Law 519

Insurance

Pratt/Corbett

CHAPTER 1: THE NATURE OF INSURANCE

A. Definition

Purpose of Insurance

- personal: protection from risk
    - ie: house fire, illness preventing work, death prior to paying off mortgage
    - -the premiums people pay for coverage depends on the likelihood that they will suffer a loss: determined by examining risk-factors related to that insurer (ie. What is being insured, how much it is worth, who is doing the insuring, value of any potential loss)
- societal: spreading risk
    - **see n.2, p. 5 scenario:** the fundamental purpose of insurance is to pool risk - to spread the risk of misfortune by pooling funds. Thus at the end of the year, everyone has paid the same amount to ensure that in the case of loss, they can be indemnified. No one is better or worse off, notwithstanding who the unlucky person is.
    - insurance works by spreading the risk of loss amongst a number of people with the same risks = slightly socialist idea, which runs contrary to insurance companies that make money by not paying out claims
    - in order to ensure that risk is societally spread, need *regulation*

The Importance of Insurance Law

- impacts almost all legal relationships: litigation almost always involves lawyers hired by insurance companies or people suing to collect from insurance companies for torts
- subrogation (not normally allowed in contract law) is allowed because of the contract between the parties
- privity (contracting on behalf of a 3rd party) is allowed for life insurance (different from regular contract)

Regulation of Insurance

- 1) controls placed on the formation and operation of insurance companies
- 2) **regulation of the content and enforcement of insurance contracts** **focus of this class**
    - substance of insurance contracts
    - obligations of the parties
    - qualifications of the intermediaries (agents/brokers)
    - **in Canada, regulated by:**
        - common law
        - statute
            - federal = *Insurance Companies Act, Marine Insurance Act*
            - provincial = *Insurance Act*
        - CCIR and Insurance Bureau Canada: develops and harmonizes policy across jurisdictions
            - and many insurance companies will enter into inter-company agreements to ensure harmony in process and forms

Insurance Contracts are Treated Differently From Other Contracts!

- i) insurance law principles apply for the purpose of spreading the risk

- ii) principle of utmost good faith: applies due to the special dependency between the insurance company & the insured {insurance company depends on the insured for information that is only in their possession}
- iii) contract of adhesion versus mutual negotiation with an imbalance of bargaining power: special relationship involving a standard-form contract that 'sticks to you'
- iv) the state has an interest to make sure the risk is spread: why there are mandatory types of insurance

The Sources of Insurance Law

- combination of statute & common law: common law is source of basic principles; has been codified by statute in some ways but *changed* in others so important to know difference
- mostly governed by prov statutes due to constitutional obligations (exception of marine insurance)
- each province has a supervisor of ICs (superintendent of insurance in AB) who makes sure companies follow regulations that are put in place & licensing (how much risk they take on, premiums etc.)
- statute also deals with relationship between insured & insurance company: put parameters & expectations around it, make sure contracts are not unreasonable or take advantage of insurer
- each province can have different insurance statutes however the basic principles are the same:
    - insurance companies tend to operate across the country & lobby alongside provincial governmental boards for consistency
- insurance companies also make inter-company agreements to settle issues (vs litigate) for common types of disputes

Constitutional Considerations

- Insurance itself not included in division of powers, but provinces have exclusive authority to legislate on **insurance contracts** and **operation of insurance industry** by virtue of **property and civil rights**
- Federal Gov't has exclusive authority to legislate with respect to **incorporation of national insurance companies** by virtue of the power to create federal corporations
    - But: A federally incorporated insurance company is subject to provincial legislation regarding the operation of the insurance industry
- Feds also have jurisdiction over marine insurance by virtue of their power under "shipping and navigation"

Charter of Rights

- does not apply to private contracts {because IC is not the government} but can apply to statutorily imposed conditions, terms and regulations
- ***Miron v Trudel*** (1995 SCC): issue under who was entitled to claim under the policy as a spouse; claimant was a common law spouse; definition of spouse had been imposed by statutorily conditions of the *Insurance Act*
    - **What does this have to do with the Charter - gay marriage?**
- ***Morrow v Zhang*** (ABCA 2009): minor injury regulation; argument was it putting a different treatment on people who received one type of (minor injury) versus other types (ie: broken leg)
    - **probably a s. 15 problem**
- **As a general rule, statutory conditions have been upheld, when compared against the Charter**
- **NOTE:** even though the Charter does not apply to private contracts, **Human Rights Legislation** does
    - ie: ***Co-operators General Insurance Co v AB Human RIghts Commission***

Co-operators General Insurance Co v Alberta Human Rights Commission **(1993 ABCA)**

- **facts:** bf & gf obtained diff. premium quotes in spite of same driving experience, demerit points & vehicle; to calculate risks, company used stats to demonstrate male drivers under 25 are more likely to have claim ****not Charter, but contract is susceptible to Human Rights Legislation****
- **ratio:** discrimination is acceptable in the context of insurance because these are not a regular contracts: while the service of insurance coverage that is offered is the same, the **unique nature of the industry** allowing classification based on risk is the reason for the different treatment & justifies charging different premiums to different risk groups
    - due to the nature of insurance this type of discrimination is reasonable & justifiable

Key Definitions

- **1) Insurance:**
    - **common law definition** (***Bendex***): (i) undertaking by 1 person/party (a legal promise); (ii) to indemnify another person/party; (iii) that promise is made for an agreed consideration; (iv) the indemnification is for loss or liability arising from a described event; (v) where the happening/occurrence of the event is uncertain
    - ***Insurance Act* s. 1(aa):** "insurance" means the undertaking by one person to indemnify another person against loss or liability for loss in respect of 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 on the happening of a certain event and, without limiting the generality of the foregoing, includes life insurance
        - 'certain event' is bad drafting – intended to mean a '***particular event***' and not an event you know will occur
        - basically a codification of common law but statutory definition also includes **life insurance**: death is certain but *timing is uncertain*

***Re Bendex Automotive* (1971 HC)**

- discusses a number of definitions of insurance: from ON Insurance Act, case law
- not automatically insurance where the insurer invests premiums to make a profit
- **important** because ***as an insurance contract***, the Insurance Act would applies creating certain rights
- court came up with **5 elements of an insurance contract** (see p. 3)
    - **1) an undertaking of one person (INSURER** = the party who agrees to provide the indemnity**)**
    - **2) to indemnify another person (INSURED** = party who receives indemnity in the case of loss**)**
        - insured usually the person to whom proceeds are payable - could be someone named in policy or *unnamed* - could be anyone who falls within a particular defined class that is covered by the contract - ie: when you get car insurance, you are the named insured, but when you lend it to your friend, they are the unnamed insured
            - **Life/Health Insurance**
                - contracting party who purchases the policy = **assured**
                - person whose life/health is insured = **insured**
                - person to receive benefit = **beneficiary**
    - **3) For an agreed consideration (PREMIUM)**
        - usually money ***but doesn't have to be $$$*** = ratio here
        - here: benefits were provided to insured pursuant to certain collective bargaining agreements and had given certain concessions to receive this benefit - court found that these concessions could constitute consideration, didn't have to be monetary
        - **court cites US authority,** says true test does not the character of the consideration but whether or not the contract is aleatory in nature - consideration is the employee's covenants as found in the collective agreement: the true test is not the character of

consideration agreed to be given (money, property or services) but whether the agreement to pay depends on chance

- **4) from loss or liability in respect of an event (PERIL)**
  - fire, hail, flood, death, illness etc.
  - item/thing insured = **SUBJECT MATTER OF INSURANCE**
- **5) the happening of which is <u>uncertain</u> (SEE SLIDE)**

- **ratio:** the reimbursement agreement *was* an insurance contract instead of a collective agreement as there was (i) an undertaking by the company (ii) to indemnify each employee covered by the collective agreement from (iii) loss or liability in respect of medical expenses which the employee might incur during the currency of the agreement, the happening of the event giving rise to the expense being (iv) uncertain

- **2) Insurer:** party who agrees to indemnify (to pay) against a particular event (vs insured – party who receives it)
  - anyone can agree to indemnify but only insurance if collects $ in return as this is consideration (ex. parent & laptop)
  - if it is considered to be an insurance arrangement, the insurer must be licensed & comply with IA conditions
- **3) Assured:** the party who buys the contract of insurance
  - occasionally used interchangeably to refer to the insured but tends to be only used in the context of life insurance
  - insured/assured can be the same person however if you are buying it for someone else, you are the assured & they are the insured
- **4) Beneficiary:** the person/entity that will receive the indemnity on the death of the insured
  - ex. if you buy life insurance for yourself, you are the insured & the assured but you must name someone else as the beneficiary
- **5) Named Insured/Unnamed Insured:** named is the person listed on the insurance contract; unnamed is the person covered by the contract even though their proper name doesn't appear on it
- **6) Premium:** the consideration paid by the insured/assured for the promise to indemnify; amount varies depending on likelihood of loss
- **7) Policy:** generally refers to an insurance contract though not always (ex. standard auto policy may end up being part of someone's contract but it isn't a contract itself as there are no contracting parties attached to the document)
  - IA: policy is a document evidencing an insurance contract but is not a contract unless parties bind themselves to it
- **8) Policy Limits:** every insurance contract has a max amount companies agree to pay as an established term of the contract; will be abided to unless something goes totally wrong
- **9) Term of Insurance**: duration of insurance coverage (how long parties agree to be bound to the contract)
  - different from term of a regular contract (provision/condition)
- **10) Deductible**: the amount the insured is going to be responsible for before the insurance company's obligations to pay are triggered, higher deductibles tend to mean lower premiums as it is less likely the insurance co will be involved
- **11) Subject Matter of Insurance:** the item/event you are insuring against (ex. the house, the car)
- **12) Subject Matter of Contract of Insurance:** an insurance contract is always about money regardless of the subject matter of insurance
- **13) Statutory Condition:** could call it a statutory term/provision required under the IA

- neither party essentially agreed to it as a term & if IC fails to put them in, it is as if they are there

- **14) Coverage:** encapsulates everything - what does this insurance contract apply to? What is being insured? How long will it be for? What is the risk you are insuring against?
- **15) Agent/Broker/Underwriter:** middlemen standing btwn insurance co & insured for the purpose of selling insur
    - **agent**: works for actual insurance company (ex. sales agent for allstate only sells allstate products)
    - **broker**: tries to find best of many possible insurance products & matches you with a company
    - **underwriter**: person at insurance company who asses the risk of loss & the resulting premiums for coverage
- **16) Adjuster/Claims Examiner**: the employees/agents of the insurance company (hired by them) who deals with you after a loss
- **17) Endorsements:** added insurance that company may agree to (usually attached for a slight increase in premium)
    - ex. most companies exclude damage resulting from a swimming pool – one can buy an endorsement providing coverage for this
- **18) Indemnity**
    - insured should not profit from coverage
    - **indemnification:** should put you back in the exact same position as prior to the event
    - but number of reasons why this is not completely possible
        - deductible: will always be in the hole somewhat
        - based on *estimates* of value
        - replacement cost insurance: can put you in a *far* better position, so not true indemnity
        - **note:** <u>life insurance</u> = pre-agreed value that will be paid on death, thus often called **non-indemnity insurance**
    - assumes two things
        - 1) apart from the contract itself**, insured has a stake in the subject matter of the insurance** (insurance v wager)
            - = requirement that you have an **<u>insurable interest</u>**
        - 2) the loss suffered is capable of being **valued or quantified**

B. Classification of Insurance

<u>Major Categories</u>

- 1) private versus public
    - re: nature of the provider
- 2) marine versus non-marine
- 3) indemnity versus non-indemnity
    - see above: life insurance
- 4) group versus individual
    - is it just for you? or for a group of workers?

