COURT OF APPEAL FOR ONTARIO

CITATION: Aviva Insurance Company of Canada v. McKeown, 2017 ONCA 563
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Juriansz, Pepall and Miller JJ.A.

BETWEEN

Aviva Insurance Company of Canada

Applicant (Appellant)

and

Fran McKeown, Roland Spencer, Dolly Singroy, Renelyn Agaloos, Naoise Hefferon, and Joanne Hacker

Respondents (Respondents)

Eric K. Grossman, for the appellant

Valinie (Val) Chowbay, for the respondents

Heard: April 27, 2017

On appeal from the judgment of Justice Wendy M. Matheson of the Superior Court of Justice, dated September 26, 2016, with reasons reported at 2016 ONSC 6017.

Juriansz J.A.:

A. OVERVIEW

[1] This appeal is about the nature of the notice an insurer must give in order to exercise its statutory right to examine under oath an applicant who has claimed benefits under the *Statutory Accident Benefits Schedule* ("SABS"), O. Reg. 34/10, a regulation under the *Insurance Act*, R.S.O. 1990, c. I.8. Section 33 (2) of the SABS provides that an applicant for SABS benefits "shall submit to an examination under oath" if requested by the insurer. Section 33 (4) 3 requires an insurer to give the applicant reasonable advance notice of the "reason or reasons for the examination."

[2] Six applicants for benefits demanded Aviva Insurance Company of Canada provide a "reason" in the sense of a "justification" for its request that they attend examinations under oath. Aviva brought an application in the Superior Court for a declaration that a justification was not required to compel a person claiming statutory accident benefits to attend at an examination under oath, and for an order compelling the six applicants to attend examinations.

[3] The application judge dismissed the application and issued a declaration that an insurer must provide a "justification" to compel an applicant for benefits to attend an examination under oath if the insurer requests one pursuant to s. 33(2) of the SABS. She denied Aviva's request for an order that each of the six applicants for benefits attend for an examination under oath.

[4] Aviva appeals, but only in respect of three of the six respondents to the application. I would allow the appeal, set aside the application judge's declaration, and replace it with the declaration that an insurer is not required to provide a justification for its request that the applicant attend an examination under oath. I would grant an order that each of the three respondents to the appeal attend an examination under oath.

B. DECISION BELOW

[5] The application judge began her analysis by noting the proper approach to statutory interpretation. 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 the legislature.

[6] She identified the purpose of the 2003 legislative reform of the automobile insurance regime that created the examination under oath ("EUO"). She said the purpose was to "address rising auto insurance premiums by putting forward a balanced reform package designed to ensure that injured people received the care they needed while reducing red-tape, fraud and abuse."

[7] The application judge briefly considered the entire s. 33, but her principal focus was on the requirement in s. 33 (4) 3 that the insurer provide reasonable advance notice of "the reason or reasons for the examination".

[8] She reasoned, at para. 80, that: “The ordinary meaning of ‘reason’ is *why* something is happening. It is not the scope of the examination, but why the examination is being pursued” (emphasis in original). She concluded, at para. 79, the notice provision “is not satisfied by a general statement that the examination will be about entitlement to statutory accident benefits or a general reference to the purpose and/or scope of the examination.” Rather, she issued a declaration, at para. 90, that “a justification is required to compel a SABS claimant to attend an examination under oath under s. 33 of the SABS, specifically a reason or reasons that must be disclosed under s. 33 (4) 3 of the SABS.”

[9] The application judge found support for her conclusion in an earlier decision of the Superior Court: *State Farm Mutual Automobile Insurance Co. v. Aslan*, 2016 ONSC 2725, 130 O.R. (3d) 474 (Ont. S.C.). She rejected the conclusion of the Financial Services Commission of Ontario (“FSCO”) arbitrator in *Kivell v. State Farm Mutual Automobile Insurance Co.*, [2016] O.F.S.C.D. No. 119 (F.S.C.O. Arb.) who found that notice of the general type of questions that will be asked at the EUO is sufficient.

