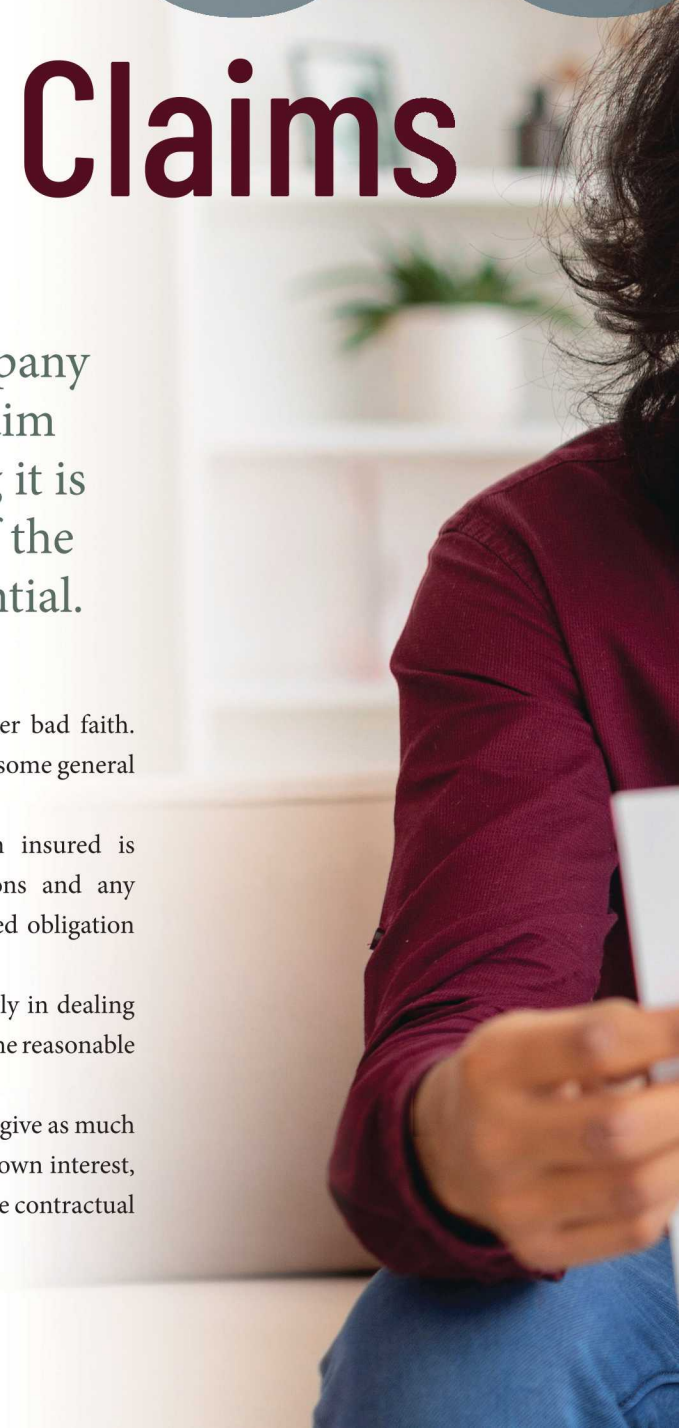
DISCO in Bad Faith Claims

BY ROBERT BEN



Alleging an insurance company has handled or denied a claim in bad faith is easy. Proving it is hard. Effective discovery of the insurance company is essential.

What is Insurer Bad Faith?

Much has been written on what constitutes insurer bad faith. Each case turns on its own facts. However, there are some general principles that can be gleaned from the caselaw.

The relationship between an insurer and an insured is contractual. In addition to the express provisions and any statutorily mandated conditions, there is an implied obligation that the insurer will deal with claims in good faith.[1]

This requires an insurer to act fairly and honestly in dealing with its insured, and in a way that is consistent with the reasonable expectations of the parties to the contract.

