Developing the Bad Faith Claim Against the First Party Auto Insurer

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OTLA Winning the Bad Faith Case IV

ONTARIO TRIAL LAWYERS ASSOCIATION

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Ontario law recognizes quite clearly the statutory accident benefit insurer's duty of the utmost good faith to its insured and its potential liability for punitive damages should it be breached.

As recently as February 9, 2004, Justice Himmel in *Alfred v. Allstate Insurance Company* [2004] O.J. No. 848 stated in regard to a bad faith claim arising from a SAB insurer's denial of home modifications:

> "The legislation under which the claim is made by the plaintiff is remedial legislation and must be given a broad and liberal interpretation...In my view, under the contract of insurance, the insurer is obligated to treat the insured with good faith and to approve reasonable expenses that arise as a result of the accident."

The difficulty arises, however, when counsel for a party injured in a motor vehicle accident is attempting to determine just what actions by the SABS carrier will result in it being ordered to pay punitive damages.

In *Alfred v. Allstate*, Justice Himmel incorporated the Court of Appeal's statement from *702535 Ont. Inc. v. Lloyds Non-Marine Underwriters* (2000) 184 D.L.R. (4th) 687 into the SAB bad faith action and stated:

> "The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement.
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> A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith...
>
> In some cases, the risk of being found liable for consequential damages resulting from unsuccessfully contesting a claim under a policy would constitute a substantial disincentive for insurers to deny claims, even those which they reasonably and in good faith, consider to be either unfounded or inflated. In a general sense, insurers and insureds have a common interest in ensuring that only meritorious claims are paid. Increased payments by insurers lead to increased premiums for insureds.
>
> In order to effectively screen claims, insurers must be free to contest those claims, which in good faith, they have reason to challenge, and without running the risk that if they are ultimately found to be wrong, they will be liable to indemnify

> the insured for losses not underwritten in the policy contracted for by the insured."

The case of *Ambrosie v. Wawanesa Mutual Insurance Co.* [2002] O.J. No. 67 is an example of a judicial reluctance to award punitive damages where the breach of contract arises from the *Statutory Accident Benefits Schedule*. In *Ambrosie*, Justice Daudlin made the following findings of fact in an action claiming income replacement benefit arrears and damages for bad faith where he ordered the insurer to pay 7½ years of income replacement benefits wrongfully denied:

1. The benefits were denied in March of 1994 "in the face of notification in January 1994 by their rehabilitation consultant that the plaintiff was not likely to return to gainful employment".

2. In the year preceding the termination of benefits (in addition to the plaintiffs' evidence), the insurer had three independent medical examinations affirming the plaintiff's disability with the caveat she may get better or she may not.

3. No further defence medical report was conducted until 5 years after the denial. This defence medical report supported the insurer's denial. This report was characterized by the court as:

   i. Riddled with errors; and

   ii. Seriously flawed and clearly unreliable.

Notwithstanding what I would have thought was a fertile factual situation for an award of punitive damages, the court found:

> "After review of all of the facts of this case and considering the law presented by both sides as it relates to the issue of aggravated damages and punitive damage, I am persuaded that though perilously close the defendant has not so breached the expressed or implied conditions of the policy and statutorily mandated conditions as to warrant a finding of bad faith."

The court found as part of the basis for denying punitive damages:

> "I am persuaded that the statutory interest rate maintained and awarded adequately compensates the plaintiff and the conduct of the defendant was not so egregious as to warrant a finding of bad faith nor the award of punitive or aggravated damages and I would dismiss the claim therefore."

It is almost certain that had this case been arbitrated a FSCO, the arbitrator would have granted a special award in excess of $50,000.00.

For example, less than 3 months ago, Arbitrator Miller, at the Ontario Financial Services Commission, made a similar ruling and declared an insurer had wrongfully denied income replacement benefits to its insured. In the decision of *Amato v. Wawanesa Mutual Insurance Co.* [2003] O.F.S.C.D. No. 180. Arbitrator Miller stated:

> "Clearly, in the face of the above medical evidence, Wawanesa's termination of benefits was unreasonable. At a minimum with these medical findings, Wawanesa should have had Mr. Amato re-examined before terminating his benefits...
>
> Terminating an applicant's income replacement benefits is a very serious matter with potentially serious consequences. An insurer contemplating the termination of income replacement benefits or maintaining a denial, must act reasonably and consider all of the documentation before it. An insurer cannot pick and chose information that favours its own position while ignoring relevant information that favours the applicant...
>
> Wawanesa not only unreasonably delayed paying Mr. Amato his income replacement benefits, but also it unreasonably terminated Mr. Amato's income replacement benefit on October 24, 2000. Moreover, Wawanesa continued to unreasonably withhold this benefit after October 24, 2000 in the face of cogent, reliable medical evidence that should have been considered. The result of the unreasonable withholding of benefits unnecessarily caused Mr. Amato financial hardship which affected his health.