[10] The application judge reasoned that the requirement that an insurer provide the “actual reason” or “justification” for the examination was in keeping with the insurer’s obligation of good faith. The insurer, she said, at para. 81, “must have a good faith reason to take this additional step and must be prepared to disclose it in advance of the examination.” She recognized that an insurer would be

reluctant to give a specific reason in a fraud case, thus losing a "tactical advantage" and possibly hindering the examination. But she rejected this concern, at para. 82, because "[t]his sort of tactical advantage, based on surprise, has been removed from civil litigation." Continuing the analogy to civil litigation, she observed that a claimant in a tort action would have advance notice of the insurer's position through a statement of defence before any examination for discovery would take place. And, the applicant would have a corresponding right to examine the insurer.

[11] The application judge also found that requiring the insurer to provide its "actual reason" for the examination in advance was consistent with the overall statutory scheme. It ensured that insurers did not request EUOs as a matter of course. Permitting them to do so would increase the overall cost of the system and reintroduce a more adversarial process into what is intended to be an efficient, no-fault regime.

[12] Another reason the application judge offered for concluding s. 33 (4) 3 created a substantive right was that the required notice should be meaningful to unrepresented applicants.

[13] The application judge did not find persuasive the insurer's argument that requiring an insurer to provide a justification for the examination would result in additional dispute and litigation over the adequacy of the reason provided. She

was satisfied that EUOs would proceed upon insurers conveying to claimants a good faith specific reason for them.

[14] She concluded, at para. 87, that in the case before her "only general references to the purpose and/or scope of the examination were provided to the respondents. They were not given notice of the actual reason or reasons that Aviva was pursuing an EUO". Therefore, Aviva's notices were not compliant with s. 33.

[15] The application judge issued a declaration that a justification is required to compel a SABS claimant to attend an EUO, and denied the requested orders that each of the respondents attend an EUO.

C. FRESH EVIDENCE

[16] The respondents sought to place material before this court that had not been before the application judge. The material consists mainly of medical reports related to the processing of the respondents' applications for benefits. The materials do not meet the test for admission of fresh evidence articulated in *R. v. Palmer*, [1980] 1 S.C.R. 759. I would deny the motion to admit fresh evidence.

D. ANALYSIS

[17] The application judge's interpretation of s. 33 is reviewable on a correctness standard. As I explain below, in adopting the meaning "justification" for the word

"reason", the application judge drew unsupported inferences, employed extraneous considerations, and failed to consider the entire legislative context of s. 33 (4) 3.

[18] In my view, reading the words "reason or reasons" 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 the legislature leads to the conclusion that s. 33 (4) 3 does not require an insurer to include in its notice to an applicant a justification for its request the applicant attend an EUO.

(1) The provision

[19] The text of section 33 reads as follows:

> 33 (1) An applicant shall, within 10 business days after receiving a request from the insurer, provide the insurer with the following:
>
> 1. Any information reasonably required to assist the insurer in determining the applicant's entitlement to a benefit.
>
> 2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.
>
> 3. The number, street and municipality where the applicant ordinarily resides.
>
> 4. Proof of the applicant's identity.
>
> (2) If requested by the insurer, an applicant shall submit to an examination under oath, but is not required,
>
> (a) to submit to more than one examination under oath in respect of matters relating to the same accident; or

(b) to submit to an examination under oath during a period when the person is incapable of being examined under oath because of his or her physical, mental or psychological condition.

(3) An applicant is entitled to be represented at his or her own expense at an examination under oath by such counsel or other representative of his or her choice as the law permits.

(4) The insurer shall make reasonable efforts to schedule the examination under oath for a time and location that are convenient for the applicant and shall give the applicant reasonable advance notice of the following:

1. The date and location of the examination.

2. That the applicant is entitled to be represented in the manner described in subsection (3).

3. The reason or reasons for the examination.

4. That the scope of the examination will be limited to matters that are relevant to the applicant's entitlement to benefits.

(5) The insurer shall limit the scope of the examination under oath to matters that are relevant to the applicant's entitlement to benefits described in this Regulation.

(6) The insurer is not liable to pay a benefit in respect of any period during which the insured person fails to comply with subsection (1) or (2).

