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Chapter 1: The Nature of Insurance

Definition of Insurance (*Re Bendix Automotive* and *Ferme Vi-Ber Inc v La Financiere agricole du Quebec*)

Section 1(a)(a) of the Insurance Act defines insurance as: *the undertaking by one person to indemnify another person against loss or liability for loss in respect of a certain risk or peril to which the object of the insurance might be exposed or to pay a sum of money or other thing of value in the happening of a certain event.*

Basic elements include (*Re Bendix*):

1. An undertaking of one person
2. To indemnify another person
3. For an agreed consideration
4. From loss or liability in respect of an event
5. The happening of which is uncertain

- Consideration in a contract of insurance usually takes the form of a cash premium, but this doesn't always have to be the case
    - A "contract of insurance" doesn't change nature just because consideration is not a cash premium – in this case consideration was the employee's covenants found in their collective agreement

Three main characteristics of an insurance contract (*Ferme Vi-Ber Inc*):

1. An obligation on the client to pay a premium or an assessment;
2. The occurrence of a risk; and
3. An obligation on the insurer to make a payment to the client if the insured risk occurs.

Other rules:

- The occurrence of risk under an insurance contract must be **"an event that is uncertain and does not depend exclusively on the will of the parties"**
- If the promised payment is not based on the occurrence of a risk but on the occurrence of an event that is certain in terms of its occurrence, its prematurity or its severity, the contract is not an insurance contract
- Need an actual stake in the loss (**insurable interest**) for an insurance contract – otherwise is simply a bet
- The fundamental purpose of insurance is to pool risks
- The subject matter of the contract of insurance is always the indemnity (i.e. money)

Key distinctions between insurance and a bet:

- A bet has upside potential (where the gambler can end up better off than your original position)
- In insurance, there is no upside potential, so the insured should in theory just be placed in the same situation as they were before.
- The key distinction then is the word **INDEMNIFY:** to make whole (**NOT better, NOT worse**).
- In a gambling situation, there is no **insurable interest** on the outcome
- Purpose of an insurance contract is fundamentally different because it spreads the risk to protect the individual

Ferme Vi-Ber Inc v La Financiere agricole du Quebec
Facts: Appellants are QB farm producers that participated in the ASRA Program - La Financiere undertook to protect them from income fluctuations associated with the agricultural market. Appellants contested certain decisions made by LF in determining their compensation payments. Argued that the ASRA Program was a contract of insurance and that LF improperly incorporated additional income into its calculations to reduce their compensation under the program - they submitted it engaged the principle of interpretation based on the "reasonable expectations of the insured"
Issue: The application of private law to the implementation of certain government financial support programs - SCC had to identify rules governing the interpretation of the rights and obligations of the parties to the ASRA program administered by La Financiere
Reasons:

- The program is not a contract of insurance and can't be subject to the rules applicable to insurance contracts - doesn't have the **three main characteristics of an insurance contract:**
    - **An obligation on the client to pay a premium or an assessment;**
    - **The occurrence of a risk; and**
    - **An obligation on the insurer to make a payment to the client if the insured risk occurs**
- The contract of insurance concept presupposes that the client continues to be a debtor in respect of the premium even if the risk does not occur (different here where the surplus was redistributed)
- The occurrence of risk under an insurance contract must be **"an event that is uncertain and does not depend exclusively on the will of the parties"**
- **If the promised payment is not based on the occurrence of a risk but on the occurrence of an event that is certain in terms of its occurrence, its prematurity or its severity, the contract is not an insurance contract**
- Terminology of contracts of insurance is not conclusive to say that the contract is actually an insurance contract

Insurance Terminology

In life insurance:

- **Insured:** person who is insured
- **Assured:** person who takes out the policy
- **Beneficiaries:** person(s) who take the benefits of the policy to go

Named insured: named in the policy, usually the person paying
Unnamed insured: person in the policy by virtue of some definition of the policy (e.g. "all employees and agents are covered")
Subject matter of insurance: the "soon to be protected"
Most insurance policies are **indemnity policies**:

- Indemnity – you are made whole, return to the position you were in before the loss
- This is the goal of most insurance policies, but is generally not possible because:
    - Everyone pays a deductible
    - Estimates of losses mean some are over or under compensated
    - Replacement cost insurance versus actual cash value insurance
        - Replacement: may find yourself in a better position
        - Actual cash value: may find yourself in a worse position
    - Indemnity presumes the loss suffered is capable of being replaced, but sometimes this is not the case
    - General principle is that the valuation of the amount paid out is linked to the value of the loss

Classification of Insurance

Why is full indemnity never achieved?

- Money is not always the best compensator, and insurance assumes that the subject matter can always be monetarily valued
    - E.g. personal attachments
- Difference between what policy gives you and what your actual loss is
    - Caps
    - Deductibles
- Valuation information is not always accurate
    - Your item might be unique
    - Or it cannot be replaced for what it is worth
        - Few people have replacement cost insurance on their car, because it is more expensive
        - Instead we have cash value replacement, which frequently is not enough
- A 'life' cannot be indemnified, so life insurance is non-indemnity insurance

Types of Insurance

Precise classifications differ across Canada – here we focus on the classifications in Part 5 of the *IA*

- General insurance provisions (applies to every insurance contract unless otherwise below)
- Auto insurance
- Fraternal societies (ignore for this class)

- Hail insurance for crops
- Life insurance
- Accident and sickness insurance

Each of these have different rules around things like notice requirements, action details, termination, etc. However, nearly all of these sub-parts have **statutory conditions**, a group of conditions found in that subpart that form part of almost every insurance policy in AB (i.e. SPF1 – standard for auto insurance in Alberta – the statutory conditions are all found in Part 5 of the IA).

Note: The new IA has its own limitation periods; thus, it's important to know what type of insurance you are dealing with because different policies have different limits. These limitation periods do *not* apply retroactively.

Historical change: In the past, we also had "fire insurance", and this created problems when modern insurance companies started to issue multi-peril policies. It became unclear whether insurance was governed by the fire insurance clause or some other section. This section no longer existed.

KP Pacific Holdings Ltd v Guardian Insurance Co of Canada

Facts: The appellant owned a hotel that was damaged by fire. The appellant made a claim for the loss under its insurance policy, and the insurer took the position that the claim had not been brought within the applicable statutory limitation period.
Reasons:

- The dominant policy today is "all-risks" policy - this is good for consumers, but creates complications with old statutes
- The comprehensive policies in this case were found to take precedence
- Multi-peril policies fall within "general"

Holding: Claim wasn't statute barred

Churchland v Gore Mutual Insurance Co

Facts: Residence was broke into and property was stolen. Same issue as previous case where insurer argued the claim was statute-barred
Reasons:

- Assumption that insurance policies can be neatly classified is no longer tenable
- Multi-peril policy was held to fall under the "general provisions" instead of specific

Limitations for Bringing an Action

General insurance (s. 526 of the *IA*) provides two limitation periods:

1. Claims for property loss (under general policy)
- 2 years after the claimant became aware or should have become aware (conducted reasonable due diligence) of the damage
2. Claims for non-property loss
- 2 years after the cause of action arose

No insurance contract in Alberta can be harsher than these provisions. Further, these Statutory Conditions cannot be relied upon by the insurance company unless they are attached to the policy.

Auto insurance (s. 558(1) of the *IA*) provides again two limitation periods:

1. Claims for property damage
- 2 years after the loss or damage arose
2. Claims not for property damage
- 2 years after the cause of action arose.
- Cause of action is often when the insurance company refused to pay you.

The *Limitations Act* does not apply to auto insurance.

Hail insurance (s. 636 of the *IA*) provides a limitation period of within 2 years of loss or damage to crops.

Life insurance has no statutory conditions at all. The relevant limitation period (s. 677 of the *IA*) is 2 years of filing a proof of loss, OR 6 years after the death of the person.

Accident sickness (s.708(3) of the *IA*) provides a limitation period of 2 years after the cause of action arose, or when you knew or should have known of the loss.

- Further, if disability insurance is paid for a while and then stopped, the limitation is 2 years after the first period when the benefits should have been paid but were not.

The Insurable Interest

In Canadian CL an insurance contract is not legally enforceable unless the insured has an **insurable interest** in the subject matter of the policy, or else the contract is invalid. Today, this requirement is usually modified by statute depending on the type of insurance coverage.

The purpose behind this requirement:

1) To preserve the public policy against betting and wagering;
2) Preserve the principle of indemnity;
3) Prevent an insured from intentionally bringing about a loss.

- The insurable interest cannot be created from the insurance contract – <u>it must exist independently</u>

Guidelines for an insurable interest: (*Kosmopolous*)

1) Insured has to have a pecuniary interest in the subject matter of insurance
2) Interest has to be presently vested in the property (mere hope of obtaining isn't enough)
3) Not demonstrated by legal title along, although legal title is a presumption of having an insurable interest
4) Insurable interest can be defeated on public policy basis in some circumstances (e.g. if the goods were stolen and a policy of insurance was obtained, but this info wasn't disclosed)

TEST: **FACTUAL EXPECTANCY TEST** (set out in *Kosmopolous*)

- An insured has the insurable interest necessary for an enforceable insurance contract if apart from the contract itself, the insured would benefit from the continued existence of the subject matter of the insurance, and would suffer a loss from its destruction

<u>Statutory modification of insurable interest</u>
Provincial statutes have defined a theory of relationships that give rise to insurable interest in the life insurance context. Typically, the person must be related to you in some way, where their death will impose some cost on you. In other words, who else's life can you insure other than your own (s. 647):

- Spouse
- Children
- Person (natural) to whom the duration of their life you have a pecuniary interest in
- Directors and officers, key employees
- Anyone whose education you are paying for

Proving insurable interest

- The owner holds the burden of proof, on a balance of probabilities, in proving there is an insurable interest that exists
- Courts lean in favour of finding that an insurable interest exists

***Constitution Insurance v Kosmopoulos* (1987 SCC)**
<u>Facts:</u> K was the owner of a company called Spring Leather Goods. Originally was a sole proprietorship, later incorporated the business and then changed the name to Kosmopolous Goods Limited, was the sole shareholder. Problem - although incorporated,

treated all the assets as if they were his. Obtained an insurance policy for insurance, described the insurance policy as his own name and the company's name, not the incorporated name. Insurance company said he didn't have an interest once a fire happened because it was in the incorporated name not his
Issue: Whether a shareholder of a corporation has an insurance interest in the assets of that corporation (traditional view is no)
Reasons:

- Tendency to always lean in favour of finding an insurable interest where possible, especially because the underwriters sold the policy, received the premium, and only now are making a 'technical defense'.
- The *Macaura* principles were never extended to all types of insurance, such as life and health insurance.
- The reasons for keeping this old principle just don't stand anymore:
    - **Policy against wagering**; people don't really use insurance contracts this way anymore, and plus, wagering isn't really the problem where someone does have a valuable relationship to the property (but it just isn't 'legal').
    - **Indemnification for loss**: the principle just operates as a trap for the unwary
    - **Destruction of the subject matter**: people without a legal interest will destroy the subject matter to collect the proceeds. Court says this is the criminal justice system's job

Holding: Canada declines to keep using this test, and instead moves to the 'factual expectancy test'

Insuring the Interests of Others

Since insurance is a contract, an 'owner' is anyone with an insurable interest in property. As well, since the usual rules of privity apply such that only those who are insured under the contract can benefit from the insurance or enforce the coverage. This has been softened by the SCC, according to the following: (*Fraser River*)

1. Did the parties to the contract intend to extend the benefit in question to the third party seeking to rely on the contractual provision?
2. Are the activities performed by the third party seeking to rely on the contractual provisions the very activities contemplated as coming within the scope of the contract in general, or the provision in particular, again as determined by reference to the intentions of the parties?

- Intention to extend a benefit may be express or implied (*London Drugs v Kuehene*)
- No over-indemnification because purchaser of insurance is considered to be holding as trustee for the other person's interest

Partial Interest
Courts have said you can have an insurable interest in only the part of the subject matter of insurance (e.g. buying in instalments, leasing a vehicle.

Where the purchaser of insurance has some insurable interest in the subject matter, they can obtain insurance coverage. Two requirements:

1) They have to obtain coverage for the other party's interest; and
2) The insurance has to specifically allow for that kind of coverage and it must be disclosed to the insurer.

Keefer and Quebec Bank v Phoenix Insurance (1901 SCC)

Facts: K sold land to C for $2000, paid in installments. Title to property was agreed to transfer to C when all the payments were made, and K would maintain property insurance on the land until the title of transfer took place. A fire occurred and was valued at $1740, but C had only paid K $800. Insurance company refused to pay K more than $1200, his remaining interest.
Issue: Can an unpaid vendor recover not only his beneficial interest but also the beneficial interest of the vendee?
Reasons:

- Yes – he is entitled to recover the full value of the property destroyed, provided that the whole interest was insured
- **A person with a limited interest can insure the total value of the subject matter**
- **Two requirements:**
    - The form of the policy must be such as to enable him to recover the total value (could be limited by not insuring the whole value); and
    - Must have intended to insure the whole value

Spencer v Continental Ins Co (1945 DLR)

Four rules for making a policy available for the benefit of a person not named in it (elaborated on *Keefer*):

1) The policy itself must contain some clause to indicate that the contract is more than a contract of personal indemnity on behalf of the person named
2) The person for whose benefit the contract is made must be in existence and ascertainable at the time the contract is made
3) Must be an intention to insure on their behalf
4) Must have authorized or subsequently ratified the contract

Dudelzak and Landry v Non-Marine Underwriters, Lloyd's London (1986 ABQB)

Facts: Wills stolen from a law firm during a break in. They had a normal business policy but didn't have a legal or equitable interest in the wills (property of the testators). Under the narrow definition they (1) didn't have a cause of action; so (2) no insurable interest.
Issue: Were the wills property covered under the equipment floater?
Reasons:

- The insured had an insurable interest in the wills – **factual expectancy test** used
- A **proprietary interest is not necessary to found an insurable interest**, and the **mere possession** of the subject matter of insurance may in some cases be sufficient
- The parties intended that the wills be insured for their full insurable value

Holding:

- The cost was measured by the cost of duplicating the lost wills - secretarial time is covered, but not the lawyer's time
- The insured was entitled to recover additional expenses for reproducing the wills

Companies often take out life insurance on a very important employee – this is ok. But, in life insurance, you must get a person's consent to insure their life. the consent requirement in law means that even if you leave the company, their interest continues because you consented. Consent includes:

- Clause that indicates that is what is happening
- The person for who the benefit is being made, must be in existence and ascertainable at the time.
- Intention to insure on their behalf
- Must have authorized or subsequently ratified the contract.

***Insurance Act* in AB codifies the CL principle**

- Statutory condition 2 in fire and property insurance policy wording states unless specifically stated in the contract, the insurer is not liable for loss or damage to property owned by any person other than the insured unless the interest of the person is stated in the contract

Insurance Running with the Property

- An insurance policy does not run with the land because it is a personal contract and between the original parties to it unless it is assigned (*Rayner*)
- The risk is different between individuals
- **Modern rules:** don't disagree with the above, but the contractual terms during a purchase/sale of property have implications:
    - In absence of a contrary agreement, the purchaser of real property assumes the risk of loss from the date of the interim agreement
    - But standard form interim agreements usually state that all building and property will remain at the risk of the vendor until the adjustment date, and that all insurance policies and the proceeds thereof will be held in trust for the parties as the interests may appear.
    - Courts will sometimes try to uphold the vendor's insurance policy even after title has property transferred, by attempting to find some remaining insurable interest on the vendor's part

When Insurable Interest is required

- The *IA* is silent on when the insurable interest must exist, but it **has to exist at the date of the loss** for there to be a valid insurance contract otherwise the insured hasn't 'lost' anything and there is no need for indemnity
- Whether the insurable interest has to exist at the time the contract is entered is less clear, some conflict on this in case law
    - Some say it doesn't have to exist here, as long as the **insured has a reasonable expectation of an interest at the time of contracting and this transpired into an actual insurable interest at the time of the loss**
- Life insurance is always an exception – the insurable interest only has to exist at the time the contract takes effect

Chapter 2: The Principle of Indemnity

Insurers Obligation to Indemnity

Indemnity is the process of making the insured whole for the amount that they lost.

Insurance exists in order to indemnify against a loss, i.e. to compensate a person for an injured loss so that the person is financially restored to his or her pre-loss position. Insurance does not allow an insured to profit from a loss.

Most insurance contracts are contracts of indemnity because, in order for insurance proceeds to be payable, the insured must:

1. Prove that the loss was caused by an insured risk; and
2. Prove the value of the loss which was suffered

Insurance contracts can be classified as **"open" policies or "valued" policies**

- Open: provides payment limits but an insured's right to recover insurance proceeds depends on the actual pecuniary loss suffered up to the policy limits (value determined on the date of loss)
- Valued: sets out a pre-determined value to be paid upon the destruction of the insured items (or for life insurance, on the death of the insured) (value determined on the date of entry into the contract)
    - For property insurance, valued policies are useful for certain goods (e.g. artwork, hard to value after a loss)

Note: Life insurance is not a contract of indemnity because the insurance proceeds are payable upon proof of death

Public Policy Considerations

Insurers and courts may refuse to indemnity the individual if the loss is caused by:

1. Illegal activity
2. Losses caused by criminal acts
3. Losses that are based in intention

For courts to interfere with the freedom to contract, public policy must be demonstrated to **convincingly outweigh before coverage is denied**

Illegality

Dominion Fire Insurance v Nakata (1915 SCR)

- Public policy consideration was that no cause of action could arise out of a wrongful purpose. The insurance contract was for fire insurance on a brothel, but the court said that the policy was necessary to facilitate the illegal or immoral enterprise and did not enforce the contract
- Even though the insurance contract itself was not illegal, it could still be vitiated by the court if it was in connection with an illegal or immoral enterprise

Criminal Acts

Oldfield v Transamerica Life Insurance Co of Canada (2002 SCC)

- Public policy rule in question was that a criminal shouldn't be able to profit from crime, and the rule extends to those who claim through the criminal's estate
    - No distinction drawn because the estate's claim is equivalent to a claim brought by the criminal
- Here the insurance policy did not provide for the result that would occur if the insured died while committing a criminal act
- Court held that **the innocent beneficiaries are neither criminals nor claim through the criminal's estate, so the public policy rule is inapplicable**

The public policy rule from *Oldfield* is modified by s 533 of the AB *IA*

- S 533 states that unless the insurance contract provides otherwise, insurance proceeds are payable to anyone entitled to claim under the policy where the loss is unintentionally caused by the insured's criminal act

- Example of "providing otherwise": Section C of AB's Standard Auto Policy SPF #1, which excludes coverage for loss to the insured vehicle if the loss to the insured's vehicle occurs while the insured was driving while impaired
- In the absence of a statutory provision like s 533, the CL rule applies

Standard of proof for a criminal act is on a balance of probabilities

- In order to successfully deny coverage on the grounds that a loss was caused by a criminal act, the insurer must prove on a balance of probabilities that the insured committed the criminal act (*Hanes v Wawanesa*)

Suicide

- Life insurance intent to bring about a loss – means suicide or murder
- Suicide is no longer explicitly excluded by public policy (see *IA* s 657) – if a contract doesn't have a term about suicide, it will likely be void for public policy
  - This section allows for contracts to have a clause that covers suicide, this clause is no longer illegal

Dhingra v Dhingra Estate

Facts: D had a group life insurance policy, wife was beneficiary and vice versa. D had a mental disorder, the couple had been separated for 15 years, he killed his wife and was charged with murder but found not criminal responsible. Dhingra estate submitted an accidental death claim requesting proceeds
Issue: if there was intent to bring about the loss by D, then the policy would be void for public policy - the problem is if someone doesn't have mens rea
Holding: In this case, public policy did not apply to prohibit payment of the life insurance proceeds to the beneficiary
Ratio: the public policy rule that prevents an insured from claiming insurance proceeds for a loss intentionally caused by the insured's criminal act does not operate to prohibit coverage where the insured is found not criminally responsible for the criminal act due to a mental disorder

Scott v Wawanesa

Facts: Insured owned a home under a multi-peril policy, his son burned down his home intentionally. Policy specifically excluded coverage for loss intentionally caused by the insured
Issue: Has it been burned down by the insured?
Holding:

- The named insured was the father - son was an unnamed insured, so considered to be no coverage under the policy because the loss was brought about unintentionally by the insured
- *IA* was amended to create a statutory severance - means when insurance covers more than one person and one of those insured's breaches the terms of the policy, the insurance policy will sever and the other insured's who didn't commit a breach will be covered, the one who did is severed

Ratio: Alberta's *Insurance Act* was amended to provide policy exclusions for loss caused by the intentional or criminal act of an insured to not bar the claims of an innocent co-insured

Valuation

Open Policies

Provides payment limits but an insured's right to recover insurance proceeds depends on the **actual pecuniary loss suffered** up to the policy limits (value determined on the date of loss). The insured must prove how much they have lost.

How an open policy values what needs to be indemnified depends largely on the type of the policy. Whether it's one or the other depends on the terms of the policy, may be difficult to discern: (see ***Machtinger***)

1. **Actual cash value**: the value of the assets less the depreciation
2. **Replacement:** the insured receives a replacement, meaning there is a potential for betterment

Courts look to the intrinsic value of the item lost – but valuation can be altered by contractual terms:

1. **Guaranteed replacement cost endorsement:** provides that as long as certain conditions are met, the insurer will pay the full cost of building repairs regardless of policy limits

2. **Scheduled loss endorsement:** may provide for payment of either replacement cost or an assigned value for personal property, without reference to the actual value of the loss incurred
3. **Co-Insurance clause:** may require the insured to maintain insurance up to a stated percentage of the value of the insured property, failing which the insurer will only pay a portion of the full value of a loss to the property
    a. By underinsuring the value of the property, the insured becomes a 'co-insured' when a loss occurs

Where the insurer makes the election to repair or re-build, the insurer is bound to that choice even if the costs of repairing or rebuilding end up exceeding the actual cash value of the damage (*Northwest Electric*)

Actual cash value, when dealing with the rights of an insured to acquire salvage rights to an insured vehicle upon paying cash for it, the amount is the value of the vehicle less the deductible payable by the insured.

Goods will be treated as totally lost when they have been totally destroyed (total loss) or where the cost to repair them exceeds their value when repaired (constructive total loss)

Requirement that there is a deductible in insurance policies

- In automobile contracts, the insurance company can take the car (salvage rights) even though the deductible was paid
- This provision was challenged in *Holly Insurance* – court said that the actual cash value is the value minus the deductible – insurance companies are entitled to collect the deductible and take the salvage after they pay out the actual cash value

***Leger v Royal Insurance* (1968 SCC)**

Facts: An old and dilapidated building/lot burned down but had depreciated in value since it had initially been appraised.
Issue: What was the value at the time of destruction?
Reasons:

- The amount of the loss is the real or intrinsic value to the insured, this is often identical to the market value but not always
- The actual cash value must depend on the circumstances applicable to each individual case
- Other appropriate options in different circumstances:
    - Replacement cost less appropriate reduction for depreciation
    - Investment value based on capitalized value of the income

Ratio: It is the intrinsic value of the physical property to the insured at the time of loss with no allowance being made for loss of future profit or other consequential loss – often equivalent to the market value but not invariably so. Not necessarily the appraised value

***Matchtinger v CAA Insurance Co* (2018 ONSCJ)**

- Two types of protection in the insurance industry: actual cash value coverage and replacement cost coverage
    - Actual cash value: property is insured to the extent of its actual cash value. Recognizes that the insurer is entitled to deduct reasonable depreciation from the value of the loss
    - Replacement cost: insured is entitled to the full cost of repair or replacement without any deduction for depreciation. Goes beyond the notion of indemnity, it **recognizes that depreciation is an insurable risk - justifiable because without it many property owners would be unable to cover the shortfall caused by depreciation**
- An insurance policy is a contract of indemnity "according to its terms" - policy addresses the extent of indemnity provided, and consequences flowing from this
- Note: actual cash value is probably closer to true indemnity since because property depreciates over time, it prevents a betterment from being obtained

Valued Policies

Sets out a pre-determined value to be paid upon the destruction of the insured items (or for life insurance, on the death of the insured) (value determined on the date of entry into the contract).

***Raymond v US Fire* (1973 SCC)**

Facts: Insurance on model of Notre Dame cathedral, artist spent 15 years carving. Model appraised at $80 000, an insurance policy was issued. Wording of policy was for $80 000, premium was $2000. Model destroyed by fire. Court of Appeal reduced about to $6000 because that was the insurance companies value of the model, they didn't consider it a work of art
Issue: After agreeing to treat it as a work of art, could the insurance company argue the opposite?

Reasons:

- Civil Code says you can't look at the premium to determine the value of the insurance
- SCC said that they felt based on the premium of $2000, this meant that the insurance company had treated it as a work of art, and since the insurance company had treated it as a work of art when the contract was made, it was probably a value based policy and they chose the expert's opinion - $80 000 judgment was restored
- Insurance company can't decide to treat something as a normal policy after agreeing to treat it as a work of art

Ratio: When the insurers are or their agents is party to an appraisement of the property for the purpose of insurance**, the amount to settled is probably prima facie proof of value, but otherwise the amount stated in the policy as the amount insured on any particular subject is not even prima facie evidence of the value**

***Re Art Gallery of Toronto* (1961 OR)**

Facts: Paintings stolen from the art gallery, later recovered but had been damages and thus depreciated in value

Issue: Insured contends that they are entitled to recover the actual loss on each item insured up to the insured value of such items as listed in the policy, the insurer submits that the policy is a "valued policy" and its liability should be determined by calculating the percentage of depreciation after ascertaining the actual loss

Reasons:

- For a valued policy, the most important thing is that they have agreed on the value of the total loss
- Court agreed with the insurance company - said this is a valued policy and the insurance company only has to pay the proportional share of the value
- In fine arts policy, if you undervalue the amount of the piece you insure, this will affect your ability to recover since you have pre-agreed the amount to be paid

Holding: The money paid for the partial loss sustained should be determined by applying the percentage of actual depreciation resulting from the theft to the agreed values as set out in the policy

Sue and Labour Clauses

May be contained in an insurance contract, it requires the insured to take reasonable steps to protect the insured from further damage where a partial loss has already occurred. It also obligates the insurer to reimburse the insured for some or all of the costs associated with the protective steps.