<u>Statutory Conditions - s. 540 {GENERAL}</u>

- Conditions that are ***deemed*** to be part of every contract in force in AB
- Must be printed on every policy with the heading “Statutory Conditions”
- No variation to, omission of, or addition to any SC is binding on the insured

MOST IMPORTANT CLASSIFICATION: OLD Insurance Act, Part 5

- insurance statutes divide contracts into classes & it is not always clear which Part of the Act governs a specific claim
- must know the class of insurance dealing with as it has implications on IA provisions that apply & the interpretation of the contract: how courts classify insurance effects substantive rights of parties to an insurance contract
- IA (AB) is a piecemeal statute as insurance classes arose as they were needed: IAA reclassifies with overarching view
- statute classifies by item or risk: under the current statute, most classifications relate to the item being insured (ie. Life, auto) but others are risk-based (hail, weather)
    - **subpart 1: General**
        - No Limitation - Limitation Act Applies
            - no specific limitation period: if type of insurance doesn't fall under sub-classes, **then 2 year limitation period under Limitation Act applies**
            - **note:** IAA changes this to make it a matter of general insurance applicable to all contracts for there to be a 2 year limitation period (some exceptions)
        - general provision applying to every type of insurance in AB ***unless*** separate provision is in IA
        - No liability insurance is caught in part by the general provision but there are issues that arise that aren't here
    - **subpart 2: Fraternal Societies**
        - Professor isn't sure what this means exactly, rare to deal with
    - **subpart 3: Fire**
        - Statutory Condition 14 - **1 year** - loss or damage
    - **subpart 4: Life**
        - no statutory conditions
        - s. 590: within one year of filing proof of loss or 6 years from death
    - **subpart 5: Auto**
        - SC - s. 614 - SC 5(3) Limitation
        - Damage to vehicle: 1 year after accidents
        - Damage to person or property - 1 year after CoA arose
    - **subpart 6: Accident and Sickness**
        - SC s. 671 - SC 12- Limitation
        - 1 year after date of insurance became payable
    - **subpart 7: Livestock**
    - **subpart 8: Hail**
- Problems:
    - different **limitation periods**, different obligations, different rules!
    - causes problems: completely unclear looking at your policy which subpart it would fall under
        - historically, policies were more discrete
        - **now, usually sold a multi-policies**: house insurance for fire, theft, liability, flood
            - covers a number of different topics
            - so where should these policies be categorized
- Other classification issues
    - Loss reporting requirements for fire insurance contracts;
    - Modified subrogation rule for fire insurance
    - Termination requirements for fire insurance

    - Licensing requirements for life insurance
    - Material risk reporting requirements for fire insurance
- Cases show how courts struggle with the idea that different classes of insurance have varied rights/limitations

***Tri-Service Machine Ltd & Tri-Service Oilfield Manufacturing Ltd v US Fire Insurance Co* (1994 ABCA)**
- **facts:** all-risk policy in place; loss caused by ***theft*** but IC refused to pay due to problem with contract; insured sued for coverage after 1 year; insurer said that all-risk policy covers fire loss so fire section of IA would apply meaning the limitation period of **1 year** applies to keep insurer from being able to sue; but claimant argued the policy fell under the general section so limitation period was **2 years**
- **Issue:** does the all-risk policy fall under "fire" or the "general" section (which limitation period applies?" **how should insurance contracts be classified under the IA?**
- **Reasoning:** courts *considered* a variety of approaches
    - i) look at contract as a whole to decide if fire insurance is the primary peril – if it is, then section would apply
    - **ii) nature of perils in multi peril policy must be looked at separately and the important part is the peril itself**
        - ABCA went with this approach based on wording of IA ('loss arising from fire')
        - **theft caused the loss and fell under general section thus 2 year limitation period**
- **Ratio (ABCA):** when classifying, must look at the nature of the perils in a multi-peril policy separately; **the peril itself will be determinative**
    - **Note**: this approach was problematic because insurer must wait until loss to know what limitation period would be & insured wouldn't know how long they have to sue
    - ICs didn't like decision as it gets around 1 yr limitation period so they tried to write it into contracts
        - **BUT: Limitations Act says that 2 yr limitation period can't be reduced by contract, only by statute**
    - example of recurring tendency of the courts to interpret contract to favour insured in recognition of power differential between large companies and individual insured
    - **Established the state of law in AB: what is nature of the loss suffered**
        - compared to NB, which takes approach (i): what is the nature of the contract itself?

***KP Pacific Holdings v Guardian Insurance Co of Canada* (2003 SCC)**
- **different from ***Tri-Service*** because conflict is between general & fire provisions, not between IA and Limitations Act****
- **facts:** hotel was insured under all-risk policy but damaged by fire, IC argued that suit was time-barred as KP sued after 1 yr (**note:** challenge based on BC statute - for **fire insurance, limitation period was 1 year from <u>date of the loss,</u>** but for **general insurance, limitation period was 1 year from <u>filing the proof of loss</u>**
- **decision:** multi-peril policy covered under general provision, not fire provision - **insurer's claim not barred**
- **reasoning**
    - based on reading of the Act, history of act & its definitions which did not suggest an intention to include multi-peril policies
        - can not say legislature intended multi-peril policies to fall under fire category
    - rejected the idea of classification - an <u>antiquated idea</u> with no bearing on modern insurance contracts
        - dominant policy in today's world is the "all-risks" or "multi-peril" policy

- advised legislatures to consider reclassifying the types of insurance = Amendment Act
    - explicit, strong language that Insurance Acts are not working
    - fitting multi-peril policies under general section is not a perfect solution - a more primitive code compared to the specific sections that is *generally unfavourable to insureds*
- **ratio:** instead of 'shoehorning' multi-peril policies into outdated classification system, simply say specific provisions don't apply to multi-peril policies, and thus governed by the general section;
    - **Note:** following the ABCA's reasoning re: multi-peril policies, this would have fit under fire because that was the nature of the peril - **SCC says AB approach was wrong**
    - **Multi-perils policy falls under *general* (confirmed? in *Churchland*)**

***Churchland v Gore* [2003 SCC]** *confirms *KP**
- **facts:** same as *KP* except loss caused by theft
- **decision:** SCC says we are concerned with policy as a **<u>whole</u>** versus how loss is caused - will not do interpretive gymnastics to make this policy fit into fire insurance categorization so general provision applies
- **issues arising from this case:** in both cases, SCC disapproved of how the classification system is not being modernized to fit commercial realities; the problem is we are stuck with these cases as a matter of law
    - some of these issues will be resolved once IAA in place as multi-peril polices will fall under the general part so don't need to classify
    - 2 year limitation period will apply to all insurance contracts with a few limited exceptions
    - ***i) does the SCC intend for its comments to apply outside of BC or is it something specific to the BC statute?***
        - comments suggest it was generally intended ('prov insurance statutes are out of date' vs specifically pointing to BC)
        - in other jurisdictions, lower courts have distinguished the legislation as insurance companies have argued the statute is different so should be treated differently
    - ***ii) cases only deal with limitation period in the statute:*** there are other statutory conditions & provisions in fire insurance section so does this mean they also don't apply to a multi-peril policy or was this just re: limitation periods?
    - ***iii) can you get around these cases by writing your contract to impose terms on the whole thing:*** may depend on the content of your legislation (ex. AB Limitation Act prohibits this)

***Fenrich v Wawanesa* [2005 ABCA]**
- **Facts:** Multi-risk insurance policy **purchased by claimant's father** to cover house; House flooded and resulted in property damage to claimant's things; **son brought action** against Wawanesa (within time); there was an issue of whether he had standing so he sought to add father as a Plaintiff;
- **Issue**: What limitation applies?
- **Decision:** Limitation Act applies
- **Reasoning:**
    - **Limitation Act, RSA 2000, c.L-12, s. 2(4)**: This act does not apply where a claimant seeks (a) a remedial order based on adverse possession of real property owned by the Crown **OR (b) a remedial order the granting of which is subject to a limitation provision in any other enactment of the Province**
    - **s. 6** contains **special limitation period** for adding claims to existing pleadings**
    - ***Policy Included a Statutory Condition (Fire) = 1 year limitation**
        - court said this is **<u>not</u>** a statutory limitation period, just a **<u>contractual limitation period</u>**

- **s. 6 of the Limitation Act Applies**: amendment of pleadings.
- **Ratio:** Insurance companies can't contract out of limitation periods
- **Commentary:** It unnecessary to determine whether the KP case applied to Alberta**.** Court did also state that if the claim related to a fire loss, the fire insurance limitation may still apply (obiter)
    - left the door open that ***KP*** and ***Churchland*** might not apply in AB at all (remember ***Tri-Service*** dealt with a conflict between the IA and Limitations Act - this will become irrelevant when the IAA comes into force and Fire Insurance goes under General)

Insurance Amendment Act (2008)

- ****IMPORTANCE** Part 5 (FIRE) is repealed and replaced**
- **Subpart 1: General**
    - has its own limitation period: **526(1)**: An action or proceeding against an insurer under a contract must be commenced
        - (a) in the case of **loss or damage to insured property**, **not later than 2 years after the date the insured knew or ought to have known that the loss/damage occurred**, and
            - = Property: two years after you reasonably knew of the loss or damage
        - (b) **in any other case, not later than 2 years after the date that the cause of action against the insurer arose**.
            - = Other: two years after CoA arose
        - **(2)** This section does **not** apply to contracts of **automobile insurance** and **hail insurance**.
            - doesn't say it doesn't apply to life policies, but it must not because it has its own limitation period
    - **Statutory conditions = 540(1)** Subject to subsections (2) and (3), (a) the conditions set out in this section are deemed to be part of every contract in force in Alberta and must be printed on every policy under the heading "Statutory Conditions", and (b) no variation or omission of or addition to any statutory condition is binding on the insured. **(2)** This section does not apply to contracts of automobile insurance, hail insurance, surety insurance or any other class of insurance prescribed in the regulations.
    - ****IMPORTANCE**** = fire insurance section has been eliminated, now falls under general, and as a result, multi risk policies now fall under general as well
- **Subpart 2: Auto**
    - **Limitation: 558(1)** An action or proceeding against an insurer under a contract must be commenced
        - (a) in the case of loss of or damage to the automobile, not later than 2 years after the occurrence of the loss or damage, and
            - = Auto Damage: two years after loss or damage arose
        - (b) in the case of loss or damage to persons or property, not later than 2 years after the cause of action against the insurer arose.
            - PP = two years after cause of action arose
    - **Statutory Conditions: s. 556**
- **Subpart 3: Fraternal Societies**
- **Subpart 4: Hail**
    - **Statutory Conditions**: **s. 636**
        - **SC 16 contains limitation period:** ACTION BROUGHT WITHIN TWO YEARS: An action or proceeding against the insurer in respect of **loss or damage to the crop insured under the contract must be commenced not later than 2 years after the occurrence of the loss or damage**.

- **Subpart 5: Life Insurance**
    - No statutory conditions (same as original)
    - **Limitation s. 677**
        - Increases time period to 2 years after proof of loss under **s. 674** OR
        - 6 years after the date of death (same as before)
- **Subpart 6: Accident and Sickness Insurance**

C. Insurable Interest

1. What is an Insurable Interest

What is an "insurable interest"?