(7) Subsection (6) does not apply in respect of a non-compliance with subsection (2) if,

(a) the insurer fails to comply with subsection (4) or (5); or

(b) the insurer interferes with the applicant's right to be represented as described in subsection (3).

(8) If an applicant who failed to comply with subsection (1) or (2) subsequently complies with that subsection, the insurer,

> (a) shall resume payment of the benefit, if a benefit was being paid; and
>
> (b) shall pay all amounts that were withheld during the period of non-compliance, if the applicant provides a reasonable explanation for the delay in complying with the subsection.
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> (9) Clause (2) (a) shall not be interpreted as prohibiting an additional examination of the applicant under oath, under Ontario Regulation 283/95 (Disputes Between Insurers) made under the Act, at the insurer's request that is conducted for the purpose of determining who is liable under section 268 of the Act to pay statutory accident benefits in respect of the accident.

(2) Grammatical and ordinary sense of the word "reasons"

[20] The present appeal concerns the interpretation of s. 33 (4) 3 and the meaning of the phrase: "The reason or reasons for the examination."

[21] "Reason" is a simple but flexible word used in common parlance. It can mean, as the application judge found, a justification for some act or decision. It is used in this sense in s. 42 (16) of the SABS. That provision requires an insurer who has determined that an applicant is not eligible for attendant care benefits for expenses incurred more than 260 weeks after the accident to give the applicant "notice of its determination, with reasons". In this sense it is used most often, as in this example, in the plural as in "reasons for decision".

[22] The word "reason" used in the singular can also simply mean an account or explanation of something or some state of affairs. It is used in this sense in s. 64 (17) of the SABS. That provision allows an alternative to personal service where

"for any reason, it is not possible to personally deliver the document to the person".

[23] Due to the different meanings associated with the word "reason", the grammatical and ordinary sense of the word is only the starting point. The word must be understood in harmony with the scheme of the Act, the object of the Act and the intention of the legislature.

(3) Purposive analysis

[24] As outlined in section B of this decision, the application judge's conclusions were driven by what she believed best attained the statutory objective of controlling the cost of automobile insurance premiums and providing for benefits to accident victims regardless of fault. She concluded, at para. 84, that requiring an insurer to give a "justification" for requesting an EUO "ensures that insurers do not simply request these examinations as a matter of course, increasing the overall cost in the system and re-introducing a more adversarial process into what is intended to be an efficient, no fault regime."

[25] I see several problems with this reasoning. In part, this reasoning rests on inferences unsupported by the record. In part, this reasoning employs extraneous considerations. In the sub-sections that follow, I review the object of the Act and intention of the legislature, and identify the errors in the application judge's conclusions in this regard.

(a) Object of the Act and the intention of the legislature

[26] There is no dispute that the two main overall objectives of the Ontario automobile insurance regime are consumer protection and guaranteed compensation of victims: *Smith v. Co-Operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, at para. 11; *Peixeiro v. Haberman*, [1997] 3 S.C.R. 549, at paras. 22-24.

[27] The parties are agreed that the legislature's specific purpose in introducing the 2003 legislative changes, which included the EUO, was to protect consumers from rising automobile insurance premiums.

[28] The legislative concern of protecting consumers from rising insurance premiums is manifested by the passage of the *Automobile Insurance Rate Stability Act, 1996*, S.O. 1996, c. 21 and the *Automobile Insurance Rate Stabilization Act, 2003*, S.O. 2003, c. 9, and its several amendments.

[29] After the government enacted the *Automobile Insurance Rate Stability Act, 1996*, regulations introduced what is now s. 33 (1) of the SABS. Section 33 (1) placed a positive obligation on a claimant to provide to an insurer any information reasonably required to assist in determining the claimant's entitlement to benefits and, if requested, to furnish a statutory declaration.

[30] A few years later, the government again addressed increasing insurance premiums in Bill 198, *Keeping the Promise for a Strong Economy Act, (Budget*

Measures), 2002, S.O. 2002, c. 22. This omnibus statute introduced changes to the automobile insurance system that, again, were primarily intended to realize cost savings within the industry. Ontario Regulation 281/03, which accompanied Bill 198, introduced the EUO in s. 12. This provision took its place as s. 33 (2) of the 2003 version of the SABS.