- For some types of insurance contracts they are mandated by statute
- Can be a double-edged sword for the insured – although it entitles the insured to some compensation for steps to protect the party, the insured's failure to take appropriate steps may be viewed as a breach of the insured's contractual obligation

Under the general section of the IA (s. 540 and statutory condition #9: salvage), if there is loss or damage, the insured must take all reasonable steps to prevent further loss or damage or to prevent loss or damage to other property. Auto also has a sue and labour clause in s.556 (statutory condition #41b).

If you don't take immediate steps, you can be in breach of policy, which means you may not get paid for damage. This is a high burden.

Generally speaking then, the insured is entitled to indemnification if:

1. Costs relate to loss falling within policy
2. Expenses must be reasonable
3. Costs must be incurred to prevent further damage from a *materialized* risk.

Need to distinguish against steps taken to protect against a risk that has ***already materialized***, and steps to reduce a future risk.**



For exam: go through three criteria and say what a court might find and not find through application

Office Garages v Phoenix Insurance (1966 HC)

Facts: Claim on a fire insurance policy - L is the owner and plaintiff, Office Garages Limited is the tenant of a building. The premises were insured by the defendants against loss or damage by fire or explosion. The building was leased to BP Canada. An explosion occurred. Costs were incurred through investigating the cause of the explosion and taking steps to improve the facilities so than an explosion would not reoccur.
Issue: Is the insurer required to cover the cost of taking reasonable steps to prevent further damage to the property?
Reasons:

- Section 9(1) of the Insurance Act: in the event of any loss or damage to any property insured under the contract, the insured shall take all reasonable steps to prevent further damage to the property damaged
- Section 9(2) if the insured incurs expenses to protect the property: the insurer shall contribute pro rata towards any reasonable and proper expense in connection with steps taken by the insured
- There was a duty on the plaintiffs under the insuring contract to protect the property from further damage, they were entitled to recover any reasonable expense incurred in performing this duty

Hartford Fire Insurance Co v Benson & Hedges (1978 SCC)

Leading SCC case on s&I clauses
Facts: Explosion of a bottling tank in a brewery killed 2 people and caused damage to the premises. Respondent retained the services of a company to determine the cause of the failure and to determine if any of the other bottling tanks were faulty
Issue: Was engaging the experts a reasonable step taken by the respondent to prevent further damage to the property?
Reasons:

- Are the accounts of the experts "reasonable and proper expenses in connection with the steps"? Judge classifies into three categories and found that the cost of detecting the cause of the explosion in the bottling tank is part of the loss suffered by the respondent as a result of the explosion - this is recoverable
- The work of inspecting the tanks that were not ruptured to determine if they were safe did not *per se* prevent any damage or further damage to any property insured
- There is a distinction between the obligation to minimize a loss and the obligation to minimize a risk that has yet to materialize - at CL, the insure has a duty to mitigate his loss but he is under no obligation to minimize the risk
    - **The damage to be mitigated must result from the contingency that has occurred, rather than being the consequences of another contingency that hasn't yet occurred**
    - **Preventative work isn't a materialized risk and won't be claimable**
- Distinguished *Office Garages* - in this case there was either a direct causal connection between the original loss and that which the insured had attempted to mitigate or avert, or it was effectively the same loss
    - This decision is not the authority for the proposition that statutory condition #9 (section 122(1) Insurance Act) creates an obligation upon the insured to take such steps as may be necessary to prevent the occurrence of a risk which hasn't yet been created or increased by the loss that already happened

Holding: The respondent is entitled to recover only the part of the accounts of the expert in respect to the detection of the cause of the explosion of the bottling tank

Subrogation and Contribution: Obligations of Third Parties to Mitigate Insurer's Burden

In some circumstances the cost the insurer has to pay out under an insurance policy can be recovered from others who are not parties to the contract (third parties) – the doctrines of subrogation and contribution allow for this.

Subrogation

Subrogation: permits the insurer to step into the shoes of the insured and recover the amount it paid out from a third party if that third party paid the loss – the insurer commences an action in the name of the insured, but the claim is for the insurer's benefit

General:

- The insurer can exercise all legal rights of recovery that the insured would have had against the third party
- Preserves the fundamental principles of indemnity – insured receives no more or less than entitled to receive
- Ensures that losses fall on the parties that caused harm
- **Insurer automatically has the right of subrogation as long as it is a contract of indemnity**

Common Law Principles

1. At CL (changed by *IA*) the insurer is only permitted to exercise its right of subrogation after it has fully indemnified the insured

2. The insurer's right to subrogate is entirely derivative – the insurer is in no better position than the insured would be in advancing the claim
    a. If the insured releases the third party, the insurer can't proceed against that third party
3. Upon fully indemnifying the insured, the insurer is entitled to exclusive control of the subrogated action (becomes the *dominus litis*)
    a. Remember only a single action exists in Canadian law for damages (insured and uninsured)
4. The insured has a duty (of good faith) to cooperate with the insurer in advancing the subrogated claim

Good Faith

- The insured has a duty of good faith to protect the insurer's right to subrogate
- This is a fluid concept – courts look at the facts on a case by case basis and narrowly define good faith
- Unless the insured is found to be malicious or dishonest they will not be found to have breached this duty

***Douglas v Stan Fergusson Fuels Ltd* (2018 ONCA)**

Facts: D owned a house and got fuel for their house that spilled when it was delivered and contaminated the property. Ms. D had no ownership interest in the property, her interest vested with a trustee in bankruptcy. Insurer wanted to subrogate and go after the person who caused the loss (Fergusson). Subrogation clause was included. Mr. D filed an assignment in bankruptcy. State Farm paid them the claim, and the trustee sold the remediated property. State Farm commenced an action prior to Mr. D's discharge from bankruptcy in the D's names.
Issue: Do the D's lack the capacity to commence a subrogated action?
Reasons:

- Concepts:
    - Recoveries by the insurer beyond the indemnified losses are payable to the insured
    - Recoveries by the insured for indemnified losses are held in trust for the insurer
- D's cause of action vested in the trustee - the policy didn't permit State Farm to commence an action in the D's name - they should have commenced the subrogated action in the name of the trustee or in the estate of Mr. D
- **Shows that the insurer's right to subrogate is only as good as the right that the insured had at the time**

***Free-Techol Tree Technology and Research Co v CIA Rail Canada Inc* (2017 ONSC)**

Facts: A train derailed and caused damage to plaintiff's property - some damages were covered by insurance but some were not. Intact and the insured got into a dispute about what was owed under the policy. Plaintiff had uninsured losses that weren't the subject of an insurance policy and sued VIA Rail. Intact neglected to commence an action for its subrogated claim, so was trying to get the plaintiff to include its subrogated action in its action
Issues: If the insurer had a right to recover in this case, and whether there was an obligation on the part of the insured to take on Intact's subrogated loss - did the insured have to cooperate with the insurer?
Reasons:

- It is a requirement at CL that the insured cooperate with the insurer in pursuing a subrogated claim - but the court said there was no clear and unambiguous obligation on the insured to do so set out in the insurance policy, and the Ontario Insurance Act didn't impose this
- **The only obligation the insured has is to cooperate with the insurer if the insurer is making a subrogated claim, but not to actual make/help file the claim**
    - If the insured had commenced the subro action then the insured would have had to cooperate - but because the insurer failed to do so, the insured didn't have to help

***Confederation Life Insurance Co v Causton* (1989 DLR)**

Facts: The insured was injured in a car accident, made a claim for wage replacement and obtained partial payment. Started a claim against the tortfeasor. Settled the losses, but she argued she hadn't received the entire amount she was entitled to - the wage loss she suffered was more than she received from both the insurer and the tortfeasor.
Issue: What happens when the coverage provided by the indemnity policy is less than the total loss experienced by the insured?
Reasons:

- **As soon as full indemnification occurs, the insurer is entitled to subrogate**
- Court said that legal fees were a cost of recovery and have to be taken into account - because they took those legal fees into account she wasn't receiving the full value of her claim and the right of subrogation didn't kick in
- **Insurance Act in Alberta modifies this principle - section 546 alters the requirement that the insured be fully indemnified before subrogation right materializes - once any payment is made, the right of subrogation kicks in**

Holding**:** The insured never received the total wage loss, and because she wasn't fully indemnified the insurer's right to subrogation never arose

Somersall v Friedman (2002 SCC)

Facts: the plaintiffs were injured in a car accident with the defendant. They filed a statement of claim and entered into an limits agreement which provided that (a) the defendant was to admit liability for the accident at trial; (b) the respondents would not claim against the defendant or his insurer in excess of his policy limit; and (c) the defendant's insurer was to make an advance payment to the plaintiffs. The plaintiffs sought to recover the remainder of their damages from their insurance company pursuant to their underinsured driver coverage (the "SEF 44 Endorsement"). The defendant then cross-claimed against the insurance company.
Issue: does the agreement between the plaintiff's and the defendant limiting the plaintiff's claim to the defendant's policy limits preclude the plaintiffs from advancing a claim against the insurance policy pursuant to the underinsured motorist provisions of its policy?
Reasons:

- Three general statements:
    - **Absent any evidence of actual or probable loss, insurers should not be allowed to raise an alleged breach of subro rights in order to bar a claim made in good faith by the insured**
    - **In the absence of contractual terms to the contrary, that the insurer's right of subro will not arise until the insured has been fully indemnified**
    - **The insured is obliged to pursue any claim it has against the third party, up until the time the insurer is entitled to and asserts control of the claim in good faith**
- If the insured might have taken "less than" but honestly and in good faith thought it was wise to accept then this is okay - the requirement doesn't impose on a policyholder an obligation to actually obtain the best deal they could have obtained

Holding: the court essentially said that the right of subro isn't really that valuable to insurers, and it was not so valuable that it needed to be reconsidered

Note: subsequent cases haven't always followed this precedent, it has been distinguished but is still good law

SEF 44 Endorsement

- Only attaches to a motor vehicle policy in AB. The effect of it is that if you have third party limits on your motor vehicle policy that injured party can recover up to this amount.
- Example: If your damages were $2 million, the third party's insurer would paid $500 000, and you're out $1.5 million. Your insurer pays the difference up to $1 million

How Subrogation has been altered by Statute

1. **Sec 546(1) *IA*:** subject to s 570, if there is any payment made by an insurer, then the insurer automatically has a subrogation right against the wrongdoer and can bring an action in the insured's name
2. **Section 546(2):** When the net amount recovered by an action or on settlement is, after deduction of the costs of the recovery, not sufficient to provide complete indemnity for the loss or damage suffered, the amount remaining must be divided between the insurer and the insured in the proportion in which the loss or damage has been borne by them.
3. **Section 546(3) and (4):** which party has control over the subrogated action
    a. (3): When the interest of an insured in any recovery is limited to the amount provided under a deductible or co-insurance clause, the insurer has control of the action.
    b. (4): When the interest of an insured in any recovery exceeds that referred to in subsection (3) and the insured and the insurer cannot agree as to (the various factors listed), either party may apply to the Court for a determination of the matters in question

In order to alter CL principles of subrogation, legislation or contractual provisions must exhibit a clear intention to do so (*Hammond v DeWolfe; Mutual Life Assurance v Marance*)

Sometimes a non-insurance contract may require one party to obtain insurance coverage for another - e.g. a tenancy agreement

- These contract provisions can have the effect of preventing an insurer from exercising its subro rights against the party for whose benefit insurance coverage is provided (*Agnew-Surpass Shoe Stores Ltd v Cummer-Yonge*)
- When a party to a lease agreement undertakes to obtain insurance against certain damages, such an undertaking operates as an assumption by that party of the risks associated with the insured losses. The undertaking bars the party from claiming damages against the other party to the lease, even if the former's loss is caused by the latter's negligence
- An explicit provision to the contrary is required to avoid this

Contribution

Contribution occurs when an insured has two policies of insurance that covers the same loss – it is invoked when the **same** insured has more than one policy of insurance covering the **same** subject matter for the **same** loss. The insured claims the entire amount from one insurer. That insurer can then commence an action to recover a portion of the loss from the other insurer(s).

The insurer commences the action in their own name (unlike subrogation), and the relevant party that it is suing is the other insurer (unlike subro where the other party is the one responsible for the loss)

Under the CL contribution entitles an insurer, upon paying an insured the full value of a loss, to recover part of the payment from other relevant insurers – although states often alter this to limit each insurers' initial liability to the insured to a portion of the total insurance coverage from all relevant insurers.

Continental Insurance Co v Prudential Insurance Co (1965 DLR)

Facts: At the time of the fire, Continental and General Accident Assurance Co each had a policy in force insuring Leclaire's building against loss or damage by fire. Continental, General and Phoenix paid the loss. They claim that Prudential is liable and bound to contribute to them Prudential's pro rata share of loss and damage
Issue: Whether Prudential's policy was in effect at the relevant time
Reasons:

- **Section 544 of the *Insurance Act* - its effect is to make each insurer responsible only for a given portion of the total insurance on the property described in the policy. An insurer can only be sued for its rateable portion**
    - The purpose of the clause is to limit the original liability of the insurers instead of requiring them to seek contribution from each other
    - Without this provision the insured would be at liberty to proceed against any one of the insurers, leaving it to the insurers to obtain equitable contribution among themselves
    - This section doesn't give one insurer who has paid more than his pro rata share the right to claim contribution from another insurer who has not
- The right to claim contribution may exist apart from s 544 - but this claim doesn't sound in contract and isn't a statutory right - it is an equitable right
- **It wasn't the intention of L that there be quadruple insurance, and he intended to cancel the policy – not equitable for Phoenix to say that it was paying more when it was the party that persuaded L to cancel his other policy**

Takeaway: this case is important for the effect that statute can have on the doctrine of contribution, and discussion of contribution as an equitable right

Musca v Wawanesa Mutual Insurance Co (2001 ABQB)

Facts: Plaintiffs had two policies for automobile insurance, purported to cancel one, and then got in a car accident
Issue: Is the applicant entitled to benefits totaling $1 million divided between the two insurers, or benefits of $1 million from each insurer?
Reasons:

- When an insured holds more than one policy of insurance that covers the same risk, the insured may never recover more than the full amount of the loss
    - The insured may select the policy under which he claims indemnity and that insurer is entitled to contribution from other insurers who have covered the same risk
- **Cancellation becomes effective immediately upon the request being made, but the request is only made once it comes to the attention of the other party**
- **Termination of a contract can't occur unilaterally - the *Insurance Act* includes specific provisions for this, contemplates the existence of more than one automobile insurance policy, and defines who liability is to be shared as between the insurers in such circumstances - but these sections don't preclude the existence of two valid policies or limit recovery to only one policy**

Family Insurance Corp v Lombard Canada Ltd (2002 SCC)

Leading case on contribution
Facts: Insured owned a horse stable, had $1 million coverage and $5 million under another. She was sued because a person was injured while riding horses at her stable. Insurance companies refused to pay because both had clauses that made them an "excess insurer" to a primary insurance policy (means the primary insurer would pay first, then excess second).
Issue: what was the extent, if any, of the liability of each insurer?
Reasons:

- Court will not allow an insurer to recover on the basis of contribution if it thinks the insurer has acted unfairly (equitable doctrine)
- **Threshold criteria for application of contribution set out:**
    - All the policies concerned must comprise the same subject matter
    - All the policies must be effected against the same peril
    - All the policies must be effected by or on behalf of the same assured
    - All the policies must be in force at the time of the loss
    - All the policies must be legal contracts of insurance
    - No policy must contain any stipulation by which it is excluded from contribution
- **If the policies can't be read in harmony, need to treat the conflicting clauses as mutually repugnant and inoperative**
    - Then the insured policies of both insurers provide the insured with primary coverage, so each insurer is independently liable to the insured for the full loss, as if the other insurer didn't exist
    - Then need to calculate the extent of each insurers' obligation to contribute - primary Canadian view is that **where liability is shared among insurers covering the same risk, the loss is borne equally by each insurer until the lower policy limit is exhausted, with the policy with the higher limit contributing any remaining amounts**
- **Court chooses to use the independent liability approach –** each insurer splits the amount since it fell under the limit of the lower policy (codified in the *IA*)

Holding: Sharing formula in one contract held to not bind the other because there was no privity of contract between the two insurers

Contribution in Statute

The approach in *Lombard* is codified in the *IA* – **sections 544 and 596**

Each insurer is liable to the insured only for a ratable portion of the loss rather than the whole loss, where overlapping coverage exists.

Sec 544: defines ratable portion – being determined on an equal basis for policies having the same insurance basis, and on an equal basis up to the lower policy limits where the policies have different limits

Sec 596: with respect to auto insurance, an owner's policy is generally designated primary, while other applicable insurance is excess

- E.g. if you are borrowing your friend's car and get into an accident, s 596 says that the owner's policy is the primary policy, so whoever sued you would claim against your friend's policy first and then if it wasn't enough to cover the loss, your policy as a driver is then the excess policy to recover against

Subrogation versus Contribution

In a subrogation action, the insurer is entitled to recover the entire amount it paid to the insured from a third party.

In a contribution action the proportionate amount of each insurer is determined and the paying insurer will recover from the others only the amount in excess of its own proportionate share.

Cameco Corp v Insurance Co of State of Pennsylvania (2010 SKCA)

Facts: Helicopter crash. One of the insurers paid out the insured then tried to exercise its right to contribution, but was time barred so tried to advance a subrogation claim.
Issue: whether, where more than one insurer has issued a policy of liability insurance with respect to the same risk and one of the insurers has fully indemnified the insured, the paying insurer can maintain a subrogated action in the name of the insured against the non-paying insurer(s)
Reasons:

- Cameco was fully indemnified by the insurer, so they couldn't have a claim against other insurers
- Where an insured is double insured, the law treats these policies as effectively one insurance policy (can't them make a claim for the same loss against other insurers)
- Subrogation only applies against third party tortfeasors – contribution is about proportionate liability to recover from other insurers

Chapter 3: *Uberimma Fides* - the Insured's Duty to Disclose

Common Law Principles

Insurance contracts are one of "utmost good faith" or "*uberimma fides*" – **requires that the parties act absolutely honestly with each other and disclose all material facts within their knowledge relating to the insured risk UP UNTIL THE CONTRACT IS ISSUED.** It is strictly enforced because successful underwriting depends on full disclosure of all matters that bear on the risk.

This duty **goes both ways –** insurance company must respond promptly and reasonably to a claim (although this rarely arises today)

CL concept, so applies and arises at CL unless altered by statute or contract – applies to all contracts and lasts for the duration of the contract, exists apart from the express terms of the contract, applies to both insured and insurer.

Requires:

1. Parties to treat each other with total honesty and be completely fair in their dealings with each other
2. Duty of utmost good faith – **give the other parties interests equal consideration to their own**

Duties:

1. Insurer must respond to an insured's claim in a timely and reasonable manner
2. Insurer must not do anything to compromise the interests of the insured and vice versa
3. Insured must be completely honest and forthright with respect to claims, and
4. Insured is required to be **completely honest, forthright and forthcoming in providing insurer with info relevant to coverage (duty to disclose)**

Holds the insured responsible for both **failures to reveal info (omission) and misrepresentations (active misrep of fact) – equally liable**

- Applies even if the insured did not intend to mislead the insurance company
- Breach of this duty means the contract was not properly formed, so it may be void (*ab initio*)
- Compare to misrep in an ordinary contract, where can't void *ab initio* – misrep in an insurance contract can be void even if that term doesn't form part of the terms of the contract

Underwriters distinguish between the "physical" and "moral" hazards presented by insured events – it is their job to judge the risk – whether coverage should be provided, and what premium should be paid

- Physical: something about the actual thing being insured (e.g. location of property)
- Moral: something applied to that thing (e.g. if the insured has ever been convicted of arson)

Problem: not always easy to figure out what is an important risk factor to the insurance company, e.g. risk factors for auto insurance may include if you're emotionally unstable or subject to personal or financial criticism.

Bhasin decision

- Is unclear if it extended the duty of good faith for insurance contracts, but did confirm that insurance contracts have this special duty of good faith because of their personal nature

Duty to Disclose

What happens when an insurance company discovers a breach of the duty to disclose

3 options:

1. Repudiate the contract (voidable contract at instance of the insurance company)
2. Treat the contract as being valid and subsisting despite the breach
3. Can treat the contract as valid despite the breach, but cancel the contract after the breach either unilaterally (pursuant to statutory conditions) or by mutual agreement

If the company chooses to declare the contract void *ab initio*, they have to return all of the premiums

Where a contract will affect others: the insurance company cannot void it for breach of the duty to disclose with respect to that other party, unless they were also party to the breach (can't void with respect to an innocent third party) – e.g. insurance on your house, may have named mortgage company as an insured

Ability to void the contract depends on:

1. Any obligation owed by the insurer to a third party (e.g. mortgage clause)
2. The insurer must refund the premiums *from the date of the breach*, and
3. The insurer must advise the insured of their decision to repudiate – if they don't, may be estopped from voiding or viewed as having waived their right to void

Note: there are a few Canadian authorities suggesting that the insurer doesn't need to return the premiums if the disclosure is *fraudulent* (intended to deceive the insurer).

Scope of the Duty to Disclose

Insured is required to tell the insurance company all material facts within its knowledge. This duty exists only up until when the contract is formed and doesn't exist after that

It limits the things that an insured has to tell the insurance company to facts, not opinions. It does not require the insurance company to tell material facts to the insurance company already knows, should know, or has undertaken to find out themselves. The insured is required to tell material facts to the insurance company, whether or not they know it is material.

Remaining questions: What is a material fact? What exactly has to be disclosed (what is a fact "within the insured's knowledge")?

Carter v Boehm (1766 Court of King's Bench)

Facts: Carter was governor, took out a policy of insurance against the fort being taken over by a third party. Claim denied by insurance company on the basis that he had anticipated a French attack and failed to advise the company, which was a breach – court found for Carter, said it was anticipation and not fact.

Reasons:

- The CL duty of disclosure requires an insured to disclose information which the insured knows or which the insured reasonably ought to know, even if the insured does not realize that the information is material to the insurance contract
- The scope of this duty is limited by the knowledge of the insurer - the insured does not have an obligation to disclose facts which are matters of common knowledge, facts which the insurer waives knowledge of or undertakes to discover by other means, or facts that are already known to the insurer
- **Basic principles of the duty to disclose:**
    1. Because the assessment of risk is based on info provided by insured, there is an absolute duty on the insurer to disclose all material facts to the insurer
    2. That duty only exists up until the contract is formed
    3. Limits the duty to disclose to *facts, not opinions*
    4. Insured doesn't have to mention things that the insurance company *already knows*, e.g. things that they take upon the duty to find out themselves, that they waive knowledge of, or that is plain and obvious to all
        i. Can't complain of a breach if the company itself says it will find out the info
    5. The CL duty requires the insured to disclose info that they know or ought to know even if they don't know that the info is material to the insurance contract
        i. Problem because not always clear what is material
        ii. Doesn't matter if you know its important - if it is important you have to tell, if not you're in breach

Main question for courts with breach: **is the risk undertaken by the insurance company different than the one they thought they were undertaking?**

Material Fact

Material fact – REASONABLE INSURER TEST from *Mutual Life:* whether if the matter concealed or misrepresented had been truly disclosed, it would have on fair consideration of the evidence influenced the insurer to have charged a higher premium or decline to issue the policy.

- This test is intended to be *objective*; it is a question of fact in each case. Objective elements include:
    - The test requires a court to review non-disclosure through the eyes of a reasonable and prudent insurer; and
    - The test provides clear criteria for determining whether non-disclosure was critical to formation of the contract (i.e. coverage would be refused or the premium would have been higher)
- It is not what the reasonable insured would have considered material, it must be considered *in relation to the insurer's acceptance of the risk*
- It is not defined in a way that automatically makes all questions asked on an application form material, because this puts the insured in an unfair position of *guaranteeing* the veracity of even the most irrelevant info requested by the insurer

Time for assessing materiality is the *date of formation of the contract.*

At CL, the *relationship* between the subject of the non-disclosure and the loss is irrelevant (doesn't matter if there is no connection). If you fail to give proper disclosure, there is still a breach.

Non-material facts: non-disclosed info is not material if it would have resulted in a lower premium, if it would have had no effect on the premium or decision to provide coverage, or merely delayed the formation of the contract.

Mutual Life Ins Co v Ont Metal Prod (1025 DLR)

Facts: Life insurance policy was taken out on S. On the form he asked whether he had been treated by a physician or was being prescribed medication, and he answered "no", even though he had received several rounds of injections from a doctor (but this wasn't prescribed for any illness). S died of cancer that was unrelated to the injections. Insurer denied coverage because of his failure to disclose injections. At trial the insurer called a physician *employee* of the company, who said that he didn't think the company would have done anything differently if the injections had been disclosed

Reasons:

- Court found that S had failed to disclose the injections
- They were not material facts, because if the injections had been disclosed they would not have impacted on either (1) the insurer's decision to issue the insurance, or (2) the terms (premium) agreed upon
- Therefore, no breach of S's duty to disclose
- Privy Council said material fact is not what a **reasonable insured** would have disclosed, instead must be considered **in relation to the insurer's acceptance of the risk**

Knowledge

What does the insured need to disclose?

Need to disclose facts that the insured knows or reasonably ought to have known, whether you know it is important or not (CL rule). This applies only to the insured's awareness of the facts themselves, not the insured's appreciation of the significance of those facts to the insurance contract.

There is a limitation on what the insured has to disclose to the insurer. In *Carter v Boehm*, the duty of the insured is limited by the knowledge of the insurer. No duty to disclose facts:

1) Already known to the insurer;
2) Matters of common knowledge/general facts related to the nature of the insured risk; and
3) Matters of which the insurer has waived knowledge or undertaken to find out by other means.