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The duty of utmost good faith applies to any matter arising under, or in relation to, the contract.[3] For example, it obliges an insurer to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its insured, and to assess the merits of the claim in a balanced and reasonable manner.[4] An insurer 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.[5] The duty of good faith applies and extends to every stage of the claims process, including through trial, and is not to be analyzed inflexibly.[6]

None of this is to say that an insurer will be found to have acted in bad faith merely by virtue of denying a claim, because an insurer's decision to deny a claim is ultimately wrong. Lack of good faith involves more than bad judgment, lack of diligence, or negligence. As one court put it: improper motive is an essential element of bad faith.[7]

Examples of an insurer's duty of good faith in a long-term disability benefit insurance claim would include:

1. **Duty to Investigate:** An insurer has a duty to investigate the claim in a timely, thorough, and objective manner. This involves gathering all relevant information, including medical records and reports and other information establishing the nature and extent of any disability.
2. **Duty to Act Promptly:** An insurer has a duty to act promptly and to make a decision on the claim within a reasonable time frame. Delays in processing a claim or payment of benefits can be a breach of the insurer's duty of good faith.
3. **Duty to Disclose:** An insurer has a duty to disclose all relevant information to the insured, including the policy terms, the claims process, and the reasons for any denial or termination of benefits. The insurer must also provide a clear explanation of the insured's rights under the policy.
4. **Duty to Communicate:** An insurer has a duty to communicate clearly and effectively with the insured. This involves keeping the insured informed of the status of the claim and responding promptly to any questions or concerns.
5. **Duty to Re-Consider:** An insurer's duty of good faith requires it to consider all relevant information when making a decision on a long-term disability claim, including any new medical information or changes in circumstances. This means that if new medical evidence emerges that supports the claim, the insurer must consider it in making a decision. Similarly, if the insured's condition worsens or circumstances change in a way that affects their ability to work, the insurer must also consider these changes in making a decision on the claim.
6. **Duty to Act in the Insured's Best Interests:** An insurer has a duty to act in the insured's best interests and to avoid any conflicts of interest that could influence its decision-making. For example, an insurer should not deny or terminate benefits simply to save costs or to avoid paying the claim.

A breach of the duty of good faith is independent of and in addition to the breach of a contractual duty to pay the insured's claim. It is a separate actionable wrong, which can support a claim for punitive damages.[8]

Proving Bad Faith

It should be apparent that determining whether an insurer has acted in bad faith requires an assessment of the insurer's conduct, attitude, and behaviour in respect of the claim in dispute. Often, the only way to get insight into the insurer's decision-making process is by getting access to the insurer's internal

file, and answers from the mouths of the claims handler. Thankfully, our *Rules of Civil Procedure* allow for discovery of this information by various means.

Types of Discovery

The Rules contemplate multiple forms of discovery. The first, of course, is documentary discovery. The insurer must disclose (subject to lawyer-client or litigation privilege)[9] all documents that are or have been in its possession, control, or power relevant (not merely bearing a "semblance of relevance" as under the earlier rule) to any matter in issue in the legal action.

The second is examination for discovery, which may take the form of an oral examination or, at the option of the examining party, an examination by written questions and answers. It is rarely, if ever, that a written examination is preferable to an oral examination of an insurer's representative, as answers will typically be crafted by the insurer's counsel in terms favourable to the insurer.

There are other forms of discovery available under the Rules, although they may not typically be thought of as such. For example, Rule 25.10 allows a party to demand particulars of an allegation in the pleading of an opposite party. This can be employed in the case of a vaguely drafted Statement of Defence by an insurer. Further, Rule 51.02 provides that a party may at any time (and multiple times) serve a request to admit on any other party to admit the truth of a fact or the authenticity of a document. Well crafted requests to admit can narrow factual and evidentiary disputes before discovery and at trial.