- Distinct requirement for insurance contract – must be present at the date of loss in order for valid contract to exist
- Legal concept relied upon to make distinction between insurance contracts and wagering contracts
    - Makes arrangement different from a bet as parties have a stake in the item insured: **idea that neither the insurer nor insured wants the loss to happen** (the valuable interest in the subject matter exists apart from the insurance contract and isn't created simply by purchasing in a premium)
- **Insurance Contract** – one party (the insured) pays another party (the insurer) a small amount of money (the premium) for the prospect of receiving a larger sum of money (indemnity) if a particular event occurs (insured loss)
- common law definition taken from HOL in ***Lucina v Crawford***, brought to Canada by SCC in ***Kosmopolous*** **(FACTUAL EXPECTANCY TEST)**
- **Example**: sole owner & purchaser of vehicle has insurable interest as would lose depreciated value if accident (risk you are insuring it against); where 2 people pool money for purchase, both have insurable interest regardless of amount contributed
- **Insurable Interest = Essential Element**
    - Insured must have Insurable Interest in subject matter of insurance (limited exceptions in the case of **life insurance**)
    - Insurance contract not legally enforceable in absence of Insurable Interest

Objective of Insurance Contract

- Protect Insured from financial loss by spreading risk associated with particular event
- Principle of Indemnity applicable so Insured compensated for loss suffered, but does not profit from it

Distinguishable from a Wager

- Don't want insured to intentionally bring about insured risk
- Objective of a Wager is profit
- Wagering party hopes event will occur to receive a benefit
- Wagering party's 'desire' for event to occur increases 'moral hazard' that wagering party will attempt to bring about event

Requirement of Insurable Interest designed to achieve following THREE GOALS:

- 1) Preserve public policy against wagering
- 2) Preserve principle of indemnity

- 3) Prevent Insured from being tempted to destroy Insured property or otherwise intentionally bring about insured risk

Factual Expectancy Test

- Concept of Insurable Interest has been defined by Canadian Courts
- Adopted by the Supreme Court of Canada in 1987 case of ***Constitution Insurance v. Kosmopoulos***
- Re-wrote the concept of "insured interest" and the test
- **Factual Expectancy Test**: **one has an insurable interest in the subject matter of the insurance *if you stand to suffer a loss or detriment if the insured against risk occurs***
    - "… the having some relation to, or concern in the subject of the insurance, which relation or concern by the happening of the perils insured against may be so affected as to produce damage, detriment or prejudice to the person insuring, and where a man is so circumstanced with respect to matters exposed to certain risks or dangers, as to have a moral certainty of advantage or benefit, but for those risks and dangers he may be said to be interested in the safety of the thing."
    - **"To be interested in the preservation of a thing, is to be so circumstanced with respect to it as to have benefit from its existence, prejudice from its destruction"**
        - Justice Wilson/SCC stated that to Justice Lawrence (HL ***Lucena v. Crawford***) "**a moral certainty of profit or loss was sufficient interest"**
- Burden of proof of Insurable Interest is <u>on the insured</u>
- Problematic test as potentially sacrifices certainty in the name of flexibility (appears limitless)
- Applies to all insurable interests & all types of insurance except unless it is altered by statute (ex. life insurance)
- Bottom line: simply purchasing a premium isn't enough, you need some sort of legally enforceable pecuniary interest in the subject matter of the insurance
- **Note:** IC does **<u>not</u>** have ensure you have an insurable interest when they sell the policy to you, but courts try to find an insurable interest because ICs know it's a legal requirement but lay people don't
    - *knowledge differential between ICs and potential insureds**

Constitution Insurance v Kosmospolous **[1987 SCC]**

- **Facts**: Mr. K owned and operated a leather manufacturing and sale business; Originally, Mr. K operated his business under the name "Spring Leather Goods" as a sole proprietorship; Eventually, Mr. K incorporated his business as "Kosmopoulos Leather Goods Limited" of which he was the sole shareholder & director; Although the business was carried on through the company, Mr. K always thought he owned the store and its assets; All of the business documentation referred to Mr. K o/a Spring Leather Goods; Mr. K remained the personal lessee of the premises; Mr. K obtained a fire insurance policy; The insured described on the policy was "Mr. K o/a Spring Leather Goods"'; A fire occurred in the adjoining premises, and caused fire, water and smoke damage to the company assets and to the premises; Mr. K then filed proofs of loss under his policy but the insurers refused payment
- **Issue:** can a sole director and shareholder have an insurable interest in the assets of a corporation?
- **Decision:** Yes, under the **Factual Expectancy Test**
- **Reasoning {Wilson J}**
    - Traditional view from *Macaura*: had to prove they had legal or equitable title to those assets which sole shareholder would not have (very restrictive principle)
        - in *Macaura*, HL rejected previous case with broader reasoning so the restrictive principle ruled for over 100 years
    - Insurance Company's Position: Mr K did not have an insurable interest in the damaged property because the property was wholly owned by the company

- with no legal or equitable interest in the company's assets, must follow ***Macaura***

- Mr K's Three Arguments:
  - 1) corporate veil should be lifted, and when done, it becomes clear the company's property was, in law, Mr K's property
    - **rejected:** Wilson J refused to lift corporate veil, finding that company was a distinct legal entity apart from Mr. K and <u>the company</u> owned the business assets, not him
  - 2) Mr. K had an insurable interest as bailee of the company's assets
    - **rejected:** Wilson J found this was not a bailment situation
  - 3) The court should not longer follow ***Macaura*** [1925 HL]
    - *Macaura* was the law in Ontario at the time and the defence of a lack of insurable interest would succeed if *Macaura* remained the law
    - **<u>accepted:</u>** SCC considered 2 HOL cases and agreed
- Analyzed both the ***Macaura*** Principle and the Factual Expediency Test (Dissent of Laurence J in ***Lucena v Crawford*** [HL])
  - **<u>Factual Expectancy Test</u>** stated that a person has an insurable interest in the subject matter if they will suffer a loss/benefit should something occur not enough for an expectation or hope
  - majority opinion repeated by Lord Eldon in ***Macaura***: insurable interest requires a legally enforceable right (ex. title); mere hope for or expectation of an interest in the subject matter doesn't give you an insurable interest
    - ***Macaura*** test creates an arbitrary distinction & a technical objection that can be raised by insurance companies: goes against court's tendency to favour insured
  - shareholder of corporation would have no legal interest in assets so wouldn't have an insurable interest however in applying the factual expectancy test, they may have an interest because if they are destroyed, he suffers a loss
- Considered these two definitions in the context of the policies underlying the requirement of Insurable Interest generally
  - **Policy against wagering**: restrictive defn in *Macaura* not necessary
    - just because one has legal title doesn't mean they have a financial interest
    - restricted definition can lead to a windfall as may not have pecuniary interest or endure any loss
    - broader definition protects people who have a real possibility of financial loss
  - **Indemnification for loss**: public policy restricting insured to full indemnity for loss not consistent with restrictive definition of insurable interest
    - restricted definition acts as a trap for the unwary whose interests are actually relevant to indemnity
    - extension of that definition might better implement principles of indemnity
  - **Destruction of subject matter**: restrictive definition does not necessarily have the result of minimizing incentive to destroy insured property to obtain insurance money
    - often a person with legal title has ***more*** incentive & opportunity to destroy property and get money than someone with equitable title or just an interest in the property itself
    - many remedial devices the courts can use to prevent insurance proceeds from being a windfall (ie. Hold in trust)
- **Summary**

- Policies underlying requirement of insurance interest did not support restrictive definition – if anything, they supported broader definition
- Little to commend restrictive definition of insurable interest
- Described as a 'technical objection' with no 'real merit'
- ***Macaura*** should no longer be followed
- = recognition by the courts of the modern commercial context in which insurance companies are operating
- **practical note**: court probably not happy with insurance company that would collect from a man for many years and then refuse to pay out, especially when broker appears to have failed to ask the right questions

- Conclusion:

- Mr. K as sole shareholder was so placed with respect to the business assets as to have benefit from their existence and prejudice from their destruction
- Mr. K had a moral certainty of advantage or benefit from those assets but for the fire
- He had an insurable interest in them capable of supporting the insurance policy and was entitled to recover from it

- **Ratio:** a person has an insurable interest in the subject matter if they will suffer a loss/benefit should something occur not enough for an expectation or hope; When court confronted with "no insurable interest" argument, can no longer rely on predetermined indicated but must look on case-by-case basis at the relationship between the claimant and the he/she property seeking to be compensated for
  - legal title can operate as a presumption in favour of insurable interest but can be rebutted

- Commentary:

- brings factual expectancy test into Canadian law: insurer must stand in relation to the subject matter of the insurance to stand at a loss or detriment should it occur
- test can be rejected where application is unfair on grounds of public policy (ex. ***Assaad***: bought car but was willfully blind to fact it was stolen)
- broadens the definition of insurable interest: test captures everyone with a legally enforceable interest
  - *however, must be careful what this case says because it **may not go further than establishing test & determining sole shareholder has an insurable interest** in assets of a corporation (McIntyre concurred based on these facts alone!)*
  - could likely argue it goes further, however there is a remoteness issue if it goes too far (ex. we have an insurable interest in Prof's car because that is how they get to school & if it breaks, we miss class which affects our knowledge & our career and thus impacts our finances)
  - concern that broadening definition will increase liability of IC, particularly for a single risk, is immaterial as companies can simply charge different premium; would help create more socially beneficial insurance policies with no increase in risk to the insurer

2. Insuring the Interests of Others

- Problem: when there is combined ownership (legal/equitable interests split, dual title, someone owns a house and the other is making conditional payments) or where one owns property that encompasses property owned by others
- not an issue where: (i) the insurance contract specifically says it covers the other person's interests; (ii) the contract says it doesn't matter who else has an interest (ex. allows for unnamed insurer)
- **common law**: insurer can insure the interests of others if: (i) the contract <u>permits</u> it and (ii) the party doing the insuring <u>intended</u> to do this

Keefer and Quebec Bank v Phoenix Insurance **[1901 SCC]**

- **Facts:** property owner Keefer sold his land to Cloy for $2000 to be paid in installments; it was agreed that title to the land would be transferred to Cloy when all the payments were made and that Keefer would maintain property insurance on the land until the transfer of title took place; Fire occurred and caused $1740 in damage; at the time of the fire Cloy had paid Keefer $800; IC refused to pay Keefer more than $1200 being his remaining interest in the property
- **Issue**: whether or not unpaid vendor could recover not only his own beneficial interest but the interest of the vendee as well? IOW, is the vendor entitled to insure the interests of the purchaser as well as his own?
- **Decision**: yes
- **Reasoning**:
    - Two requirements:
        - **1) Intent to insure <u>whole value</u> at policy inception** {Question of Fact}
            - court held vendor intended to insure whole property and not merely his beneficial interest: evidenced by agreement between Keefer and Cloy, beliefs of company and fact that premium is for full interest (not partial)
        - **2) Wording of policy must <u>permit</u> this** {Question of Fact}
            - terms of policy show building itself was insured
            - company agreed to make good on all losses not exceeding the 'interests' of the assured in the property (language suggests protection for all kinds of interests that arise
            - nothing in the agreement suggested he couldn't
    - Insurance Company has to pay the P the full value of the damage because the 2 common law conditions met:
- **Ratio:** a person with a limited interest can insure the total value of the subject matter and recover the whole value so long as the policy allows for it and he intended to insure the whole value at the time
- **Commentary:** if only was insuring his own interest, he could only collect for the amount he was indemnified b/c to pay him the full value means he would profit (against policy) so he must hold any profits in trust for the purchaser (shows that you must pay that person their portion of insurance proceeds when you insure their interests)

Spencer v Continental Insurance Co. **[1945 BCSC]**

- **Facts:** Spencer purchases house insurance and personal property floater (covers personal property in house, floats on top of movable contents); fire occurs in house and damages ***property including that owned by wife & son***; evidence that wife had authorized Spencer to purchase policy covering her property and that son ratified policy after it was bought; insurance company refused to pay for property arguing that Spencer didn't have insurable interest in it
- **Issue:** Did S have an insurable interest in the property of his wife and son?
- **Decision:** yes
- **Reasoning:**
    - a person with insurable interest in goods can insure on his own behalf & on the behalf of other persons' interests in the goods regardless of what type of interest they have (equitable, beneficial, legal, etc)
    - **wife**: court held S had insurable interest as they are living together & sharing its use
    - **son:** court held S had insurable interest because he had bought the item, his son was dependent & *as a father he would have felt morally responsible for replacing it* (thus has pecuniary interest)
    - **<u>**Four rules for a Valid Insurance Contract on Behalf of Persons Who are Named**</u>**

- **1) Policy must contain clause indicating contract is more than contract of mere personal indemnity on behalf of named person**
- **2) Person for whose benefit contract is made must be in existence and ascertainable at time contract is made**
- **3) Must be an intention to insure on their behalf**
- **4) Must have authorized or ratified contract**

- Study Group: more flushed out version of the SCC's two common law requirements *Keefer***

- Ratio: Four rules for when an individual may insure the property of another

- Commentary: an example of court loosening its application of factual expectancy test to give benefit to insured

What about Fire Insurance Statutory Condition #2?