Why is it that if the insurance company already knows something, there is no breach in the duty to disclose? Because the reason for the duty to disclose is because the insurance company relies on the insured to disclose information, so if the insurance company isn't rely on the insured, why should there be a duty to disclose? There is no **reliance**.

What knowledge is the insurance company expected to have? When can it be presumed it should know something?

See Canadian Indemnity

Canadian Indemnity v Canadian John Mansville Company

- Asbestos case – insurance company said that the insured didn't tell them that asbestos causes asbestos lung. Court said that everyone knows that and everyone in the industry knows it, so that's on the insurance company
- **The presumed knowledge of an insurer includes matters known by the general public and facts available and customary or well-known in the field in which it insures**
- If the insurer is providing coverage in a field, they need to know everything that everyone in the field would known
- Need to have the knowledge of the *reasonably competent insurer*

In contrast…

Coronation Insurance

- Terminated coverage after Taku Airlines had accidents. They misstated accidents – Taku said Coronation had their previous accident history in their files and could have had this info at any time – **this is different from an insurance company saying they will find out the info** (contract held to be void)
- In obiter: when the insurance is for the benefit of a third party, the insurance company can't just look to the info given to them by the insured, have to look to outside sources to confirm
- **Takeaway:** a reasonably competent insurer might vary based on whether the insurance is for the benefit of an insurer or an insured, at CL

Efforts by other courts to limit the duty of disclosure:

- Ontario: *Sagl v Cosburn* (distinguished in *Mohammed*)
    - Court held than an insurance company breaches its duty of good faith when the insurance company fails to ask for info and then denies the policy later. Basically the insurance company needs to ask, very big difference - important because can lead to punitive damages
- New Brunswick: *Thomas v Aviva Insurance*
    - Obiter suggested that the duty was on the insurance company to advise what facts were material

Mohammed

Most recent Ontario CA case on the topic, appealed to SCC

- M applied for insurance coverage, the company asked where he had lived and he failed to disclose that he had lived in Greece as part of a terrorist group and had a past conviction for manslaughter there. The court found this was a material issue and distinguished *Sagl*
- Court held that *Sagl* merely allowed a judge to infer that a question or info was *not* material (company knew about an issue in *Sagl* and didn't ask for ownership) – here simply asking about where someone lived
- Court backtracks on its decision in *Sagl* to say that the insurance company doesn't have to ask

***Badenhorst v Great West Life Assurance Co* (2013 MBCA)**

Top case until Mohammed decision comes out

Facts: The respondent applied for disability insurance with GWL, and answered "no" to questions asking about whether she had received treatment or counselling for any psychiatric disorder or had had a consultation with a physician or therapist. She had actually done both, but said that she didn't believe the questions were directed to whether she had attended marriage counselling b/c she didn't think it had anything to do with her health

Issue: Did she fail to disclose material facts, and if so, is the policy void?

Reasons:

- Disability contracts are *uberrimae fidei* - an applicant is obliged to disclose all material facts bearing on the risk to be insured - if this isn't done then the contract is voidable by the insurer
- **Materiality is to be considered only from the point of view of the reasonable insurer, and not the insured**
    - The test for materiality is whether the facts in question would have influenced a reasonable insurer to decline the risk
    - **Good faith on the part of the insured arising from his or her innocent failure to appreciate the materiality of the matter in question is not considered to be a defence against a misrepresentation**

- The life insured's duty is to disclose to the insurer the *fact* of all their symptoms, consultations and medical treatments or tests regardless of the life insured's own belief as to their importance

Holding: the respondent incorrectly answered relevant questions on her application, materiality was proven

Takeaways from *Badenhorst*:

1) Subjective opinion of the insured in interpreting the questions is irrelevant
2) Materiality is considered from the point of the insurance company, not the insured
3) Innocent failure to disclose info is not a defence

How to prove materiality?

In *Badenhorst:* insured will be found to have breached their duty to disclose, if the fact that they failed to disclose is material, in that it would have adversely affected the decision of the insured to insure the risk or set the premium.

How does the insurer prove that fact?

- *Objective test* – so the best evidence would be an *objective* source who can testify as to the standard practices in the insurance industry
- In *Ontario Metal Products* they accepted the subjective evidence of the insurer as to its practices

But the opposite occurred in Henwood…

***Henwood v The Prudential Insurance Co* (1967 SCR)**

Using subjective evidence

Facts: Insured was 21-year-old woman; previous to applying for insurance she had gone through an emotional crisis, consulted with doctors and took meds. Made life insurance application - asked if she had been in hospital or consulted a physician, didn't disclose any info about the condition. Later insured was killed in vehicle accident. When insurance company attempted to void for breach of disclosure - court confirmed that untrue info had been said

Issue: whether failure to disclose was a material fact

Reasons:

- Company called one of their own employees that was a doctor - testified if the company had known, the premium would have been higher - no evidence called by the insured to contradict this
- Only evidence wasn't objective info - court found in the absence of any info to suggest another expert would have done something differently, subjective info would be considered "some evidence"
    - **Can call one of their own employees to give evidence, will be considered some evidence and sufficient if the plaintiff doesn't call their own objective evidence - will likely be stronger objective evidence**

Dissent: onus of establishing misrep and the materiality of the facts is on insurance company, since it had admitted it was unaware of other practices their own decision couldn't be equated to a "reasonable insurer"

Changes to the Duty to Disclose in the *Insurance Act*

Order to analyze every question!

- Common law
- Statute
    - Statutory conditions
- CL alteration of statute
- Does the contract alter any of the above?
- Can the contract change the statute?
    - A contract can change the statute to make it more favourable to the insured, but not less favourable to the insured

General Insurance

Section 540 – statutory condition 1

1) When can an insurer void a contract for breach of a duty to disclose?

    a. Term "fraudulently omits" – intention is narrowed to be fraudulent or intentional
    b. Contract is void "as to any property" – this changes the CL in that the insurance company is no longer to void the contact entirely, only as to any property in which the misrepresentation or omission is material
    c. "Describes the property to the prejudice of the insurer": not whether the reasonable insurer test would cause them to decline, but if you falsely describe the property to the prejudice of the insurer

    Overall:
    - Must be a material representation
    - Contract is void with respect to the property to which the misrepresentation is material
    - The omission must be fraudulent, so there is a required intent element

    Cases: *Taylor, Bowes*

Material Change in Risk

Section 540

2) Material change in risk, statutory condition 4:
    a. Under the CL, the time at which the risk is judged is the time of contract (don't have to tell the insured if any circumstances when you applied for insurance have changed)
        i. **Change in *IA*:** requires the insured to tell the insurance company if after they have entered into a contract, the risk has changed. Makes the duty to disclose last past the formation of the contract, to the entire time the contract is in force
    b. "Within the control and knowledge of the insured" – the first half of this is new, quite unclear what it means – this section is used by courts to try and come up with some outcome-based decisions that don't have a lot of consistent rationale (see *Pearl Assurance*)

    Overall:
    - There is an ongoing duty to report a material change in risk
    - Need to report a change in facts that the insured knows or reasonably ought to know, that is in control of the insurer

    Cases: *Pearl, Watkins, Marche, Schellenberg*

Automobile Insurance

Sections 554(1) and (2), 556

1) Automobile insurance – misrepresentation, fraud or violation of condition (1):
    a. Change to intent – if an applicant for a contract gives false info on the prejudice of the insured, or knowingly misrepresents, a claim by the insured is invalid
        i. Change to "knowingly misrepresents" here suggests the duty to disclose has an intentional element (see *Sleigh v Stevenson*)
        ii. Does modify the duty to disclose, but only so far as you would reasonably know what is in the insurance application – if you are aware or should have been aware, you still misrepresented even if you didn't read the application
        iii. Knowingly doesn't mean fraudulently and doesn't mean an intent to deceive

2) Automobile insurance – (2):
    a. Alters what is a material fact because it suggests that the only things that will result in a breach of a duty to disclose is if you knowingly misrepresent or fail to disclose any fact required to be stated in the application (basically a statutory implementation of the principle that "if you know it is material, ask for it"

b. Different remedy – a claim by the insured is invalid and the right of the insured to recover the indemnity is forfeit – different than being able to void the policy (because part of auto insurance is liability insurance for the benefit of all drivers)

3) Automobile Insurance – s 556 statutory condition 1, material change in risk:
   a. After the date of contract formation, an insured must inform the insurer of material change to the risk
   b. Leaves the duty to disclose as it is in the CL but extends it to the entirety of the auto policy
   c. This applies only to the named insured

   Overall:
   - If the applicant gives false info or knowingly misrepresents, the claim is invalid (intentional element)
   - The only things that will result in a breach of the duty to disclose is if you knowingly misrepresent or fail to disclose (different remedy)
   - Duty to disclose is extended to the entirety of the auto policy for the named insured

   Cases: *Sleigh, Moxness, Merino, Seeteram*

Misdescription, Non-Disclosure, Misrepresentation

Taylor v London Assurance (1935 SCR)

Facts: many fires in the area, Taylor called to request fire insurance. Agent asked if there were any fires, and she said yes all over the country but didn't disclose that there were fires in the next county over. Insurer refused payment on the basis that she breached her obligation to breach facts

Reasons:

- This was a misrepresentation, but it wasn't intentional
- Found that the change in the statute **narrows the CL duty to be fraudulent or intentional**

Takeaway: "Fraudulently" connotes actual fraud – the words of a condition must be read in their ordinary sense

Bowes v Fire Insurance (1936 Ont SC)

Addressed whether fraudulent or intentional applies to omissions or also to misrepresentations

Facts: Insurance company denied coverage because they asked the insured if they used "metal patterns" and the insured misunderstood and answered incorrectly

Reasons:

- This was a misrepresentation, but was accidental
- Court said that the statutory condition does not change the intention for a misrep – **misrepresentations, whether fraudulent or innocent, will result in a breach of the duty to disclose**
- **An omission has to be fraudulent or intentional to result in a breach of the duty to disclose**

Changes Material to the Risk

Nahayowski v Pearl Assurance (1964 Alta SC)

Facts: P sold the premises with a conditional sales agreement. Default on the mortgage, P began foreclosure proceedings. She had a right to apply for a final foreclosure in May, in Feb the P purchased her own insurance after the purchaser moved out. Heard some windows were broken, knew the premises was vacant. After it burned down the insurer refused to pay insurance because it was vacant. P argued that statutory condition 4 required control and knowledge, and she only had knowledge, no control over the vacancy of the premises

Reasons:

- She had control - could have had a final order for foreclosure and taken control of the property, and she had sent her brother to board up the windows (exercising physical control over the property)

Note:

- Exclusion for property being vacant is common in insurance contracts - courts have interpreted this to mean if the vacancy is less than 30 days, this isn't a change material to the risk
  - Vacancy: generally considered "nothing in the property" - no furniture, clothes, etc.

    - Unoccupied: means no people
- If no exclusion in the contract, possible that failure to give notice may still be considered a change material to the risk - not anticipating that because no such exclusion, this might be a change material

Watkins v Portage La Prairie Mutual Insurance Co (1986 DLR)

Facts: W leased her property to S. When he stopped paying rent she asked him to leave. S asked W to move back in and he would stay on as a boarder. After he was supposed to have left W placed fire insurance and theft insurance over the property. Later she discovered he had stolen her property and left. W made a claim was it was denied on the basis that she had failed to advise of change that was material to the risk (the tenant was in the property rather than the owner)
Reasons:

- Statutory condition 4 makes it clear that the insured must have control of the *risk* - not control over the *property*
- W had knowledge but no control because she couldn't physically deal with him and had tried and failed to get him out
- In this case, control meant actual physical control of the property and W didn't breach the duty to disclose
- Note: Pratt says this is a case of the court creating the result that they want

Note: if the change material to the risk is unrelated to the loss, this doesn't matter – can still be a breach of the duty to disclose (see *Marche*)

Marche v Halifax Insurance Co (2005 SCC)

Facts: Owners of a house left the house vacant when they left the province - they didn't inform Halifax Insurance that the property was vacant, and it burned down. Halifax couldn't establish a vacancy at the time of the loss, but denied liability under the contract of insurance on the ground that the owners had not advised them of the earlier vacancy and that this constituted a change material to the risk that voided the policy.
Issue: Does section 32 apply to statutory conditions? (says that if a contract contains any condition that is material, it won't be binding on the insured if it is held to be unjust or unreasonable)
Reasons:

- Didn't matter that the change material to the risk was unrelated to the loss
- But - this relief against forfeiture section is very different from the one in AB (s 520)
- Court can refuse to uphold the section if the application is unreasonable - says here it seems ridiculous that the vacancy would prevent the insurance from being paid - used the **relief against forfeiture section** to do so

Dissent: Relief against forfeiture only applies to conditions in a contract that are unreasonable on their face, can't apply to statutory conditions - these aren't unreasonable because they're statutes
Takeaway: **doesn't matter for the purposes of the breach of the duty to disclose whether the material change of the risk is unrelated to the actual cause of the loss**

Schellenberg v Wawanesa Mutual Insurance Co (2020 BCCA)

Facts: Appellants had a legal medical marijuana grow operation in their outbuilding. They did not declare this as a material risk and stated that they did not read the renewal documents. A fire burned the building down and Wawanesa argued it had met the test for voiding the appellants' policy under statutory condition 4
Reasons:

- Court doesn't apply the reasonable insurer test because no expert evidence called
- Doesn't matter that the cause was unrelated to the risk - found there had been a misrep and there was a breach of the duty to disclose
- Considered relief from forfeiture - but said it **didn't apply relief from forfeiture since the insured knew the grow op was material and didn't tell this was fraudulent, and R from F is an equitable provision**

Automobile Insurance: Non-Disclosure and Misrepresentation

Sleigh v Stevenson (1943 DLR)

Facts: Mr. C was trying to get insurance for his car, and knew his insurance rate would have been high so he claimed that his mother owned the car. His mother signed the insurance application for auto insurance without having read it, and certified that she was the owner. The company denied coverage on the basis that Mr. C and his mother had knowingly misrepresented the facts
Reasons:

- Can't avoid duty of disclosure by failing to read an application form
- **Does modify the duty to disclose, but only so far as you would reasonably know what is in the insurance application**
- If you are aware or should have been aware, still misrepresented even if you didn't read the application - knowingly doesn't mean fraudulently, doesn't mean an intent to deceive

Moxness v Co-Operative Casualty Co (1979 SC)

Facts: M was buying a car and had to obtain insurance - to do so he used an insurance agent. The agent asked information from M for his insurance application. M did not disclose all information about his prior car accidents, and the agent said that when M couldn't remember the dates of his speeding tickets, that he would just get the information from the Edmonton Motor Vehicle Branch.

Reasons:

- M did disclose his prior driving convictions to the agent on the phone - this representation was material and continuing - he knew the agent had obtained this information
- **The duty is a duty to disclose and you can't disclose what you don't know. The obligation to disclose necessarily depends on the knowledge you possess**
- **This differs from *Sleigh* because here the insurance agent took it upon himself to find out the info from the Branch - M can't be held liable for a misrep if the company takes it upon itself**
- Pratt thinks the better analysis is that there can be no misrep when the insurance company undertakes to get it, not that it was innocent

Holding: The insurance company can't deny its obligation to M because he "knowingly misrepresented or failed to disclose material facts required" in the circumstances

Merino v ING Insurance Co of Canada (2019 ONCA)

Facts: Insurance company found that the misstatement in the automobile insurance application constituted a material representation that entitled them to rescind the contract, and that the insured had previously rescinded the contract by its 2002 letter

Issue: is an automobile insurer entitled to rescind an automobile insurance contract at CL, making it void ab initio, based on misrepresentation in the application?

Reasons:

- Makes it clear that nothing in s 554 says that the policy is void or voidable for a breach of the duty to disclose
- Main remedies for automobile insurance: claim by the insured for property damage is forfeit, right of insured to recover is forfeit
- Idea that the section says "knowingly misrepresents or fails to disclose"
    - **An omission has to be knowing, a misrepresentation doesn't**

Note:

- Omissions and misrepresentations may be hard to discern, which is why its hard with the "knowingly" qualification
- Could be an argument over which it is, when there is a different intent applied to the duty to disclose for each

Automobile Insurance: Changes Material to the Risk

Seetaram v Allstate Insurance Co (2019 ONSC)

Facts: couple applied for auto insurance, had a son with a G1 license. A question on the application asked if there was anyone else in the house licensed to drive, they answered no. He got a G2 license, auto policy sent a renewal and asked them to review info to ensure it was accurate, which it was not. Father read the renewal but didn't think it needed to be changed, mother didn't read.

Reasons:

- **These legal principles have been applied to the failure to disclose other licensed drivers in the same household:**
    - Standard automobile policy is that the insured must provide notice of any significant change in the status of the driver, owner or lessee of the automobile, including any additional drivers or a change in the way the automobile is used
    - Statutory Condition 1 is deemed to be known to the insureds as part of their automobile policy
    - An automobile policy is not a single continuous policy with one application or offer and one acceptance - instead, it expires at the end of each term and the renewal represents a new contract
    - Heavy burden placed on the insured to provide full disclosure
    - A fact is material if it would influence a prudent insurer in deciding whether to issue the policy or in determining the amount of the premium
    - The duty to disclose all material facts applies even in the absence of questions from the insurer, although the absence of a question may be evidence that the insurer doesn't consider a fact to be material

- The obligation of good faith requires an applicant to carefully read questions in the application - can't rely on carelessness or forgetfulness
- Can't escape the effect of the misrepresentation by stating that he or she didn't read the document before signing
- An "innocent misrepresentation" by the insured engages Statutory Condition 1
- An insured's application for insurance is not the broker or agent's - the agent has no legal duty to ensure the accuracy of the contents
    - Not quite accurate - if the agent is an independent insurance agent then Pratt agrees, any misrepresentation made on the form even if the agent knows the case is the insured's representation. But if the insurance agent is employed by a company and solicits you and you tell them an answer specifically and the agent changes the answer, can be argued that you haven't misrepresented the facts because the company knows the truth
- Applicants relied on *Thomas* for the proposition that an insurer has a duty to explain to the insured what constitutes a material risk - but the Court says this principle has expressly not been followed in Ontario - the insurer must only prove that the insured was aware of the change and that the change was within the insured's control

Holding: the insurer does not have a duty to explain to the insured what constitutes a material risk

Life Insurance: Misrepresentation

This section has no statutory conditions.

Change in s 652: **the duty to disclose is extended to both the life insured and the party applying, if they are different – it is only a breach if neither disclose it (as long as one or the other does)**

This does not change the intent required in the CL duty to disclose – it survive in this section for life insurance (must disclose if it is material, whether or not you know its material)

Murphy v Sun Life Assurance Co (1964 DLR)

Facts: M had a fainting spell, was checked by two doctors and told there was nothing wrong with him. He later applied for life insurance and answered "no" to the question of whether he had ever fainted. The insurance company purported to void the life insurance policy on the basis of a misrepresentation of fact

Reasons:

- Court confirmed that it doesn't matter that the misrep was innocent, that he didn't understand the questions were material, or that he didn't intend to defraud
- **Does not matter what the cause of death was, this doesn't affect the outcome - the question is whether in the circumstances the policy was issued, a reasonable insurer, knowing all of the facts, might have refused to issue the policy or only issued it at an increased premium**
- Question about whether the question was material - if proper answers were given the company would have postponed granting the insurance until it had the doctor's report and the policy would be different
    - No inquiry as to whether this would be the opinion of the reasonable insurer - **court found this was sufficient anyways, there was a good probability they wouldn't have issued the policy or issued a different one - Pratt says this is NOT the reasonable insurer test and is subjective**

Life Insurance: Incontestability Clause

Because it is harsh to require a person to disclose all info whether they know it is material or not when applying for life insurance, statute balance this out with the incontestability clause

Sec 653(2) of the IA: if your life insurance contract is in effect for two years, the insurance company can't repudiate the contract for a breach of duty to disclose unless it is fraudulent

Mohammad v The Manufacturers Life Insurance Co (2020 ONCA)

About misrep and incontestability

Facts: The deceased had purchased life insurance, which did not ask any questions about his status as a citizen but did state that the company may cancel the policy or deny a claim if any answers are incorrect. Unbeknownst to the appellant (husband of the

deceased) her husband had been convicted in Greece many years prior and was a member of a terrorist entity, and entered Canada under an alias. The insurance company voided the claim

Reasons:

- Court distinguished *Sagl* made it clear that the CL doesn't require the insurance company to ask about something they think is material
- Court found the insured knew his activities would be material based on the evidence
- More than 2 years had passed, so the question was whether this was a fraudulent misrep so they could void the policy despite the incontestability clause
- Court found that because he knew the info and withheld it, it was fraudulent and the policy was voided

Bureau v Manufacturers Life (1963 QCSC)

Facts: insured was a 15-year-old boy, seemed to be in good health. Boy's adoptive mom told the insurance agent of a pain in his right heel which he thought was due to being frozen in hockey. Shortly after the application the boy's mom took him to the doctor to help with the pain and the doctor said he needed to have his lower teeth removed. Boy seemed healthy and active that summer. Nothing occurred until a year later when the boy was taken to the hospital and died, cause of death was from a disease in his teeth. Insurance co denied the claim for misrep – incontestability clause so had to prove fraud

Reasons:

- No intentional fraud found because on the facts of the case, the insured was not advised of the severity of the issue, or that it was permanent. The boy also seemed very active, nothing serious to alert the parents

35445 Alberta Ltd v TransAmerica Life Insurance Co of Canada (1988 ABCA)

Facts: Insured died after the incontestability period had elapsed - could he prove fraud to void the policy? Application was signed by the insured but filled out by an agent. One of the questions was whether he had flown besides as a passenger - he answered no but he did fly planes as a hobby, and had suffered an injury from this in the past.

- There were other questions asked later but this wasn't part of the application - matters because s 652 says an application for an insurance must disclose **in the application or in any written statement furnished as evidence of applicability** - limits the info that an insurance company can rely on to be a misrepresentation
- If an insured tells the company something that is false, they can't rely on this - **has to be on an application, medical test or any written statement - this is all that the insurance company can rely on when alleging a breach of the duty to disclose**

Reason:

- Here in the subsequent process the insurance co asked more detailed questions, on the basis of which the insurance company said they believed they could prove the misrep was fraudulent - but can't do this because have to rely on written application
- Judge said can only rely on written facts in an application when you are determining if someone is in breach, **but that breach of duty to disclose did occur in the application - answered no to the question, which was in the q**
    - **Court can look at other info to determine if the disclosure was innocent or fraudulent**
- Said the doctor knew that he was a pilot and didn't disclose, but the - **doctor not considered an agent of the insurance company**

Note: **Other misrepresentations for life insurance:**

S 655(2): misrepresentation as to age

- If a person misstates age to insurance company, company can't void but can adjust the amount payable based on the premium if he had given proper information

S 652(3): misrepresentation for an application for additional coverage

- Renders voidable only in regards to the additional insurance coverage or change, not the original insurance

No ongoing duty for life insurance (unlike automobile) - if you tell the entire truth on the application and then two days after insurance company you start to smoke, etc., don't have to tell anyone

Chapter 4: The Insurance Contract

Formation of the Contract

Insurance contracts are similar to other contracts in most ways in that the law of contract applies. They are **highly regulated** because generally the insureds are less sophisticated than the insurer, and they are usually contracts of ***adhesion***. Four requirements:

1) Offer
2) Acceptance
3) Valuable consideration
4) Agreement to essential terms

The *IA* does have some special rules and elements: **(1)** typically they are not negotiated on a clause-by-clause basis and **(2)** an insurance *policy* is not the same as an insurance *contract*

What can be negotiated?

There are limits on the freedom to negotiate – legislation dictates much of the form and content, insurance contracts generally have to be approved by the government because of the sophistication difference (e.g. third party liability insurance on your vehicle, AB requires a minimum of $20 000 coverage)

What can be negotiated:
1) Premium
2) Limits of policy
3) Duration of coverage

Insurance contracts are contracts of **adhesion,** meaning they are drafted in advance by companies and then sold to clients. Because of this unequal power, the content of the policy is highly regulated to level the playing field. The Insurer must *indicate explicit terms in the policy and not be ambiguous, otherwise the court will likely find in favour of the insured*.

Policy versus Contract

Policy: instrument evidencing the contract of insurance (**section 516(3) *IA*)**
- Does not equal a contract – it recites the terms and conditions, and does not attach to a particular person or interest
- Without the party entering into an agreement to be bound by the terms and conditions, there is no insurance contract
- The policy must be supplemented by the contract setting out the essential terms
- No legal obligations by the mere existence of an insurance policy
- Mere possession of the policy does not create the contract with the insurer, only supports the evidence that a contract is in existence
-

Contract: legally binding – commitment by the insurer to indemnify the insured against the specified loss
- Sets out essential terms
- This is the reason the insurer is bound to indemnify

Van Huizen v Trisura Guarantee Insurance Co (2020 ONCA)

Difference between insurance contract and policy – reiterates the above

- The relationship between an insurance contract and an insurance policy is recognized by the statutory definitions of "contract" and "policy"
    - Under s 1 of the *IA,* a contract means an insurance contract and includes a policy and a certificate of insurance evidencing the contract
    - Policy means the instrument evidencing a contract

Offer and Acceptance

Offer: made by the person *seeking* insurance (insured)
Acceptance: made by the insurance company *issuing* the policy (the insurer)

If offer and acceptance has occurred is a question of fact, courts ask: does the evidence demonstrate that the parties clearly communicated to one another the willingness to enter into the binding insurance based upon the essential terms?

Consideration

Insurer promises to indemnify the insured, the insured promises to pay the premium.