[31] The parties offered different views of why the legislature introduced the EUO. The respondents, in their factum, assert "the EUO was introduced specifically as a mechanism to allow insurers to gather information directly from claimants in cases where it [*sic*] suspected fraud" and that "the intention of the legislature as to the use of the EUO was not only specific to reasons of fraud but intended to be limited and specific to questionable or suspicious cases rather than broad and general in its application under the SABS".

[32] The appellant offers the broader view that the EUO was created as a distinct mechanism to achieve the legislature's goals of reducing insurance costs, addressing fraud and increasing accountability.

[33] The Government's White Paper entitled "Automobile Insurance Affordability Plan for Ontario: Next Steps" (Toronto: Ministry of Finance, July 2003), the debates in the legislature, and FSCO bulletins do not support the respondents' narrow view. That said, these materials do show that concern about fraud and

abuse of the system was a significant factor in the legislative changes.[1] For example, FSCO Bulletin No. A-10/03 identifies the EUO as one of the measures intended to result in the "[i]ncrease of accountability within the automobile insurance system and reduction of potential for abuse of the SABS process and occurrence of fraud". This statement accurately reflects what was said in the legislature when Bill 198 was being enacted.

[34] I accept the appellant's view that the legislative objectives in creating the EUO were to reduce insurance costs, address fraud and increase accountability within the system.

(b) No evidence to support the reasoning that EUOs might result in increased costs

[35] The application judge was quite properly concerned with the overall cost of the system. As we have seen, reducing costs was a key objective of the legislative changes that introduced the EUO.

[36] However, there was no basis in the record that enabled the application judge to draw any inferences about the overall cost of the system. Certainly, as respondents' counsel points out, it may be inferred that the hourly rate of a lawyer who conducts an EUO will be greater than that of an adjuster who

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[1] The legislature's continuing concern about the cost of automobile insurance and fraud within the system is indicated by the passage in 2014 of Bill 15, *Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014*, S.O. 2014, c. 9.

processes a claim. On the other hand, conducting an EUO may well result in quicker and more efficient determinations of entitlement by eliminating a prolonged course of claims handling by an adjuster.

[37] The more important observation is that the application judge had no basis whatsoever for assessing how potential savings from the detection and deterrence of fraud and abuse of the system would factor into the overall costs of the system.

[38] The court is ill-equipped to make assessments of this nature, and certainly without evidence before it. What can be said is that the overall costs of the system was of great concern to the legislature, and that the legislature created the EUO as one mechanism in a major initiative to control the overall costs of the regime. The court must give effect to this object of the legislature and the evident legislative perspective that EUOs are a mechanism to reduce the overall cost of the system. Interpreting the provision on the supposition that EUOs increase costs, seems to me to run counter to the legislative objective for creating the provision to reduce costs.

[39] The application judge erred by reasoning that the use of EUOs might result in an increase in the overall costs of the system.

(c) Analogies to civil litigation are unhelpful in a statutory regime meant to replace tort law

[40] The application judge was correct in observing Ontario's automobile insurance system was and is intended to be an efficient, no-fault regime and as non-adversarial as possible. However, I do not share her apprehension that unless an insurer is required to provide a justification for an EUO, the process would become more adversarial. I see the opposite as more likely. If an insurer is required to provide a justification for an EUO, claimants could contest the validity of the proffered justification. An apt illustration is the application that gives rise to this appeal, which involves six claimants who contested the validity of the insurer's reason for requesting an EUO.

[41] When engaged in statutory interpretation the court must remain focused on the legislative intent. The SABS uses a non-adversarial tone in setting out a number of mechanisms to facilitate an insurer obtaining the information necessary to determine entitlement. The SABS provides the insurer may "request" a disability certificate, a medical examination, and so forth. That same non-adversarial word "request" is used in s. 33 (2). The legislative history reviewed above makes clear the EUO was created as an additional "mechanism" to accomplish the legislative objective of the quick and expeditious determination of claims and of increasing accountability within the system.

