those cases.

[54] Lombard relies on this statement from Justice Strathy in support of the argument that a completed application in s. 3 simply means an application in the OCF1 form and that such an application was received in the case at bar in October 2007 and it is in the interests of certainty regarding the commencement of a limitation period that it be treated as a completed application.

[55] Justice Strathy's judgment, however, does not support this argument. Properly read, Justice Strathy's judgment supports the proposition that the application received by the Fund in October 2007 was not a completed application.

[56] The facts of *ING Insurance Co. of Canada v. State Farm Insurance Companies* were that before receiving an application at all, ING as the first insurer began to process and pay the claim based on information it had received before the claimant had submitted its claim. The formal application came later, and after making further inquiries, ING concluded that the claimant was not within its coverage. ING then sent a notice of dispute to State Farm, which took the position that the notice was late because ING should be treated as having received a completed application from the moment it began to process the claim. Justice Strathy agreed with the arbitrator that ING should not be treated in this manner and that the running of the limitation period should begin with the receipt of the OCF1 form.

[57] I think that Justice Strathy's decision is correct, but it does not directly speak to the problem of the case at bar. Neither the arbitrator nor Justice Strathy in the *Ing Insurance* were being asked to address when an OCFI application was a "completed application." Rather, they were asked whether something other than an OCFI application would trigger the running of the limitation period as a completed application. They decided that something other than an OCFI application was not a completed application but they did not address when the OCFI form itself should be regarded as a completed application.

[58] The decisions of the arbitrator and of Justice Strathy in *ING Insurance Co. of Canada v. State Farm Insurance Companies*, however, do support the proposition that a "completed application" must be one that provides the essential information with sufficient particulars to allow the insurer to process and access the claim for benefits. In this regard, it may be noted that in refusing to treat ING's conduct as sufficient to commence the running of the notice period, the arbitrator in the case drew attention to the importance of receiving the OCFI form. Thus, the arbitrator stated in his decision:

> I do not think that it is appropriate to conclude that payment of two minor medical expenses is somehow an action which precludes the insurer from continuing to acquire a completed application nor is it a statement that the information provided to date constitutes a completed application. As fulsome as the information available to the insurer might be, it was not sufficiently complete to allow them to give a notice of dispute to another insurer. It did not include the disclosure authorization. In my view, it would make no sense to say that incomplete information starts a time limit running, which the insurer would be incapable of meeting absent disclosure authorizations.

[59] Earlier in his Reasons for Decision, the arbitrator stated:

> If the insurer has not sufficient authorization to allow them to legally communicate with another insurer, then the insurer cannot give notice of dispute and preserve its priority rights. Therefore, in the context of initiation of a priority dispute between insurers, I must conclude that the completed application includes not only sufficient information as to allow an insurer to understand and respond to a claim, but also requires sufficient authorization as to allow an insurer to give the notice of disputes required by the regulation. To hold otherwise would contemplate situations where an insurer would be unable to exercise the rights that the statute has created to recover indemnity from higher priority insurers. Of course, I am loath to give such an interpretation to the scheme.

[60] In *ING Insurance Co. of Canada v. State Farm Insurance Companies*, Justice Strathy agreed with the reasoning of the arbitrator and he dismissed the appeal. I also agree with the reasoning of the arbitrator in the *ING Insurance Co. of Canada* that it makes no sense to say that incomplete information starts a time limit that an insurer would be incapable of meeting without the necessary information.

[61] In the case at bar, all that happened on February 11, 2008 was that the Fund learned that it would not be receiving the information it needed to dispute its obligation to pay benefits through the medium of a MVA (Police) Report. In my opinion, this triggered an obligation on the Fund to pursue this information elsewhere, which is what it did, but it did not create a situation where the Fund should be deemed to have received a completed application, when it clearly had not received a completed application.

[62] There was no fair basis to deem the fund to have received a completed application. It had not received a genuinely completed application. It had not received a functionally completed application. It had not received external information that would supplement the standard form and make it complete. There was nothing in the Fund's conduct that would be the basis for estopping it from asserting that it had not received a completed application.

[63] I understand that it is very rare that it would be impossible to obtain a MVA (Police) Report, and thus the circumstances of this case presented a rare problem. In my view, the correct solution for that rare problem was to treat the application form as a completed application for the purposes of having an insurer (the Fund) promptly pay benefits but not as a completed application for the different purposes of allowing the insurer to exercise its rights to dispute its obligation to pay those benefits, provided that the insurer continues to take steps to ascertain the missing information.

