

**THE NEW CATASTROPHIC DEFINITION:
PARAPLEGIA, TETRAPLEGIA, AND SEVERE AMBULATORY IMPAIRMENT**

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INTRODUCTION

Effective June 1, 2016, the definition of catastrophic impairment (“CAT”) will change, pursuant to section 3.1(1) of Ontario Regulation 251/15 made under the *Insurance Act*.¹

This paper will focus upon the first two subsections of the new CAT definition:

1. (some forms of) paraplegia or tetraplegia [s. 3.1(1)(1)]; and
2. (some forms of) severe impairment of ambulatory mobility or use of an arm, or amputation [s. 3.1(1)(2)].

These sub-sections reference and incorporate the use of medical literature. The literature references disability measurement scales, namely: the ASIA Impairment Scale and the Spinal Cord Independence Measure (“SCIM”). These scales will make it more difficult for lawyers and insurers to make prompt CAT determinations. Further, the SCIM contains ambiguities that will further frustrate timely and conclusive CAT determinations.

Notably, ambiguity may actually lead to favourable outcomes for insureds. By analogy, if in baseball a “tie goes to the runner”, in insurance law a “tie goes to the insured”.

¹ Attached at **Appendix A**.

THE CAT DEFINITION: OLD VS. NEW

Old Wording

Under the old legislation², CAT was defined in section 3(2) of the *SABS*. In the old section 3(2), sub-sections (a) and (b) provide:

- a) paraplegia or quadriplegia;
- b) the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg.

New Wording

Under the new legislation, these two sub-sections are now defined in section 3.1(1), subsections (1) and (2) as follows:

(1) Paraplegia or tetraplegia that meets the following criteria:

- i. The insured person's neurological recovery is such that the person's permanent grade on the ASIA Impairment Scale³, as published by Marino, R.J. et al., *International Standards for Neurological Classification of Spinal Cord Injury*, Journal of Spinal Cord Medicine, Volume 26, Supplement 1, Spring 2003, can be determined.
- ii. The insured person's permanent grade on the ASIA Impairment Scale is **or will be**,

A. A, B, or C, or

B. D, and

1. the insured person's score on the Spinal Cord Independence Measure⁴, Version III, item 12 (Mobility Indoors), as published in Catz, A., Izkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III; Rasch psychometric validation*, Spinal Cord (2007) 45, 275-

² *Statutory Accident Benefits Schedule – Effective September 1, 2010*, O. Reg. 34/10 made under the *Insurance Act* [the *SABS*].

³ Attached at **Appendix B**.

⁴ Attached at **Appendix C**.

291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5,

2. the insured person requires urological surgical diversion, an implanted device, or intermittent or constant catheterization in order to manage a residual neuro-urological impairment, or
3. the insured person has impaired voluntary control over anorectal function that requires a bowel routine, a surgical diversion or an implanted device.

(2) Severe impairment of ambulatory mobility or use of an arm, or amputation that meets the following criteria:

- i. Trans-tibial or higher amputation of a leg.
- ii. Amputation of an arm or another impairment causing the total and permanent loss of use of an arm.
- iii. Severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person's score on the Spinal Cord Independence Measure, Version III, item 12 (Mobility Indoors), as published in Catz, A., Izkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III; Rasch psychometric validation*, *Spinal Cord* (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5.

Complications Arising from the New Definitions

i. Subsection (1): Paraplegia & Tetraplegia

The first obvious change is that “paraplegia” and “quadriplegia” (i.e. tetraplegia) are no longer terms that speak for themselves. Under the old legislation, from a practical standpoint, it was relatively simple and quick to determine if an insured fell within this sub-category of CAT. Typically, an OCF-19, OCF-3, Admission Note, Discharge Summary, or other medical record that was easy and quick to obtain would list “quadriplegia” or “paraplegia” as a diagnosis. That record was then sent to the insurer

and the adjuster could promptly conclude that the insured was CAT. No further inquiry was needed, no further testing was undertaken, and no further criteria had to be satisfied.

Under the new definition, “paraplegia” and “tetraplegia” are not stand-alone terms. They are defined by specific prescribed criteria and with reference to medical measurement scales. These criteria and scales will be reviewed later in this paper but it is interesting to point out that these criteria are a product of insurance legislation, rather than medical definition. For instance, a standard medical definition for “paraplegia” is⁵:

Paralysis [defined as loss of sensation or of muscle function] of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury...