[42] While recognizing the SABS process is intended to be non-adversarial, the application judge seemed to reason the civil litigation process should be a model for it. As noted above, the application judge considered the argument that an examination may be hindered by providing specific reasons, especially in cases of fraud. However, she rejected this concern because "[t]his sort of tactical advantage, based on surprise, has been removed from civil litigation."

[43] I regard the application judge's analogy to civil litigation to be misplaced. It does not matter that a claimant in a tort action would have advance notice of the insurer's position through a statement of defence before any examination for discovery would take place. Analogies to civil litigation are unhelpful in a statutory regime meant to replace tort law because the legislative object of the automobile insurance regime is to replace the tort resolution of disputes arising from automobile accidents with the process it prescribes. That an applicant "shall submit to an examination under oath" on a proper request of the insurer is clearly set out in the regulation. Effect must be given to the provision as written rather than attempting to make it comport with the civil litigation process.

[44] Requiring insurers to provide justification for EUOs is not in keeping with the non-adversarial process intended by the legislature.

(4) The provision in the context of the scheme of the Act and regulations

[45] A large part of the application judge's reasoning was not based on textual analysis of s. 33 (4) 3 in its entire context. Rather, in large measure, she made her conclusions after engaging in a purposive approach. In the modern approach to statutory interpretation, a purposive approach is mandated, but it must be applied to the text considered in its entire context: *Bell ExpressVu Ltd. Partnership v. Rex*, 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 26.

[46] In the sub-sections below, I engage in a more complete review of s. 33 (4) 3 in the context of the scheme of the Act and regulations.

(a) The SABS generally requires applicants to provide information to their insurers to obtain statutory benefits

[47] Section 268 of the *Insurance Act* says that every motor vehicle liability policy provides specified benefits that are set out in the SABS. The SABS requires that every motor vehicle liability policy provide certain benefits.

[48] There is a wide range of benefits: income replacement benefits, non-earner and caregiver benefits, medical, rehabilitation and attendant care benefits, lost educational expenses, expenses of visitors visiting an insured person during treatment or recovery, housekeeping and home maintenance, damage to clothing, prescription eyewear, dentures, hearing aids, prostheses and other

medical or dental devices, fees for preparing disability certificates and approving treatment plans, death and funeral benefits, and certain optional benefits.

[49] Each of the many different benefits available under the SABS could potentially require much detailed information for the insurer to determine entitlement to the benefit. The administration of some benefits can continue over a substantial period of time. The specific pre-accident and post-accident information required in any particular case will depend on the type of benefit claimed and may be extensive and ongoing.

[50] One theme of the procedures for claiming benefits set out in the SABS is that the insured person must cooperate with the insurer so that the insurer has the information necessary to determine the entitlement. For example, s. 36 (2) of the SABS provides that an applicant for income replacement, non-earner, or caregiver benefits, or payments for housekeeping or home maintenance services, must provide a disability certificate to the insurer.

[51] Similarly, the SABS creates a number of mechanisms that allow the insurer to request information and documentation from the applicant. Generally, when the insurer makes a request pursuant to one of these mechanisms the applicant is obligated to comply. Section 33, itself, contains one such mechanism. Section 33 (1) requires the applicant, within 10 days of a request by the insurer, to

provide information reasonably required to determine entitlement and a statutory declaration of the circumstances giving rise to the application for the benefit.

[52] Read as a whole, the SABS creates statutory benefits and requires applicants to take steps to facilitate an insurer's determination whether they are entitled to the benefits claimed or to their continuation. Thus, requiring an insurer to provide a "justification" for its request for an EUO is not in keeping with the cooperative approach to information sharing throughout the SABS.

(b) In other provisions, the SABS qualifies an insurer's right to make requests of an applicant

[53] While a theme throughout the SABS is that an applicant for benefits must cooperate with insurers to provide information reasonably necessary to determine entitlement, the insurer's right to obtain information is specifically qualified in some provisions.