- **On its face**, it states that the contract must specify the extent of a person's interest in the property
- **However,** it has been interpreted as **codifying the common law** to simply require that the person insuring the property has ***some sort of insurable interest in the property***
    - 'owner' or 'ownership interest' actually means insurable interest
    - misinterpretation not corrected by legislature in ***IAA*** so this remains the law
- **See IAA s. 540 SC#2***: The insurer is not liable for loss or damage to property owned by a person other than the insured unless (a) otherwise specifically stated in the contract, or (b) the interest of the insured in that property is stated in the contract.*

St Paul Fire v Chaleur **[1983 NBCA]**

- **Facts:** (note: predates ***Kosmopoulos*** so based on old case law requiring legal entitlements for Insurable Interest) W has legal title to a scanner but transfers physical possession to C who holds it as security for a loan; C insures the scanner but **doesn't** name W in the contract; scanner stolen while W is using it; C claims on insurance policy but Insurance Company refuses to pay because (i) C doesn't have insurable interest as it is being used by W and (ii) even if there was one, he would be in breach of Statutory Condition 2 for not telling company he was insuring less than the full interest [s. 549 IA / s. 540 IAA]
- **Issue:** Did C have an insurable interest in the scanner even though it had not disclosed the nature of its interest as required by statutory condition 2 of the policy?
- **Decision:** yes
- **Reasoning:**
    - i) Insurable Interest
        - C had Insurable Interest because it had a legal entitlement to the scanner that was pledged as security for $ loaned
        - C had legal entitlement as bailee of the scanner because it would have to pay W if something happened
        - At the time it was stolen, C had a beneficial & security interest so had an insurable interest
        - **Note:** *issue wouldn't arise under Factual Expectancy test as he has an obvious pecuniary interest in the scanner*
    - ii) Statutory Condition 2: 'owned by any person other than the insured'
        - while on its face the condition seems to suggest the IC doesn't have to pay unless it is told in advance that the insurer isn't the owner of property, court said 'owner' simply means someone with an insurable interest
        - so this section simply codifies the common law on insurable interests
- **Ratio:** settled law that SC #2 is satisfied if owner had *some* insurable interest in the property

***Dudelzak v Landry & Madill* [1985 ABQB]**
- **Facts/Issue:** law firm holds wills in vault without telling IC it is holding property of someone else: IC claims this is a breach although law firm has insurable interest (would have to redo/reimburse)
- **Decision:** court said there was no breach as there was an insurable interest
- **Reasoning:** statutory condition 2 allows insured to insure for full value of property so long as has some insurable interest, no breach if limited interest of insured isn't stated in contract
- **Ratio:** brings interpretation of statutory condition 2 to AB

3. Insurance Does Not Run With the Property

- issue arises where vendor owns the property & agrees to sell it to a purchaser
    - creates a division of insurable interests & the transfer of legal title is not instantaneous
- **purchaser has an insurable interest once down-payment is made** as it has a stake in the property at this point
- however does not answer question of **whether insurance coverage goes with the property once the vendor develops an insurable interest, or whether they have to obtain their own coverage?**
- court has said that insurance doesn't run with the property:
    - while the vendor can insure other's interests for them & make a claim himself on behalf of the purchaser to hold the funds in trust, **the purchaser can't claim on this contract because normal rules of privity apply**
- **in practice, vendor would agree to buy insurance to cover the interests of the purchaser until the closing date**
- however purchaser should be advised to buy its own policy: (i) since it isn't a party to the original insurance contract obtained by the vendor, it can't make a claim to it; (ii) even if it does cover their interest, they have no way of knowing whether the contract continues to be valid
- since a valid insurance contracts requires an insurable interest at date of loss & because insurance isn't automatically assigned when property is transferred, it is important to ensure the parties in a transfer are protected!
- courts have upheld vendor's insurance policy *even after title has transferred* by finding the vendor has some remaining insurable interest: full value is payable to insured who holds it in trust for the interest of others

***Rayner v Preston* [1881 EngCA]**
- **Facts:** vendor agrees to sell home but contract for sale doesn't say anything about insuring the purchaser's interests (IOW - contract of purchase does not assign the insurance policy to the purchaser); purchaser claims from vendor's insurance contract the value of his equitable interest; Insurance Agreement makes no reference to the vendor
- **Issue:** Is the purchaser entitled to claim on the Vendor's Insurance Policy?
- **Decision**: **court rejects purchasers claim**
- **Reasoning:**
    - contract was between the vendor & his IC
    - policy didn't agree to cover someone else's interests so the purchaser has no interest in this contract simply because he has an insurable interest in the prop
    - contract of insurance is a mere personal contract for payment of money, not a contract that runs with the land
        - unless the original insurer affects an assignment to the new property owner, the policy doesn't automatically transfer by following the property

- **Ratio**: stands for the proposition that insurance policy doesn't run with the property; Insurance contract stated to be a personal contract for payment of money - unless assigned, no action can be maintained except by parties to contract
- **Commentary**: this case is different from ***Keefer*** as the vendor in that case was claiming for enough money to pay the purchaser back their equitable interest against HIS OWN policy
    - if vendor agreed to buy coverage for the purchaser & the contract allows for it, the vendor could recover all the money & hold it in trust for the purchaser but this is not going on in this case!

4. When is insurable interest required?

- **Fundamentally,** must exist at time of loss
    - otherwise insured hasn't loss anything and there is no need for indemnity
- **More debatable:** whether insurable interest must also exist at the time of the insurance
    - ***Caldwell v Stadacona Fire Insurance*** **(1883 SCC):** Ritchie CJ stated that the insurable interest must exist at the **time of the insurance and at the time of the loss**, even though the nature of the interest and even its very existence do not not have to be consistent throughout that time
    - **other authorities:** as long as the insured had a ***reasonable expectation*** of an interest at the time of contracting and insurable interest at the time of the loss, the insurance is valid
        - there are some types of insurance where it is impossible for an insurable interest in the subject matter to exist at the time the contract is formed. *Examples are: crop insurance (the crop usually does not exist yet when the contract is entered into) and liability insurance (coverage is for a future, not an existing, liability)*
- **Life Insurance**: common law & statute (**s. 646 IAA**) requirement at the inception of the policy only {ie: spouse is deemed to have insurable interest at date of contract, doesn't matter if you are divorced at date of loss)

****See Janelle's CAN for Insurable Interest Review Qs****

CHAPTER 2: THE PRINCIPLE OF INDEMNITY

The Insurer's Obligation to Indemnify

1. General

The Insurer's Obligation to Indemnify

- Insurance contracts are contracts of indemnity (not designed to profit the insured but to bring them back to where they were before the loss occurred)
- Most insurance contracts are indemnity contracts because payment is conditional upon:
    - i) Proof that the loss was caused by an insured risk AND
    - ii) Proof of the amount of the pecuniary loss suffered (**note:** life insurance different as you don't prove financial loss as beneficiary – see below!)

Procedure

- A sues B, B advises its IC that it has been sued where it has liability insurance

- A (Plaintiff) becomes the '3rd party claimant' - different from 3rd party in normal civil action where 3rd party would be the person that B is trying to blame, instead it refers to how A is claiming against the contract to which it isn't a party
- IC would hire its own lawyers to defend to claim or would try to get out of contract: if it tries to get out, B will name the IC as the 3rd party to the court action

2. Indemnity and Public Policy

Two Questions of Law Arise Regarding Indemnity:

- **1) Is the insured entitled to indemnity?** IC relies on legal considerations to determine if they must pay insured
- **2) Are there public policy reasons why an insured wouldn't be able to recover on a contract?**
    - Three public policy reasons why a court would deny insured indemnity, assuming the loss is covered by the policy and there are no breaches:
        - **i) Purpose of insurance contract is to facilitate an illegal activity**
        - **ii) Loss is intentionally caused**
        - **iii) Loss caused by a criminal act**
    - Must be raised & proven by the insurance company on BOP
    - Basis of idea is that a wrongdoer shouldn't benefit from an insurance contract
    - the courts use a narrow interpretation as the insurance company is trying to get out of valid insurance contract
    - **Note:** Court's ability to deny indemnity for such public policy reasons may be altered or codified by statute or by the terms of a give insurance contract
        - **s. 533(2) IAA**: Unless a contract of insurance provides otherwise, a contravention of any criminal or other law in force in Alberta or elsewhere does not render unenforceable a claim for indemnity under a contract of insurance except when the contravention is committed by the insured, or by another person with the consent of the insured, with intent to bring about loss or damage.
            - **Note**: by virtue of **513 IAA**, the above provision does NOT apply to a life insurance contract (other than the disability portion of a life insurance contract—see **533(1) IAA**)

Insurance for an Illegal Activity {ASK?}

- Insurer must actually be insuring the illegal activity for this exclusion to apply (IC must know about it)
- ***Dominion Fire Insurance v Nakata*** **[SCC 1915]:** Fire insurance contract on a "sporting house" that the insurance company knew was a brothel
    - court didn't want to condone it by allowing insurance payment to be made
        - majority: because she had to put forth the contract to make the claim, and on its face it said 'sporting house' ***she couldn't rely on the contract, because on its face it was illegal*** (because it had the words sporting house)
    - ***Ex turpi causa non oritur actio*** = from a dishonorable cause an action does not arise

Intentional and Criminal Acts

Cooperative Fire and Casualty Co v. Saindon **[SCC 1975]** ****READ****

- **facts:** Insured was using a gasoline power lawnmower to mow his lawn beside his trailer. Saw his neighbor (Sirois) and accused him of cutting cherry tree branches on his property. The insured lifted his

mower and approached Sirois' face, revolving blades struck the neighbors hands**;** Insured argued that he had only intended to scare his neighbor; IC saying we're not going to pay