This is a far less elaborate or complicated definition than what has been created in the *SABS*. In this medical definition, there are no qualifications based upon the ASIA Impairment Scale, no reference to the SCIM, no reference to urological equipment, and no reference to bowel function.

Similar discrepancies become apparent when searching the definition of tetraplegia and comparing it to the *SABS* criteria.

ii. Subsection (2): Severe Ambulatory Impairment

In the same way that the definitions of “paraplegia” and “tetraplegia” have been complicated by the new legislation, so has the definition for severe ambulatory impairment.

⁵ Mikel A. Rothenberg et al., *Dictionary of Medical Terms*, 3d ed. (New York: Barron's Educational Series, Inc., 1994) s.v. “paraplegia” and “paralysis”.

First, with respect to the amputation of a *leg*, under the old legislation the amputation of a leg unequivocally meant the insured was CAT. Now, under section 3.1(1)(2)(i), the amputation must be “trans-tibial or higher” for a CAT determination.

Second, under the old legislation a total and permanent loss of use of *a leg or an arm* would result in a CAT determination; however, under the new section 3.1(1)(2)(ii), the total and permanent loss of use criterion can only be relied upon if it applies to *an arm*. This criterion is now redundant given the fact that the total and permanent loss of use of an arm already qualifies as a 60% whole person impairment (“WPI”) under the American Medical Association’s *Guides to the Evaluation of Permanent Impairment*⁶ (i.e. CAT by other means).

Third, while the new “*severe and permanent alteration of structure and function*” subsection [3.1(1)(2)(iii)], which applies only to legs, might at first glance appear to be a wholly new expansion to the CAT definition, the changes are not as helpful as they might seem.

For instance, insureds who have a severe and permanent alteration of structure and/or function to their leg(s) might already be CAT on the basis of a 55% WPI or higher. By way of illustration, wheelchair dependency is considered to be an 80% WPI under the *AMA Guides*⁷.

⁶ 4th ed. (Chicago: American Medical Association, 1993) c.3 at 19 [the *AMA Guides*].

⁷ *Ibid.* c.3 at 76.

Additionally, this sub-category is reliant upon a certain score being achieved under the SCIM. This medical measurement scale contains some inherent uncertainties that will be discussed later in this paper.

THE ASIA IMPAIRMENT SCALE

Overview of the ASIA Impairment Scale

To qualify under the new definition of “paraplegia” and “tetraplegia”, we must now focus upon an insured’s grade on the ASIA Impairment Scale.

The ASIA Impairment Scale involves a neurological examination of sensory and motor function.⁸ The sensory examination looks at the insured’s appreciation of light touch and pin prick sensation at several key points, measured on a three-point scale: 0 (absent), 1 (altered), or 2 (normal).⁹ The motor examination measures the strength of key muscle functions on a six-point scale: 0 (total paralysis), 1 (palpable or visible contraction), 2 (active movement, full range of motion with gravity eliminated), 3 (active movement, full ROM against gravity), 4 (active movement, full ROM against gravity and moderate resistance in a muscle specific position), 5 (normal active movement, full ROM against gravity and full resistance in a muscle specific position expected from an otherwise impaired person).¹⁰ The examiner may also indicate that a point is not testable (NT).

⁸ Burns et al. “International Standards for Neurological Classification of Spinal Cord Injury, Revised 2011” (2012) 18(1) Top Spinal Cord Inj Rehabil 85-99 at p. 89.

⁹ *Ibid.*

¹⁰ *Ibid.* at p. 92.

A grade is then assigned based upon the degree of injury as follows¹¹:

A = Complete. No sensory or motor function is preserved in the sacral segments S4-S5.

B = Sensory Incomplete. Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5, AND no motor function is preserved more than three levels below the motor level on either side of the body.

C = Motor Incomplete. Motor function is preserved below the neurological level, and more than half of key muscle functions below the single neurological level of injury have a muscle grade less than 3 (Grades 0-2).

D = Motor Incomplete. Motor incomplete status as defined above, with at least half (half or more) of key muscle functions below the single neurological level of injury having a muscle grade ≥ 3 .

E = Normal. If sensation and motor function as tested with the ISNCSCI are graded as normal in all segments, and the patient had prior deficits, then the AIS grade is E. Someone without an initial SCI does not receive an AIS grade.