Delivery provision – modification by *IA* in section 522: this provision muddies the offer/acceptance landscape – s 522 says that that *when the policy has been delivered, the contract is as binding on the insurer as if the premium had been paid*

- *Promise to pay* is sufficient in insurance contracts as opposed to *actual payment*
- Exception to this is life insurance because the policy generally doesn't take effect until after the first premium is paid

If someone doesn't pay their premium then the insurer can terminate in accordance with statutory conditions, by giving notice. Most case law related to the delivery provision is in relation to "pink cards" – SCC has said that the pink card along does not constitute a binding policy; it is just an administrative requirement

Agreement on Essential Terms

These terms are fundamental because they go to the question of how much the premium will be. They are about *consideration.*

1) Nature of the risk
2) Duration of coverage
3) Amount of the premium payment required
4) Amount of coverage/policy limits

***Davidson v Global Insurance Co and Ocean Accident & Guarantee Corporation* (1965 OR)**
Shows how the CL applies to offer and acceptance – required contractual elements
Facts: Ocean sent the plaintiff a letter stating, "pending the issuing of the policy, this letter is evidence that coverage as outlined is in force with Ocean" but provided no further details (including a premium, term, etc.). The plaintiff then purchased another policy with Global and informed the agent from Ocean of this. After a fire occurred Global admitted liability but also claimed that Ocean was liable for a proportionate amount
Facts: Does Ocean have an obligation to pay?
Reasons:

- To have a binding contract, the parties must be **in agreement on all material terms (stated above)**
- *Delivery of the policy to the plaintiff does nothing more than make a continuing offer to the plaintiff which was open for acceptance*
- But here, the parties hadn't agreed on the amount of the premium, so no valid policy was in place despite what Ocean had indicated

***McCunn Estate v Canadian Imperial Bank of Commerce* (2001 OR)**
Facts: M and her husband had obtained credit card lines, and along with this the bank provided life insurance. The life insurance was automatically debited every month to the credit card. The bank informed them that they would be stopping the policy of providing life insurance and they must obtain it elsewhere, but continued debiting M's credit card as a result of "administrative oversight". M's estate applied for a determination of rights because the bank refused to pay under the policy
Reasons:

- CA said there had to be **requisite intent to renew the contract or create a new one**, and the intent evidenced by the policy was that it was only to go until age 70. No evidence that the contract was to be extended, or that Mrs. M accepted the contract
- Material terms did not exist here so the bank couldn't be viewed as making an offer to extend the contract – need **a consensus ad idem, an express agreement or circumstances reasonable to infer an acceptance**

Interim Coverage

You might buy a car and want to drive it tomorrow, but the insurer doesn't have time to assess the risk.

The duration of this coverage is less, so the premium will be less – the terms and conditions are typical of normal contracts and the same provisions of the Act will apply.

Note that the insurer isn't obliged to carry on with the contract – if you have interim insurance for 30 days, the insurer can end the relationship. It is in effect until:

(1) It is terminated
(2) It is replaced by the larger, more permanent policy
(3) It expires

Khosah v Canada Life Assurance Co
Facts: P applied for term life insurance. A policy was issued and premiums were automatically deducted. P went to India, while he was gone his business partner cancelled the pre-authorized payments. The insurance company wrote P a letter saying they hadn't been paid, didn't get payment, and the policy lapsed. Could pay to reinstate it provided you did so before the final expiry date of the policy. When P returned from India, Mrs. P realized the partner had cancelled the policy and provided the broker with a new authorized payment form. Canada Life put the money into an expense account, didn't tell P's that it wasn't going towards the premiums. Reinstatement was denied based on new info, company advised him of this but P had passed away 3 days earlier
Issue: Was there a contract in place?
Reasons:

- Coverage was terminated because he failed to pay the premiums, and there was no new contract for temporary insurance
- Temporary insurance agreement was never actually requested by the P's, completed or delivered, so there was no meeting of the minds

***Brochu v Vachon* (2003 Alta QB)**
Whether coverage applied to an event that happened before the policy was issued
Facts: V's owned an ATV and insured it, but at some point cancelled the coverage. V's then decided to reinsure the ATV at 4:20pm, but they didn't know their 12-year-old son had taken out a passenger on it, who was insured. V's didn't know when the insurance would start, all she knew was that she wanted the coverage for the upcoming weekend, didn't request it to be backdated. Vehicle was added after the accident happened and can't be backdated unless it was agreed upon by the parties
Issue: Was there a valid policy of insurance at 1pm when the accident occurred?
Reasons:

- Court should avoid interpretation of the contract that will provide a windfall to the insured
- **The insured can recover for losses before issuance of the policy if the broker and insurer accept the fact that they can be bound for prior incident – but there has to be ad idem for this**
- Here the court said the certificate of insurance was unambiguous as to the date and time of coverage so don't need to discuss the intention of the parties, the policy was deemed to be enforced
- **Takeaway: difficult to convince a court that something was intended other than what was evidenced by policy documentation**

Note: In *Patterson v Gallant* the SCC held that a pink card issued by an insurance company may be evidence of an insurance contract, but it is not itself a policy of insurance - a contract of insurance is not created by the insurer merely supplying the insured with a new pink card (e.g. in the case of an auto insurance offer to renew)

Duration of Insurance

Commencement - generally the policy takes effect on the date and time agreed to by the parties, but this isn't always clear

Termination – need to look at parties' **intentions as expressed in the contract,** but special rules for insurance contracts which often provide for unilateral termination mechanisms. May be terminated in three ways:

1) Natural expiry
2) Mutual agreement
    a. Parties can agree to terminate the insurance contract earlier than expected, but has to be clear evidence that both parties agree to end contractual obligations (question of fact) – see *Ellis*
3) Unilaterally
    a. Statutory conditions regulate unilateral termination methods
    b. The insured can terminate immediately on notice
    c. Insurer can terminate but must give **advance written notice and must return the unused premium. Refund must accompany the notice "as soon as practicable"**
    d. Courts **strictly interpret compliance**

Note: a breach of a statutory or contractual condition may render a policy void, or render a claim invalid while maintaining the contract in force

Ellis v London-Canada Insurance Co (1954 SCR)

Leading case on termination by mutual agreement
Facts: Insurer requested that the policy be terminated and that the insured could get a refund. The insurer had made a misrepresentation on the policy, said they would cancel and refund the policy. The insured received the cheque and cashed it
Reasons:

- Court said that by returning and cashing, they mutually agreed to terminate the policy. Since this happened before the accident in question, the court held that there was no policy in place
- **Surrendering the policy and accepting the full premium equates to a voluntary recession of the contract, can't claim the benefit of the statutory condition**

1037446 Alberta Ltd v Intact Insurance Co (2017 ABQB)

Facts: The company, S, had a fire insurance policy with Intact but neglected to make insurance premiums. At this point Intact sent a notice of termination of the policy from its office in Calgary by mail to S at its business address. The notice stated the effective date of the termination was in December of 2011. S disputes having received the notice of termination, although Canada Post confirmed it received the notice from Intact in Edmonton. A fire occurred at S's business premises in September of 2012, and after filing claim under the policy S was advised the policy was cancelled the year prior
Issue: was the policy terminated?
Reasons:

- **Courts look at the wording of the IA and the specific provisions, and apply them specifically** – since the statutory conditions were met, there was no policy in place
- Even though the act was later amended, this wasn't a clarification of the earlier provision
- **After the notice arrived at the post office, the risk that it wasn't actually delivered to the insured is laid entirely on the insured**

Ontario (Minister of Finance) v Traders General Insurance Co (2018 ONCA)

Very strict policy based interpretation
Facts: A purchased auto insurance for her two insured vehicles, but it was actually her husband L who was the registered owner of the vehicles. When the insurance company was unable to withdraw premiums from A's bank account it sent a notice of termination for failure to pay, but A didn't tell her husband about the cancellation. A's son J was out with friends and allowed his friend M to drive the car, which he crashed. M was killed and B was injured. B then attempted to start an action against the insurance company because L was the owner, but the company stated that the policy was no longer in force
Issue: was the notice of termination ineffective because it wasn't sent to the actual owner of the insured vehicle, when it was sent to the "named insured"?
Reasons:

- The Ont Insurance Act said that the insurer needed to provide an application form to the insured, which they never did. The insurer can't validly cancel the policy unless it gave the *owner* 15 days' notice

- Because the notice was only sent to the insured, and because the policy was an owner's policy, he needed to be the one advised of the termination

***Krupich v Safeco Insurance Co of America* (1985 AR QB)**

Deals with cancellation by statutory condition compliance, insurer must strictly comply with the Act to cancel a policy

Facts: The defendant mailed a notice of cancellation of fire insurance to the plaintiff, but the notice was never received by the plaintiff and a notice of cancellation was returned to the defendant, undelivered. Secondly, the defendant did not mail the refund cheque for the premium until 5 weeks later

Issue: did the defendant properly cancel the fire insurance policy?

Reasons:

- The statutory requirement allows for termination in the two ways, also says that the excess premium has to be refunded to the insured as soon as practicable
- Court found that because the insurer didn't deliver the refund of the premium until five weeks later, that wasn't as soon as practicable
- There was a policy in effect at the time of the loss

Holding: shows the importance of compliance with the statutory conditions, somewhat results-oriented

Lumbermans Mutual Casualty Company v Stone

- SCC held that an insurance contract was successfully terminated where an insurance company had sent a notice of termination and a premium refunded cheque to the insured by mail as required by the terms of the relevant statute
- This finding was made on the basis that the insurer had complied with everything it was required to do under the statute and notwithstanding the fact that the mailed termination notice had been returned, unopened, to the insurance company and had never been received by the insured.

Renewals

A renewal is a continuation of the time beyond what was originally agreed to. Renewal is a question of fact - the SCC has said that when trying to decide if a policy is renewed or not, look at:

1) *The nature of the original policy*
   a. Continuous: policy specifies in the policy that there can be a further extension (e.g. life insurance)
   b. Non-continuous: doesn't provide for automatic renewal, requires a new bilateral contract agreed upon by both parties, need to agree again on essential terms

2) *The renewal procedure that is contemplated*

Where a contract isn't renewed or otherwise terminated early, it will lapse. Reinstatement requires a **new** bilateral agreement

Life insurance is an exception – legislation requires 30 days grace period for renewal (usually renewal occurs once the payment is made)

Interpretation of Terms

Insurance contracts are subject to interpretation by the courts – use basic rules of interpretation. Conflicts arise as to what a policy covers/doesn't cover:

1) Was the risk that occurred, one that was insured? (**coverage**)
2) If the risk is insured, did the losses stem from that risk? (**causation**)

Auto policies often talk about the "use and operation" of the vehicle, need to show causation for coverage – what does this mean?

Courts are mindful of *unequal bargaining power,* the fact that the insurer drafted the contract and that insureds are less sophisticated – courts **impose a high burden on insurers to be specific with wording so insureds can understand these contracts**

Note: need to recite on exam that insurance contracts are contracts of *adhesion,* so insurer must reflect their meaning in the policy

Test in *Consolidated Bathhurst*

Two-part test (slightly modified in *Ledcor*)

1) Step 1: Determine the **intention** of the parties at the time they entered into the contract as revealed by the wording of the contract, and give effect to that intention. Use the following to do so:
    a. Look for the plain and ordinary meaning of the terms not defined
    b. Clearly worded terms should be given full effect in the context of the contract read as a whole
    c. Pick the most reasonable meaning if there is an undefined word with more than one meaning
    d. Objective of contracts shouldn't be negated by a technical interpretation (a result that would result in a windfall for the insurer or an unanticipated recovery for the insured should be avoided)

If after going through these steps it <u>can</u> be determined what the meaning of the terms should be, then you stop here – this is the end of the analysis (but on an exam still proceed after acknowledging this)

2) Step 2: If ambiguity is found – define the disputed term in a way that reflects the **reasonable expectations** of both parties. IF not resolved, then:
    a. Apply contra proferentum
    b. Interpret coverage clauses broadly and exclusions narrowly (benefit of the doubt to the insured and find there is coverage)
    c. Fulfill the reasonable expectations of the parties
    d. Focus on consistent judicial interpretation (so we can look at the case law and know how this term is likely to be interpreted based on previous cases, to allow for *certainty*)

Burden of proof: burden of proving a claim falls on the insured. After this, the burden shifts to the insurer who has to show there is a reason why the claim shouldn't be paid.

Takeaway: if you get to a term in a contract or policy in dispute, the way a court will decide how to interpret is through this test

General Rules for Interpretation of Terms

1. Policies should be interpreted using the wording contained therein – give plain and ordinary meaning to these words
2. Courts analyze on a case by case basis – fact driven
3. Courts apply general principles of insurance contracts to try and ascertain and intention and expectation of the parties
4. Courts keep in mind that the contracts were written by insurers, not insureds

Jesuit Fathers v Guardian Ins (2006 SCC)

Good case for fundamental rules of interpretation – discusses how public policy factors in
<u>Facts:</u> context of residential schools
<u>Issue:</u> did a policy apply to claims of abuse brought against a residential school? How to interpret the word "claim"
<u>Reasons:</u>

- Insured argued the court should interpret coverage broadly because of the public purpose served by insurance
- Court said that we have to look at the actual wording of the policy and read it as a whole – **contextual concerns can't override the established principles of insurance contract interpretation**
- Coverage found not to exist

Note for exam: these are fact driven cases, court is frequently divided and the issues are subjective. For exam, need to show you can go through the steps but not necessarily looking for the "right" answer

Brissette Estate v Westbury Life Insurance (1992 SCR)

Outlines what the steps are and how to resolve, good for showing how divided a court can be when applying these rules
<u>Facts:</u> Husband and wife had joint life insurance. Husband murdered the wife and was convicted. The insurance company brought a motion to dismiss the appellant's claim that the estate was entitled to payment of the insurance proceeds including the accidental death benefits because the contract didn't specify whether or to whom proceeds could be paid in the event that public policy prohibited payment to the designated beneficiary

Issue: did the insurance company have to pay under the policy? Depends on the interpretation of the contract
Reasons:

- Nothing ambiguous about the contract, it clearly said that money should be paid to the survivor – clear intention at the time of entering into the contract
- Because the contract didn't account for this situation, the court did not want to read that into the contract
- It was against public policy to enforce the policy, so the majority found that the insurance proceeds were not payable

Dissent:

- Found the policy to be ambiguous because it didn't specify what would happen to the proceeds. Thought that the insurer shouldn't benefit from a public policy situation, and the survivor should be paid and the money held in a trust for the wife's estate

***Ledcor Construction Limited v Northbridge Indemnity Insurance Company* (2016 SCC)**

Coverage provisions should be construed broadly, and exclusions should be construed narrowly. This case shows how important it is for the court to go through the steps, can have very expensive consequences

Facts: Building of Epcor tower in Edmonton, they had an all-risks CGL policy. Company was retained to clean the windows after it had been constructed. While cleaning the company damaged them so they all had to be replaced
Issue: would the CGL cover the replacement of all the windows, or was this part of the company's work and thus excluded by the workmanship exclusion?
Reasons:

- Court went through the test for interpretation – primary principle that *if you can determine what the term means by giving effect to the intention of the parties, looking at clear language, etc., then do so*. If ambiguity remains, apply contra proferentum, apply coverage broadly and exclusion narrowly
- The court found that after applying the test, the exclusion of what was "faulty workmanship" was ambiguous. It said the purpose behind the builders risk policy is crucial in understanding reasonable expectations in the test – the purpose is to provide broad coverage for projects for high premiums charged and the peace of mind
- **An interpretation of the exclusion clause that precludes coverage from all damage resulting for the workmanship undermines the purpose of the builder's risk policy – best interpretation to reflect the intent is the one by the insured**

Holding:

- Court read the exclusion clause in light of the policy as a whole. Resultant damage was replacing the windows, which was deemed to be covered. But the insurance company didn't have to pay for the windows to be cleaned, which was the work itself
- **Little sympathy for insurance companies when ambiguities occur**

Commercial General Liability Policy (GCL):

Most businesses are required to have this kind of insurance. Every CGL policy excludes coverage for negligent workmanship.

Every CGL policy contains this exclusion: "this policy does not ensure the cost of making good faulty workmanship, unless physical damage was not otherwise excluded by this policy results" – means always an exclusion for *negligent workmanship, but exception to the exclusion is resultant damage*

***Funk v Wawanesa Mutual Insurance Co* (2018 ABCA)**

About the SEF 44 and interpretation of a term

Facts: The respondent was driving and had to swerve off the road to avoid being hit by an oncoming car coming into his lane. He suffered injuries and was paid $200 000 from the Fund, but now claims from the appellant a further sum under the SEF Endorsement. The appellant disputes this because there was no physical contact between the cars, and the SEF requires "physical evidence indicating the involvement of an unidentified automobile" and "physical contact of such automobile"
Issue: could the respondent make a claim despite the SEF that said there had to be contact between the vehicles?
Reasons:

- Used the 2 step test from *Bathurst*- court said there was no ambiguity when the contract was read as a whole – *the SPF and the SEF need to be read as a whole because there was only one definition of unidentified motorist*
- Court found that this does lead to an unjust result, but **public policy does not carry the day or trump rules of interpretation (this is very rare), risks throwing certainty out the window, meanings in policies become meaningless**
- **Even if the outcome may seem unjust, the court is very reluctant to do anything but follow the rules or lean on public policy**

Holding: CA found that the respondent couldn't claim

SEF Endorsement

Called a "family protection endorsement", provides that if the party that injures you in an accident has less coverage under their liability section than you do, the policy pays out to the extent of their limits and if the claim is greater than that, your policy will cover the difference.

Will *only kick in* if the limits are different and the claim is beyond the tortfeasor's limits.

Motor vehicle accident claims fund

If someone who doesn't have insurance injures you, or the party is unidentifiable, you can make a claim against this fund for your injuries. It only pays out $200 000.

***Cardinal v Alberta Motor Association Insurance* (2018 ABCA)**
SEF incorporates SPF language. Doesn't matter that the individual didn't know about a provision for it to have effect
Facts: respondent was injured while riding as a passenger in a car that was being driven without the consent of the owner. The respondent's mother had an SPF No 1 policy that contained an SEF 44 Endorsement. The respondent claimed indemnity for her injuries pursuant to the SEF 44, but the appellant denied coverage because there was no consent of the owner.
Issue: is it fair to deny coverage on the basis of facts outside his knowledge?
Reasons:

- **Court said the SEF 44 isn't a standalone policy, it rather specifically incorporates the SPF language – so the exclusion in the underlying policy still applies**
- There is no ambiguity, it is clear here that no consent exclusion exists
- Normal for insurance policies to contain exclusion clauses
- Court applied plain and ordinary meaning test – it doesn't matter that the appellant didn't know the car was taken without consent – remedies like this should lie with the legislature, not the courts

Use and Operation

Almost every motor vehicle policy uses the phrase "use and operation" – ***Amos* is the most important case**

Components of motor vehicle insurance:

1. Part A: third party liability coverage
2. Part B: no fault benefit coverage
    a. If you are in an accident, your own insurer will pay you disability/medical benefits up to the prescribed amount
3. Part C: collision coverage

***Amos v Insurance Corp of British Columbia* (1995 SCR)**
Important case – deals with first party benefits (same as no-fault benefits)
Facts: Appellant was attacked by a gang of 6 men while driving his car, sustained serious permanent and disabling injuries. He was insured by the respondent under a standard auto insurance policy, and applied to the respondent for medical and other benefits under section 79(1) of the Revised Regulation under the Insurance Act, but was denied in lower courts because his injuries didn't arise out of the ownership, use or operation of his vehicle
Issue: did A's injuries result out of the use and operation of his vehicle?
Reasons:

- **Amos two-part test: purpose & causation**
    1) *Purpose* – did the accident result from the ordinary and well-known activities to which automobiles are put?
    2) *Causation* – is there a causal relationship between the injuries and the use and operation of the vehicle, or is the connection merely fortuitous
- Application: driving a van is using the vehicle for its ordinary purpose, so he passed part 1 of the test. Court found that part 2 is also met – the van was more than just the site of the shooting, because it resulted from the gang's attempt to gain

entry into the vehicle, so there was enough of a connection between the injuries and the use of the vehicle. The shooting wasn't random and there was no intervening act to break the chain of causation

Note: important to note that Amos was applying for first party benefits – other cases have distinguished it for this reason (Amos was a no-faults benefit case, expectation of the parties is said to be different)

Citadel General Assurance Co v Vytlingham (2007 SCC)

SEF 44 case as opposed to no-fault benefits case in Amos

Facts: Respondents' vehicle was struck by a large boulder dropped from an overpass by T and A. T and A received substantial prison sentences but M received catastrophic injuries and S suffered psychological harm. The respondents received "no-fault" benefits exceeding one million dollars

Issue: could the V's claim on their SEF 44 endorsement? Was it out of the use and operation of the tortfeasors policy?

Reasons:

- Argument that because they used the vehicle for transportation to the scene, this was use and operation so the policy should pay out
- Court distinguished *Amos* on the basis that it was for no-fault benefits
    - It is helpful to relate the claimant's *injuries* to the "use or operation of a motor vehicle", but it is not a template to resolve indemnity coverage (aka the "motorist" issue) because the type of insurance coverage and coverage requirements didn't require the presence of an at-fault motorist
- Court applied *Amos* test:
    - Vehicles ordinarily used to transporting, so purpose wasn't an issue
    - For causation, **had to be a connection between conduct as a motorist and the injury sustained so this part was not met – there was a break in the chain of causation when he got out of the vehicle and dropped the rock**
        - The rock was what caused the loss, not the use and operation of the vehicle

Use and causation from *Citadel*

Use of a motor vehicle

- SCC says that the phrase "ordinary and well-known activities to which autos are put" signals that someone who uses a vehicle for non-motoring purposes can't expect to collect motor vehicle insurance (can't apply over broadly)
- Coverage can't be denied simply because the tortfeasor is engaging in criminal activity (insurer is selling peace of mind, think of drunk driver example)

Causation

- For coverage to exist, there must be an unbroken chain of causation linking the conduct of the motorist as a motorist to the injuries in respect of which the claim is made
- The claimant must implicate the vehicle in respect of which coverage is claimed in manner that is *more than merely incidental or fortuitous*
- If the vehicle's involvement is held to be no more than incidental or fortuitous or "but for", and is ruled severable from the real cause of the loss, then the necessary causal link doesn't need to be established
- Contribution doesn't mean the tort was committed in the capacity as an at-fault motorist within the meaning of the endorsement – the action of rock throwing in this case was entirely severable from the use or operation of the vehicle

Lumbermens Mutual Causality Co v Herbison (2007 SCC)

Third party liability

Facts: W stepped away from his car with the engine running and negligently shot at a target in the dark that he thought was a deer, but was actually a person. H sought to have the motor vehicle policy satisfy the judgment because the injury arose out of the use and operation of a vehicle

Issue: Can the person recover from W's driver auto insurance policy?

Reasons:

- No – **not every activity associated with the use or operation of a vehicle will engage coverage, and the negligent shooting was an act independent of the ownership, use or operation of the truck. The truck merely created an opportunity for the damage to be inflicted, without any causal connection to the legal basis of tortious liability**
- Automobile insurance requires the victim to demonstrate that the *"liability imposed by law on the insured is for the loss or damage arising from the ownership or directly or indirectly from the use or operation of the insured's vehicle"* - here the use of the truck only created an opportunity for the damage to be inflicted, there was no causal connection

Note: both of the above cases respect the *Amos* interpretation with respect to no-fault benefits, but say that the wording and interpretation here is different than third party benefits interpretation. Intention of no-fault section is so that there is always some opportunity to access benefits, so this is generally interpreted more broadly.

Basically: for no-fault sections, interpret more generally because of intention to provide opportunity to access benefits

Arrunda & Haekel v Allstate Insurance Co (2007 ABCA)

Section B benefits case – adopted Amos but less inclined to be generous with interpretation of Section B after this
Facts: A was driving his vehicle when it was involved in a moving transaction with two other cars, his assailants. The other cars left the scene and he waited by his car for the police to come, but then his assailants came back and he was stabbed to death. The automobile insurance policy stated that the insurance company must pay accident benefits in the event A's death occurred "directly and independently of all other causes by an accident arising out of the use and operation of an automobile"
Issue: could his widow collect section B benefits from the policy?
Reasons:

- Court had to decide whether the death of A arose directly and independently of all other causes out of the use and operation of the vehicle
- Section B required a *direct* connection between the vehicle and the death – the injuries he sustained were the result of an assault, so there was a break in the chain of causation
- Presence of the phrase "directly and independently of all other causes" narrowed the interpretation and required that the use of the vehicle be the direct and proximate cause of the injury – court said that if this wasn't included, the *Amos* interpretation would apply

Note: **Court adopted the *Amos* test, but is less inclined to be generous with their interpretation of section B benefits subsequent to this decision**

On exam, need to note that courts will treat section B claims differently than others. Still need to start with *Bathurst* for intention, then for use and operation cases the *Amos* case is also applied

Derksen v 539938 Ontario Ltd (2001 SCC)

Good example to show narrow interpretation – two concurrent causes doesn't mean coverage should be excluded
Facts: The contractor (Ontario Ltd) was contracted to lay cable. Z was a shareholder of the contractor, as well as an employee and foreman. The contractor owned a truck that was covered by auto insurance, and two other insurance policies - a commercial general liability policy and an excess coverage policy. The CGL excluded coverage for bodily injury or property damage arising out of the ownership, use or operation of an automobile. During clean up of a site Z failed to properly secure a steel plate in the truck. While he was driving it flew off the truck and killed a child.
Issue: which of these policies should respond to the loss, if any? Did the loss arise out of one auto related incident, or were there two concurrent causes? If there were two concurrent causes, did the CGL exclusion apply?
Reasons:

- The accident was the result of two concurrent sources of causation – it wasn't just the "use or operation" of the vehicle
- CA found that the policies all provided coverage – two concurrent causes of the accident, one was the negligent clean up and the other was from driving.
- If there are two concurrent causes, does the CGL still have the effective exclusion?
    - ***Just because there are two concurrent causes does not mean there should be excluded coverage*** – insurers have language available to them that would remove all ambiguity from the clause if they wanted to
    - Need to give intention to the reasonable expectations of the parties
- **Exclusion clauses should be narrowly interpreted, only the loss attributed to the auto insurance should be excluded. The other losses arising from negligence should be covered by the CGL**

Accident

Insurance contracts are designed to pay out uncertain/contingent events. They are not designed to pay out expected things like wear and tear, or something you intended to bring about.