Discovery Plan

Before embarking on discovery, it is important to be mindful of Rule 29.1.03(1). Where a party to an action intends to obtain evidence through discovery of documents, oral examination for discovery, or examination by written questions,[10] the parties must agree to a discovery plan. The discovery plan must be in writing, and shall include, among other things: the intended scope of documentary discovery taking into account relevance, costs and the importance and complexity of the issues in the particular case; and, the names of persons intended to be produced for oral examination for discovery. The Rule is often ignored in the belief such formalities are not required because opposing counsel will work things out as they go. This is a dangerous attitude. Rule 29.1.05(1) provides that if parties have failed to agree upon or update a discovery plan, the court may refuse to grant any relief for discovery related disputes that may arise after discovery is underway.

Documentary Discovery Goals

When seeking documentary discovery from an insurer, don't expect voluntarily generous disclosure. The insurer will quite possibly be making only minimal disclosure. Insist on compliance with the Rules and production of all relevant documents.

Relevance, of course, is in large part determined by the issues as defined by the pleadings. That said, although an insured's pleadings are a factor to be taken into consideration in determining whether documents are relevant, they are not the only factor. If that were the case, an insured could simply plead in a creative manner to allow it to embark on a fishing expedition. This is precisely what the Rules were intended to avoid when they were amended to move from the laxer "semblance of relevance" test to "relevance."[11]

Allegations of bad faith that have no basis in fact, without more, cannot be the basis for production of an insurer's internal file.[12] "There has to be some fire

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beneath the smoke."[13] There must be "plausible" allegations that an insurer failed to act with the utmost good faith. Alleged breaches must generally be individually identified in the pleadings and supported by material facts.[14]

Assuming the pleadings contain sufficient factual foundation, much of the insurer's internal files and other documentation ought to be produced. This would potentially include all internal guidance, training manuals, and claims policies for adjusters, and all non-privileged records in any form relating to the or arising out of the decision to deny the insured coverage (i.e., the claims file).[15]

If the insurer is uncooperative, there is helpful caselaw to rely upon:

> "In a first party bad faith case… where the insurance company has refused to pay benefits claims under the policy, the critical issue is whether the company had a good faith basis for its decision. This in turn requires a number of other inquires, including the substance of the investigations…the information available to the company at the ime its decision was made, and the manner in which the company arrived at its decision…the insurance company's claims file constitutes the only source of this information.
>
> …Bad faith actions against an insurer, like actions by client against attorney, patient against doctor, can only be proved by showing exactly how the company processed the claim, how thoroughly it was considered and why the company took the action it did. The claims file is a unique contemporaneously prepared history of the company's handling of the claim in an action such as this; the need for the information in the file is not only substantial, but overwhelming."[16]

Another helpful example:

> "A court considering whether the duty of good faith owed by an insurer has been breached will look at the conduct of the insurer throughout the claims process to determine whether in light of the circumstances, as they then existed, the insurer acted fairly and promptly in responding to the claim.
>
> Ontario Courts have found that the only way that an insured can ascertain whether its coverage claim was handled improperly and in bad faith is by production of the insurer and broker's internal files showing how they handled or should have handled, the coverage request, and the information available to them at the material time."
>
> "…Where [the insurer] repeatedly pleads that it "fully investigated" the losses before denying coverage, [the insurer] is compelled to produced their entire claims and investigation files in relation to the coverage claims and bad faith claims…"[17]

Bad faith claims are established by showing how an insurer unfairly and unreasonable handled a claim, exposing the way it arrived at its decision:

> "…in an action [in bad faith]…the need for the information in [the insurer's file] is not only substantial, but overwhelming…anything and everything in the file during the period that the company maintained its refusal to pay. If the company has separate manuals dealing with how to handle potentially litigious claims, then these too should be produced, factoring in the state of mind of the insurer in dealing with its insured."[18]

Oral Discovery Goals

It is important to approach oral examination for discovery purposefully. There are two primary goals: (1) to learn from the insurer the case you have to meet at trial; and (2) to obtain helpful admissions that can be read into the record against the insurer at trial.