Under the new legislation, an insured is unequivocally CAT based upon an ASIA Impairment Scale grade of A, B, or C. The CAT determination can also be made based upon a grade of D; *however*, the insured must then satisfy one of three further criteria related to: urological dysfunction, bowel dysfunction, or mobility impairment according to the SCIM.

Concerns with Incorporating the ASIA Impairment Scale

The ASIA Impairment Scale is considered to be a valid and objective scale that *can* offer consistency between assessors.¹² That it can, does not mean that it *will*. Apart from potential inter-assessor variability, other challenges are predicted.

¹¹ *Ibid.* at p. 96.

¹² Dr. Harold Becker, Letter to Senior Policy Analyst, *The Financial Services Commission of Ontario* (12 May 2011) 2.

First, ASIA impairment grades are not necessarily found in every hospital chart and, certainly, lawyers and adjusters are not qualified to assign a grade to an insured. In fact, the ASIA Impairment Scale does not define who or what kind of health care professional is duly qualified to conduct the examination and assign a grade. Discrepancies in scores could arise from discrepancies in the examiner.

Second, the new definition requires that the person's "neurological recovery is such that the person's *permanent* grade" can be determined. Query what will happen if one medical expert concludes that the insured has reached sufficient neurological recovery to assign a permanent grade, whereas another prefers a "wait and see" approach after some period of active rehabilitation.

Third, section 3.1(1)(1)(ii) does not require that the person's permanent ASIA grade *presently* be A, B, C, or D (+ other criteria); rather, if the ASIA grade "*will be*" A, B, C, or D (+ other criteria) then the insured is CAT. The words "will be" expand the definition of CAT by including insureds whose injuries may not presently meet the requisite ASIA grades but will in future when consideration is given to such factors as: the insured's prognosis; natural progression of his or her injury; the likelihood of future deterioration, surgeries, secondary complications, and/or deconditioning; and/or the compounding impact of aging.

With respect to the issue of aging, it is important to keep in mind that the test for causation in accident benefits is “material contribution”¹³. We submit that if the impairment is not CAT until it is compounded by the natural “wear and tear” that comes with aging, it matters not that “wear and tear” is not accident-related. All that matters is that the initial injury materially contributes to the severity of the impairment. A CAT determination, though it may be made with consideration to future disability, is a determination that is made in the present. So should someone who will be CAT at age 80 be considered CAT now?

Reliance upon the ASIA Impairment Scale will likely lead to more examinations, more costs, and more delays before a CAT determination is made. This will especially be so for those who score only a grade D on the ASIA Impairment Scale in that they will have “won only half the battle.”

THE SPINAL CORD INDEPENDENCE MEASURE

Overview of the Spinal Cord Independence Measure

As noted earlier, the SCIM is referenced as part of the criteria for meeting the CAT definition if either: a) an insured scores a D on the ASIA Impairment Scale or b) an insured claims to have a severe and permanent alteration of structure or function in his or her leg(s).

The SCIM typically measures 17 different functions: feeding, bathing (upper and lower body), dressing (upper and lower body), grooming, respiration, sphincter management -

¹³ *Monks v. ING Insurance Company of Canada*, [2008] ONCA 269 (CanLII) at paras. 87-92.

bladder, sphincter management – bowel, use of toilet, transfers: bed-wheelchair, transfers: wheelchair-toilet-tub, mobility indoors, mobility for moderate distances (10-100 meters), mobility outdoors (more than 100 meters), stair management, transfers: wheelchair-car, and transfers: ground-wheelchair.

Notably, the new CAT definition does not incorporate the full SCIM. Rather, it incorporates only 1 of the 17 sub-scales: “mobility indoors”.

Also of note, on the SCIM, the “mobility indoors” sub-scale is broken down into scores ranging from 0-8; however, the new CAT definition will only be satisfied if an insured achieves a score ranging from 0-5. The full scores are noted below:

0. Requires total assistance
1. Needs electric wheelchair or partial assistance to operate manual wheelchair
2. Moves independently in manual wheelchair
3. Requires supervision while walking (with or without devices)
4. Walks with a walking frame or crutches (swing)
5. Walks with crutches or two canes (reciprocal walking)
6. Walks with one cane (**excluded from CAT definition**)
7. Needs leg orthosis only (**excluded from CAT definition**)
8. Walks without walking aids (**excluded from CAT definition**)

Concerns with Incorporating the SCIM

First, the fairness of taking only part of a 17-component scale, and further taking only one part of that one chosen sub-scale is questionable. Rather than taking a robust, global assessment of mobility function, this new definition “cherry picks” one component of mobility.