As a general rule, *insurance contracts exclude coverage for expected events. They commonly give coverage to accidents/things resulting from accidental means.*

Grey area in between with negligent accidents – lots of nuance to what constitutes an accident and what should be covered by an accident insurance policy. Trend in cases has been to expand the definition of "accident"

Martin v American International Assurance Life Co (2003 SCC)

Expectations test – *reckless conduct vs accidental conduct*

Facts: The insured, E, was a doctor addicted to opiate medications. He was found dead from an intravenous injection of opioids. His insurance policy describes itself as an accidental death benefit provision, stating that the insurance company will pay the benefit if the insured's death resulted directly, and independently of all other causes, from bodily injury effect solely through external, violent and accidental means

Issue: Was the dosage a deliberate act so that it was foreseeable and not accidental?

Reasons:

- Almost all accidents have some deliberate actions in their immediate causes - to say that these actions were accidental would result in the insured rarely or never obtaining coverage
    - CA said that you don't need to make a distinction between accidental death vs accidental means of death
    - **To determine if death occurred by accidental means, we need to look to the chain of events as a whole and consider whether the insured expected dearth to be a consequence of his actions and circumstances**
    - Death is not non-accidental just because the insured could have prevented it by taking greater care, or that a mishap was reasonably foreseeable. Just because someone engaged in risky activity doesn't mean death wasn't accidental (although at some point, the decision to "court death" becomes equivalent to an intention to die)
- Need to apply the **expectations test to all cases where death appears to be accidental:**
    1) What did the insured, in fact, expect?
    2) If we are not sure – what would a reasonable person endowed with the factual beliefs of the insured and placed in their circumstances have expected?
- Always need to pay attention to the insurance policy – but note that it is always open to the insurer to narrow coverage by means of explicit exclusion clauses
- **Burden of proof:**
    - Onus is on the plaintiff to establish *prima facie* that the death was accidental. The plaintiff must show evidence that permits the trier of fact to infer, on balance, that the insured's death was accidental within the ordinary meaning of that word. The burden then shifts to the insurer to displace these inferences

Holding: doctor did not intend to die, fell within the coverage

Co-Operators Life Insurance Co v Gibbens (2009 SCC)

Interpretation of accident – just because a claimant can establish their problem was unexpected doesn't mean its an accident

Facts: G attempted to claim under an accident insurance policy after having unprotected sex and contracting genital herpes, which in turn causes inflammation of his spinal cord and resulted in him becoming paraplegic. Under the policy, the insurance company was obligated to pay G if he suffered paraplegia through "external, violent and accidental means"

Reasons:

- General principles of interpretation:
    1) Words like "accident" should be given their ordinary meaning - accident is defined as "any unlooked for mishap or occurrence"
    2) A generous interpretation should be given to the term "accident" unless a policy clearly restricts it - need to take care to not convert an accident policy into a general health policy
    3) The words of an insurance contract, when ambiguous, should be construed against the drafter (*contra proferentem*)
    4) Where a policy is ambiguous, effect should be given to the reasonable expectations of the parties
    5) Importance of continuity of interpretation - certainty and predictability are in the interest of the insurance company and the insured

- Need to keep in mind that diseases are transferred all the time from person to person – **don't want to convert an accident policy into a health policy – accident is an event not in the ordinary course**
- Distinguished *Gibbons* from *Martins* because *Martins* wasn't a disease case – **just because a claimant can establish that their problem was unexpected, without more, doesn't establish that the loss occurred as a result of an accident**

Holding: benefits not granted, this would be an overextension. *Martins* was distinguished

Nelson v Industrial Alliance Pacific Life Insurance Co (2012 ABCA)

Unexpected doesn't mean accident

Facts: Was the death of a swimmer from cardiac arrhythmia, triggered by immersion in cold water, a loss resulting from bodily injury caused by an accident within meaning of an accidental death insurance policy?

Reasons:

- An accident is defined as an unlooked for mishap or occurrence, but not ever unexpected mishap is an accident. The term accident must be interpreted in accordance with an ordinary person's understanding, and the entire chain of events must be examined to determine whether a loss was accidental
- Generally, a bodily infirmity caused by disease in the ordinary course of events is excluded from the concept of accident
    - A loss if not accidental, even if unexpected, if it results from disease in the ordinary course of events
    - In the case of a disease which pre-dates the event, there is no coverage is the event "simply provided an occasion on which the pre-existing disease manifested itself
- Here the loss was not accidental, even though it was unexpected. He died from natural and not accidental causes.

Note: for exam need to go through exercise that the court did in terms of applying the general interpretation tests for ambiguous vs unambiguous, then if it deals with accident pull reasoning from this case

Intentionally/Wilfully Caused

Common to see exclusion clauses denying coverage for intentionally causes losses. Easy to understand in the context of arson, but not in the case where the insured's deliberate action results in unintended but foreseeable losses.

Cooperative Fire v Saindon (1975 SCC)

Where an insured intends on causing some harm, or where some action is going to result in harm, an exclusion for intentionally caused loss applies even if the insured didn't intend the degree of damage that was caused

Facts: Dispute between two neighbours. One notices that some of the branches on his tree had been cut off. He goes to his neighbour, who says it was his son. S cut off his fingers with his lawnmower. S had a comprehensive personal liability policy which had an exclusion for bodily damage caused intentionally by the insured

Issue: does the word "intentionally" in the exclusionary clause cover both intentional and reckless acts?

Reasons:

- **Public policy rule – just because you break the law doesn't mean that your insurance policy shouldn't provide coverage, unless you *intended* to break the law**
- Immediate cause of the injury was a combination of the tipping of the mower and the man protecting himself - although the mower raising had more serious consequences than intended, it was still the intentional gesture that caused the damage
- Fell within the meaning of an intentionally caused loss for the purposes of the policy exclusion

Criminal Act

Section 533(2) of the *Insurance Act*

Wong Estate v Liberty Mutual Insurance Co (2009 ABQB)

Facts: Lam worked at a daycare that Wong attended. Wong suffered serious injuries and death while under Lam's care. Lam was convicted of criminal negligence causing death. Lam was insured, but there was an exclusion clause stating that she was not insured for claims arising from bodily injury or property damage caused by any criminal act or willful negligence by the insured

Issue: could the insurer rely on the exclusion clause?

Reasons:

- **Public policy rule in sec 529(2) of the IA:** provides that *unless a contract of insurance provides otherwise*, a contravention of any criminal or other law in AB doesn't render the claim for insurance unenforceable except when the contravention is committed by the insured with intent to bring about a loss or damage
    - Basically: **this section provides that unless a contract of insurance "otherwise provides", a criminal act by the insured does not vitiate coverage unless there was *intent* to bring about the loss or damage**
- The words "any criminal act" in the policy were clear and unambiguous, and L's conduct was criminal, so the *IA* doesn't apply because the exclusion clause does otherwise provide

Holding: the "criminal act" exclusion applies

Vacant or Unoccupied

People will often own rental properties and have insurance on the property, but between tenants their property is vacant. Most of these policies have exclusions for if the property is left vacant

***Taylor v Co-operators General Insurance Co* (2017 ABQB)**

Presence of the appellant to conduct renovations didn't make him an occupant of the property

Facts: respondent owned a house and rented it out. The tenants moved out early so he decided to renovate the house - he slept in a trailer parked adjacent to the house on some days and only used the house to store some tools in it, but did not have any person items inside. A fire broke out and caused serious damage. The insurance company denied the claim on the basis that the house was vacant for more than 30 consecutive days, which is an exclusion from coverage

Reasons:

- Primary interpretative principle of insurance policies - **where the language of the policy is unambiguous, effect should be given to that clear language** - here the term "vacant" was defined in the policy clearly
- When a policy defines a term, care must be taken not to substitute a judicial definition for one chosen by the parties
- The term "resident" in this was a "permanent inhabitant", someone who carries on the normal functions of occupancy of a dwelling
- Conducting renovations to rental premises don't necessarily mean that the owner resides in the dwelling - here there was no evidence that the respondent was residing in the dwelling

Holding: the insurance company was not obligated to indemnify the respondent because the house was vacant

Claims on the Policy

Duties of the Insured

Once a loss occurs, there are a number of steps required for an insured to get paid insurance:

1. Provide notice of loss to insurance company
2. Provide details of claim to insurance company

The insurance company must investigate, verify and respond to claims, which includes:

- Confirm the validity of insurance policy
- Confirm applicability of policy to loss
- Assess amount of compensation owed

To facilitate these steps, the law confers a number of rights and duties upon both of the parties to an insurance contract. CL duties can be altered by **(1) statutory duties** or **(2) contractual duties** – these duties vary depending on the type of insurance in question

Insured's CL duties upon a loss: (part of the insured's duty of utmost good faith)

1. **Provide timely notice of the loss to the company**
2. **Provide an *accurate* proof of loss and amount of loss**
3. **Cooperate with the insurance company (includes not doing anything to prejudice insurer)**

A) Notice of Loss

Timely notice

- An insured must advise the insurer that a loss has occurred if he hopes to recover the proceeds of his policy – *timely notice* is very valuable to the insurance company because it will *allow them to investigate the loss while the evidence is still fresh* and take some action to mitigate its own loss if possible.

Time periods

- At CL there is no particular time period stated to give notice of loss – all time periods are statutory or contractual. It is therefore typical that insurance policies contain an **express provision** (notice of loss clause) requiring an insured to report losses within a specific time period.

- Notices of loss clauses are **often a statutory condition** (remember that actual contractual policy condition cannot be more strict than statutory condition but could be more relaxed).

- The effect of this contractual time period makes timely notice a **condition precedent** to the insured's right of recovery under the policy – insurance company may be able to deny coverage if it didn't receive prompt notice of the claim.

Failure to comply with notice of loss provision

- An insured who does not comply with the notice of loss provision in the policy may forfeit his right to insurance proceeds.

Burden of proof

- The *insurance company* bears the burden of proving that the insured failed to comply with the notice obligation if they wish to rely on it to suggest that the insured forfeited coverage.

- **Basic principle of insurance law:** the burden of proof rests on the insured to establish a right to recover under the terms of the policy.

- Burden requires an insured claiming recovery to show that:

    1) A valid insurance policy exists
    2) A loss has occurred
    3) The loss occurred during the time period covered by the policy
    4) The loss falls within the coverage of the policy and
    5) The amount of the loss.

- **Once met, then the burden shifts to the insurance company to prove a breach of the timely notice requirement** (or other breach of the policy).

Compliance with notice of loss clause

- Whether the insured has complied with the notice of loss clause is **very fact specific.** Need to look at both:

    1) The facts of the situation; and
    2) The wording of the notice of loss clause.

- The wording varies significantly between policies and type of coverage involved.

Examples:

1. **General insurance:** s 540, statutory condition 6(1) – **"immediately"** give notice in writing to the insurer
    a. 540(3) statutory condition 1 and 6-13 apply to property loss only – no timeline for non-property loss (i.e. liability), so need to look to the policy
    b. Even though no timeline and nothing in the policy doesn't mean there is no requirement to give notice of loss – CL duty to give notice of loss still exists, presumably within a reasonable time

2. **Auto insurance:** s 556, statutory condition 3(1)(a) – **"promptly"** give notice
    a. Applies to both property and liability in accident
    b. 4(1)(a) – **promptly** for damage to auto

3. **Accident and sickness insurance:** s 705, statutory condition 5(1)(a) – **30 days after claim arises**

Issues that courts grapple with when trying to apply such notice provisions include:

1. What is the **triggering event** (see *Glenburn Dairy* and *North Lethbridge Garage*), and
2. Was the loss reported within a **certain time frame of that trigger**

TEST: would a reasonable man, in the position of the insured and with the knowledge of the insured conclude that a loss has likely occurred?

- Need to look at all the circumstances, subjective and objective test
- *Canadian case law confirms* that an insured who honestly believes that the duty to report is not triggered is not relieved of his duty to report **if that honest belief was not an objectively reasonable one**

***Glenburn Dairy Ltd v Canadian General Insurance Co* (1953 BCCA)**

Even if the insured thinks that the potential claim is frivolous and vexatious, and that they are unlikely to be held liable, they still have to give notice

Facts: policy required the insured to report the occurrence of an "accident" "as soon as practicable". The accident was that a third party stubbed her toe at the insured's premises. The insured was aware of the incident, but unaware that the plaintiff was really hurt. The third party didn't claim damages until 10 months after the accident

Reasons:

- The insured failed to fulfill this duty – the fact that he honestly believed that the third party was unlikely to seek recovery did not change the insured's obligation to disclose the occurrence of the "accident"

***North Lethbridge Garage v Continental Casualty* (1930 WWR)**

Facts: Child was injured by insured's auto (driven by its employee) in July 1928. Manager of insured learns about it several days later, investigated and was told the child had fallen off the car. Policy investigated, said it was not important. Two months later the insured received a letter making a claim on behalf of the child. It ended up being two months before the insured's insurance company was given notice

Issue: Auto policy required "immediate written notice of an accident causing loss", but the statutory condition provided for notification of any loss to be provided "promptly" – which applies?

Reasons:

- Two month delay was found to be prompt in the circumstances – but note that in *Duchene,* a 5 week delay was found to violate the requirement for prompt notice
- **Best rule: as soon as an objectively reasonable person suspects there MIGHT be a claim, then notify. If not – at risk.**

Parent v Northbridge General Insurance

Action under s 534 of the IA -where the plaintiff gets a judgment against the defendant and it remains unsatisfied, if the plaintiff finds out they have insurance coverage that would cover the loss, they can claim directly against the insurance company

Facts: P was involved in an altercation at a bar, W, where he ended up suffering significant injuries. He sued W and ended up getting the statement of defence struck. After obtaining summary judgment P discovered the Northbridge Insurance policy. The company denied liability on the grounds that W did not notify the company in a timely fashion (over 7 years had passed)

Reasons:

- **Section 534 – direct claim against insurer. If you can prove:**

- Judgment against the insured;
- Existence of liability contracts covering the insured;
- That the loss is within the coverage provided by the insurance policy;
- Insured is entitled to indemnity under the policy.

- Because the insured wasn't entitled to indemnity, W wasn't either.

Holding: failure to notify the insurance company was non-compliance with the policy, so no coverage

B) Providing Proof of Loss

Again – burden requires an insured claiming recovery to show that:

1. Valid insurance policy exists
2. A loss has occurred
3. The loss occurred during the time period covered by the policy
4. The loss falls within the coverage of the policy, and
5. The amount of the loss.

Insurer can't respond until it obtains proof of all of these – the purpose of the proof of loss is to enable the insurer to determine the amount of its liability, and the validity of the claims as soon as possible and without the requirement for court proceedings (note: its called "proof" because its generally **sworn under oath**)

Proof of loss clause

- Like the notice of loss clause, the insured's obligation under the clause is generally a *condition precedent* to the insured's right to recovery under the policy – but, it is a separate and distinct obligation from giving a notice of loss - a proof of loss contains more details and includes a statement as to the amount of the loss

- Proof of loss might = notice of loss, but notice of loss does NOT equal proof of loss

- Whether the obligation has been fulfilled by the insured depends on the facts and circumstances of each case

Time frames for proof of loss

Insurance policy clauses and statutory conditions generally require the insured to provide a proof of loss within a specific period of time – again, no CL time frame, so maybe "reasonable"? Need to look to policy/statutory conditions in the *Act*.

General: s 540, statutory condition 6(1)(b) – as soon as practicable

Auto: s 556
- Liability (section B) 3(1)(c): immediately on receiving a document from the claimant
- Auto damage (section C) 4(1)(c): 90 days

Accident and sickness: s 705, statutory condition 5(1)(b) – 90 days

Issues for the court:

1. ***Was the proof of loss provided within the time frame? (time frame for compliance)***
    a. Usually fairly straightforward manner once the date of the triggering event under the proof of loss clause has been identified
    b. Again, where the time deadline is prescribed in more general terms (i.e. as soon as practicable), courts have to evaluate that requirement as a question of fact in all of the circumstances

2. ***Was the information in the proof of loss sufficient to satisfy the proof of loss requirement? (sufficiency of info)***
    a. Determined based on a standard of reasonableness

b. Requires the insured to provide whatever information it has in its possession, or could reasonably be obtained by the insured

Note: insured's duty of utmost good faith underlies the Court's assessment of the sufficiency of the info provided by an insured. The insured must provide info which, in the circumstances, might reasonably be expected by the insurer in order to evaluate the insurance claim - THEREFORE MUST BE ACCURATE

***Swan Hills Emporium & Lumber Co v Royal General Insurance Co of Canada* (1997 SC)**
If you wilfully misrepresent (even if the statement is immaterial) the entire claim is invalid
Facts: Fire policy covered a building; the building and its contents were destroyed. Prior to the fire the sheriff had come to the premises and seized all of the stock. The insured wrote to the insurer to provide notice within a month. He took the inventory that the sheriff provided, makes some changes - adds 3 televisions so the value of the loss exceeds the policy limits. The inventory form and the proof of loss was **sworn by the representative of the insured company**. Later learned that the televisions weren't destroyed, the proof of loss was inaccurate so coverage was denied
Reasons:

- This was a wilfully false statement, thus was a forfeit claim under the policy
- **It did not matter that the wilfully false statements were immaterial – the breach of good faith was still breached**
- The false statements in the proof of loss vitiated the insured's **whole claim for the building and the contents, even though fraud related to the contents only**
- An insured who commits fraud is *not entitled to relief against forfeiture*

This idea is codified in AB - *If the insured provides a fraudulent proof of loss with respect to a claim, they forfeit their loss to recover for that claim*

General/auto – typically provide that fraud by the insured with respect to a claim forfeits the insured's right to recover for that claim (not from all contractual obligations)

- General: s 540 SC 7
- Auto: s 554(1)(c)

Burden of proof in proving fraud is on the insurance company, on **balance of probabilities**

Must prove actual fraud – may not presume fraud from omitted or inaccurate information

C) Duty to Cooperate

The first two duties are really part of this – but depending on the insurance involved, this obligation can involve a lot more. This duty takes on a significant aspect in the case of **liability insurance**, in that the **insured must assist in conducting a proper defence of the insured and in concluding a settlement on advantageous terms**

Insured will likely need to:

1) Produce all of its records that are relevant
2) Give evidence under oath
3) Secure the attendance of witnesses

Because of this, most modern liability policies typically include the express provisions:

- Prohibiting the insured from assuming liability for any claim (but can now apologize without assuming liability – s 26.1 *AB Evidence Act*)
- Imposing a general duty on the insured to cooperate with the insurer in the defence of the action (but insured doesn't need to pay for anything)

Contractual duty is a **condition precedent** to the insured's right to recover – if they don't cooperate, may forfeit any indemnity

Lack of cooperation generally must be more than trivial, but be **material and substantial** – but in some cases courts have found a breach where it is arguably lesser

Note: cooperation policies in insurance contracts are subject to the usual principles of policy interpretation

Ruddell v Gore Mutual Insurance Co (2019 ONCA)

Lack of cooperation must be substantial – no inconsequential or trifling breach of obligation should serve to exonerate the insurer from his contractual liabilities under the policy

Facts: S was driving a car and got into an accident, where his passenger was injured. The car was owned his mother, G. G provided a statement of claim and was later sent a letter at the address she provided to put her on notice that the amounts claimed in the statement of claim exceeded her policy limit, and she was advised of her responsibility to cooperate in the defence of the action. She was told to keep the insurance company informed of any change in address. For years no one was able to find G. When they finally did the company argued that G had breached her policy by failing to cooperate with them in defending the action

Issue: did G breach the policy by failing to cooperate?

Reasons:

- Leading case of *Canadian Newspapers* says that the duty of the insured to cooperate requires him to assist **willingly and to the best of his ability**
    - If there is a material breach the insurer can refuse to defend the action, but the breach must be substantial, otherwise the insurer is not exonerated from his contractual duty
- **Depends on the facts of the case** - when B was first contacted she gave a full statement, lots of info – only thing she didn't do was provide an updated address
- This wasn't a substantial breach – not having her didn't make a significant difference, and contacting her again wouldn't make a different
- No breach of duty, it was her son that made a difference

Thorensen v Merit Insurance (1963 DLR)

Moving and failing to notify the insured is not a breach of the duty to cooperate

Other specific examples of breach of this duty:

1. Insured failed to respond to letters and other communications by the insurer seeking additional information about the incident giving rise to a lawsuit against the insured (*Thompson*)
2. The insured, without involving the insurance company, investigated and settled a claim brought against him (*Colliers*)
    a. Similarly – insured paid the judgment on a claim while the insurance company was still deciding whether to appeal (*Fidelity & Casualty Co*)
3. The insured failed to keep the insurer informed about the status of the lawsuit against the insured and various offers to settle made by the third party claimant (*Canadian Newspapers Co*)
4. The insured intentionally failed to attend hearings, provide evidence or assist in obtaining witnesses in the course of a lawsuit commenced against the insured (*Slatter*)
5. Where the insured promoted the action brought against him (*Walters*)
6. Where the insured lied to the insurer about the circumstances of the accident for the first 2-3 months following the accident (*Provident*)

What if the insured meets all of the duties, and the claim is still not paid? Then bring suit against the insurer.

Limitations

After proof of loss

To give an insurer the opportunity to properly review a claim, insurance legislation commonly provides than an insurer is not obligated to pay a claim brought by the insured until a specified amount of time has passed from the date the insured submits the completed proof of loss.

This basically means that until this period of time has passed, the insured has no cause of action against the insurer for the insurance money.

General:

- Sec 524: no action lies for the recovery of money payable under a contract of insurance until the expiration date of 60 days after proof;
    - Of the loss, or
    - Of the happenings of the event on which the insurance money is to become payable

Or a shorter amount if prescribed in the contract of insurance itself.

Basically: can't bring a claim until after you filed your proof of loss and 60 days have passed so that the company has time to look at it and pay you - often people try to bring actions without filing proofs of loss

Auto:

- SC 6(2)(f) s 556: The insured shall not bring an action to recover the amount of a claim under this contract unless the requirements for a proof of loss have been met (SC 3 and 4), or until the amount of the loss has been ascertained as therein provided, or by judgment against the insured after a trial or by agreement between the parties with the written consent of the insured.

Basically: similar provision for auto, need 60 days (SC 6(1))

On actions

General: limitation in s 525

- Property – two years after reasonably knew of loss or damage
- Other – two years after cause of action arose (same as *Limitation Act*)

Auto: limitation in s 558(1)

- Auto damage – two years after loss or damage arose
- Personal property or injury – two years after cause of action arose (same as *Limitation Act*)

Hail: limitation statutory condition 16 s 636

- Two years after the loss or damage

Life insurance: s 677

- Within two years of the proof of loss or 6 years after death

Question: when does the limitation start to run?

- **Date of loss (accident/incident)?**
- **Date that the cause of action arose (denial/refusal to pay benefits?)**

***Smith v Cooperators General Insurance Co* (2002 SCC)**

About statutory interpretation in the context of limitation periods – insurer's obligation extends beyond merely communicating the limitation period

Facts: The appellant was the victim in a car accident, she claimed and received statutory benefits from the respondent, who later stopped paying them and wrote to the appellant with the reasons why. The appellant then issued a statement of claim for ongoing statutory benefits. The respondent argued that the appellant's claim was time-barred by s 218 of the IA, which requires that any court action or arbitration claiming statutory benefits be commenced within two years of the insurer's refusal to pay

Issue: Was there a proper refusal by the respondent to trigger to the limitation period?

Reasons:

- SCC rejected the insurance co's limitation defence – **the claim is not time barred because the insurer had not terminated benefits in accordance with the statutorily mandates procedure, they had only advised of the first step in dispute resolution.** Because of this the two year period never began to run because the benefits weren't properly terminated
- Even though she knew of the limitation period in the mediation report, the court doesn't find this sufficient to cure the insurer's defects. **The obligation extends beyond merely communicating the limitation period**
- Dissent (Bastarache J): didn't interpret the legislation as requiring the insurer to advise the insured of the appropriate limitation period, thought it started to run when the insured was advised of the termination of benefits

Holding: Insured had two years from the date advised of mediation to request mediation

Notes:

- The AB Fair Practices Regulation 128/2001 requires than an adjuster advise a claimant of the limitation period *if not represented by counsel* – if this isn't done the limitation may not start to run
- *Smith* applies only to the limitation period – the plaintiff still had to prove her claim – doesn't establish that coverage was provided under the policy

Golic v ING Insurance Co of Canada (2009 Ont CA)

Apparently opposite result from Smith. Differences – included relevant statutory sections AND Insured had twice before been involved in the mediation process

- The court found that a disability insurer sufficiently complied with the statutory termination requirements by advising the insured of the dispute resolution process and relevant statutory sections
- Key to the court's finding was the fact that the insured in this case had twice before been involved in the mediation process

Exceptions to Duties

Duties of the insured (as discussed above) are condition precedent to recovery on the policy, and if the insured fails to properly meet the requirements of any of them, she has forfeited her right to recover under the policy.

This seems unfair – what if it was inadvertent or doesn't even hurt the insurance company?

Some principles of law may be pled that would allow the court to ignore a breach of a duty under an insurance contract.

- This happens because of **unfairness: voiding a contract for breach of contract that is a minor/technical breach, or if the breach was previously condoned**

As a result, CL and statutory principles have developed excuses for a contracting party from its contractual breach in certain circumstances.

Three principles that could be used to prevent an insurance company from denying coverage:

1) **Relief from forfeiture**
2) **Waiver**
3) **Estoppel**

Relief from forfeiture

Equitable doctrine that allows the court to excuse the insured's breach in circumstances where the forfeiture of coverage would be **unfair** to the insured.

Purpose: to prevent the insurer from denying a critical benefit to the insured on the basis of a technical breach which is not substantively prejudicial to the insurer (see *Falk Bros*)

Because it is equitable, it is **discretionary.** There can be no relief where an insured has intentionally or maliciously breached its obligation, where the insured's unreasonable conduct has led to the breach, where the insured lied about the circumstances giving rise to the breach, or where the insurer is unduly prejudiced by the breach.