[64] This solution provides a consistent interpretation of what amounts to a completed application; namely, an application that completes its purpose of providing the essential information for an insurer to assume its obligations and to exercise its rights. Under this solution, an insurer would not be able to delay making payments if it had sufficient information for that purpose, but paying benefits would not trigger the running of the 90-day limitation period, much in the same way that paying benefits did not trigger the running of the 90-day limitation period in *ING Insurance Co. of Canada v. State Farm Insurance Companies*.

[65] Returning to the case at bar, in my opinion, the Arbitrator erred in law in deciding that the application was a completed application on February 11, 2008. In my opinion, applying the correct law to the facts as found by the Arbitrator, the application was a completed application on June 3, 2008. It follows that the notice a few days later to Lombard was a timely notice.

The Repayment to the Fund

[66] The consequences of my conclusion that the Arbitrator erred in law in her interpretation and application of s. 3 of Ont. Reg. 283/95 is that her award should be set aside, and that there should be an order declaring that Lombard is liable to pay the ongoing statutory accident benefits, if any, of Mr. Berhe.

[67] It also follows that Lombard should reimburse the Fund for the accident benefits already paid to Mr. Berhe.

[68] In its notice of appeal, the Fund also claimed repayment of "all adjusting and investigating fees, expenses and costs paid to date."

[69] There, however, is a dispute about whether Lombard should also pay these costs. In her arbitration award, Arbitrator Novick stated: "[I]n view of the above result, I make no findings regarding my jurisdiction to order repayment of the costs incurred by the Fund in investigating this matter."

[70] There is a divergence in the arbitration case law and no judicial pronouncement about whether an arbitrator on a priority dispute has the jurisdiction to award a reimbursement beyond the repayment of the statutory benefits.

[71] This issue is discussed in the arbitration decision *Her Majesty the Queen in Right of Ontario as Represented by the Minister of Finance v. Lombard General Insurance Company of Canada and Kent & Essex Mutual Insurance Company* (August 14, 2009, B.R. Robinson, Arbitrator). In that case, Arbitrator Robinson reviewed several arbitration decisions, and he concluded that the jurisdiction existed, and he tied it to the principle of unjust enrichment and to the arbitrator's equitable and statutory jurisdiction to order restitution.

[72] I agree with Arbitrator Robinson that in the circumstances of resolving a priority dispute between insurers under Ont. Reg. 283/95 that an arbitrator has the jurisdiction to order reimbursement beyond repayment of the statutory benefits. In my opinion, this jurisdiction is provided by ss. 1 and 7 of Ont. Reg. 283/95. Section 1 provides that "all disputes as to which insurer is required to pay benefits under s. 268 of the Act shall be settled in accordance with this Regulation." Section 7 provides that "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.*"

[73] In the case at bar, the arbitration agreement between the parties included as an issue in dispute, the following:

> If so, is the Fund entitled to recover the costs it has incurred beyond the benefits it has paid out is liable to pay Mr. Berhe under the *Statutory Accident Benefits Schedule*? Specifically, can the fund recover the costs incurred in its investigation of this matter, and if so, what is the proper amount owed by Lombard?

[74] I also agree that this jurisdiction is tied to the idea of unjust enrichment, which entails that the costs for which reimbursement is being sought are costs that were incurred for the ultimate benefit of the insurer that will assume responsibility for the statutory benefits. Put differently, the first insurer cannot recover for costs that do not benefit the insurer assuming responsibility for the statutory benefits. In the case at bar, the connection to unjust enrichment entails that the Fund would not necessarily be held harmless for all expenses and costs it paid to date. Rather, it would be entitled to recover only those costs that unjustly enriched Lombard because Lombard is saved having to incur those expenses.

[75] Unfortunately, Arbitrator Novick did not rule on the issue of whether Lombard should also pay <u>all</u> adjusting and investigation fees, expenses and costs paid to date. If the parties cannot agree about these items, then the matter should be referred back to the arbitrator to decide the matter on the basis of the principles of unjust enrichment.

<u>Conclusion</u>

[76] An order should issue in accordance with these Reasons for Decision.

[77] If the parties cannot agree about the matter of costs, then they may make written submissions beginning with the Fund within 20 days of the release of these Reasons for Decision followed by Lombard's submissions within a further 20 days.

Conclusion

[78] Order accordingly.

Perell, J.

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Released: March 25, 2010

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