Second, the other mobility sub-scales that have been excluded from the new CAT definition are ones that would perhaps better identify or reflect “real life” functional disabilities.

For example, the sub-scale “mobility for moderate distances (10-100 meters)” has been excluded from the CAT definition. That means that the fact that someone may be able to walk 10 meters indoors without assistance but not 11 meters is irrelevant under the new definition. The problem with arbitrarily cutting off the mobility range at 10 meters is that in “real life” more than 10 meters is required to “get around.” Someone who can walk 10 meters indoors without assistance, but not walk from a hospital entrance to the examining room 40 meters away would not be CAT under any sub-category that references the SCIM.

Third, there is no guidance in either the SCIM itself or the legislation as to the conditions under which the testing is to be undertaken. This can lead to ambiguities in scoring and, therefore, CAT determinations. Again, this will lead to further examinations, costs, and delays.

Ambiguities Arising from the SCIM

Below is a list of areas of potential ambiguity that may arise from testing under the SCIM.

i. Point in Time

Recall that when dealing with the definition of paraplegia and tetraplegia under section 3.1(1)(1)(ii), the words “or will be” are used to indicate that an insured’s future ASIA grade may be considered when determining if he or she is CAT. Comparatively, when dealing with the definition of severe ambulatory impairment under section 3.1(1)(2)(iii), there is no specific “cue” to the future; the legislation simply reads:

Severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person’s score on the Spinal Cord Independence Measure....and applied over a distance of up to 10 meters on an even indoor surface is 0 to 5.

It is not clear, therefore, when testing under the SCIM is to be conducted. This may lead to questions when injuries are permanent and are known to have severe consequences but those severe consequences may not develop until well into the future.

Consider an insured who suffers a crush injury to his or her foot and ankle. One of the fractures extends into the ankle joint. Open reduction and internal fixation surgery is required immediately (“ORIF”). Post-operatively, the insured requires crutches for six weeks, after which he or she manages with only a single can. Three months post-accident, the insured is walking without any mobility aids at all. The long-term prognosis for this insured, known from the very outset of injury, includes: arthritis and future surgery/surgeries down the line, including ankle replacement and/or ankle fusion.

The insured retained someone to test him or her under the SCIM three weeks post-ORIF while he was still walking with crutches to get 10 meters indoors. He is sent for an IE,

which does not take place until six months post-crash, by which time the insured does not need any walking aids. Is this insured CAT or not?

Notably, in the 2014 decision of *Waldock v. State Farm Mutual Automobile Insurance*¹⁴, when determining whether an insured's orthopaedic injuries were CAT, Arbitrator Knox considered testimony by an orthopaedic surgeon that the insured was facing significant risk of developing arthritis and infection in the injured right knee, as well as a likelihood of future worsening of limitations and further surgeries. This decision arguably marked the first time that an Arbitrator incorporated *future* impairments into a *current* CAT determination. This decision may be helpful when applying and/or interpreting the new section 3(1)(2)(iii) in future.

ii. Time of Day

Another issue is the time of day at which testing under the SCIM is undertaken. For many paraplegics and individuals living with severe orthopaedic injuries, their "real life" level of functioning depends upon the time of day. In the morning, after sleeping for hours without real movement or activity, it can often be difficult for people with these types of injuries to "get up and get going." It can be a very slow process that may first require some stretching or manipulation by a rehabilitation therapist.

Consider an insured who is sent for an insurer examination ("IE") with respect to the SCIM at 1 p.m. after he or she has had physiotherapy earlier that morning. He or she has "loosened up" and is able to walk up to 10 meters indoors with only a cane. A rebuttal report, however, is obtained based upon testing that took place at 8 a.m. when the insured

¹⁴ FSCO A13-001725 (10 November 2014).

was still tight from getting up in the morning and needed crutches. Is this insured CAT or not?

iii. Activity Level

Another functional variable for many individuals with paraplegia and severe orthopaedic injuries is the level of activity that has been undertaken in the day.