A court must decide **on the facts** of each case, whether it should be granted. In order to grant relief the insured must satisfy the court that:

1) As a matter of law, the doctrine of relief from forfeiture can be applied to the case at bar – **is it available (can we)?**
2) The facts of the case merit the application of the doctrine – **is it merited (should we)?**

Be cautious not to confuse a notice condition (requirement to give timely notice) with whether an insured reports a claim at all under a claims made policy.

- Claims made: insurance company is responsible for negligence claims while the policy is in force

- If its not made during that period, then no coverage – policy not engaged, can't relieve from forfeiture when not engaged (only when established)

- Occurrence based policy: policy responsible for negligence that occurs while the policy is in force

Is it available?

Three factors are relevant:

1) The **source** of the court's power to grant relief;
2) The **type of insurance** involved; and
3) The **nature of the insured's breach.**

Although it began as an equitable doctrine, the court's authority to grant relief from forfeiture has become **supplanted by statute –** means that CL relief from forfeiture no longer exists in AB.

Two possible sources for relief from forfeiture:

1) **AB Insurance Act s 520 (*specific relief*)**

    a. Only applies to insurance contracts – some are expressly contradicted (e.g. subpart B for auto)
    b. Applicable if the court considers it inequitable that there was a forfeiture or voidance of insurance because of **imperfect compliance** with the **proof of loss** or **another matter or thing done or omitted** to be done by the insured or the claimant – then the court can relieve against the forfeiture of avoidance on any terms

2) **AB *Judicature Act* (s 10) (general relief)**

    a. Not restricted to the insurance context
    b. Basically court can grant relief against all penalties and forfeitures and impose any costs, etc., that it sees fit

Type of insurance:

Specific

- General insurance (including section 520) doesn't apply to life insurance, accident and benefit insurance
    - So **can't use specific relief from forfeiture** for life or accident and sickness insurance claim denials

Type of breach/condition:

Specific

- Only applies to **post loss breaches** – so if there is a pre loss breach of life insurance the only possibility is to try to get general relief
    - Cannot deal with things before the loss
    - Pre loss breaches that constitute conditions precedent to coverage (e.g. disclosure, reporting change material to risk) are **conditions precedent** to coverage, so can't be given relief by this section
        - Per *Kozel:* a court should find that a breach constitutes non-compliance with a condition precedent only in rare cases where the breach is substantial and prejudices the insurer. Otherwise, its imperfect compliance and relief is available

General

- SCC suggested that you probably can use this to grant relief in an insurance contract, but always been in obiter
- See *Saskatchewan River Bungalows* – nothing authoritative to say definitively

Nature of the insured's breach:

Specific

- Sec 520 can be applied if there has been imperfect compliance with a condition as to proof of loss
    - It therefore limits the breach to ***imperfect compliance*** instead of *complete non-compliance*
    - If very serious, then non-compliance. If not very serious, likely imperfect
- Not a lot of guidance – need to look to *Falk Bros*

If there is no coverage, there can be no relief against forfeiture. It does not apply to a missed limitation period, or a failure to pay insurance premiums which results in a lapse of the policy.

***Falk Bros Industries Ltd v Elance Steel Fabricating Co* (1989 SCR)**

Guide on imperfect versus perfect compliance

- The purpose of allowing relief from forfeiture in insurance cases is to prevent hardship to beneficiaries where there has been a failure to comply with a condition for receipt of insurance proceeds, and where leniency in respect of strict compliance with the condition will not result in prejudice to the insurer
- **Suggests imperfect compliance is less serious than non-compliance**
    - E.g. failure to give notice of a claim within a given period is a less serious breach than failure to bring an action within a stipulated time
- Relief from forfeiture can be granted in respect of delayed notices of claim but is NOT available with respect to a missed limitation period

***Monk v Farmers Mutual Insurance Co* (2019 ONCA)**

Specific relief not obtained – used Saskatchewan test. Relief doesn't apply to a failure to pay insurance premiums because it would result in a lapse of a policy

Facts: The appellant, M, hired a company to refinish the exterior of her house, but damage was sustained. She had a home property insurance policy with Farmers. She did not inform the Farmers until two years after the damage and was informed that the claim was time-barred. M then sent Farmers a notice of claim and commenced an action for indemnification, stating that she was not properly advised about her rights to coverage. Farmers relied on the defence that M failed to report the damage "forthwith" and provide proof of loss "as soon as practicable" as required in the IA. M sought relief from forfeiture

Reasons:

- **Relief from forfeiture** (*Saskatchewan* test)
    - The power to grant is *discretionary*
    - The insured must **show three things:**
        - **1)** That his or her conduct was reasonable
        - **2)** That the breach was not grave
        - **3)** That there is a disparity between the value of the property forfeited and the damage caused by the breach
    - Some debate if all three steps need to be show, but this court says they do
    - Main focus is always on the **reasonableness of the breaching party's conduct**
- **Conduct:**
    - The reasonableness part of the test requires a court to consider the nature of the breach, what caused it, and what (if anything) the insured attempted to do about it
    - "Imperfect compliance" does not automatically result in the claimant being entitled to relief – still has to demonstrate on the facts
- **Gravity:**
    - Court looks at both the nature of the breach itself and the impact of the breach on the contractual rights of the other party
    - Can have an impact on the insurer – consider the loss of the ability to investigate the circumstances, take remedial action early to reduce the scope of the loss, and the right to maintain a subrogated claim
- **Disparity:**
    - Consider the disparity between the value of the property forfeited and the damage caused by the breach
    - Court must conduct a type of proportionality analysis which involves comparing the disparity between the loss of coverage and the extent of the damage caused by the insured's breach

Holding: M attempted to escape the consequences of her late notice – reasonable conduct not present, she wasn't allowed to obtain relief

Note: Relief from forfeiture applies to an insured's ability to claim coverage under an existing policy. It can't be applied where the insured's breach impacts the **existence of the insurance contract or to insurance coverage.** It does not apply where:

- Where an insured fails to report a claim under a "claims made" policy (where the coverage is limited to claims which have been made within a particular period of time) (*Sawyer v Canadian Lawyers Insurance*)
- To an insured's failure to report a change material to the risk, because the duty to report a material change is a condition precedent to coverage (*Seetaram v Allstate*)
- To a failure to pay insurance premiums, which results in a lapse of the policy (*Pluzak v Gerling Global*)
- To a missed limitation period (*Presco Industrial v SGIO*)

Parent v Northbridge

Perfect vs imperfect discussion, second half of the analysis

- Confirms that a failure to give notice is something that relief from forfeiture could potentially apply to – can be considered an imperfect compliance even though this is basically non-compliance
- Note: Pratt says perfect vs imperfect discussion is confusing in caselaw, no bright line rule

Note: tests for relief from forfeiture

- There have long been considered to be two tests, one from *Bluerange Resorts* and the one applied in *Monk*
- But – Pratt says they are basically the same
- **Short rule for both:** court should only grant in circumstances where it is more fair to relieve the insured for its breach, rather than to hold them accountable. The claimant requesting needs to have clean hands, otherwise it is automatically unavailable. Both of these are inclusive rather than the alternative, so need to have *all* the factors.
    - **No relief from forfeiture where:** (1) insured unintentionally or maliciously breached obligation; (2) unreasonable conduct led to the breach; (3) where the insured lied about the circumstances giving rise to the breach; (4) where the insurer is unduly prejudiced by the breach (e.g. insured's delay in notifying led to a loss of the insurer, impaired ability to investigate, etc.)

Two part test to grant specific relief from *Bluerange Resorts*

1. Has the insured been prejudiced by the imperfect compliance?
2. Would it be fair to hold the insured to strict compliance to the relevant obligation?

Three part test for general relief from *Saskatchewan Bungalows* (applied in *Monk*)

1. Conduct of the claimant - was it reasonable in the circumstances (remember its an equitable remedy)
2. Gravity of the breaches - how bad is the breach?
3. Disparity between value of the property forfeit and the damage caused by the breach - is it substantial?

Waiver and Estoppel

This doctrine relates to the idea that the insurer must have affirmed the contract to make it unfair or unjust for the insurer to later deny coverage. Waiver and estoppel are different, but when one applies they often both do.

Waiver

- **Intentional** relinquishment of a **known** right (two requirements – needs to be voluntary, need to know what you're giving up)
    - Intention may be (1) expressed in a formal legal document; (2) expressed in an informal fashion; (3) inferred from conduct
- Purposeful decision by the insurance company not to hold the insured to a particular insurance obligation, alteration of the contractual term
- Can occur before or after a breach, can be express or implied

Estoppel

- Insurance company or insured has brought about or allowed some conditions to exist that would make it inequitable to claim a right that they would otherwise be entitled to
- Prevents the insurer from denying coverage on the basis of the insured's breach of contract where **(1)** the insurer represents that the contract won't be enforced and **(2)** the insured **relies** on this statement to his detriment

In AB **all waiver must be in writing** (at CL can take any form, but this is altered by the *Alberta Insurance Statute*)

- Subsection 2 of s 521 says that just because an insurance company gets an appraisal or completes proof of loss and starts to adjust a claim, this doesn't constitute a waiver
- Ontario court of appeal held that an insurance company does not waive the insured's obligation of disclosure by not insisting on a written application – the insured remains under an *uberrimmae fides* obligation to disclose material facts

An insured can waive or be estopped from relying on a missed limitation period *(Oliver v Elite Insurance Co)* (for limitations periods look to waiver and estoppel for relief, not relief against forfeiture)

Saskatchewan River Bungalows Ltd v Maritime Life Assurance Co (1994 SCR)

Leading case on waiver and estoppel

Facts: life insurance case - premiums were due every year, grace period of 30 days after which the policy would lapse. It could be reinstated by the insured when within three years on a written application and subject to unpaid premiums, and submission of evidence to show good health. Premiums were usually paid on time, but then started to expire. In 1981 the insurance company accepted late payment and didn't require evidence. The insured mailed a cheque to the insurance company for the premium - but didn't include the full amount, later sent more for the difference but wasn't received. Company sent a late payment notice but said they would still receive payment. Insured never became aware of the lapse or late payment until months later. At this point both premiums were refused. Insurance company rejected the claim for benefits when the insured died

Issue: did the company waive the right to timely payment?

Reasons:

- **Waiver:**
  - Waiver occurs when one party to a contract or proceedings takes steps which amount to foregoing reliance on some right or defect in the performance of a party
  - The underlying principle is that a party should not be allowed to go back on a choice when it would be unfair to the other party
  - Elements include **(1) full knowledge of rights**; **(2)** an **unequivocal and conscious intention to abandon them**
  - This is a **stringent** test since no consideration moves from the party in whose favour waiver operates – *overriding consideration is whether one party communicated a clear intention to waive a right to the other party*
- Was the waiver still in effect?
  - Waiver can be **retracted** if reasonable notice is given to the party in whose favour it operates
  - The "reasonable notice" requirement has the effect of protecting reliance by the person in whose favour waiver operates
  - An **informal communication** of a party's intention to insist on strict compliance with the terms of a contract is sufficient notice
- Here – M had full knowledge of the rights under the policy, so the question turned on interpretation. The Court held that M's letter where it accepted late payment even though the policy was no longer in force constituted waiver
- **Relief against forfeiture:**
  - Not available here because the first element of the test, reasonable conduct requirement, was not met – respondents knew that F was terminally ill and uninsurable but still chose to have their correspondence delivered somewhere they didn't often get it
  - Couldn't use specific relief because it was about life insurance – obiter said could probably rely on general

Gilewich v 3812511 Manitoba Ltd
Makes it clear that defending a claim brought against by the insured could constitute a waiver of the right to deny coverage

Gregory v Jolley
Insurance Co doesn't waive the insured's obligations to disclose by not insisting on a written application

Oliver v Elite Insurance
An insurer can waiver or be estopped from relying on a missed limitation period

Duties of the Insurer

Duty to Respond

The insurer has their own set of duties: to investigate, verify, and respond. All of this must be done in good faith. There are two primary duties on an insurer:

1) **Duty to defend:** to pay for and instruct legal counsel

2) **Duty to indemnify**: to pay any judgment or settlement awarded against the insured

The scope of each is dependent on the contract. The duty to defend helps both parties – the insurer retains control, the insured doesn't have to deal with the money, time and expense.

A breach of the insurance contract can be considered a breach of good faith – if no reasonable basis for denial, there can be liability for significant punitive damages

Enforcement Mechanisms

Basic principle of damages: wronged party needs to be put back in the position they were in before. Generally the court will order rescission or specific performance of a contract

- See *Witten* and *Fiddler* for compensatory damages vs punitive.

Punitive damages: where the conduct by the party constitutes an actionable wrong, or the conduct is sufficiently egregious

- Breach of the duty of good faith is **the independent actionable wrong** that can give rise to punitive damages
- In some cases courts have awarded punitive damages against the insured (*RBC*)

- Two requirements: (*Vorvis*)
  1) Conduct of one of the parties constitutes an actionable wrong (for good faith, breach of this is the actionable wrong)
  2) If the conduct is sufficiently egregious, it warrants punishment so that party is deterred

- In *Pilot v Whiten:* decided that in the insurance context, a breach of the duty of good faith was a separate actionable wrong that could give rise to punitive examples. Must then also meet the second criteria

Compensatory damages: designed to compensate the wronged party for the loss that they suffered, and put the wronged party in their prior position had the loss not occurred

Aggravated damages: not a punitive purpose, takes into account intangible losses such as mental distress

Good faith: insurance contracts give rise to a reciprocal duty of good faith

- Insurer has a higher duty to respond with utmost good faith because the court will consider the vulnerability of the insured (courts keep in mind that insurance contracts are peace of mind contracts)

RBC General Insurance Co v Field (2016 ONSC)

Facts: Insured claimed extra accident benefits for almost $230 000. Field was operating a vehicle with her license suspended while the accident occurred, so she wouldn't be able to claim some of these benefits because of this but she failed to inform the insurance company of this. They sued her for false statements and fraud

Reasons:

- Claim for punitive damages is made out
- They can only be awarded for an actionable wrong that is independent from the cause of action that makes up the main part of the claim
- Even if an independent wrong is proven that can support a claim for punitive damages, the quantum of those damages must be **proportionate** to the harm done
- Here the duty of good faith was breached and an award for punitive damages was given

***Vorvis v Insurance Corporation of British Columbia (*1989 SCR)**

Punitive damages are recoverable in breach of contract cases, provided that the defendant's conduct that gives rise to the claim is itself an "actionable wrong". SCC caveat that it is to be cautiously exercised

Facts: Wrongful dismissal case. Judge awarded in compensatory damages, rejected the mental distress claim - CA also dismissed the appeal for punitive damages

Reasons:

- **Punitive damages:**
  - Designed to punish – constitute an exception to the general CL rule that damages are designed to compensate the injured, not to punish the wrongdoer
  - **An award for punitive damages must always receive the most careful consideration and discretion**
  - **Not recoverable for breach of contract unless the action was also a tort for which punitive damages are recoverable**
  - Rare because when the defendant has breached a contract the remedies open to the plaintiff must arise from that contractual relationship which the parties agreed to accept
  - Punitive damages can only be awarded in respect of conduct that is of a nature as to be deserving of punishment because of its **harsh, vindictive, reprehensible and malicious nature**
- **Aggravated damages:**
  - Take into account intangible injuries

Holding: SCC said that the conduct wasn't sufficiently offensive to constitute an actionable wrong

***Whiten v Pilot Insurance Co (*2002 SCC)**

Leading case for setting out the test and guidance for good faith, drastic example of insurer breaching duty of good faith

Facts: 1994 the Whiten's house was destroyed by fire, destroyed all their belongings. W's made a claim on their fire policy. The insurer made one payment of $5000 to cover the cost of a rental property, then without notice, insured cut off the payments and refused to pay the fire loss. Insurer (Pilot) did so because it suspected that the W's had burned their own house down. Pilot hired an adjuster to investigate, ultimately they said there was no evidence of arson. Pilot then requested that the insurance crime prevention bureau to review this analysis - they also said there was no evidence. Then hired another adjuster and an engineer, who concluded the fire was accidental. Plaintiff had to pay $340 000 in legal fees to recover $300 000 owed to them. Jury at trial awarded $1 million to the W's

Reasons:

- Punitive damages: the test limits the award to misconduct that represents a **marked departure** from the ordinary standards or decent behaviour. B/c the objective is to punish rather than compensate, these damages straddle civil law (compensation) and criminal law (punishment)
- **Overview of Canadian practice with punitive damages:**
  1. Punitive damages should not be limited by "categories". The control mechanism is about determining circumstances that warrant the addition of punishment
  2. General objectives of punitive damages are punishment, deterrence of wrongdoers, and denunciation
  3. Primary vehicle of punishment is the criminal law, so punitive damages should only be resorted to in exceptional cases and with restraint

4. The words "high handed, oppressive and vindictive" doesn't provide sufficient guidance to the jury in setting the amount - need a more principled approach
5. Emphasis on rationality - the court should relate the facts to the purposes of punitive damages and ask how an award would **further one of the objectives and what is the lowest award that would serve that purpose**
6. Can use punitive damages to relieve a wrongdoer of profit where compensatory damages would amount to nothing more than a "fee" earn greater profits
7. None of the CL jurisdictions have created a formulaic approach (except by statute) - focus should be on the defendant's misconduct, not the plaintiff's loss
8. Governing rule for quantum is proportionality
9. Juries should receive more guidance and help from the judges in terms of their mandate
10. Punitive damages are **not at large** - an appellate court can intervene if the award exceeds a rational limit

- **Punitive damages for breach of contract:**
  - *A breach of the contractual duty of good faith is independent of and in addition to the breach of contractual duty to pay the loss - it is an "actionable wrong"*
  - Note: insurance companies have asserted claims for punitive damages against their insured for breach of the mutual "good faith" obligation in insurance contracts

- **Jury award:**
  - Standard of review is **rationality**: Unlike compensatory damages, punitive damages are **not at large** for courts have greater scope and discretion on appeal. Review should be based on the court's estimation as to whether the punitive damages serve a rational purpose. *Was the misconduct of the defendant so outrageous that punitive damages were rationally required to act as deterrence?*
  - **Test:** whether a reasonable jury, properly instructed, could have concluded that an award in that amount, and no less, was rationally required to punish the defendant's misconduct
    - Proportionality is key - the more reprehensible the conduct, the higher the rational limits to the potential award
      - Level of blameworthiness may be influenced by many factors, including: (1) whether the misconduct was planned and deliberate; (2) the intent and motive; (3) length of period of the conduct; (4) attempt to conceal or cover up; (5) awareness of wrongdoing; (6) if the defendant profited; (7) if the interest violated by the misconduct was known to be deeply personal to the plaintiff, e.g. professional reputation.
      - Degree of vulnerability such as financial or other is relevant where there is a power imbalance (e.g. *Norberg v Wynrib*)
      - Harm or potential harm directed specifically at the plaintiff
      - Need for deterrence
      - Proportionate after taking into account other penalties
      - Proportionate to the advantage wrongfully gained by a defendant from the misconduct

Holding: The SCC restored the $1 million punitive award – found that the more devastating the loss, the more the insured is at the mercy of the insurer. The obligation of good faith means that the insured's peace of mind should have been Pilot's objective. A million was within rational limits – vulnerability shouldn't have been used as a negotiating tactic

***Fidler v Sun Life Assurance Co of Canada* (2006 SCC)**

Punitives not commonly payable

Facts: F was diagnosed with chronic pain problems. She was covered by a disability policy - allowed for benefits for 2 years if unable to do the job you were doing at the time of the disability (most policies after that say you have to be disabled from any and all jobs that you are qualified to receive disability beyond this period). F received benefits for 6 years. Then Sun Life said they thought what she was doing on a daily basis was incompatible with receiving these benefits. Sun Life had no evidence that she was incapable of working, but had surveillance of her completing daily tasks. F's doctor confirmed that she was not fit to work, she advised the insurer of this. In response, Sun Life had an independent medical examination done, their doctor said she was increasingly able to consider returning to work. Sun Life (5 years later) offered to pay.

Issue: could F receive aggravated or punitive damages?

Reasons:

- SCC follows the decision *in Hadley v Baxendale* to inform analysis: damages must be such as may fairly and reasonably be considered either arising naturally from such breach of the contract itself, or such as may reasonably be supposed to have been in the contemplation of both parties
- **Mental distress and damages:**

- Historically: mental distress not generally recoverable for breach of contract because (1) perceived minimal nature of suffering and (2) contract breaking treated as an incident of commercial life where players are expected to have mental fortitude
    - Then Denning held that mental distress could be recovered for certain kinds of contracts - the "peace of mind" exception to the general rule emerged - confined to contracts which had as their object the peace of mind of the contracting party
- **Today:** the right to obtain damages for mental distress for breach of contracts that promise pleasure, relaxation of peace of mind has been widely accepted in Canada. In *Vorvis*, the court described cases awarding mental distress as standing for the proposition that in some contracts the parties may have contemplated at the time of the contract that a breach in some circumstances may cause a plaintiff mental distress - *it is thus clear that an independent actionable wrong is not always required*
- **Damages for mental distress for breach of contract may, in appropriate cases, be awarded as an application of the principle in *Hadley* - court should ask "what did the contract promise?" and provide compensation for those promises** (same principle as contracts generally, restoring parties to the position they contracted for)
- **This does not mean that all mental distresses associated with a breach of contract is compensable** - in normal commercial contracts, the likelihood of a breach of contract causing mental distress isn't usually in the reasonable contemplation of the parties
- **Test: Court must be satisfied that: (1)** an object of the contract was to secure a psychological benefit that brings mental distress upon breach within the reasonable contemplation of the parties, and **(2)** the degree of mental suffering caused by the breach was of a degree sufficient to warrant compensation. **Note:** mental distress does not have to be the dominant aspect of "very essence" of the bargain, as long as it was in reasonable contemplation of the parties

- **Aggravated damages:**
    - Describe an award that aims at compensation, but takes full account of the intangible injuries such as distress or humiliation, that may have been caused by the defendant's behaviour
    - Two types:
        - True aggravated damages: arise out of aggravating circumstances, rest on a separate cause of action, usually in tort
        - Mental distress damages which do arise out of the contractual breach itself: awarded under the principles of *Hadley,* exist independent of any aggravating circumstances and are based off of the parties expectation
- **Good faith:**
    - Duty of good faith requires an insurer to deal with its insured's claim fairly - applies to both the manner in which the insurer investigates and assesses the claim, and to the decision whether or not to pay the claim
    - In making a decision to refuse payment, insurer must assess the merits of the claim in a balanced and reasonable manner, not denying coverage or payment to take advantage of the insured
    - **But - the duty of fairness doesn't require the insurer to be correct about the outcome - denial of a claim that ultimately succeeds is not, in itself, an act of bad faith**

Holding: The object of this disability contract was to secure a psychological benefit that brought the prospect of mental distress upon breach within the reasonable contemplation of the parties (intangible benefit of financial security, large financial pressures associated with not working). Secondly, the mental distress here was of a degree sufficient to warrant compensation (substantial loss over 5 year period, Connie genuinely suffered additional distress)

Takeaway:

- Court says it is not unusual in a breach of contract case that people feel wronged, but that is not what aggravated damages are designed to compensate for (has to be a **provable detrimental psychological effect** that brings on the mental distress, and that this is **sufficient to warrant compensation**)
- Affirmed *Whiten* – punitives possible where there is a marked departure from standards of decency in breach of contract
- Important to remember that **an insurer doesn't have to be right** when they decide to deny a claim

*Usanovic v Capitale (*2017 ONCA)

Good faith is different from a fiduciary duty – in AB have to give notice to the insured of the applicable limitation period in 5 days of denying the claim

Facts: The appellant was an eaves trough installer. He bought an insurance policy from Capitale protecting him against disability arising from accidents. He subsequently fell of a roof and suffered injuries. He received benefits for four years, when the respondent terminated benefits because he no longer had a "total disability" as defined by the policy - he had 60 days to submit medical records in support of his disability but did not do so. Later, the appellant was told by counsel that there was a two-year limitation period on

his claim. The appellant alleges that if the respondent told him about the limitation period when it denied his claim, he would have brought the action prior to two years

Issue: can the duty of good faith be extended to require an insurer to disclose info outside of the policy (limitations period)?

Reasons:

- The duty of good faith requires an insurer to deal with claims by its insured in good faith - this is an implied obligation in addition to the statutory conditions and express provisions in the policy (but the scope hasn't been precisely delineated)
- **Good faith is different from a fiduciary duty** - the insurer is not obliged to treat the insured's interests as paramount, but must give as much consideration to the welfare of the insured as to its own interests
- General requirements of the duty:
    - 1) Insurer must act promptly: delay may operate to the disadvantage of the insured, will frequently be under financial pressure to settle quickly. Must act with reasonable promptness and pay claims in a timely manner
    - 2) Insurer must act fairly: applies to both the manner in which the insurer investigates and assesses the claim and the decision whether or not to pay the claim - must assess the merits in a balanced and reasonable manner, not take advantage of the insured
- At its highest, *the obligation of good faith and fair dealing arguably carries with it a positive obligation on the insurer to inform its insured of the nature of the benefits of the policy* - the company does **not** have to provide limitation periods, this is the role of the legislature
    - Note: **AB has specific notice requirements - an insurer must give written notice of the applicable limitation period within 5 days of denying a claim** (not required when the insurer is aware the claimant is represented by counsel and for certain types of claims) - see s 5.3(7)

Holding: Appellant barred from bringing an action, duty of good faith not extended

Duty to Defend

By their express terms, liability insurance policies ordinarily require the insurer to fulfill two duties:

1) Duty to instruct and pay legal counsel to defend the insured – **DEFEND**
2) Duty to pay any judgment/settlement within the policy limits – **INDEMNIFY**

Benefits both parties – insured has legal costs paid for an insurer controls the defence of the action

Trigger for duty to indemnify is obvious: after the court delivers the judgment
Trigger for duty to defend is more difficult: but crystallizes **before** the merits of the claim are determined

SPF 1 indicates that if you're involved in a motor vehicle accident for which you are sued and it comes under the terms of your policy, the insurance company will hire a lawyer to act on your behalf. Courts look to your insurance policy to determine when the duty to defend is triggered.