- **Policy Coverage**: to pay on behalf of the insured all sums which the insured shall become obligated to pay by reason of the liability imposed by law upon the insured…for damages including damages for care and loss of services, because of bodily injury or property damage.
- **Policy Exclusion**: did not apply to bodily injury or personal damage caused *intentionally by or at the direction of the insured*
- **New Brunswick Public Policy Rule** (**AB IAA s.533(2)**): "Unless the contract otherwise provides, a violation of any criminal or other law in force in the Province or elsewhere shall not *ipso facto*, render unenforceable a claim for indemnity under a contract of insurance **except where the violation is committed by the insured** or by another person with the consent of the insured, with intent to bring about loss or damage

- **Issue:** whether the insured intentionally caused the injury?
- **Decision:** Trial J dismissed claim against IC, conduct was criminal; CA reversed and allowed claim because intention was to scare only, not to cause personal injury; **Majority SCC allowed appeal, reinstated trial judge's ruling, holding there was no coverage and dismissed claim against insurer**
- **Reasoning (majority):**
  - Injury was eminently foreseeable – constituted a criminal act.
  - caused damage and the fact that the "scare" intended by the respondent had more serious consequences than he anticipated does not alter the fact that it was his threatening gesture that caused the damage
  - ****intentionally causing the loss means intentionally causing some harm****
    - refused to draw lines based on how great damage should be, *doesn't have to intend to cause full extent of the harm just needs an intention to cause any degree of loss/damage in order to engage public policy exclusion*
  - respondents actions were in breach of the public policy rule in the NB *Insurance Act*
- **Reasoning (dissent)**
  - Issue is whether the word "intentionally" includes both intentional and reckless acts
    - Yes this *was* criminal, but that does not mean the same thing as "intentional" and therefore it is not excluded
  - Insurance company should still have to pay: what he was doing was reckless so liable, fails to go into insurance principles
  - General rule: coverage provisions construed broadly while exemption provisions are construed narrowly
- **Ratio: intentionally causing the loss means intentionally causing some harm**

Oldfield v. Transamerica Life **[2002 SCC]**

- **Facts:** Mr. Oldfield carried 30 cocaine filled condoms in his stomach. One burst, causing death. His wife (separated for some time) claimed the proceeds of Mr. Oldfield's life insurance company. The life insurance was in lieu of child and spousal support after separation. Insurance Co resisted payment arguing that it would be against public policy because it would be tantamount to permitting a criminal to benefit from his or her own crime
- **Issue:** Is there a public policy rule that renders a life insurance contract unenforceable where the insured dies accidently as a result of his own criminal act, regardless of who the beneficiary is? If so, is the rule inapplicable because the insurance contract was obtained pursuant to a *bona fide* contract for value?
- **Decision:**
  - Trial and CA – no such public policy rule

- SCC Majority – it is **not** against public policy to permit the innocent beneficiary to obtain the proceeds of a life insurance policy **where the life insured *accidentally* dies during the course of the criminal act.**

- **Reasoning:**
  - Public Policy Rule
    - public policy rule at issue is that criminals should not be permitted to profit from crime
      - unless modified by statute, public policy operates independently of rules of contract
      - if policy here specifically excluded coverage in the event that the insured died committing a criminal act, there would be no need to resort to public policy
    - the rule extends to those who claim through the criminal's estate because the estate's claim is equivalent to a claim brought by the criminal
      - **but innocent beneficiaries are neither criminals nor claim through the criminal's estate, and thus the public policy rule is inapplicable**
      - the beneficiary here "has not asserted her right to the insurance proceeds as a successor of the insured but as an ordinary beneficiary with the result that her claim is not tainted by any illegality on the part of her husband"
  - Review of Prior Case Law
    - ***Brissette Estate v. Westbury* (1992 SCC)** J. Sopinka held that it is consistent with public policy that a person should not be allowed to insure against his or her own criminal act irrespective of the ultimate payee of the proceeds
      - but this would have serious repercussions for *bona fide* creditors who provide value to obtain an interest in life insurance - would run contrary to longstanding principle that there is "no illegality in a stipulation that, if the policy should afterwards be assigned *bona fide* for valuable consideration, it might be enforced for the benefit of others, whatever may be the means by which death is occasioned"
      - Sopinka J's statement not intended to eliminate this longstanding exception to the public policy rule - ***Brisette* does not bar a claim by an innocent beneficiary where the insured does not intend the insured loss**
    - ***Home Insurance Co of New York v Lindal* [1934 SCC]:** insurance co. here argues that this case stands for proposition that where an insured contravenes any law, the insurance contract is unenforceable regardless of who the beneficary/claimaint is
      - not the proper interpretation: had nothing to do with innocent third party beneficiary
  - Review of Statutory Provisions
    - **AB IAA s. 665:** permits beneficiary to enforce an insurance contract for his/her benefit, escaping the doctrine of privity of contract
      - principle behind the section = third party can be in no better position than insured
      - Does this include public policy defences or only statutory defences
        - **STUDY GROUP: third party beneficiary is allowed to collect but the actual person who died wouldn't be able**
          - possible critique of the case: giving beneficiary greater rights than the person themselves would have had

- **Ratio**: public policy rule should be narrowly applied so that it doesn't preclude innocent 3rd party beneficiaries from claiming from a life insurance policy; contracts can be drafted by insurance company to preclude against this situation

- **Commentary**
    - **obiter:** public policy rule distinguishing between an innocent beneficiary and one who claimed through the insured's estate was arbitrary. Suggests that it might be appropriate to modify the public policy rule so as to permit an innocent person who claims through the criminal's state to take insurance proceeds – left to another day.
    - **L'heureux-Dube (concurring)** agreed with result but thought application of **Forfeiture Rule** should have been considered = although a wrongdoer cannot profit from his or her crime, neither should an insurance company be allowed to abrogate its responsibilities under a contract by invoking a rule of public policy.
    - **Relevant standard of proof that insured committed a criminal act = balance of probabilities (*Hanes v. Wawanesa* [1963 SCC])**

***Hamzeh v Safeco Insurance Co* (1988 ABQB)**

- **Facts:** the insured had insured jewelry brought into the country by her father in law; he had never declared it at the border; according to the *Customs Act,* undeclared property like this could be subject to seizure by Canadian govt for up to 3 years after brought into country
- **Issue**: Given it is seizable by the govt, was their still insurable interest in the property?
- **Held**: She had accessory interest in the property, and because it was not intentional, the public policy argument should not be applied and coverage should not be denied.
    - **essentially saying, not her fault, she's innocent, shouldn't deny her coverage**

***Wong Estate v. Liberty Mutual* [2009 ABQB]**

- **Facts:** Mandy Lam operated a day care facility. While in her care, Nicole Wong suffered serious head injuries and died. Lam was convicted of **criminal negligence** causing death. She was not convicted of manslaughter, because Justice Macklin was not convinced that she had intentionally assaulted Nicole. Lam had coverage for **personal liability** = legal liability for unintentional bodily injury or property damage arising out of **your** own personal actions. **Exclusion 10** = you are not insured for: Bodily injury or property damage caused by any **criminal act** or **willful negligence** by an Insured…
- **Issue:** Can the insurance company rely on "exclusion 10"?
- **Decision:** Yes - exclusion applies to the facts of this case and therefore P cannot recover
- **Reasoning:**
    - Lam argued that exclusion is too ambiguous and there should be some reference to intent as onus is on insurer to draft clear and unambiguous clause particularly where statutory provisions may apply
    - court considers how IC can protect themselves by contracting out of statute by considering whether reference to 'criminal act' is enough to get around statutory exclusion
    - General Principles of Interpretation from ***Brissette***
        - The court must search for an interpretation from the whole of the contract;
        - Where words are capable of 2 or more meanings, the meaning that is more reasonable in promoting the intention of the parties will be selected;
        - Ambiguities will be construed against the insurer;
        - An interpretation which will result in either a windfall to the insurer or an unanticipated recovery to the insured is to be avoided.
    - **s. 533(2) IAA** - **unless the contract provides otherwise** a criminal act by the insured does not vitiate coverage unless there was intent to bring about the loss or damage.
    - **But here Exclusion 10 did provide otherwise** - therefore, liability excluded.
    - considers conflicting laws in other jurisdictions:

- i) NBCA: 'criminal act' not specific enough to demonstrate insurance companies intent to avoid statutory provisions
- ii) ONCA/BCCA/US: <u>'criminal act' suggests intention to exclude coverage for any act caused by criminality whether or not caused intentionally so it is sufficient</u>

- **Ultimately ABQB** sides with latter as reference to 'any criminal act' is clear & unambiguous: result is that L couldn't recover under policy as it committed a criminal act as was prohibited under policy

- **Ratio:** Basically confirms common law public policy rule re: criminal acts, and interpretation of insurance contracts

3. Valuation

<u>Valuation of the Loss</u>

- Insurance contracts can be classified as "open" policies or "valued" policies
  - **Open** : provides payment limits, but the insured's right to recover proceeds depends on their actual pecuniary loss suffered within those limits
    - open policy has payment limits – have to prove you suffered each dollar you say you suffered
    - **Actual Cash Value =** The real or intrinsic value to the insured
      - Often equivalent to market value but not invariably so.
      - Sometimes it is replacement cost less depreciation
      - No allowance for loss of future profits or other consequential loss
  - **Valued**: sets a pre-determined value to be paid upon the destruction of the insured item (or death of the insured in the case of life insurance)
    - useful in the context of property insurance for certain goods, like artwork which might be difficult to accurately value after the loss occurred

<u>Actual Cash Value (ACV) versus Replacement Cost</u>

Leger v. Royal Insurance **(NBSC Appeal Div 1968)** ***shows how the court assesses actual cash value***

- **Facts**: 2 ICs insure property under open policy, building is in need of repair & scheduled for demolition, catches fire three times but arson couldn't be proven, eventually destroyed by fire; appellant filed proofs of loss with the ICs but both companies refuse to pay; P alleges that trial judge did not apply the proper principles of law in assessing the actual cash value at the time of destruction;
- **Issue:** how does the court assess actual cash value?
- **Reasoning**
  - **Policy Covered the lesser of:**
    - Actual cash value at time of destruction; or
    - The interest of the assured; or
    - The sum set out in the policy
  - **THREE THINGS to look at for valuation of open policies**:
    - (i) actual cash value at the time of destruction
    - (ii) the interest of the assured (insurable interest for full/part of property);
    - (iii) policy limits
  - **Held that actual cash value is defined <u>as the real/intrinsic value of the item to be insured on the date of loss</u>**

- don't take into account future contingencies (ie. Future demolition): question is what it is worth on the date of loss
- while **replacement cost** MINUS **depreciation** is **USUALLY** the way to determine actual cash value, ***it isn't the only way***:
  - **(i) market value**
  - **(ii) tax assessment**
  - **(ii) value of rent received by insured month**
  - **(iv) replacement cost**
- in the circumstances & based on insured value of the property (no competing insurable interests), court concluded that **value was most closely reflected by rental value** so did calculation based on rent leaving out contingency of demolition)
  - **case shows that when litigating valuation, you want to give the courts multiple options & argue which is best**

- **Ratio:** actual cash value is defined as the real/intrinsic value of the item to be insured on the date of loss with no allowance made for loss of future profit or other consequential loss (IOW, the value which has been taken from the property of the insured); ACV must depend on the *circumstances applicable to each individual case* and may include **4 factors: (i) market value, (ii) tax assessment, (iii) value of rent received by insured month, (iv) replacement cost**