[54] Section 44 allows insurers to require an applicant to be examined by a health professional or an expert in vocational rehabilitation. The insurer must give the applicant notice of the required examination, which under s. 44 (5) must include "the medical and any other reasons for the examination". The granting section, which gives the insurer the right to require an examination, however, has a built in qualification that the proposed examination must be "reasonably necessary". Section 44 (1) allows an insurer to require an insured person to be

examined by a health professional or vocational rehabilitation expert "for the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit" but cannot do so "more often than is reasonably necessary". This qualification applies to the first such examination required by an insurer, according to the case law developed by FSCO arbitrators. See, for example, *Augustin v. Unifund Assurance Co.*, [2013] O.F.S.C.D. No. 211 (F.S.C.O. Arb.), at para. 37.

[55] Section 37 allows insurers to request an applicant to submit a new disability certificate "if an insurer wishes to determine if an insured person is still entitled to a specified benefit". Like s. 44 (1), the provision that grants this right to insurers has the built-in qualification that the insurer may not make the request "more often than is reasonably necessary". This qualification, too, applies to the first request made for new disability certificate.

[56] These provisions may be contrasted with s. 33 (2). If the legislative intention were to require an insurer to provide a justification for its request, one would expect the granting provision to limit the right to circumstances where an examination is reasonably required. This is especially so since s. 33 (2) has two built-in qualifications: An applicant is not required to submit to more than one EUO, and is not required to submit to an EUO during a period when physically, mentally or psychologically incapable of being examined.

[57] It is significant that other provisions require requests the insurer makes to be "reasonably necessary", but s. 33 (2) does not.

[58] The mechanism provided by s. 33 (2) of the SABS seems akin to the right of an insurer to examine an insured person under oath that is provided by O. Reg 777/93. The regulation sets out statutory conditions for the purpose of s. 234 of the *Insurance Act* that are included in all contracts of automobile insurance. Section 6 (4) of the regulation provides that the insured "shall submit to examination under oath". While there are some textual differences, s. 33 (2) also provides an applicant "shall submit to an examination under oath".

(c) The notice requirement is set out in a list of other procedural requirements

[59] I find it significant that the requirement to provide notice of the "reason or reasons for the examination" is included in s. 33 (4) and is not included as one of the qualifications in s. 33 (2). The other requirements set out in s. 33 (4) are what may be described as procedural in nature. The insurer must make reasonable efforts to schedule the EUO for a time and at a location that are convenient for the applicant. Also, the insurer must provide reasonable advance notice of the date and location of the examination, that the applicant is entitled to be represented at the EUO, and that the scope of the EUO will be limited to matters relevant to the applicant's entitlement to benefits. That notice of the "reason or

reasons for the examination" is embedded in s. 33 (4) with these other matters may be taken as some indication they are of a similar nature.

[60] Section 33 (4), taken as a whole, is not structured to qualify the mandatory language in s. 33 (2). This implies the "reason or reasons" an insurer must include in its notice are of a procedural nature.

[61] This does not mean the notice provided may be *pro forma* and that an applicant cannot contest the adequacy of the notice. An applicant can contest the adequacy of the notice in the same way as he or she can contest the convenience of the date and location of the examination. However, the room for dispute is much reduced from what would be possible if the insurer were required to provide a justification for its request.

(d) There is no redundancy between the requirement for reasons under s. 33 (4) 3 and the scope of examination under s. 33 (4) 4

[62] The application judge was also concerned that unless an insurer were required to provide the "actual reason" or "justification" for requesting an EUO, there was the potential for redundancy between the reason for the examination addressed under s. 33 (4) 3 and the scope of the examination under s. 33 (4) 4. I do not share the concern. The reasons for the EUO provided under s. 33 (4) 3 may well indicate what is within the intended scope of the examination. Section

33 (4) 4, on the other hand, bears on what must be excluded from the scope of the examination.

(e) The scheme already addresses potential abuse of EUOs

[63] Another reason the application judge offered for requiring insurers to provide a justification for requesting EUOs is to prevent them from abusing the system by requesting needless EUOs as a matter of course. There was no basis in the record to support the application judge's premise. This was merely a submission by respondents' counsel. Before us respondent's counsel submitted: "Today, it is commonly discussed and reluctantly accepted by the Plaintiff's bar that blanket EUO requests without reason have become standard practice."