The SCC has established a low threshold in order to determine if this duty arises. The trigger/threshold is set out in a trilogy of cases: *Nichols, Scalera, Meneco:*

Nichols v American Home

*Sets out the actual test – **"pleadings rule"***

- Lawyer was sued for fraud, N defended himself and was awarded party-party costs. He wanted to get the costs back from his professional liability insurer, who denied the claim on the basis that the policy specifically excluded coverage from fraudulent acts
- Issue: was there a duty to defend?
- Reason:
    - SCC agreed with the insurer: *duty to defend arises only if the facts alleged in the pleadings, if true, would be covered by the policy*
    - Established the **pleadings rule: pleadings govern the duty to defend such that an insurer must defend if the pleadings in the third party action raise the mere *possibility* that a claim within the policy may succeed**
        - Look at the pleadings/statement of claim and say: if the facts are proven true, would the policy cover that act? If yes – duty is triggered
    - The *widest latitude* should be given to the allegations in the pleadings in determining whether they raise a claim within the policy (hence the language "mere possibility")

- Not dependent on the insured being *actually liable* – what is important is what is alleged, and what the insurer by the terms of the contract is required to provide coverage for

Pleadings rule NOT dependent on the defendant actually being liable – what is important is what is alleged and what the insurer, by the terms of the contract, is required to provide coverage for

Non-Marine Underwriters v Scalera

Enhanced Nichols – looks to the true meaning of the pleadings as opposed to the language

- Court considered the practicality of the pleadings rule post-*Nicholas*
- Third parties were intentionally drafting the pleadings rule to trigger the duty to defend
- Court said that the relevant question is **whether the substance of the pleadings against the insured gives rise to a duty to defend. What matters isn't the *wording* used in the pleadings, but the *true nature* of the claim**
- **Three-part test:**
  - **1)** Without determining the merits and assuming all factual obligations are true, the court must determine which assertions in the pleadings could be supported by those factual allegations (true nature of the claim)
  - **2)** Where multiple claims are pled, the court must determine if any are entirely derivative of one another (arising from the same action, causing the same harm – are they just calling it something else to trigger the duty to defend?)
  - **3)** Ask would any of the claims, if proven true, require the insurer to provide indemnity (duty to defend only extends to claims falling within policy coverage)

Moneco v Commonwealth

*Established the **intrinsic evidence rule** – what else can the court look at to decide if there is coverage? Can look at extrinsic evidence as long as that evidence is referred to in the pleading that is the subject of the examination*

- Is there anything else the court can look at to determine what the actual nature of the claim is? Here the court wanted to look at a contract
- Court can consider **extrinsic evidence,** namely contracts, to be looked at as long as it is ***expressly referred to in the pleadings***

***Progressive Homes Ltd v Lombard General Insurance Co of Canada* (2010 SCR)**

Solidifies the pleadings rule – have to look to the policy itself to see if it is a covered loss – need to go through the steps of interpretation (intention, plain and ordinary meaning, ambiguity, etc.)

- **Duty to defend:**
  - An insurer is required to defend a claim where the facts alleged in the pleadings, if proven to be true, would require the insurer to indemnify the insured for the claim
  - It is irrelevant whether the allegations in the pleadings can be proven in evidence - means that the duty is not dependent on the insured *actually* being liable and the insurer *actually* being required to indemnity - what is required is the mere *possibility* that a claim falls within the insurance policy
  - In examining the pleadings to determining if the claim is within the scope of coverage, the parties to the contract are not bound by the labels selected by the plaintiff
    - This means that the use of absence of a certain term doesn't determine whether the duty to defend arises - is it about the *true nature or the substance of the claim*
- **To determine if the contract would provide indemnity if the pleadings are true, need to go back to the primary interpretive principles:**
  - **1)** Is there coverage? Go through interpretation
  - **2)** If there would be coverage for the allegations (mere possibility) then the duty to defend is triggered
  - **3)** Then, the insured can go look at any exceptions to the exclusions
- Here – the allegations in the pleadings were that the defects in the complex led to resultant damage – this is an exception to the exclusion under a CGL, so because the CGL would have to respond to resultant damage, this shows there wouldn't be coverage for this. SCC ultimately said that the duty to defend was triggered

***Creative Door Services Ltd v AXA Pacific Insurance* (2018 ABCA)**

Facts: Alta Steel needed a garage door, contracted with Creative Door who subcontracted with a numbered company. As the person was putting the door in he was electrocuted, sued Alta Steel for his personal injury. They issued a third-party claim against Creative Door, said they breached their contract with Alta by failing to provide a subcontractor covered by workers compensation (this was a term of the contract between them). Creative Doors insurers, AXA, declined to defend the third-party claim, CD issued a statement

of claim that the insurers were required to defend. Policy had provisions saying that the insurer had to pay if the insured was liable to pay another party by reason of obligations imposed by the insured
Issue: how to interpret the word “contract” and “occurrence”
Reasons:

- Duty to defend is wider than the duty to indemnify
- CA found that the statement of claim that alleged Alta was liable to the plaintiff for compensatory damages because of bodily injury, the third-party notice sought to transfer that liability through contract. Definition of contract included any written contract, so there is a possibility that the respondent would be liable for compensatory damages that Creative assumed under the contract

Markham (City) v AIG Insurance Co of Canada (2020 ONCA)

Primary vs excess coverage

- Facts: The City of Markham rented a hockey rink in a community center to the Waxers hockey club. A young boy was injured by a puck and sought damages from the City and Hockey Canada. The City is insured by Lloyd's under a commercial general liability policy, and is an additional insured to Hockey Canada's insurance policy with AIG. AIG accepts responsibility, but claims that Lloyd's has a concurrent duty to defend and must pay an equitable share. AIG also claims that is has a right to participate in the defence alongside Lloyd's
- Issue: (1) Does Lloyd's owe the City a concurrent duty to defend? (2) Does Lloyd's have to pay an equitable share of the defence costs? (3) Does AIG have the right to participate in the defence?
- Reasons:
  - **(1) Concurrent duty to defend?**
    - *Relationship between an insured and insurer* -
      - Contractual one governed primarily by the terms of the insurance contract. Language should be construed in accordance with the usual rules of construction
    - *Duty to defend claims* -
      - Duty to defend where there is a "mere possibility" that the true nature of the claim, if proven, falls within coverage and trigger the insured's duty (*Progressive*). If the pleadings allege facts that, if true, would require the insurer to indemnify the insured for the claim, then the insurer is obligated to provide a defence even though the actual facts may differ from the allegations in the claim. However, an insurer is not obligated to pay costs incurred solely to defend uncovered claims
    - *Primary and excess coverage* -
      - **Primary:** liability attaches immediately upon the happening of the occurrence that gives rise to the liability
      - **Excess:** provides that the insurer is liable for the excess above and beyond that collected on primary insurance
      - **When both:** the limits of the primary insurance must be exhausted before the primary carrier has a right to require the excess carrier to contribute to a settlement
    - Application: Lloyd's has a duty to defend the City against the claims in the action not covered by the AIG policy. They are free to seek a final determination of coverage after the action is resolved. AIG is the primary insurer for claims resulting in bodily injury or property damage from the operations of Hockey Canada up to the policy limit because the AIG policy doesn't contain an excess provision
  - **(2) Lloyd’s have to pay an equitable share of defence?**
    - Where two insurers have an obligation to defend the same claim, the insured is entitled to select the policy to claim indemnity (then the insurer may be entitled to contribution after).
    - *The allocation of defence costs as among insurers who have a concurrent obligation to defend is a matter of fairness. Allocation is not an exact science, so the TJ's determination is owed considerable deference*
    - Application: Each of AIG and Lloyd's has a duty to defend at least some of the claims in the action. Because there are two primary insurers, Lloyd's is more comprehensive, and there is a concurrent duty to defend, the fairest way is to require each party to pay an equal share of the defence costs pending final determination of the action
  - **(3) AIG have the right to participate in defence?**
    - *Governing principles*
      - An insurer who has a duty to defend has a prima facie right to control the conduct of that defence. To remove the insurer's contractual duty to defend and control the defence, there must be a *reasonable apprehension of conflict of interest on the part of counsel appointed by the insurer*
      - Question: whether the circumstances of the case create a reasonable apprehension of conflict of interest if that counsel were to act for both the insurer and the insured in defending the action. The onus is on the insured to establish a reasonable apprehension of conflict of interest on the part of the insurer

        - The court needs to balance the insured's right to a full and fair defence of the civil action with the insurers' right to control the defence
    - Application: there are multiple conflicting interests. The Court accepted AIGs proposal to create a system to protect confidential info in separate files so all parties could participate

Holding: Both policies might provide coverage for the allegations made by the injured party, so **both insurers had the obligation to defend –** at a minimum, Lloyd's owed the city the duty to defend claims outside the scope of their policy

Takeaways:

- If both policies might provide coverage, both insurers have the obligation to defend
- Where both insurers have an obligation to defend, the insured is allowed to select the policy under which to claim, thus which insurer can control the defence
- Where there are two insurers, it is inequitable to make one insurer pay all the costs – both parties may be responsible for defence costs
- To interfere with the fundamental rule that the insurer who has the obligation has control of the defence, there has to be an appreciation of a conflict of interest between the parties

Duty to Settle

The **insurer has the duty to make reasonable efforts to settle a claim within the insured's limits of coverage,** so that you are not exposed personally.

If a claim falls within the limits the insurer's duty is easily fulfilled, as it only must consider its own interests – it will pay the full claim,

If the claim exceeds the limits, the **insured may be personally exposed**

- Where the claim may exceed the limits, the insurer must disclose all material info to the insured so the insured is aware of all strategy and risks
- Have to send the insured a letter immediately if a claim exceeds coverage
- Advise the insured to seek his/her own counsel
    - Caveat: often statements of claim are inflated – its more when there is a *reasonable possibility* that the claim could be higher than the policy limits

Insurer isn't in breach of the duty to settle every time there is a judgment above the limits – it must have made ***best efforts*** to resolve the claim within the policy limits, or it may face a claim by its own insured

Dillon v Guardian Ins Co (1983 Ont HC)

- 5 year old sustained severe brain injury as a result of a motor vehicle incident. D had motor vehicle liability policy with $50 000 limits. Before trial the plaintiff said to the insurer that they could settle for $45 000 - $46 000, insurer said no, D went to trial and was found liable for $78 000 - D was exposed to $28 000 above the insurance policy. D sued his insurer for that amount
- Court said that in refusing to pay more than $45 000 to settle and below the insured's policy limits, the insurer didn't use reasonable care to protect its insured and was guilty of bad faith

Most important thing: if your insured is sued for an amount over their limits and you think the claim is likely to exceed, they need to be obstructed to obtain their own lawyer over and above their policy limits - only responsibility is to settle under those limits where you can. You don't have to be *right every time,* have just had to assess the claim reasonably based on information, case law, etc., best efforts

Chapter 5: Third Party Rights and Obligations

The term "third party" just means that other people aren't parties to the insurance contract. These people don't participate directly in the creation of the contract and likely aren't parties to the negotiation process, don't pay premiums, etc. Despite this they **may have rights and obligations vis a vis the insurer**

- E.g. unnamed insured: person driving a vehicle with the insured's consent (s 599 of the IA contemplates anyone driving with consent as being an unnamed insured and thus a third party who would have rights under a contract of insurance that wasn't their own)

Assignees

Important to remember that insurance contracts are **personal** – insured is insured based on the risk they represent – so if the subject matter of the insurance is transferred to someone else, the insurance coverage typically **doesn't transfer**

Two ways an insured can generate an assignee:

1) An insured can assign the proceeds of a contract; or
2) They can assign the contract itself to someone other than the original party

Assignment of the proceeds

- You agree that if there is a loss, the proceeds of the policy will be paid to someone other than yourself (the insured)
- This is allowed because the contract of insurance is still remaining exclusively between the insurer and insured, the risk isn't changing and the loss is dependent on the contract between the two parties that originally existed.
- No requirement to "ok" this with the insurer because the risk is the same
- **Problem:** third party's ability to recover is dependent on the insurer's obligation to pay the insured. If there is a breach by the insured of the contract, third party won't receive any money

Assignment of the contract itself can occur if certain conditions are met

- This is a *substitution* of a third party for the insured
- Need **approval** from the insurer – can't just assign because it is a **material change in the contract,** a brand-new risk
- Validity of the original contract is immaterial (even if the assignor defaults) – replacement contract is determined on its own terms

Peters v General Accident Corp (1983 ER)

Facts: K sold a car to P, handed over the policy of insurance with the car. Claimed this was an assignment of the policy of insurance

- Where the insurer must indemnify the policyholder, the contract is in its very nature not assignable – the effect of the assignment would be to impose on the insurance company an obligation to indemnify a new insured without assessing or altering the new risk
- Because the policy is **inherently personal,** it is not assignable at the volition of the insured

Springfield Fire and Marine Insurance Co v Maxim (1988 SCC)

Facts: insurance company insured a flourmill. M had misrepresented his loss history in the original contract. M transferred the property into his wife's name and told his insurer about this, asked to have it transferred, and the insurer agreed. Fire happened and the insurer realized M had made a misrep, then refused to pay on the contract
Issue: did M's material misrep on the original application have a bearing on the validity of the policy?
Reasons:

- When the insurer agreed to transfer the contract, **a new contract was created** that replaced the old one. The insurer couldn't deny coverage on the basis of a breach committed by the insured
- Insurer could have had a brand new application form for her, but failed to do so

Mortgagees

When a lender (mortgagee) takes security in a debtor's property it is in the interests of the lender to see that the property is insured against damage or destruction, and that any insurance proceeds are payable first to the mortgagee.

Three options for doing this:

1) **Can purchase its own insurance on the secured property**
    a. Considering the number of mortgages that banks issue daily, would be cumbersome for them to purchase their own policy of insurance on every secured property
2) **Can take an assignment of the proceeds of insurance**
    a. But if the insured is in breach, they don't get the proceeds
3) **Can require the mortgagor to insure the property with an insurance contract that contains a <u>mortgage clause</u>**
    a. This is a common solution
    b. Mortgage clauses are an express term of the contract between the mortgagor and the issuer of the mortgaged property, ordinarily concluded to satisfy the mortgagor's requirement to obtain insurance coverage for the mortgagee's interest
    c. This clause creates a ***separate contract of insurance*** *between the mortgagee and insurer*

Mortgage clause

- Express term of the insurance contract
- Mortgagee has a contractual cause of action against an insurer to enforce a coverage claim
- Subject to the same principles of interpretation
- Enforceable only while the insured continues to have **insurable interest** in the subject matter of the insurance (only while the mortgagee has an outstanding security interest in the property, the insurance contract is collateral to the mortgage debt)
- **Stat condition 5, s 539:** prohibits the insurer from cancelling or altering the policy without notice to the mortgagee (need to provide written notice in five days and refund excess premiums as soon as practicable)

- **Two major implications of the clause for the insurer:**
    - **1)** The insurer can't rely on the mortgagor's acts, omissions, default on the main contract, to deny coverage to the mortgagee on the collateral contract (even if the insured commits a breach, **mortgagee is not affected by that breach**)
    - **2)** By the explicit terms of the mortgage clause, the insurer does have a **limited right of subrogation against the mortgagor** if it breached its obligations under the main contract (insurer can subrogate as against the mortgagor to recover the money it has to pay out, **exception to the rule** that an insurer can't subrogate as against its own insured)

Co-operators General Insurance Co v National Bank of Canada (1988 AR)

Insurer can't rely on an insured's omission to deny coverage

<u>Facts:</u> Coastal Cedar got a loan from the bank, was required as a result to make the bank a loss payee on the insurance policy, which it did. The company then changed insurers and it intended to keep all of the same coverage, but inadvertently omitted the mortgage clause. There was a fire, bank sought recovery for the loss and the insurer said there was no mortgage clause

<u>Issue:</u> was there any implicit contract to create the mortgage clause?

<u>Reasons:</u>

- Court found that an oral contract existed between the insurer and the bank. When the rep of the company instructed the broker to get the new policy when it changed insurers, she **implicitly** created this "promise" to have the money protected
- The effect of the mortgage clause is that the **insurer can't rely on an insured's omission to deny coverage to the mortgagee** under that collateral contract

Royal Bank of Canada v State Farm and Casualty Co

Where there is conflict between the mortgage clause and the insurance policy, the court will give effect to the mortgage clause' wording (it takes precedence)

<u>Facts:</u> Homeowners, Deeks, owned a house with a standard insurance policy. Deeks defaulted on the mortgage and the property. The bank was aware of the vacancy and took control of the property but didn't foreclose, so it remained vacant. Was then destroyed

by fire and a claim was made on the policy. Insurance company said the insured had a duty to advise if the property is vacant, and by not advising it was a breach because of the material change of risk
Issue: who was the insured within the meaning of the statutory condition? Can the insurer avoid the policy on the basis that they were not notified that the house was vacant?
Reasons:

- The wording of the statutory condition said that the *insured had to notify the insurer* – but the mortgage clause expressly distinguished a mortgagee from an insured. The policy described the Deeks as the named insured and the bank as the mortgagee
- Court said we can't read the word "insured" as the same because the wordings conflicted – *where there is conflicting wording between the original policy and the mortgage clause, the mortgage clause takes precedence*
- Court looked at the language as a whole and said it didn't clearly reflect the insurer's intention – a breach by the mortgagee couldn't be used as a defence here
- If the insurer wished to be able to void a mortgagee's coverage in the event of a change material to the risk within that mortgagee's control and knowledge it should have used language to that effect

Holding: insurer was not allowed to void the policy

Hum v Grain Insurance and Guarantee Co
Supports Royal Bank – breach by the insured is not going to affect the mortgagee's right to recover under the policy
Facts: Fire occurred, but it was deliberately set by the insured's tenant. The bank submitted a claim but it was rejected on the basis that the loss was not covered (said that a loss from a malicious act was excluded)
Issue: did the mortgage clause supersede the exclusion, or was coverage for the loss excluded under the policy so the bank couldn't recover?
Reasons:

- Court held that *Royal Bank* is the authority for the fact that the mortgage clause trumps the insurance policy if they are in conflict
- The exclusion endorsement was inconsistent with the standard mortgage clause, so the court didn't apply it

Auto Liability Insurance

Number of different auto policy schemes across Canada:

1) **Tort based** system (used in **AB**)
    a. Whoever is at fault pays for the damages incurred by the person who is not at fault
    b. Some limits: *Minor Injury Regulation* in AB suggests that if there is only a minor injury you can get $5000 (meaning that if you get better in 6 months you only get this, if more than 6 months its "chronic")
2) No fault system
    a. It doesn't matter who is at fault – everyone who is injured in an accident is entitled to benefits (e.g. Quebec)
    b. You give up general damages for pain and suffering (in a personal injury case this is the largest component of damages)
3) Mixture
    a. Can choose under which one to be insured under (e.g. Saskatchewan)
    b. If you choose no fault, no one can sue you for tort but you also can't sue anyone in tort, if you choose tort you can sue and others can sue you

SPF 1 is the standard motor vehicle policy in Alberta. It has three parts:

1) Third party liability
    a. Comes to the rescue when involved in an accident and you hurt someone else, and that person brings an action against you in tort
2) Section B (no fault benefits)
    a. Comes to the rescue when involved in an accident, whether or not it's your fault – you and everyone in your car has access to benefits
    b. Pays for things like physiotherapy, chiropractic care, medications
    c. Only valid for 2 years after the date of the accident

3) Property loss
    a. Pays for the damage to the car

For liability insurance, you can sue someone even if you don't have a contract with them. Two sections allow this:

1) Auto: section 579 – allows you to bring a claim directly against an insurance company if you're injured in an accident and you get judgment against someone who has hurt you
2) General liability insurance: s 533(2)

Overriding policy goal in AB: to ensure that there is a minimum of $200 000 per *accident* (not person) to compensate people injured in motor vehicle accidents that are caused by others

One of the most important aspects in all insurance claims is that the accident victim can sue the insurance company directly to recover the insurance money directly (even though no privity of contract)

Each provincial auto legislation has a "rights of creditors" section (AB s 579) that gives a third-party victim a claim directly against the liability insurer. If they have an unsatisfied judgment against the insured – **even if the insured was in breach of the policy** (this is how an auto right of creditor claim is different than a general right of creditor claim)

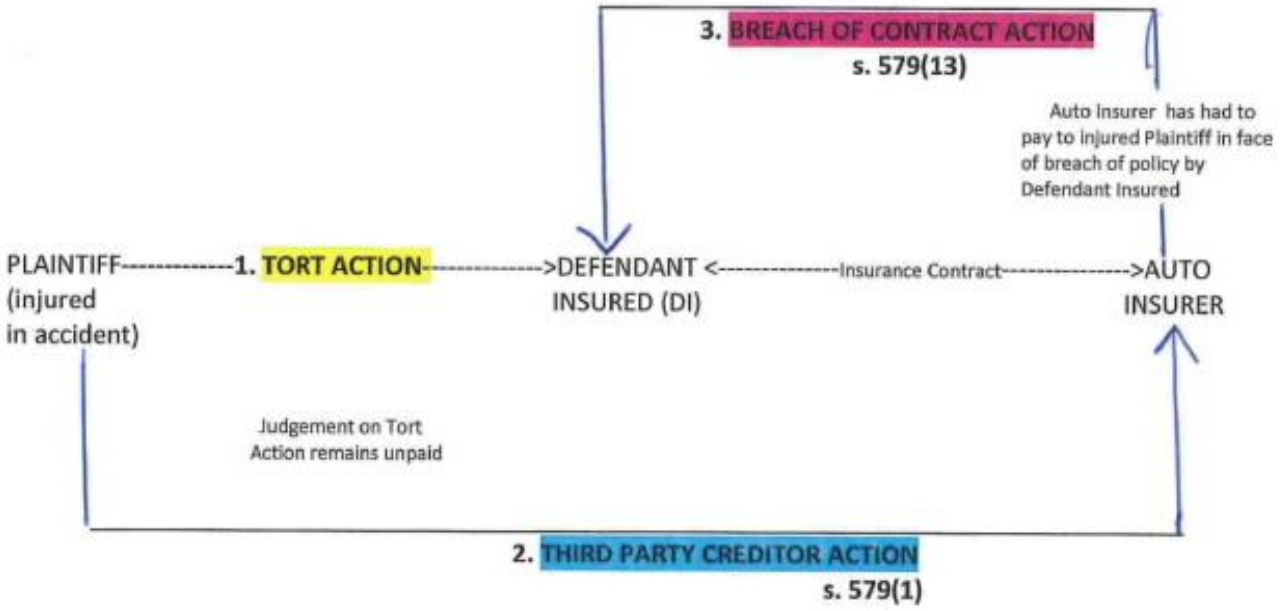
Potential Insurance Related Actions

Whenever there is a car accident, there are a number of different actions that can arise:

1) **Tort action:** action brought by the victim against the owner and driver of the car for damages

2) **Rights of creditors action:** brought by the victim against the driver/owner's insurer if the victim has unsatisfied judgment against the insured (**section 579 action**)

3) **Reimbursement action:** action by the insurer against its own insured for the amount it had to pay out to the victim even if the insured was in breach of the insurance contract
    a. Need a **judgment** to have been obtained in the tort action! A **settlement alone is not sufficient** to ground a reimbursement action to proceed
    b. This action only occurs if the insurer has had to pay out the victim, when the insured was **in breach of policy.** They can then try to collect against an individual who was in breach of the policy, and therefore not contractually entitled to indemnification for the loss



1. Tort Action

Very straightforward claim where the victim alleges that the other driver/owner was negligent, caused the accident, and that the accident caused the plaintiff damages. Two major issues are: **(1) liability** and **(2) quantum** (the amount to which the plaintiff is entitled)

Why sue both the driver and the owner? Because the primary policy is the owners' policy – the owner is liable for every driver who drives with his consent

Sample claims: usually personal injury, also
- Damage to car not covered (no collision (Section C) coverage))
- Deductible
- Increase in premiums
- Loss of value of car

Defences: regular tort defences
- Contributory negligence
- No negligence by defendant
- Third party was the cause of the accident
- Causation
- Remoteness, etc.