***Martin v. Travelers Indemnity* (1985 BCSC)**

- **Facts:** P had removed paneling/door/windows/contents then building was destroyed by fire; after fire she told insurance company she was planning on demolishing building; Insurance company refused to pay based on the defence that the house had no value based on P's intention to demolish it; P argued that ACV is at least the $35 000 limits of the policy
- **Issue:** Is P's intention to demolish the house relevant in valuation of the property?
- **Decision:** No
- **Reasoning:**
  - even though she had already taken steps towards demolition, **intention is ultimately a future contingency** so it shouldn't be taken into account when determining actual cash value (follows ***Leger***)
    -court followed policy by capping actual cash value by **replacement cost less depreciation {STANDARD FORMULA}** ignoring intention: She was entitled to ACV, it could not exceed what it would cost to repair or replace the house
  - case shows how strict the courts are in requiring actual cash value to be determined on date of loss: nothing beyond the date of loss will impact their assessment
    - **NO FUTURE CONTINGENCIES**
- **Ratio:** plans for future demolition does not affect the actual cash value of a building
- **Commentary:** failure to take into account future contingencies makes insurance cases different from torts; distinction necessary because ICs take into account contingencies when underwriting contract so shouldn't be allowed to again

Pre-Valued Policies

- Policy Provisions
  - Except where otherwise hereinafter stated, the amount of such loss or damage shall be estimated in accordance with the actual value of the property at the time of the loss or damage, allowing for depreciation…
- purely a matter of contract as policy has a value assigned to it

- insurer agrees to pay specific amount when loss occurs without checking to see the value of the loss after the fact
- 'valued policy' applies to life insurance because when you buy it, you buy it for as much as you are willing to pay without any requirements for proof on worth
- 'valued policy' is also used to refer to policies where the value of the item is set in the demands (ie. Art, jewelry, things appraised before the loss or are of subjective value) value assigned on the day contract entered into

Raymond v. U.S. Fire **[1973 SCC]**

- **Facts:** R insured carving of Notre Dame Cathedral; first appraisal by US fire valued it at $85 000; policy issued based on this amount classifies carving as "Art Treasure"; wording said coverage was provided for 'actual value of the product' - confusing because it uses the language of an open policy even though it pre-assigns values; model is destroyed & USF does a post-loss adjustment & determines that item only worth $6000 on date of loss; insured argues IC should be tied to 1st valuation b/c: (i) it was a pre-valued policy & IC agreed to pay $85000 on full loss so shouldn't be able to revalue item on date of loss, or in the alternative(ii) this is an open policy of insurance with limits of $85000 – while determine value on date of loss, should be able to consider many sorts of evidence to determine valuation so should accept 1st appraisers valuation instead of the 2nd; IC relies on QB civil code; QBCA overturns trial judge and says IC only has to pay $6000; R appeals
- **Issue**: whether the IC, after agreeing to treat the article as a work of art in fixing the premium paid to it, can after the loss take the stance that it was not a work of art?
- **Decision:** unclear whether policy is open or pre-valued - either way $85 000 should be awarded because if it is valued, they agreed to pay that amount & if it was open, they prefer the 1st appraisal
- **Reasoning:**
    - **Que Civil code 2575**: The sum insured does not constitute any proof of the value of the object of the insurance; such value must be established in the manner required by the conditions of the policy and the general rules of proof, unless there is a **special valuation in the policy**.
        - not necessary to determine if "description by Fraser Brothers" (1st expert) is a "special valuation in the policy"
- **Commentary:** shows how critical it is to properly characterize a policy: while it ultimately didn't matter here, in most cases it would

Re Art Gallery of Toronto **[1961 On HC?]** ****ruling case on how to deal with partial loss under a pre-valued policy****

- **Facts:** all risk policy issued to Art Gallery of Toronto to cover three types of property: Section A covered fine arts (with an insured value for each item), Section B covered sculpture and statuary (with an insured value for each) and Section C covered miscellaneous articles which were not listed and provided for a total coverage of $175 000. Six paintings from Section A stolen and recovered with substantial damage; values of paintings mentioned in contract were **$640,000 but on the date of loss they were actually worth $1,045,000** (had appreciated in value & were underinsured); when paintings are found they are only valued at **$631,900, so gallery claims lost value of $413,100 due to damage** (insured argued that the lost value was within coverage agreed upon so should be paid for the actual loss on each item up to the insured value under the policy - this is how it would work in an open policy as $640,000 would be policy limit & loss is within this at $413,000); Insurance Company said this was a valued policy so **$640,000 isn't just the *limit but governs everything* -** so on partial loss they would only pay a ***percentage*** of this (took percentage of damage from theft, multiplied it by agreed upon value of policy) which totals $**252,999.04**
- **Issue**: How should compensation for partial loss be calculated under a pre-valued policy?

- **Decision:** sum to be paid to Gallery for partial loss they sustained is to be determined by applying the *percentage of actual depreciation* resulting from the theft to the agreed pre-determined values set out in the policy: **side with Insurance Company**
- **Reasoning:**
    - In a contract of insurance, effect must be given to the intention of the parties to be ascertained from the words they have used
        - Policy: **s. 9** This company shall **not be liable for more than the amount set opposite the respective articles** covered hereunder, which amounts are agreed to be the values of said articles for the purpose of this insurance.
    - here the contract is not to insure the owners for the actual value of the items up to a certain amount but to insure them on the ***basis that the items are to be taken to BE of the values set opposite the respective articles***
        - there is provision in the policy that the agreed value shall apply only in the event of a total loss
- **Ratio:** where there is a partial loss on a valued policy, you only have to pay the percentage loss as stated in the value statement of the contract;(actual loss/actual cash value on date of loss) x insured value on date policy made = how much company owes
- **Commentary:** shows that the fact it is a valued policy has a significant impact on valuation: if it was an open policy, insurer would have to indemnify for **FULL LOSS**, whether total or partial, up to the policy limits
    - Open policy: intention to indemnify for the **LOSS**, up to a certain value
    - Pre-valued policy: intention to indemnify for the **ITEM**
        - so if its only partial loss (ie: still have the item) not going to be able to collect full value of the item (**PARTIAL LOSS** means you can only recover **PARTIAL VALUE**)

4. Sue and Labour Clauses

What are sue and labour clauses?

- Contractual provision which requires Insured to take ***reasonable steps*** to protect Insured property from further loss or damage from same insured risk when property has been partially damaged by an Insured risk
    - where the insured goods have been damaged, **the insured is obligated to protect the goods from further damage**
- Provided for in *Insurance Act* as well as in insurance contracts {under the title "sue & labour clause"}
- Where Insured expends $ to protect goods, the insurer is **obliged** to reimburse insured according to their respective interests
    - But double edge sword because Insured's failure **to make an effort** to protect goods (ie: remaining salvable property after a fire) will be a breach of the policy
- **Problem with Sue & Labour requirement:** difficult to distinguish between Insured taking steps to mitigate risk and Insured expending $ to reduce future risks which have not yet arisen --> will become more clear in the cases

Three Requirements Recovery of Sue and Labour Costs

- Insured can only recover sue and labour costs if:
    - 1) Costs relate to loss falling within policy coverage
    - 2) Expenses are reasonable

- **3) Costs must have been incurred to prevent further damage from a materialized risk** {topic of consideration for the SCC}
    - **depends whether interpreted as "latent" "continuing risk" OR**
    - **"imminent danger"**

Example:

- Scenario: Insured gets in MVA, under S&L clause it has an obligation to protect the car from further damage so if it isn't drivable they must get it off the road, IC obligated to pay for cost of towing to preserve the vehicle
- **i) If insured leaves the vehicle on the road & someone else hits it totaling the vehicle**: IC doesn't have to pay for the additional loss because there was a failure to comply with the S&L Clause
- **ii) If insured phones tow truck but car gets hit before it gets there totaling it**: IC still has to pay as effort taken to comply with S&L clause that simply didn't work situation where insurer will pay for full amount of damage plus compensation for efforts taken so may be over policy limits
- **iii) Insured hires a helicopter to lift the car**: this is not a 'reasonable effort' so IC doesn't have to pay for this unreasonable charge
- **iv) If insured tries to chain car to the pavement to prevent a theft from occurring while the car is on the road**: IC doesn't have to pay as duty *only relates to the peril in question* (must relate to actual loss)

Statutory Changes

- **1) S&L Clause required in Certain Contracts**
    - **General - IAA s. 540 SC 9**
        - **codifies concept of a sue and labour clause: wording different but obligation essentially the same**
    - **Auto - IAA s. 556 SC 4**
- **2) Insured must take reasonable steps to protect damaged property or any other insured property that might be affected by the same risk**
    - ex. **partial fire** in building – **must deal w/ all property** in building to ensure it doesn't suffer from loss by fire
- **3) Insurance Company only pays pro rata portion, *as opposed to common law which requires payment for all* General - IAA s. 540 SC 9**
    - statute requires IC to contribute on 'pro rata basis' to the cost of the steps taken (in proportion to the amount that the loss is insured/the interests of the IC)
    - Example: if you only insured $50,000 of a $100,000 home, IC only pays for 50% of your efforts
    - ****Auto insurance – exception to pro rata rule****
        - **IAA s. 556 SC 4(1)** requires insured to take reasonable steps but insurer doesn't pay pro rata as **policies are always for the full value of the car**
        - specifically prohibits payment for further damaged if insured fails to do this

Office Garages v. Phoenix Insurance* [1966 ONHC]** **what steps are considered ***reasonable**

- **Facts**: P the owner and tenant of garage and service station building; building leased to BP Canada which in turn sublet to Office Garages; an explosion occurred and caused $8000 of physical damage to the building which had a value of $900 000 at the date of the loss; the policy limit was $813 000; to avoid another explosion, the insured hired an engineer to inspect the tanks & make recommendations to prevent future similar damage which included improving facilities; insured spent $45 000 to improve facilities but IC refused to pay because steps were unreasonable - **argued loss was only $8,000 so shouldn't spend $45,000 preventing future loss)**
- **Issue:** Were the costs recoverable as 'reasonable steps' to prevent further damage to the property?

- **Decision:** Yes
- **Reasoning:**
    - Court found that overflow of gasoline from basement tanks resulted in a vapor which was ignited caused explosion which resulted in damage to premises
    - **Problem:** Soil under building having been contaminated by gasoline **had to be removed to avoid risk of further explosion**
        - **different from next "tank" case because here there is a *problem* and in the other tank case, there only *might* be a problem of shoddy workmanship**
    - P argued that it as insured was obliged to take all reasonable steps to prevent further damage to property and if did not do so and loss resulted, he could not recover under policy
        - **IAA 540 SC #9 – 9(1)** The insured … shall take all reasonable steps to prevent further damage to any such property so damaged and to prevent damage to other property insured hereunder including … its removal to prevent damage …
            - **note:** wording becomes important in *Hartford*
        - If insured does incur expense to protect property – **SC 9(2)** … The insurer shall contribute pro rata towards any reasonable and proper expense ….
    - Court affirmed ***there was a duty on plaintiffs*** under contract to protect property from further damage and they were entitled to recover any reasonable expense thereby incurred
        - these Buildings were valued at $900K, insured by insurers at $813K– so even though the damage was relatively small at $8K, the expenditure of $27K was not unreasonable to prevent further damage to building dg valued at $900K
    - **pro-rata calculation**: in this case coverage was $813,000/$900,000 – multiply this by what they have spent $45,000 to determine what PI would pay
- **ratio:** in determining reasonability of steps to prevent future loss, must consider the ***amount of potential loss being avoided*** (full value of the property = $900k) ***and not the amount of loss actually suffered*** (=$8000)
- **commentary:** example of circumstances where court will allow such expenses to be recovered - this is a very fact-specific exercise

Hartford Fire Insurance Company v. Benson & Hedges (Canada) Limited **[1978 SCC] - ****Leading Canadian case on S & L clauses**