Consider an insured with a serious ankle injury who undergoes an IE at 10 a.m. By that hour, he or she had not had to stand much on the ankle and, therefore, is able to get by with only one cane. The IE assessor leaves, concluding that the insured is not CAT. The insured carries on with his or her day, trying to engage in some normal activities of daily living. By 6 p.m., the ankle is swollen, painful, weak, and the insured is exhausted. He or she has to resort to using a walker to get around the home and give the ankle some much-needed respite. Is this insured CAT or not?

iv. Weather

Another “real life” problem that often affects paraplegics and people with severe orthopaedic injuries is the weather. Cold temperatures and/or dampness can wreak havoc on an insured’s mobility.

Consider an insured who is tested in March and requires supervision while walking because of the tightness and/or pain caused by the cold temperatures. By the time the IE is undertaken in July, the insured only needs a leg orthosis to walk the 10 meters indoors. Is this insured CAT or not?

On the topic of weather, quite concerning is the fact that the new legislation only incorporates the “mobility indoors” sub-scale of the SCIM. That means that outdoor environmental factors are not considered. Whereas someone may be able to walk indoors for up to 10 meters without aids, this same person may not be able to walk outdoors for 10 meters due to the wind. This is yet another “real life” factor that the new definition fails to take into account.

v. Consistency/Number of Assessments

Some of the questions above come down to the issue of consistency. One hour, one day, one month an insured may be able to do something that he or she cannot do the next hour, day, or month. That is the problem with a “one shot” assessment. The legislation does not indicate that an average score over different conditions or times is to be undertaken, and yet it does not explicitly limit testing to one particular occasion either. Consistency is an important consideration when it comes to paraplegics and other insureds with severe orthopaedic injuries.

Consider an insured who is able to walk up to 10 meters indoors without assistance 49 out of 50 times, but 1 out of 50 times suffers a bad fall. Is this insured CAT or not?

vi. Breaks

Another “real life” factor that is not explicitly addressed in the SCIM is how long the 10 meters should take or how fluid the mobility should be within those 10 meters. For many paraplegics and other insureds with severe orthopaedic injuries, function is not a matter of “can or cannot” but rather “cannot for long”, “cannot quickly”, or “cannot without breaks.”

Consider an insured who is able to walk 10 meters indoors without assistance; however, he or she has to pace the steps extremely slowly and with breaks between each step such that this process cannot be considered walking in any “real life” terms. Is this insured CAT or not?

vii. Pain & Medication

Neither the SCIM nor the legislation address pain associated with mobility. Again, for many insureds with serious orthopaedic injuries the issue is not whether they “can or cannot” walk, but rather the level of pain they will have to endure to do it and whether that level of pain may be mediated by medication.

Consider an insured who is perhaps too proud for his or her own good. He or she walks the 10 meters indoors without assistance, suffering excruciating pain the entire time. By the time the assessor leaves, the insured has to be non-weight-bearing for the rest of the day, take painkillers, and/or go to physiotherapy. Is this insured CAT or not?

Consider another insured who suffers from debilitating pain when weight-bearing. This insured, however, takes a Percocet 20 minutes before being assessed under the SCIM. With the help of that Percocet, the insured is able to walk the 10 meters indoors without assistance. Is this insured CAT or not?

xiii. Pre-Existing Conditions

Neither the SCIM nor the legislation explicitly references the idea of pre-existing conditions and, in particular, whether it must be the accident-related injury that is the direct cause of the score on the SCIM.

Consider an insured who suffers a tibial plateau fracture to his or her right leg. This fracture in-and-of itself may not result in wheelchair dependency or even the use of double crutches. If that same insured, however, already had limited mobility in his left ankle due to a pre-existing ankle fusion, it might now that the insured cannot compensate with his or her “good leg”. Is this insured CAT or not?

The SCIM and legislation may be silent on the issue of how to assess the functional impact of an injury in the context of a pre-existing injury or impairment but the case law is clear on that point: when assessing an insured for catastrophic impairment, the impairment must be regarded in the context of being superimposed upon a pre-existing condition.¹⁵

ix. Aging

As noted earlier, section 3.1(1)(2)(iii) does not prescribe when or at what point in time testing is to be undertaken. Although this subsection does not explicitly refer to what “will be” the case for the insured, it equally does not indicate that an insured’s “current” SCIM score must be 0-5.

Consider an insured who is currently able to walk 10 meters indoors with only a single cane. The assessor opines, however, that by age 65 he or she will need a wheelchair due

¹⁵ *Desbiens v. Mordini*, [2004] CanLII 41166 (ONSC) at paras. 209-210.

to the compounding effects of aging overlying the actual injury. Is this insured CAT or not?

x. Direction

The SCIM is based upon whether and to what extent the insured can walk, but it does not specify a particular direction.