Lenkewich v Landry

Facts: Involved a fender bender in a parking lot. Both cars backing out at the same time, truck ended up backing into smaller car. Victim had collision coverage under the car, but she had a deductible that she had to pay, and after the accident her premiums went up. Brought an action for damages for the deductible and increased premiums, evidence being that the premiums had almost doubled, and the adjuster had adjusted the claim at 50% and she had previous at fault accidents

Reasons:
- Court accepted as common knowledge that:
  - Auto policy premiums went up for certain drivers who were involved in accidents and made claims on their policy
  - Not common knowledge of guidelines for those increases
  - Common knowledge that premiums were rising for everyone
  - Driving record accumulates, after a certain number of claims, infractions, etc., the premiums might go up
- The truck was 100% liable for the accident – there was no way of knowing why premiums went up- might award damages in an appropriate case with appropriate evidence, but not here (only awarded damages for the deductible)
- **Why 100% at fault in tort but adjuster imposed 50% fault and premiums increase**
  - Alberta Insurance Companies have all agreed to a **fault chart** for property damage claims **only** – not equivalent with tort (*Interprovincial Arrangement* fault chart), circumstances are ignored
  - Only applies to **automobile property damage**
  - Under the fault chart, if the defendant is 100% at fault, the "at fault" insurer will also pay the deductible, in which case the victim's insurer won't even collect the deductible from their own insured
  - But – this **doesn't bind** the court in their determination of tort-based fault for the accident

The Timing Problem – Duty to Defend

A portion of the Section A auto liability coverage is the insurer's duty to defend the insured against the tort claim of the victim (duty to defend). It **arises immediately upon the insured being sued.**

Issue: what is the insured is still concerned that there was a breach by the insured that might void their coverage? If they begin to defend the insured, the insured may raise the argument that by complying with the duty to defend, the insured has confirmed that coverage exists, and that they cannot later claim that the insured was in breach of the policy and bring the third action for recovery (waiver and estoppel)

There are a few things an insurance company can do to ensure they comply with their duty (or right) to defend without losing the right to claim contribution against the insured later: **non-waiver agreement or reservation of rights letter**

Non Waiver Agreement or Waiver of Rights Letter

Documents used by insurers to preempt claims by insureds for waiver and estoppel if the insurer commences defending a claim pursuant to a duty to defend when there remains outstanding an issue as to whether the insured has breached a policy provision disentitling them to coverage

- Clearly not voluntarily giving up a right (no waiver in writing as required by the Act)
- No reasonable reliance by the insured – no estoppel

These documents provide the insured with written notice of a coverage issue, and written confirmation that the insurer is not intending, by its subsequent actions, to forfeit its right to deny coverage

- Note that when the plaintiff sues the defendant, they only have 20 days to file a defence
- Insurer might not have time to figure out if they have to defend

Purposes of using one of these tools:

- Allow an insurer to **suspend its decision to deny coverage** for a given loss, while **permitting the insurer to continue its involvement** in investigation, defending and possibly resolving the tort action

- Preserve the right of the insurer to recover any amounts paid out in the settlement or in satisfaction of a judgment or claim of the third party (s 579(13) – non waiver agreement only))

- Allows the insured to be defended – often can't afford

Neither of these tools have a legislated form. Important points for them:

1. The documents must **clearly** set out the rights which are reserved to the insurer – to be interpreted strictly against the insurer
2. The documents will not be enforced if the terms or the relevance of the agreement **were misinterpreted** by the insurer or otherwise misunderstood by the insured
3. The documents are **not effective once the insurer has denied coverage**

Non Waiver Agreement

- The insurer and insured mutually acknowledge and agree to the insurer's reservation of right to deny coverage later, despite investigating/defending the plaintiff's tort action on behalf of the defendant

- Both need to sign and agree, so it could potentially include other terms as well
    - E.g. under s 579 must have a "judgment" in tort action to bring a reimbursement action under s 579(13) – could include a provision that the insured is entitled to seek reimbursement from the insured if it **settles the victim's tort action** instead

- Must be VERY clear or not enforceable

Reservation of Rights Letter

- Insurer **unilaterally** informs the insured of the insurer's intention to preserve its right to deny coverage – doesn't require any agreement by the insured to be effective

Halifax Insurance Co v Williams (1966 Ont Co)

Non-waiver agreement

Facts: Insurance company had paid to a third-party claimant on behalf of the insurer for damages. The insurer then claimed the money back for a statutory breach by the insured, that he had loaned his car to an unlicensed driver. To protect his friend who had borrowed it he said he had given explicit permission, which he had not. If this was true there was no obligation to defend the claim

or defend the third party. Insured had low level of intelligence and education, and the non-waiver he was being asked to sign was blank, was asked to sign it as a formality. It actually specifically pointed out that the company raised the issue of coverage
Reasons:

- Court found that the document had been misrepresented by the adjuster, and because it was signed under a misrepresentation the court wouldn't enforce it
- **Non-waiver agreements must be very clear, provided to the insurer without any misrep as to what it is in order to rely on it**

Allstate Insurance of Canada v Foster (1972 Ont Co)

Reservation of rights
Facts: Insured involved in motor vehicle accident, insured convicted of operating a vehicle while impaired by alcohol. Company settled third party claim but no judgment was obtained and no non-waiver agreement was entered into, but a reservation of rights letter was sent. No authority of permission to settle the third-party claim was ever granted by insured to insurer. Insurance company brought an action against their own insured to recover the money they had paid because he was in breach of the policy. Insured brought an application to strike the action

- Note: driving while intoxicated is not a breach of insurance policy in AB – insurance companies can't deny you coverage if driving while drunk (think policy implications)

Reasons:

- Court said the reservation of rights letter is effective to ensure no waiver or estoppel defence can be raised, BUT **that alone** doesn't give the insurance company a **right to claim against their insured**
- The reimbursement action is essentially an insurance company subrogating against their own insured – this isn't allowed
- It only can do this under s 579 because it has statutory allowance to do so when it pays out under a tort judgment – since it had settled and no judgment obtained, no right to collect the money despite the breach of contract

Holding: action dismissed – no right to claim over

Note: the only ways for the right to claim over is preserved:

1) Judgment
2) By agreement between the insured and insurer (non-waiver agreement, s 579)
3) Potentially assignment of the claim from plaintiff to insurer

Third Party By Order

Non-waiver agreement and reservation letter can only be used up until the point the insurance company is investigating to deny coverage. Once they have decided, they can't use either as an excuse to continue defending the action

Third party by order allows the insured to remain involved in the action in order to have some input into the liability and quantum in the tort action (in case it is later determined there is coverage in place) (**s 579(14)(15)**)

- Only once coverage has been **denied**
- May be made a third party in any action in which the insured is a party and in which a claim is made against the insured
- **Rights** in the action as a third party:
    - Contest the liability of the insured to the plaintiff, contest the amount of the claim, deliver any pleadings, disclosure of records, can question and cross examine witnesses at trial (same rights as a defendant in the action)

Giese v Hunking (1971 Alta)

Can't be added as a third party by order unless and until they have denied liability
Facts: Action commenced against H for the death of his daughter in a motor vehicle accident. Action was set for an assessment of damages, about $8000 awarded. He never informed insurance company of action, they didn't know until after the judgment was awarded. This was a breach of the policy, no notice of the claim provided. Here the insurance company didn't deny coverage (although they could have on failure to give notice), they wanted to be added as third party by order. Plaintiff suggested insurance company can't do this until it denies liability, court agreed
Reasons:

- Can't become a third party by order unless and until you have denied liability

- Court was considering allowing a third party by order after a judgment had been entered – court here said they might do this

***Re Perfaniuk* (1961 Man CA)**

Different from Giese – court adds the insurance company as a third party even though no evidence they denied coverage prior

Facts: The appellant was injured in bike accident, he was the passenger that collided with defendant's truck. The defendant's truck was insured and the appellant brought an action against the appellant. Defendant did not notify the insurance company and did not defend. Default judgment was entered. An assessment hearing was held with damages at 13k. Shortly thereafter, the appellant's lawyer and went to insurance company and showed them the judgment. This was the first they had heard of it. The insurer applied to be added as a third party by order and asked default judgment to be set aside. The plaintiff argues that the statutory right to intervene under the *IA* only subsists until final judgment, but comes to an end when that judgment has been entered

Reasons:

- Court found that the insurance company was the one most impacted by the judgment, wasn't fair to allow the judgment to proceed without their input
    - Would be a matter of "grave injustice to deny the insurer, who had no knowledge of the action until after judgment, the right to be entered as a third party"
- A substantial **pecuniary interest** in the outcome of the litigation is possessed by the insurance company rather than by the defendant – while the defendant didn't defend, this shouldn't prejudice the rights of the insurance company

Holding: was never discussed if they had denied coverage to the defendant prior to being made a third party by order – this suggests maybe denying coverage is less important than we think BUT *Hunking* is an AB case

2. Creditor's Right Action (s 579)

Liability insurance contracts are between the insured and the insurer only. However, in addition to benefitting the insured, an auto liability contract **benefits a whole class of third parties,** those who might be justified or suffer a loss as a result of a motor vehicle accident with the insured, at the fault of the insured.

At CL only parties to a contract have a right to enforce the claim and the third party has no direct claim against the insurer if the defendant insured chooses not to claim against insurance company, of if the insurer denies coverage to the defendant – so **provincial insurance legislation alters the CL rule of privity with respect to liability insurance policies (gen and auto)**

"Judgment creditor action" clause: subject to certain conditions, a third party who obtains judgment against an insured wrongdoer is entitled to bring an action directly against the wrongdoer's liability insurer to recover judgment

- All liability contracts (general liability provisions): s 534, plaintiff stands in the shoes of the insured

- Auto liability provision – s 579

S 579 will allow for recovery by the third party directly if:

- The third party obtained **judgment** against a person
- The insured is under a **liability insurance** contract (provides the insured party with protection against claims resulting from injuries and damage to people and/or property)
- The policy provided **indemnity** to the insured with respect to the third-party claim against the insured

Rules:

1) The judgment can be obtained through **summary or default proceedings, or consent**

2) Upon proving the existence of a liability judgment against the insured, the third party does not need to prove that the judgment was correct, or re-establish the insured's liability to the third party (**don't need to 're litigate'**)

3) The judgment **must be based on a claim that falls within the scope of coverage provided by the insurance policy**

4) The third party is not bound by any judgment regarding coverage which may have been issued in an action brought by the insured against the insurer (because they weren't a party to it)

Distinct from the tort action

***Bourbonnie v Union Insurance* (1959 Alta SC)**

The only defences an insurer can raise in a s 579 action deal with whether there is coverage

Facts: Plaintiffs husband was a passenger in a car driven by Mr. Hall. Both were drunk. Car got into accident and husband was killed. Plaintiff recovered judgment of 14k against Mr. Hall for the death of her husband. Counsel for insurance company was aware of action all along. Although they didn't defend (because insured was drunk so denied coverage), they watched the entire proceedings. None of the judgment was paid by Mr. Hall, so plaintiff commenced s.579 action. Hall had auto liability insurance with limits of 25k. The insurer claimed (1) volenti; (2) contributory negligence; and (3) breach of the condition by the insured for being drunk

Issue: what defences could the insurer raise?

Reasons:

- The first two defences (volenti and contributory negligence) have nothing to do with the obligation of the insurer to provide coverage to the insured, and to satisfy a judgment that has been obtained against the insured – only available in the action based upon insured's negligence, which is over (can't re litigate!)
- The only defences available are **those either expressly or implicitly provided for in the terms of the IA in a s 579 action:**
  1) No coverage was in place (note – does not extend coverage where *none applies in the first place,* e.g. if never obtained permission to drive a vehicle, no coverage, not a breach of coverage)
  2) The claim does not fall within the coverage
  3) No judgment has been recovered
  4) Judgment has been satisfied
- In respect of **insurance above the statutory minimum**, the insurance company can use any defence it could have raised against the insured, but not before this point (**s 579(11)**)
  - E.g. misrepresentation, breach of contract, breach of statutory condition
  - **Can never raise a defence that relates to a breach of stat condition 2** (under 16, prohibited license…)

Only applies to a judgment on the claim

- If a claim is brought and you know there are other potential claims out there, this creates a problem for insurance companies

- Sec 579(7) allows them to pay the money into court. Once they have done this they have met their obligations, it sits there until the court determines who has claims and how it should be divided (likely waiting until limitation period elapses)

- If you don't do this, at risk of having to pay out in excess of the limits because policy limits must be available for all judgment creditors, can't be reduced by out of court settlements

***Scale Estate v The Cooperators General Insurance* (2018 ONCA)**

Facts: Summary judgment claim s 579 - S had been killed while a passenger in E's vehicle, S's estate is suing E's estate - one action by S, G S and C had also died in the accident and brought actions. Only S didn't give notice to claim, the broker asked if they wanted to make a claim, no response was ever received. Cooperator settled with G, S and C - no judgments. No one contacted S to ask if they wanted to make a claim, no one searched for if a claim had been filed. Prior to the settlements being reached a claim had been filed before the limitation expiry date. Cooperator said no money payable to S because the policy limits of $1 million were paid out to the others (first come first serve basis).

Issue: Did the insurance company have to pay out the claim even though the policy limits were already exhausted?

Reasons:

- First come first serve isn't how it works – if more than one claimant comes forward and the limits are exceeded, ***paid out on a pro rata basis***
- Court said they did not actually pay out pursuant to s 579 because there was **no judgment** – brought not only for the person bringing the action, but also for every other claimant (can only reduce the "pot" here by the judgment that has been paid)
  - Since this wasn't the case, the entire limit had to be made available to the Scale estate
- **If an insured settles with some claimant, they might be liable under s 579 in excess of limits –** the policy limit must be available for all the judgment creditors, can't be reduced by out of court settlements
- **To avoid this: s 579(7)** if someone brings a claim and the insurer believes there may be other claimants, can apply under this section for an order to pay the money into court so the court will sort it out

- It **didn't matter that the company didn't know the Scale estate made a claim** under s 579 – they knew there *might* be a claim from her

Limited defences available to the insurer

S 579(4): a person claiming under s 579 is not prejudiced by:
- **Any act or default of the insured** before or after that event in contravention with this section or the terms of the contract
- **Any contravention of the CC or a statute** of any province

S 579(11): when the contract(s) provide coverage in excess of the statutory limits ($200 000), the insurer can use **any defence it is entitled to use against the insured other than a defence from a breach of stat condition 2** (prohibited use by the insured)

<u>These sections mean that for any portion of the claim that falls within the minimum policy limits of $200 000, the only real defences are:</u>
1) The contract was not in force at the time of loss; or
2) The loss falls outside the defined coverage of an existing contract
    a. E.g. non-owned auto policies being used for carriage or hire, there is no coverage, driver had no consent to drive (policy covers only those insured or those with consent)

The offset is the insured's statutory right of recovery against its own insured for amounts it has to pay to a third party that **it would not have had to pay to its own insured** – in essence, the insurance company has a **statutory right of subrogation against its own insured**, which is generally prohibited at law

Jivraj v Edwards (1999 ABCA)
Ownership can't be used to deny coverage under $200 000
<u>Facts:</u> State Farm had issued a standard auto policy to Irene Edwards. Irene didn't actually own the car, because the son was the driver and owned it. This was a breach of duty to disclose. The son, Gordon, had been convicted of impaired driving and was not allowed to have a car. He was driving and caused an accident and caused injury to the plaintiff Jivrav. State Farm cancelled the policy, reimbursed the premiums, arguing that with the misrepresentation there never was a policy. The administrator paid out the damages to expedite things, and now they are arguing with State Farm that they should have paid it
<u>Issue:</u> was Gordon an uninsured driver (so the MVACF had to pay the third party's damages) or did State Farm have to respond to the claim by the injured third party? Who has to pay Jivraj's damages?
<u>Reasons:</u>
- At Trial Irene was found to have no ownership in fact or law in the vehicle, and therefore no insurable interest. Because of this no insurance contract ever came into existence, and there was no insurance on the vehicle. Gordan was an uninsured driver and the MVAF should pay the judgment
    - This was based on an older case out of the ONCA in *Minister of Transport et al v London & Midland* (1971)
        - This case suggested that the insurance company couldn't raise other misrepresentations as a defence, but they could raise misrepresentations as to **ownership, because it affected coverage**
        - The vehicle wasn't owned by the insured named in the contract, so he couldn't give permission for anyone to drive the car, and coverage wouldn't have existed at all
    - BUT there was also another line of interpretation in ***Marshall*** *v Law Union and Rock Insurance* (1958)
        - Said the statutory right of recovery excludes a defence for **any misrepresentation** by the insured, including a misrepresentation as to the ownership of the vehicle
    - After the trial judgment issued in this case, the ONCA issued a new case *overruling London and Midland and following Marshall*
- Majority in Alta CA said that the ONCA has removed the basis for the TJ's decision - **agreed with the *Marshall* line of cases** and found that **State Farm was not entitled to raise the issue of misrepresentation as to ownership against the third party**
- <u>AB: **a misrep as to ownership is the same as any other misrep when it comes to a section 579 action - none can be raised for the first $200 000, only after this amount**</u>
- Dissent:
    - Agreed with the majority that the Act precludes the insurer from defending an absolute liability claim on the ground that the policy is not an owner's policy and is therefore void from the outset
    - However, can still defend the action on the basis that the policy doesn't provide coverage to the judgment debtor

- The owner's policy presumes that the person identified in it as the owner is the actual owner - provides coverage to anyone operating the vehicle owner by the named insured with the consent of the named insured
- The defence section was intended to prevent the insurance company from defeating an absolute liability claim on the ground that the policy was void *ab initio*
    - It was never intended to require an insurance company to pay third party judgments recovered against persons not entitled to indemnity under a policy deemed valid and existing
    - This case involved a motor vehicle liability policy. The defence precludes the insurance company from denying that the policy was in force at the time of the accident
    - BUT the motor vehicle liability policy doesn't provide indemnity to Gordon - his use of the vehicle can't be said to have been with the consent of the named insured, Irene, because Irene wasn't the owner of the vehicle and thus had no power to grant or withhold consent. Gordon was driving because the vehicle was his and he had exclusive control, not because Irene let him

Note: motor vehicle accident fund

- Will provide a source for recovery for persons injured (not property damage) by an uninsured driver
- If injured by uninsured or unknown driver, can bring an action for recovery against MVACF
- Limits: statutory limit of $200 000

Ashton v Tu (1998 Ont CA)

Policy may cover a loss before the issuance of the policy. Event not "uncertain" because it had already happened

Facts: A person went in and applied for insurance, and asked for a backdated policy. For some reason, the agent agreed and a backdated policy was applied for. As it turns out, the insured had been in an accident after the date of the policy but before the date on which the policy was actually applied for. State Farm denied the claim, claiming fraud (delay in reporting and misrep)

Issue: was the dad's car insured by State Farm at the time of the loss?

Reasons:

- It is possible to have a policy cover loss before the issuance of the policy
- There was a wilful and fraudulent misrepresentation because the application contained questions about accidents in the past 6 years, and was told there were none
    - Because of this State Farm had no obligation to indemnify the *insured*
- Indemnity for the plaintiff:
    - Because of s 579(4) and (5) if Ashton's (the plaintiff) claim is one for which indemnity is provided by a Motor Vehicle Liability Policy, then he can claim
    - Defences constitute breach of coverage
    - Original argument by State Farm was that this is not an insurance contract because that would require an "uncertain event" and here the event wasn't uncertain because it had already happened, but this was ultimately unsuccessful
- Application:
    - The agent had actual authority to issue the binder and insurance certificate
    - Backdating the policy was within her ostensible (if not actual) authority
    - She bound State Farm to the risk as of Friday and had issued an instrument evidencing a motor vehicle liability policy
    - Because of s 579(5) cannot now claim that the policy was void *ab initio*
- **If the court allowed the defence that there was no contract in the first place, this would seriously undercut the protection given to innocent third parties**

Defences available in excess of statutory limits

Marcus v Western Union Insurance (1964 DLR)

Relief against forfeiture case – can be granted in favour of the third party if that relief can be granted to the insured

Facts: Note this is NOT a case considering the statutory limits, it is an analogous case - here the insurance company's defence was that the coverage in the policy for passengers was "extended insurance" (old construct that basically required insurance did not cover gratuitous passengers) - an analogy is being drawn here between gratuitous passenger coverage and coverage over the $200 000 minimum

- Markus was a passenger in a car driven by Nagy. The car was in an accident and Markus claimed against Nagy. Nagy was held liable and judgment was awarded in favour of Markus. Markus then sued Nagys insurer (third party creditor action). The insured had not properly reported the claim when it was made, failed to cooperate in defence of the action, and therefore the insured forfeited the right to recovery

Reasons:

- Because the coverage is extended coverage, the insurance company **can avail itself of any defence it can raise against the insured** including failure to cooperate and failure to provide notice
- But the third party suggested that the insured could be entitled to **relief against forfeiture**
    - **Relief from forfeiture can be granted in favour of an injured third party provided that the circumstances are such that relief could be granted to the insured**
    - Here the insurance company was not prejudiced by the insured's breach, so the insured should be relieved from forfeiture with respect to his failure toward not filing the statement of claim
- This is because the insurer didn't really ask Nagy to do anything in the action - they only wrote to him once, didn't require his assistance to defend the action, etc.
    - Therefore the insurance company has not proved the insured's failure to cooperate

Holding: Insurer is liable to the plaintiff OVER $200 000 as well

So R from F is granted to both the insured and the plaintiff - the plaintiff can only get it if the insured can -basically the third party gets this *through* the insured, they "step into their shoes"

MacKinnon v Canadian General Insurance Company (1976 SCR)

Can only raise "all the defences" after it (not another insurer) has paid out the statutory minimum

Facts: Two insurers (owner's policy was the "first loss" policy, and the driver's was excess insurance). Each provided the statutory minimum limits in place at the time, $35,000. Judgment for the third parties was held to be $67, 287. The first loss insurer paid the $35 000. The plaintiff then sued for the balance of $27,000 against the driver's insurance

Issue: could the second insurance company raise the issues that it had against its own insured as defences, because the statutory minimum had already been paid to the plaintiff?

Reasons:

- Turned on the equivalent of s 579(11)
- Majority said that **each insurer may only raise the defences after it (not another insurer) has paid out the statutory minimum**
- Dissent: once coverage of the statutory minimum has been provided by a policy, any excess coverage whether by that insurer or another can be set up as against the third party, all the defences that the insurance company could have raised as against the insured
    - Based on the policy rationale for the section, the dissent makes more sense

Schoff v Royal Insurance Co of Canada (2004 SBCA)

Facts: Mother (Nancy Goyan) fraudulently misrepresented that she was the owner of the car, when her son actually was. She also misrepresented her own accident history and a number of other matters including the number of cars she owned and how many licensed drivers she had in her house.

Issue: to what extent, if at all, could Royal deny coverage?

Reasons:

- Trial:
    - Charles (the son) was driving with the consent of the insured Mrs. Goyan and was therefore an insured under the Royal policy
    - Third party plaintiff relied on the "notorious information exception" to the duty to disclosure - TJ held that Royal could not rely on the misrepresentations because of other knowledge which it had prior to the accident, and chose not to make further inquiries
    - Suggested Royal should have been put on notice when it learned that Mrs. Goyan had misrepresented her own driving record
    - Royal could not deny coverage, even for an amount in excess of the $200 000
- CA:
    - Agreed with the TJ that Charles drove the vehicle with Mrs. Goyan's consent and as an unnamed insured under Mrs. Goyan's insurance policy. Because of this, the insurance company must pay **at least** the minimum statutory limits

- If Mrs. Goyan had made a claim in these circumstances it would have been denied because this was a fraudulent scheme. There is no principle that a fraudster, having obtained the contract by fraud, can succeed in enforcing it on a doctrine akin to contributory fault

Holding: Judgment against Royal decreased to $200 000

Defences always available

A motor vehicle liability insurer can successfully resist a third-party auto claim if the contract in question was not in existence on the date of the loss, or if the loss does not fall within policy coverage

Winch v Keogh (2006 OJ)

No coverage

Facts: During an accident Mr. Kough wasn't driving his own vehicle, he was driving someone else's van that weighed over 4,500 kg. He was insured to drive other's vehicles, but not those that were over 4,500 kg

Reasons:

- Trial:
  - No coverage - the third party can't recover where there is no coverage or indemnity in place for the insured. S 579 action only becomes an issue after the possibility of indemnity to the insured is established
  - The owner of the van suggested that s 579 was misinterpreted by the court - once it was established that a motor vehicle liability policy was issued to the insured, then s 579 applied - only issue is consent to operate vehicle or cancellation of policy before the accident
- CA:
  - NO coverage - the loss must still fall within the scope of the coverage, which it doesn't here

Merino v ING Insurance Company of Canada (2019 ONCA)

Good summary of the law of 579

- If the insurance policy is validly terminated **before the accident, then there is no coverage - s 579 does not apply**
- But, here the court found that termination had not been properly done by the respondent, so coverage was actually in place

3) Reimbursement action: recovery by the insurer against the insured

Terrigno v Peace Hills General Insurance Company (2011 ABQB)

The insured doing nothing is not sufficient to permit the insurer to seek reimbursement in the absence of a judgment against the insured

Facts: Son was in an accident while driving insured mother's vehicle with her permission. At the time of the accident the son's license to drive was suspended for unpaid fines in Ontario. The son denied liability for the accident. The Insurer advised him to get the liability issue settled or it would settle the third parties' claims as it saw fit - the son didn't do so, so the insurer settled the third parties' claims. The insurer brought an action against the son for reimbursement of $14,400 paid to the third party for personal injuries sustained in the accident on the basis that the son breached the statutory condition of policy (driving while not licensed to do so).

Reasons:

- Provincial court:
  - While there was no judgment that would allow for the reimbursement action, the insured had acquiesced to the settlement by doing nothing when urged to settle the action by the insurer
- Alta QB:
  - TJ was wrong when he said there was no "hard and fast rule requiring a judgment" - there is such a rule, set out in s 579
  - No authority holding that the insured's acquiescence, doing nothing, was sufficient to permit the insurer to seek reimbursement in the absence of a judgment against the insured

State Farm Mutual Automobile Co v Mawere (2012 ONCA)

What is required for the insurer to recover against the insured – judgment, express non-waiver agreement, or an assignment

Facts: Stassinos and Mawere were in a motorcycle accident, and Mawere was at fault. Mawere claimed property damage under his own policy ($5000) which was paid by State Farm. State Farm retained the motorcycle as salvage and settled with Mr. Stassinos for bodily injury. However, State Farm discovered that Mawere had breached the policy - but still paid Stassinos because of s 579(5). They sought recovery from the insured for the property damage that was paid to him and the personal injury paid to Stassinos ($125,000)

- Mawere brought an application striking the s 579(13) claim because there was (1) no judgment; and (2) no non-waiver agreement allowing State Farm to recover the amounts paid

Reasons:

- Court considered s 579(4) and (13)
- Concluded that **in order for the insurer to recover against the insured there must be:**
    1. A judgment against the insured in a tort action;
    2. Express non-waiver agreement between the insured and insurer concerning the amounts paid by the insurance company to the third party; or
    3. An assignment of the cause of action from the third party to the insurer, against the insured
- None here, so no right to recovery

Note: possibly one other way in *Cooperative Dire and Casualty v Richie* (1983 SCC)

- Court found that because the defendant insured admitted liability to the third party claimants, the insured acquiesced to the insurer settling the third party claims. Accordingly, the absence of a judgment by the third party claimant against the insured didn't prevent the insurer from recovering the settlement amount from the insured (Pratt says don't rely on this)
- Admitting liability was a breach (not cooperating with the insurance company)