A good discovery eliminates surprises at trial. Often, it helps avoid a trial and is the foundation for a negotiated settlement. You can't have a good discovery if the person being examined on behalf of the insurer had no personal involvement in the claims handling.

When serving a notice of examination on the insurer, specify exactly who you want to examine. Rule 31.03(2) provides that when examining a corporation for discovery, the insured may examine *any* officer, director or employee on behalf of the insurer unless the court orders otherwise. In almost every case it makes sense to demand the person who actually handled and denied the claim be examined. If there was more than one claims handler, the Rules contemplate, on consent or with leave of the court, examination of more than one person.

Insurers who refuse to produce knowledgeable witnesses do so at their peril. In a recent case, a jury's record-setting punitive damages award against an insurer was upheld, in part because the insurer "failed to call the

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critical witnesses (i.e., the actual claims adjuster) to provide the context about their handling of the file."[19]

Conduct of the Examination

I would commend the short but very useful article by Robert Harrison and Richard Swan in the Winter 2024 edition of The Advocates' Journal on how to execute an effective examination for discovery.[20] The authors remind us that while a lawyer's natural tendency is to want to "pin the witness down" through a tightly controlled cross-examination eliciting helpful admissions, one should not be afraid of open-ended questions to learn the opponent's version of events, helpful or not. Discovery, not trial, is the time to hear everything the opposing party has to say, especially if it is adverse to one's client's case.

There is no standard template for examination for discovery of an insurer in a bad faith case. One has to be alive to the facts and issues in the particular case, and the witness at hand. Every lawyer will and must have their own approach. That said, I offer the following outline of potential areas of inquiry and questions that might be put to an insurance claims handler in a long-term disability case where good faith is in issue:

1. **Introductory Questions:** After confirming the claims handler or adjuster has sworn or affirmed to tell the truth and his or her answers bind the insurer, it is helpful to put on the record that if any of your questions are unclear the adjuster should say so, otherwise you will take their answers as responsive to the questions asked. This avoids later attempts to clarify, qualify, or otherwise change the evidence. Early on it is also helpful to get an admission that the adjuster (or someone with the insurer) has read and approved the Statement of Defence.
2. **Define the Database:** Ask what the adjuster has reviewed, and who the adjuster has spoken to (apart from their lawyer), in preparation for the examination.
3. **Affidavit of Documents:** Ask what efforts were undertaken to prepare the insurer's affidavit of documents to ensure diligence and full production. Ask for the basis and particulars of any privilege claims so you can assess their validity. If there are privileged statements from witnesses, investigation or surveillance reports concerning your client, ask for the facts contained within those documents.
4. **Understand Qualifications, Experience, Role:** Get the adjuster's education, qualifications, and work experience. Confirm their role and function with the insurer. How many claims files is the adjuster responsible for? How many do other adjusters handle? How did your client's particular claim get assigned to the adjuster?
5. **Internal Policies and Guidelines:** If not already produced, ask what adjuster training or claims handling manuals or policies exist and are supposed to be used in the claims process. What, if any, training did the adjuster actually receive?
6. **Duty of Good Faith:** In an insurer bad faith case it is particularly useful to elicit a number of what should be uncontroversial admissions of concerning the insurer's duty of good faith. These can be read in at trial as part of the insured's case to great effect, setting the stage for the judge or jury. Seeking admissions concerning the insurer's legal duty of good faith should not be met with any objection. Rule 31.06(1) requires a witness to answer any proper question relevant to any matter in issue in the case. The word "matter" is wide enough to include both a question of fact and the actual position taken by a party on a legal issue.[21] Some pertinent leading questions include: Does the adjuster agree that the insurer has an obligation of dealing in good faith with its insured? A duty to act fairly toward its insured? That