[64] The unsupported premise should not have played a role in arriving at the proper meaning of "reason". When looking at the scheme of the Act and regulations as a whole, it is clear that a dissatisfied applicant can allege the insurer lacks good faith in processing a claim in a manner already prescribed by the legislature.

[65] The insurer's duty to act in good faith applies throughout its processing of an application for benefits, and the practices of an insurer are subject to the general supervision by the Superintendent: *Financial Services Commission of Ontario Act, 1997*, S.O. 1997, c. 28, s. 5(2)(c). Among the Superintendent's broad

powers in respect of the *Insurance Act*, is the power to investigate and sanction "Deceptive Acts and Practices" (s. 440 of the *Insurance Act*).

[66] Deceptive acts and practices are proscribed by s. 439 of the *Insurance Act*. The list of Deceptive Acts and Practices is set out in O. Reg. 7/00, which is entitled *Unfair or Deceptive Acts or Practices*. Included in the list is "Any examination or purported examination under oath that does not comply with the requirements under the Act or the regulations." Therefore, this is the legislated route to address non-compliant EUOs.

[67] I might add that the vulnerability of an applicant to a needless and abusive EUO is truncated by the legislation. The only possible consequence to an applicant who fails to attend an EUO is a suspension of benefits for the period of non-compliance (s. 33 (6) of the SABS). The applicant could still claim the benefits at arbitration before a FSCO arbitrator at the time these disputes arose, or now before the License Appeals Tribunal. See FSCO decisions: *Salah v. State Farm Mutual Automobile Insurance Co.*, 2005 CarswellOnt 8338 (F.S.C.O. Arb.), and *Balanki v. Zurich Insurance Co.*, 2005 CarswellOnt 2670 (F.S.C.O. Arb.).

[68] I should not be taken to diminish the plight of an applicant whose benefits are suspended, but consequences of noncompliance with s. 33 (2) are much less onerous than of noncompliance with s. 44 of the SABS, for example. Recall that under this provision, an insurer may require an insured person undergo an

examination by regulated health professionals or vocational rehabilitation experts. Section 55 prevents an insured person from proceeding to arbitration if they have not complied with an insurer's request that they undergo an independent medical or vocational rehabilitation examination per s. 44.

[69] I point this out merely to show an applicant can refuse to attend an EUO they regard as needless and abusive and still proceed to arbitration.

[70] In summary on this point, the scheme already addresses potential abuse of EUOs by insurers. Reading in an additional requirement to provide notice of justification is not necessary to promote fairness in the scheme.

(f) FSCO has not interpreted the provision to require notice of a "justification" for an EUO

[71] As a final note, the application judge considered but was not persuaded by the reasoning in *Kivell v. State Farm Mutual Automobile Insurance Co.*, [2016] O.F.S.C.D. No. 119 (F.S.C.O. Arb.). In *Kivell*, Arbitrator Mongeon found that s. 33 (4) 3 did not provide a substantive right to be provided with the reasons as to why the insurer wishes to conduct an EUO. He stated that: "The reason or reasons do not have to be detailed, they merely have to give the Applicant notice about the general type of questions that will be asked."

[72] At the time this application was brought, the court and a FSCO arbitrator had coordinate, or shared, jurisdiction to determine disputes of this nature. An

insured person could either refer the dispute over claimed benefits for mediation and arbitration by FSCO, or could commence an action in the courts under s. 281 of the *Insurance Act*. The court need not defer to a tribunal in interpreting the relevant legislation when jurisdiction over the legislation is shared: *Rogers Communications*, 2012 SCC 35.That said, when exercising coordinate jurisdiction, a court should proceed with a full appreciation of the expertise of the tribunal, especially where the issues to be determined are confined to matters of process under the tribunal's home statute. The tribunal will have institutional expertise concerning such issues and may have developed a body of case law that will be of considerable assistance to the court. In this case, the application judge took no note of the tribunal's expertise in the process for determining disputed claims under the SABs.