Consider a paraplegic who can walk *forwards* for 10 meters indoors with just a cane, but who requires supervision to walk *backwards* for the same distance. Is this insured CAT or not?

xi. Prosthetic

Notably, the SCIM refers to the use of walking aids such as a cane, crutches, and a wheelchair but does not refer at all to prosthetics. Recall that under the new CAT definition, insureds with a *below* trans-tibial amputation are not automatically CAT.

Consider an insured whose foot has been amputated below the ankle. He or she is able to walk 10 meters indoors using a single cane if wearing a foot prosthetic, but otherwise would require two crutches to go the distance. Is this insured CAT or not?

APPLYING LEGAL PRINCIPLES TO THE AMBIGUITIES

Ambiguities can be problematic as they may ultimately delay CAT determinations and increase costs. Sometimes these ambiguities may result in denials being overturned by Arbitrators. The key for lawyers representing insureds whose CAT designations may

have been denied or who may not otherwise “obviously” present as CAT will be to find an area of ambiguity and relate that ambiguity to well-established legal principles that ultimately favour a finding of CAT.

A summary of helpful legal principles for that purpose is provided below:

- One of the main objectives of automobile insurance is consumer protection¹⁶.
- The *SABS* is considered to be remedial legislation, designed to get needed funds to insureds expeditiously and with a minimum of fuss.¹⁷
- The goal of the legislation is to reduce economic dislocation and hardship to accident victims.¹⁸
- Accident benefits are intended to be payable on a non-adversarial, expedited basis.¹⁹
- The *SABS* should receive a large and liberal construction and interpretation as will best attain its objectives.²⁰
- Insurance coverage provisions should be construed broadly while coverage exclusions or restrictions are to be construed narrowly in favour of the insured.²¹
- If there is doubt in the legislation and two possible interpretations, the one most favourable to the insured should be given.²²
- An inclusive interpretation of the definition of CAT would be consistent with the intent of the *SABS*.²³

¹⁶ *Smith v. Co-Operators General Insurance Company*, [2002] 2 S.C.R. 129 at para. 11.

¹⁷ *Wawanesa Mutual Insurance Company v. AXA Insurance Canada*, [2012] ONCA 592 (CanLII) at para. 90.

¹⁸ *Arts (Litigation Guardian of) v. State Farm Insurance Co.*, (2008), 91 O.R. (3d) 394 (C.A.) at para. 16.

¹⁹ *Correia v. TTC Insurance Company Limited*, FSCO A00-000045 (27 October 2000) at 38; aff'd FSCO Appeal P00-0061.

²⁰ *M.M. v. Guarantee Company of North America*, FSCO A10-000338 (19 September 2012) at 16; *Security National v. Hodges*, FSCO Appeal P12-00029 at 13.

²¹ *Canadian National Railway v. Royal and Sun Alliance Insurance Co. of Canada*, [2008] 3 S.C.R. 453 at para. 32; *Henry v. Gore Mutual Insurance Company*, [2013] ONCA 480 at para. 21.

²² *July v. Neal*, [1986] CanLII 149 (O.C.A.).

²³ *Aviva Canada Inc. v. Pastore*, [2012] O.J. No. 4508 (C.A.) at paras. 44-46.

- There is an implied obligation in every insurance contract that the insurer will deal with claims from its insured in good faith. This duty requires an insurer to act promptly and fairly when investigating, assessing, and attempting to resolve claims made by its insureds.²⁴
- An insurer's duty to its insured is not dependent on whether or not the insured is represented by counsel.²⁵

CONCLUSION

The new sub-sections defining CAT for paraplegia/tetraplegia and severe ambulatory impairment are undoubtedly more complex than the comparable sub-sections under the old legislation. In an accident benefits regime that is already costly and confusing, the new wording will only lead to further uncertainty, dispute, delay, and cost. It will be critical for lawyers representing insureds who may, in particular, have to deal with the SCIM to “think outside the box” and identify ambiguities for the benefit of the insured.

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²⁴ *702535 Ontario Inc. v. Non-Marine Underwriter's Members of Lloyd's London*, [2000] CanLII 5684 (O.C.A.) at para. 27.

²⁵ *Kuchiak v. Wawanesa*, FSCO Appeal P97-00025A (8 December 1997) at 8.