is should not take an adversarial approach to its insured? That it cannot make unreasonable demands of its insured in order to establish entitlement? That it cannot take an unnecessarily formal approach to claim (i.e., it cannot rely on minor technical deficiencies in forms when it is clear from material provided in support of claim that the insured requires benefits)? That it acknowledges delays in paying otherwise due benefits can be harmful to an insured recovering from physical or psychological or other injury? That it recognizes delays or denials in paying reasonably due benefits can be harmful to an insured recovering from physical or psychological or other injury? That it must give proper and careful attention to insured's claims (i.e., responding to applications in a timely and clear manner)? That it cannot simply rely upon physicians or other assessors hired by it as basis for denial of benefits? That claims decisions must be based on a fair and balanced consideration of all available information? Including new information subsequently obtained? Including information from the claimant? That the insurer has an obligation to continually reconsider entitlement? There can be many more leading questions along these lines. If the adjuster refuses to make a clear admission, it is simply a matter of putting the opposite proposition to them (i.e., Are you saying you have *no* obligation to reconsider a denial despite new information?). An "I don't know" answer can be equally damning.

7. **Claims Handling Process:** Inquire about the claims handling process. How does the adjuster deal with and evaluate claims? What is the insurer's protocol? What information is required from the insured? What happens if additional information is required? Determine whether the claims decision is the adjuster's alone or whether colleagues or superiors are involved.
8. **Scope of Authority:** Try to understand who has claims decision making authority within the insurer. Did the adjuster have that authority? Was her ability to approve a claim limited in any way? Limited to a certain monetary amount? Requiring higher authority above a certain amount? Who is involved in the decision to deny a benefit?
9. **The Claim:** It is critical to thoroughly examine the adjuster on the handling of your client's particular claim. When was the claim received? What coverage was sought? When was coverage determined and how? On what basis? Who made the decision? Who was consulted? Precisely what medical or other information was reviewed? If the insurer relied on internal medical or other assessors, what was the education, training and experience of those assessors? Do they work exclusively for the insurer? Did the adjuster provide all available medical and other information to its assessors or only selective information? Why did the adjuster prefer their opinions over the insured's doctors? What portions of the insurer's medical reports did the adjuster rely on? Does the adjuster rely on any other evidence? Was additional information requested or obtained from the insured? Did the adjuster reconsider the denial after obtaining that new information? On what section or clause of the insurance policy did the adjuster rely in denying benefits? Did the adjuster rely on any other clauses? What reasons were given to the insured for the denial at the time the denial was made? Does the adjuster contend that the claims handling procedures followed, or investigations pursued, were adequate and how?
10. **Putting Your Case Through the Adjuster:** Knowing that the insurer's discovery evidence can be read in at trial as part of the insured's case, it can be highly effective to take the adjuster through helpful medical and other evidence you intend to rely upon. For example: Do you agree the insured made a claim on this date? That he provided the necessary medical and other information in support of his claim in a timely way? That he responded promptly to your request for additional information? You are aware the insured consulted with Dr. Jones concerning his condition? You agree Dr. Jones diagnosed him with the condition? Dr. Jones provided treatment for the condition? The insured complied with that treatment? Dr. Jones' notes document ongoing symptoms? Dr. Jones findings suggest the insured would meet the disability test under the insurance policy? You don't have any information suggesting Dr. Jones is not competent? Or not objective in his assessment of the insured? When you received Dr. Jones' records/reports, you did not ask for clarification or further

information respecting his diagnosis or opinion? When you received a contrary opinion from your own medical assessor, you did not ask Dr. Jones to address the difference of opinion?