- **Facts**: Benson operated Formosa Spring Brewery bottling beer; Bottling tank in new plant exploded killing 2 employees, injuring several others and damaging premises; couldn't use bottling cellar for several months due to extensive damage but resumed production quickly using alternative means; Benson hired expert to determine cause of failure of bottling tank; Main cause found to be poor workmanship in construction in the welding of the head to the tank's body; **Other tanks also found to be defective so BH hired company to fix these defects at a cost of $60 000** = alleged purpose of "minimizing loss under the policies"
- **Issue:** whether steps taken were reasonable & proper and hence the $60K recoverable under SC 9 or the Sue and Labour Clause?
    - note: subscription policies = multiple insurance companies take on portions of a risk, a way for insurer to spread the risk, common in large commercial projects/businesses
    - Some of policies contained **s. 540 SC #9 "SALVAGE"**
    - Multi peril subscription policy contained "SUE AND LABOUR CLAUSE" (**see p. 72)**
- **Decision:**
    - **Work covered by expert classified into 3 categories:**
        - 1) detection of cause of rupture in tank = **RECOVERABLE**

- 2) inspection of unruptured tanks to determine soundness **{were also looking for problems to prevent rupture in other tanks}** **= NOT RECOVERABLE**
- 3) re-inspection of tanks after re-welding = **NOT RECOVERABLE**

- No coverage for costs of inspection of un-ruptured tanks under S & L clause or SC #9 because this risk hadn't *materialized* so didn't prevent any damage or future damage per se and because exclusion in place to prevent repairs related to faulty workmanship in the first place

- **Reasoning: IAA 540 SC 9 Analysis**
  - **court had to determine** whether accounts were reasonable and proper expenses in connection with steps Benson required to take under (1) of the SC to prevent further damage to the damaged property and to prevent damage to other property insured
  - 1) cost of **detecting cause** of explosion in tank was found to be **part of the loss** suffered by Benson as a result of explosion
    - insured can hardly be expected to repair damaged property without knowing the cause of the damage {**so analysis didn't even need to delve into SC #9}**
    - cost of those services rendered by expert found to be recoverable from insurer as part of loss and quite apart from SC #9
  - 2) **inspection of un-ruptured tanks** intended to show whether welding was also defective
    - did not reduce or extinguish risk any more that it was created or increased by them
    - risk of some other tanks exploding always existed: work of expert served to surface risk and make it know to insured and insurers
    - thus work under this 2nd category did not per se prevent any damage or further damage to any property insured under the policies and that risk of explosion not reduced by inspection but by re-welding (though noting inspection necessary prerequisite to correction of defective workmanship in some of un-ruptured tanks), **the cost would be recoverable from insurers only if SC 9(1) permitted it**
      - if and to extent Benson obligated by SC 9(1) to correct faulty workmanship in tanks that had not exploded
    - **so ISSUE: whether obligation in 9(1) is limited to prevent damage that would otherwise normally result from the peril that has already come into operation OR whether it also extended to averting occurrence of another peril so as to prevent the damage that would normally result from such other peril**
      - distinguished between the obligation to minimize a loss and the obligation to minimize a risk that had yet to materialize
      - at common law, insured has duty to mitigate his loss, ***but under no obligation to minimize risk* = distinction between obligation to mitigate loss AND obligation to minimize risk**
      - obligation in SC 9(1) arises if one of insured perils comes into operation: so whatever the policy is written to insure against, it is dependent on one of those things coming into play
        - indicates that damage to be mitigated **must result from contingency that has occurred** as opposed to being consequence of ***another*** contingency that has yet to occur -- ****different reasoning than *Garages* case****
        - need direct causal connection between original loss & that which insured had attempted to mitigate or avert
    - **Restrictive view by the court of SC #9:** that contractual expression of common law duty of insured to mitigate its loss and only required insured to prevent a loss that would be normal consequence of an event that has occurred

- Obligation of Benson under 9(1) **limited** to preventing damages resulting from explosion of tank that exploded
- Did not extend to correcting faulty workmanship in unexploded tanks so as to reduce risk of explosion in those tanks
- Such risk was stated to be another hazard which exited independently from and was not result of explosion of tank that exploded
- Was made known by explosion but was not caused by it- Court of view that Benson not obligated by SC 9 to determine whether unexploded tanks were also defective

- **Reasoning: Sue and Labour Clause**
  - Court referred to Faulty Workmanship exclusion clause - **"this policy does not insure against… the cost of making good faulty materials, workmanship, construction or design but his exclusion shall not apply to damage resulting therefrom"**
  - If cost of making good defective workmanship of tanks is not covered by policy, then expenses necessary to determine if the tanks were faulty could **not** be recovered under the same policy
  - Expenses stated to be an accessory of those incurred to correct defective workmanship
- **Ratio:** insured has a duty to mitigate *loss* but not to mitigate *risk* - damage to be mitigated **must result from contingency that has occurred** as opposed to being consequence of ***another*** contingency that hasn't yet occurred - need direct causal connection between original loss & that which insured tries to avert
- **Dissent: Justice Dickson** - follows reasoning of ONHC in *Phoenix*
  - Broader view of what constitutes a loss associated with materialized risk
  - Measures taken by insured were reasonable to prevent damage to its other insured property
  - **Dickson's Test: Danger "imminent" in his view so long as cause of explosion unknown and potential of other tanks to explode was unknown**
    - SC #9 ought to extend to prevention of further damage to insured property from same risk (went beyond the one tank that exploded)
    - Risk apprehended was of tank explosion from faulty welding
    - Majority ignored the "other property" wording in their interpretation of SC #9
  - Latent & continuing/same risk posed by potential explosion of 'tanks' due to faulty workmanship so inspection & re-inspection would be covered under S&L
    - Just because different piece of property is involved, doesn't mean different risk incurred!
    - Since damage occurred, measures taken were reasonable steps to prevent damage to other property insured within the meaning of SC 9
- **commentary:** Today, Dickson's approach of interpreting **whole Statutory Condition** would probably be favoured today
  - incongruent with *Garages*: but maybe distinguishable because we're talking about an entirely *separate* tank - remember *Garages* was just a ONHC decision
  - shows that outcome will depend on the facts of the case but that it is not always easy to determine: **questionable how far the courts will go when saying there is a risk that has materialized**
  - when dealing with S&L clauses, must look at contract in general because some steps that are taken might be excluded in other parts of the contract (in this case, costs of making good faulty materials was specifically excluded)

B. The Principle of Indemnity: Subrogation

Definition

- **Equitable common law doctrine, applying only to open policies** {not pre-determined, up to $x amount}
- Defined in *Confederation Life Insurance Co. v. Causton* as "the substitution of one person for another"
- Allows Insurer to step into Insured's shoes and pursue (& recover from) third party who may be responsible for insured loss
    - but cause of action is still between insured & tortfeasor as latter has no obligation to IC
- Only applies to an open policy (ie. not life insurance)
    - actual cash value that IC can prove on the date of loss (not value assigned in contract)

Purposes of Subrogation

- **1) Preserves fundamental principle of indemnity by ensuring that "insured receives no more and no less than a full indemnity"** {insured can't recover from tortfeasor and IC}
    - where insured recovers from tortfeasor directly, principle of subrogation means IC doesn't have to pay insured
    - if insured collects from IC & tortfeasor, insurance company can recover from insured to prevent over-indemnification
- **2) Ensures "that the loss falls on the person who is *legally responsible* for causing it"**
    - See *Somersall v. Friedman*
- **3) Makes it easier for insured to be compensated**

Procedure:

- (i) look at contract itself
- (ii) look at statute
- (iii) look at common law

If there was no subrogation = two issues

- Insured could potentially double recover for a loss by obtaining insurance proceeds from Insurer as well as damages from responsible third party
    - Subrogation ensures Insured is fully compensated for, but does not profit from an insured loss
- Insured could recover full value of loss from insurer and have no incentive to pursue third party who caused loss
    - Subrogation allows insurer to assume insured's right of recovery against third party, and preserves legal accountability of third party

Doctrine of Subrogation & Principle Indemnity = Linked concepts

- As long as insurance agreement = contract of indemnity then insurer has a right of subrogation arising from that contract
- Arises from the common law, with some contractual and statutory modifications to the common law
- comes up heavily insurance defence: subrogated files where insured tries to sue third party in tort after recovering from insurance company

Common Law Principles

- **1) Insurer's right of subrogation depends on full indemnity: insurance company has no right to subrogate until insured has been fully indemnified for their loss** (either just from IC or from IC+tortfeasor, whole loss needs to be made up}
    - No prior right materializes in IC

- Insured fully indemnified when Insured receives full compensation for insured loss, EXAMPLES:
    - policy limits of $20,000, loss suffered $10,000 – if IC pays full value of loss at $10,000 they have right of subrogation as they have fully indemnified the insured for his loss
    - policy limits of $20,000, $10,000 loss, $1,000 deductible – IC only required to pay $9,000 due to deductible ***however*** under common law they wouldn't have the right to subrogate as they haven't fully indemnified the insured **(insured would still be out $1000)** IC can waive deductible & pay full amount of loss at $10,000 to gain right to subrogate -- **IC would have to pay deductible to get this right**
    - policy limits of $20,000, loss of $25,000 with no deductible - loss exceeds value of insurance coverage so insured is **'underinsured'** – IC can't subrogate under common law as insured still has unpaid losses due to lack of coverage for the final $5,000
    - policy limits of $20,000, loss of $20,000 to property, personal injuries of $5,000; insurance is only for property damage so there is an uninsured loss for the personal injury - if IC pays $20,000 for property then they can still subrogate although there is still uninsured personal injury loss as **obligation to fully indemnify only pertains to property/item/subject matter covered by insurance contract**
        - ****uninsured** situation is different from under-insured**
        - **problem:** can only be 1 cause of action per event so the tortfeasor can't be sued separately by the insured & IC for different types of loss, the IC & insured must coordinate their claims
            - negligence for the IC to take away insured's cause of action so IC's lawyer should ensure there wasn't additional uninsured loss suffered
            - cause of action not taken away if IC reaches a settlement with tortfeasor as settlement isn't a cause of action
            - if they coordinate, the judgment divided between insured & uninsured loss
- **2) Insurer cannot subrogate against its own Insured**
    - Insurer entitled to conduct subrogated action upon full indemnity
    - Insured has CL duty to cooperate with Insurer - makes sense because it would be difficult for insurer to prove action without this cooperation {see #6 below}
    - When insurer subrogates, the action is commenced in the **insured's personal name** (and you wouldn't sue yourself!)
    - **Essentially:** can't give with one hand but take with other
    - example: if insured indemnified for loss caused by their own negligence, can't sue them - even if overpaid in the end
- **3) Any shortfall from tortfeasor is borne by IC**
    - ie: where a judge awards less than the loss in the case of a coordinated action (IC subrogating for $20k in property damage and insured suing for $5k in personal injury, judge awards $23k - **insured gets $5000 and IC bears the loss and takes $18k**)
    - derived from obligation of insurance company to fully indemnify for any losses
- **4) Once insured is fully indemnified & the IC is given the right of subrogation, the IC fully controls the subrogated claim against wrongdoer**
    - **except** where loss is uninsured as insured would be suing for something too (**coordination**)
- **5) The only right of recovery of the IC against the wrongdoer is that the insured would have had**
    - wrongdoer can raise any defence it has against the insured as it is as if they are being sued by the insured: doesn't affect substantive rights or law between the insured & the tortfeasor
- **6) The insured has a duty to cooperate with the insurance company in pursuing its subrogated claim**