[73] The coordinate jurisdiction of the court and the FSCO Tribunal no longer exists. Bill 15, *Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014*, S.O. 2014, c. 9, amended the *Insurance Act*. The former s. 281 has been repealed and the present s. 280 (3), which came into force on April 1, 2016, now provides that no person may bring a proceeding in any court with respect to the resolution of disputes in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory benefits to which an insured person is entitled. Since April 1, 2016, the License Appeal Tribunal has the exclusive jurisdiction to resolve such disputes, subject to appeal or judicial

review in the courts. In those appeals or judicial reviews the courts will accord the License Appeal Tribunal due deference.

[74] In any event, I regard Arbitrator Mongeon's interpretation of s. 33 (4) 3 in *Kivell* as persuasive. It is consistent with the statutory interpretation analysis that I have undertaken in these reasons.

(5) Conclusion

[75] For these reasons, I conclude s. 33 (4) 3 does not require an insurer to include in its notice of an EUO a justification for its decision to request an EUO. A general statement of the purpose of the EUO that gives the applicant notice of the general type of questions that will be asked is sufficient.

E. APPLICATION TO THE PRESENT APPEALS AND DISPOSITION

(1) Renelyn Agaloos

[76] Renelyn Agaloos applied for accident benefits from Aviva on May 19, 2015, arising from an accident on April 25, 2015. A disability certificate (Form OCF-3), dated June 12, 2015 was submitted on her behalf stipulating she met the disability test for income replacement benefits, non-earner benefits, and housekeeping and home maintenance benefits, with an anticipated recovery period of more than 12 weeks. Ms. Agaloos did not respond to Aviva's request for information pursuant to s. 33 (1) of the SABS. Counsel for Aviva wrote to counsel for Ms. Agaloos seeking to arrange an EUO. Eventually, Ms. Agaloos

provided the information Aviva had requested under s. 33 (1). A further course of correspondence followed that culminated with Aviva sending a formal notice of an EUO on January 7, 2016, informing counsel for Ms. Agaloos that it had unilaterally set the EUO for January 27. In part, Aviva stated:

> An examination under oath is required in order to assist [Aviva], your insurer, in determining entitlement to specified benefits, medical and rehabilitation benefits, attendant care benefits, housekeeping and home maintenance expenses and costs of examination arising from the loss of April 25, 2015. The scope of the examination will be limited to matters that are relevant to your entitlement to said benefits.

[77] Counsel for Ms. Agaloos took the position that the EUO was not "reasonable and/or necessary". Ms. Agaloos did not attend the examination.

[78] In my view, the notice satisfied the requirements of s. 33 (4) 3. I would issue an order that Ms. Agaloos attend an EUO.

(2) Fran McKeown and Roland Spencer

[79] Fran McKeown and Roland Spencer were injured in a motor vehicle accident on January 13, 2015, and separately applied for accident benefits on February 17, 2015. Aviva sought to arrange an EUO for each of them and their solicitor resisted on the basis that they had not been provided with a proper reason for the EUOs. The exchange culminated with Aviva providing a formal Notice of Examination on November 20, 2015 that stated that the purpose of the EUO was to:

> evaluate your potential entitlement to accident benefits, and specifically your application for Non-Earner Benefits, Attendant Care Benefits, Medical Expenses, and the Cost of the Examinations including In-Home Assessment and Chronic Pain Assessment.

[80] The respondents maintained their position that Aviva had not provided an adequate reason for the EUO and failed to attend the EUO.

[81] In my view, the notice satisfied the requirements of s. 33 (4) 3. I would issue an order that Fran McKeown and Roland Spencer attend an EUO.

F. COSTS

[82] The appellant's costs of the appeal are fixed in the amount of $20,000.00, inclusive of disbursements and applicable taxes. The appellant is also entitled to costs of the application, however, as the appeal involved only three of the respondents below, I would fix those costs of the application in the amount of $5000.00, all inclusive.

Released: "SEP" July 4, 2017

"R.G. Juriansz J.A."
"I agree. S.E. Pepall J.A."
"I agree. B.W. Miller J.A."