> ...pursuant to subsection 282(10) of the *Insurance Act*, Mr. Amato is entitled to a special award of $40,000.00 inclusive of interest."

In *Ambrosie v. Wawanesa Mutual Insurance Co.*, the court made no reference to this entitlement being barred to the insured by choosing to litigate the issue as opposed to arbitrating.

If the courts are going to use the 24% statutorily mandated prejudgment interest rate as a basis for finding an otherwise valid claim for punitive damages has already been compensated, then we will be travelling a tough road ahead in obtaining punitive damages arising from acts of bad faith by auto insurers related to the provision of statutory accident benefits to their insureds.

To Litigate for Bad Faith Damages or to Arbitrate for a Special Award

No other insurance contract in the Province of Ontario has a statutorily declared punishment for an insurer unreasonably withholding or delaying payment of SAB benefits as is provided in motor vehicle insurance.

Section 282(10) of the *Insurance Act*, R.S.O. 1990, c. I-8, as amended, provides that:

> If the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the no fault benefit schedule, shall award a lump sum of up to 50% of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2% per month, compounded monthly from the time the benefits first became payable under the schedule.

One must seriously consider the usefulness of claiming punitive damages in court arising from a SAB denial when the effect is to lose the benefit of Section 282(10).

However, it is my belief that in the proper case, judges and juries who have been properly instructed in the statutory accident benefit scheme, will award substantial punitive damages.

In order to accomplish this, I offer the following considerations:

1. Pleadings

In addition to particularizing in as much detail as possible, the alleged acts of bad faith, use the pleadings to instruct the court. Many judges will not be familiar with the SAB legislation. You do not want the court to conclude upon being presented at trial for the first time with the intricacies of the *Statutory Accident Benefit Schedule* and its detailed dispute resolution mechanism that they have little interest. Use the pleadings to ensure that the court understands how the benefit schedule intends insurers to always use the utmost good faith and that if the insured had arbitrated a denial and an arbitrator has ruled the denial unreasonable, then a significant special award (quasi) is mandatory.

I have attached a draft pleading to the end of this paper which has been my attempt to accomplish the above.

2. Use the FSCO Decisions

There is a dearth of judicial authority interpreting unreasonable denials or delays by statutory accident benefit insurers. The Financial Services Commission, however, has 14 years of detailed and lengthy arbitration decisions particularizing the duties of and the manner of how a SAB insurer should act. Use these decisions to constantly remind the court that this is first party coverage. I would recommend delivering to the judge at the beginning of the trial a statement of law quoting extensively from the rulings of the FSCO arbitrators, the statutory accident benefit insurer's duties and obligations.

3. Remind the Insurer

Too often the insurer is allowed to forget that their wrongful acts have serious consequences. If the wrongfully denied benefit is harming your client's rehabilitation, get the treating physician to say so and forward it immediately to the insurer. It is not enough to simply do it once every six months, do it monthly. Have the expert point out to the insurer quite

clearly that the effective window to maximize rehabilitation is being closed by the passage of time. If the denial concerns income replacement benefits, tell the insurer if your client's mortgage is in arrears or if the family's children are having to do without items they require.

4. Keep a Record

All too often, insurers insist that the insured cross every "t" and dot every "i" in applying for a benefit while completely ignoring their own obligations. I recommend that early on in the case you prepare a detailed chronology of all of the acts by the insurer that were a breach of their procedural obligations in addition to their substantive breaches. To this end, I urge you to keep making valid claims notwithstanding that they may also be denied.

5. Obtain Your Witnesses Through Correspondence

Ask the adjuster more than once to have not only the denial but the entire file reviewed by their supervisor, claims manager and legal counsel to ensure that what the insurer is doing to their insured is known and

affirmed by senior representatives at the insurance company and not the acts of a rogue employee. If the adjuster refuses to advise you if this is done, simply copy the letter to the president of the insurance company with a note that the employee will not respond to your request. This will result in the denial in the claim being reviewed by the above noted individuals who can then be identified, their files produced, and potentially, summoned at the trial.

6. Keep the Insurer Busy

I strongly recommend that while your case is proceeding to trial, you continue to add to the acts of bad faith by applying as much as possible for more benefits. If the insurer continues its acts of bad faith through wrongful denials from the time the statement of claim is issued to trial, their position will be that much worse.