11. **Expert Evidence:** Once litigation is underway, the insurer may obtain and rely upon a litigation expert to support its denial. Ask whether the insurer has any findings, opinions, or conclusions, preliminary or otherwise, on any of the matters in issue and that she provide the particulars required under Rule 31.06(3) unless the insurer undertakes not to call the expert as a witness at trial.
12. **Surveillance/Investigations:** In a long-term disability claim the insurer may have conducted surveillance of the insured to support the denial. Ask whether the insurer has conducted any such surveillance and, regardless of any claim for privilege, to provide particulars (i.e., dates, times, observations). Remind the insurer that disclosure of any surveillance is an ongoing obligation under the prevailing caselaw. The same is true concerning investigations such as statements obtained from neighbours, co-workers, or others.
13. **Potential Witnesses:** Ask for the names and addresses of all persons who might reasonably be expected have knowledge of the transactions and occurrences in issue in this case, including any former employees of the insurance company (who can be summonsed as witnesses or examined out-of-court before trial).[22]
14. **Pleadings:** Avoid letting unsubstantiated pleadings remain a mystery. If any appear in the insurer's Statement of Defence, ask what facts or evidence the insurer relies upon in support of the allegations.
15. **Close the Door:** At the conclusion of your examination, it can be effective to ask whether the adjuster has told you all the facts and evidence upon which the insurer intends to rely in support of the allegations made and positions taken in the Statement of Defence.

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NOTES

[1] *702535 Ontario Inc. v. Non-Marine Underwriters Members of Lloyd's London,* 2000 ONCA 5684.
[2] *Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company),* 2017 ONCA 395.
[3] *Kang v. Sun Life Assurance Company of Canada,* 2013 ONCA 118.
[4] *Non-Marine Underwriters, supra.*
[5] Ibid.
[6] *Kang, supra.*
[7] *Zurich Insurance Co. v. Modern Marine industries Ltd.,* [1993] N.J. No. 264 (S.C.T.D.).
[8] *Whiten v. Pilot Insurance Co.,* 2002 SCC 18 (CanLII).
[9] While there is conflicting case law on whether an insurer who relied on a legal opinion to deny coverage has waived privilege over the that legal opinion (see, for example: *Samoila v. Prudential of American General Insurance Co. (Canada),* 2000 CanLII 22690 (ON SC) and *Dexter v. Economical Mutual,* 2007 NBQB 146 (CanLII)), it appears waiver will be rare, perhaps only where the insurer has pleaded in its Statement of Defence that is has relied on a legal opinion in denying a claim.
[10] Compelled medical examinations are also covered by the Rule.
[11] *Intact Insurance Company v. Malloy,* 2020 NSCA 18; *Nordik Windows Inc. v. Aviva Insurance Company of Canada,* 2025 ONSC 633.
[12] Ibid.
[13] *Nordik Windows, supra.*
[14] Ibid.
[15] It should be noted that the caselaw has generally drawn the line at insurer's internal claims reserve, absent some factual basis that those reserves informed the claims handling. See: *Non-Marine Underwriters, supra.* It should also be noted that although an insurer's finances are a relevant consideration in assessing the appropriate level of any punitive damages, the mere claim for punitive damages is insufficient to compel disclosure at the discovery stage. If the finances of the insurer become relevant at trial, the trial judge can order necessary disclosure at that time. See: *Filanovsky v. Filanovsky,* 2009 CanLII 9457 (ON SC).
[16] *Nordik Windows, supra.*
[17] *Sky Solar (Canada) Ltd. v Economical Mutual Insurance Company,* 2015 ONSC 4714 (CanLII)
[18] *Samoila v. Prudential of American General Insurance Co.* (Canada), 2000 CanLII 22690 (ON SC).
[19] *Baker v. Blue Cross Life Insurance Company of Canada,* 2023 ONCA 842 (CanLII).
[20] "Conducting a skillful examination for discovery, in contemplation of trial" by Robert Harrison and Richard Swan, The Advocates' Journal, Winter 2024.
[21] *Six Nations of the Grand River Bank v. Canada (Attorney General),* 2000 CanLII 26988 (ON SCDC).
[22] See Rule 36: Taking Evidence Before Trial.