7. Improper Adjusting

Many insurers use the DAC system to adjust the claim. The DAC system is, in essence, an interim injunction while the parties resolve the dispute.

However, the DAC's do not create a dispute. In order for a DAC to become involved, the SAB insurer must have already denied the claim. It is an act of bad faith by the insurer to deny a benefit for no reasonable reason and relying on the DAC system to hopefully prove them right. [1]

It has always amazed me that prior to a termination of benefits by insurers providing long-term disability benefits, an insurer's "medical team" typically reviews the claim and provides the adjuster with an opinion. In the over-worked and under-staffed adjusting world that makes up the Ontario motor vehicle insurance industry today, adjusters routinely deny benefits on no other basis then their own untrained and unqualified opinions. Ensure you document, in detail, these acts by the insurer.

8. Splitting Your Case

For many years, I believed that you either had to chose to arbitrate or litigate and that you could not "mix" the issues. However, last Spring, in a decision named *Bolger v. CGU Insurance Co. of Canada* (2003)

[1] This is potentially even more significant given that on March 19, 2004, FSCO proposed to place into effect, by the end of December 2004, a new DAC system. The conclusions of the new DAC "Assessors" are proposed to be "treated as prima facie evidence in arbitration or court cases where no other compelling evidence is introduced to the contrary."

O.F.S.C.I.D. No. 88, Arbitrator Anne Sone ruled that an insured could arbitrate for certain benefits at the Financial Services Commission and at the same time, maintain an action in the courts for different benefits and punitive damages provided the statement of claim in the court action withdraws "all claims that may potentially overlap with the claims being decided at the arbitration."

Arbitrator Draper, on behalf of the Director of Arbitrations, denied the insurer's motion to appeal Arbitrator Sone's preliminary order. One of the uses of this technique is the obtaining through the bad faith action, productions and discovery evidence which would not otherwise be obtained at an arbitration, but very useful in proving an insurer's unreasonable withholding or denial of benefits.

9. Determine What the Insurer Sent to the DAC

The time must be taken to ensure that when the insurer sent the file information including the medical evidence to the DAC, that they did not omit evidence or opinions contrary to their denial. All too often, the insurer will omit evidence supporting the insured's claim and explain it

away as simply a clerical error. Ensure you examine for discovery on the manner in which the insurer prepares their medical brief and have the original produced at the examination for discovery which will hopefully allow you to create an inference that it begs credibility to conclude the omission was mere clerical error.

10. The Future

NEW LEGISLATION

Since October ~~1993~~ 2003, we have seen extensive amendments to the *Statutory Accident Benefits Schedule* and the Act. We have a new threshold and much more onerous and technical form requirements in order to obtain benefits.

If you are faced with an adjuster who is maintaining a rigid and technocratic approach to applications for benefits and refusing to consider them stating the forms are incomplete, remind them that Section 31(3.2) of the amended SABS provides this can only be done "if the insurer, after a reasonable review of the incomplete application, is unable to determine without the missing information if a benefit is payable".

On September 9, 2003, the Insurance Bureau of Canada, presented to the Ontario motor vehicle insurance industry, a satellite course on the new SABS. The IBC specifically stated in regard to a question about alleged incomplete applications that if the benefit is "otherwise needed the insurer should not deny payment if the collateral payment calculations are not completed."

OTHER PARTIES

Last summer, Justice Lane in the decision of *Lowe v. Guarantee Co. of North America* [2003] O.J. No. 3345 ruled there is no action against a DAC or its members for bad faith.

In addition, the law is unclear as to whether or not an adjuster can be sued personally for acts of bad faith. In favour of being able to claim from the adjuster personally, are the decisions of *Spiers v. Zurich* (1999) 45 O.R. (3rd) 726 and *Kogan v. Chubb* [2001] O.J. No. 1697. However, in the decisions of *Curtis v. State Farm* [2003] O.J. No. 3064 and *Burke v. Buss* [2002] O. J. No. 2938, the court has ruled:

> "The law in Ontario is that, assuming breach of the duty of good faith is a tort, it arises out of the contract between the insured and insurer and is not a tort for which an employee can be sued."

We will await the final word on this issue from our appeal courts.

Conclusion

Auto insurance in the Province of Ontario is changing at an ever increasing rate. If one is to claim bad faith damages from an insurer, it is incumbent upon counsel to stay ahead of the changes. Presently, many of the adjusters in the Province of Ontario, do not understand the new SAB legislation. This month the Insurance Bureau of Canada released figures showing the insurance industry's profits for 2003 soared to a record of $2.6 billion. A 673% increase over 2002!

It is the responsibility of the plaintiff's bar to bring meritorious bad faith cases before the courts. Remember, judges read newspapers too.