Statutory Modifications - SEE JANELLE'S SUMMARY TABLE

- **1) **Very significant: don't need *FULL INDEMNITY*****
    - Statutory provisions expressly modify principle of 'full indemnity' permitting Insurer to exercise subrogation rights upon payment of '**any**' or '**part**' of insured loss
    - **General - IAA s. 546**
    - **Auto - IAA s. 587 (?)**
- **2) Proportional Sharing** = if only receive a portion of the indemnity from responsible third party, the insured and insurer ***share pro rata*** **{see formula in the Act}** -- **compare CL principle #3**
    - Statutory provisions also provide for proportionate sharing of net recovery from tortfeasor where net recovery falls short of full indemnification to Insured
    - **General - IAA s. 546(2)**
    - **Auto - IAA s. 587 (?) - maybe only under IA s. 651**
- **3) Control under Auto**
    - Provisions of policy can also specify whether Insured or Insurer have control over subrogated action against third party (not automatically controlled by insurer if they indemnify insured)
        - i) if insured only paid deductible by insurer, control of loss goes directly to IC as they have bulk of interest in a resolution
        - ii) can apply to court to make determinations where there is a failure to agree on control of lawsuit (unique to auto section, not included in fire section where common law still applies)
    - **IAA - s. 587(?) - maybe only under IA s. 651**

Confederation Life v. Causton **[1989 BCCA]**

- **Facts:** Insured became permanently disabled as a result of a car accident; incurred lost wages in excess of $100K because she was unable to work; Insured was insured for lost wages by Confederation and Disability policy did not contain any agreement that would modify the common law; Confederation paid insured $18K under policies; In addition, **Insured sues tortfeasor driver and recovers approximately 75% of her lost wage claim**; IC tries to claim back its $18k to prevent double indemnification; Lawyer took 25% of her judgement so even w/ $18K paid to her by Confederation, insured recovered less than her total wage loss - Insured argues she wasn't fully indemnified so at CL the IC shouldn't be able to collect anything
    - ***note: almost *all* disability policies only indemnify for a portion of the total loss***
    - ***note: no statutory conditions in place at this time, dealing exclusively with common law***
- **Issue**: whether insurer entitled to share on a pro rata basis in proceeds recovered by insured from wrongdoer where insured has not recouped full loss, although insurer paid full amount due under indemnity insurance policy **(= was Confederation entitled to get their $18k back?)**
    - When does the right to subrogation arise? On recovery by insured of a portion of loss suffered, or only on recovery of full loss (to prevent double recovery)?
- **Decision: IC not entitled to the $18k** - Subrogation only arises where insured has been fully compensated so even if IC pays everything they are required to under the contract, the insured is free to pursue claims & recoup losses up to amount where would not be overcompensated
- **Reasoning**
    - even if subrogation isn't mentioned by statute or contract, it applies to indemnity aka open policies of insurance because it is an **equitable common law doctrine**: this was an open policy because paid percentage of actual loss & not pre-determined value so subrogation applies
        - Court said it was apparent under the policy that insured entitled only to indemnification for loss and once that was achieved as a result of payment of insurance money, insurer then entitled in equity to be placed in same position as

insured – with same remedies and rights the insured had re: recouping loss from third parties

- Reaffirmed the underlying principles we discussed above: application of doctrine of subrogation thus prevented insured from being paid twice for same loss
- **Recognized that insured never received total wage loss – she received 75% of it**
  - $ received also subject to charge against it for legal fees
  - Thus: her net recovery of her claim for wage loss was 88% of her loss
- **Since she was never fully indemnified for the wage loss which was the subject matter of the insurance, the insurer's right to subrogation never arose**
  - **no right to subrogation when P insured has not been completely indemnified**: because Insured had to pay portion of judgment to lawyer, she was **under-indemnified** so subrogation was not allowed at common law
  - doesn't matter if IC paid everything they were obligated to under contract
  - **TEST is whether insured recovered everything they lost** – factor in these costs as it is an equitable doctrine
- court also said that if insurer wants a claim to money on pro rata basis, the policy must be clear on this point

- **Ratio:** *To determine if insured was fully indemnified, must consider costs related to reasonable recovery against 3rd party, such as* legal fees - **test is whether insured recovered EVERYTHING they lost, not just recovery of *actual* loss**
- **Commentary:** Result would be different if statutory provisions applied
  - if it was property policy for fire loss (s. 553 in IA or s. 546 in IAA would apply) – right of subrogation arises upon any payment made so full indemnification for loss is irrelevant
  - statute also allows IC to recover pro-rated amount of whatever is claimed from 3rd party: under common law they get nothing back but in this case they would get

Mutual Life Assurance Co. v Marance **[1996 ABCA]**

- **Facts:** Insured can not work due to MVA injury and **recovers loss of income disability benefits of $45K from IC** still has loss of income calculated at $72K; specific clause under Reimbursement Agreement, that insured agrees to repay insurer any amounts recovered from third party for loss of income 'that exceed 100% of my income lost'; Insured sues third party tortfeasor for losses including loss of income; Insured's lawyer becomes concerned that circumstances of MVA and events leading up to same presented substantial risks – because AT THE TIME, gross negligence had to be established on part of tortfeasor, and tortfeasor raised volenti defence {**not the law in AB anymore}**; claim settled at **one global amount of $178K** even though insured's lawyer thought that was at about 50% of what claim was worth; Insurer tries to exercise subrogation under contractual term to claim amount paid; Insured argues that since settlement doesn't itemize what portion is for loss of wages, insurer can't subrogate
- **Issue:** whether insurer entitled to share in recovery of damages made by insured in **settlement** of personal injury claim
- **Decision: Held that $178K settlement was not full recovery of assessable value of claim** - since subrogation is an equitable doctrine & since contractual provision isn't clear in changing right of IC to claim back, they aren't allowed to exercise subrogation rights in these circumstances
  - at common law, decision would have been the same because P wasn't fully indemnified
  - ****remember Janelle's procedure - i) contract, ii) SCs, iii) CL****
- **Reasoning:**
  - reimbursement agreement provided that insured would replay insurer for recovery made for loss of income that exceeded 100% of same
  - Recovery of $178K included all other heads of damage not just wage loss

    - court reluctant to accept argument of over-indemnification as it was a **settlement** (compromise to reflect uncertainties of liability in claim versus adequate representation of actual claim)
    - notes that IC has been involved the entire way & did not indicate they would view settlement amount as over-indemnification
    - since this is an equitable doctrine & since contractual provision isn't clear in changing right of IC to claim back, they aren't allowed to exercise subrogation rights in these circumstances
- **Ratio:** 2 main points: (i) contract must make it clear that IC is relying on subrogation right outside of common law **(ie: contract doesn't refer to "settlements" explicitly)**; (ii) courts won't allow IC to subrogate where it was inequitable to do so

SEF 44 Endorsement or Family Protection Endorsement

- if you're driving and in an accident with someone who is **uninsured** or **underinsured** and they are at fault, you can make a claim for the balance
- Used to be an 'optional' endorsement and still listed as so but practically mandatory
- Plaintiff must be "legally entitled to recover" damages from an underinsured motorist in order to access their own insurer's pool of coverage for such circumstances
- Obliges insurer to indemnify each eligible claimant for the amount they are legally entitled to receive from an inadequately insured motorist as compensatory damages
- ****Good example of contractual modification to the principle of subrogation****

***Somersall v. Friedman* [2002 SCC]**

- **facts:** S sues F for personal injury after a MVA; F only insured up to $200 000; S and F, without telling insurance company, enter into "Limits Agreement" in which: **F admits liability** and **S agrees not to claim against F in excess of his policy limits of $200K**; S proceeds with lawsuit to prove extent of damages above $200k and seeks to recover the remainder of their damages from their **SEF insurer (= **an excess insurer**, not the primary one)** S&Y Insurance; S&Y added as a D so that S can recover anything above $200k from them; but S&Y becomes aware of the Limits Agreement:
    - S&Y argues they are not obliged to pay anything **because they are only liable for whatever F is liable for** & under limits agreement F would never be required to pay more than 200,000; respond by issuing a 3rd party notice naming F as the subrogated claim because if they have to pay the sum over $200k they will sue him because he was at fault;
    - F relies on Limits Agreement and argues S&Y can't raise a subrogated claim against him because insurer can only exercise the same rights as the insured
    - S&Y say if this is true, then they don't need to pay at all because insured has breached its duty to cooperate by effectively giving away subrogation rights of the IC
        - SEF 44 had subrogation clause stating that IC has subrogated any rights of insured where claim is made under endorsement (not on payment) & specifically requires insured to cooperate with insurer except in pecuniary way in pursuit of any subrogated action
    - **ESSENTIALLY:** F and S&Y are relying on the Limits Agreement as a modification of subrogation rights to avoid paying amount owed to S
- **Issue:** whether Limits Agreement precluded S from advancing claim against insurer under SEF 44 Endorsement?
- **Decision: No - SEF IC was still on the hook for the losses in excess $200k** - Limits Agreement doesn't change anything

- previously, acting for SEF 44 IC you would say to third party IC that they had better look after their client or else they would sue the third party who would then likely sue their own IC for bad faith (**removed this risk for the primary carrier)**
- changed the perspective and position of an SEF 44 Insurer - **if underlying limits are removed by Limits Agreement, there is nothing IC can do** (right of subrogation rendered meaningless)

- Reasoning [discusses principles of subrogation, like what we covered last class]

- **First** – keep in mind the underlying objectives of doctrine of subrogation – to ensure insured receives no more and no less than full indemnity, and that loss falls on person who is legally responsible for causing it
    - **<u>If insured enters into limits agreement, insurer has lost nothing by inability to be subrogated</u>**
    - Insurers should **<u>not</u>** be allowed to raised alleged breach of subrogation rights to bar a claim made in good faith by the insured
- **Second** - insurer's right of subrogation does not arise until insured fully indemnified
    - Insurer may not control process of litigation until full indemnity met
    - In equity, insurer would not yet be entitled to assert or pursue subrogated claim in the case since they had not indemnified the insured fully
- **Third –** insured obliged to pursue any claim it has against third party up until such time as insurer is entitled to and does assert control of claim in good faith
    - since subrogation clause doesn't make it clear that insured can't entered into settlement, relies on common law
    - Subrogation is an equitable doctrine - so long as insured genuinely believed entering into Limits Agreement was wise and prudent, they **<u>must</u>** be regarded as having acted in good faith
    - No evidence here that insured did anything in bad faith to disentitle him from coverage under contract: limits agreement only entered into because F had no money
- Subrogation rights against underinsured or uninsured drivers stated to be "rarely very valuable at all" and successful recovery in subrogation claim "really a windfall for insurer"
- No good policy reason for Court to read into contract a provision that will so gravely prejudice insured when insurer will likely gain little but exemption from very payment for which insured has faithfully paid monthly premiums to ensure entitlement
- In view of "near negligible value of subrogation right", would be overreaching to regard loss as significantly changing insurer's position
- **Risk that insurer has assumed effectively compensated for by insured monthly premium**
    - "Without being cynical, … would be very surprised indeed if loss of a subrogation right with little practical value were significant enough to have any effect whatever upon the insurer's balance sheet" **- no evidence as to whether F had any assets or what IC's balance sheet was so these are all comments by the SCC in the absence of comments on the issue**

- **Ratio:** In the absence of a contractual provision to the contrary, an Insured is free to enter into a Limits Agreement which will render an IC's subrogation rights meaningless
    - **-** **Resounding statement from SCC that ability to exercise subrogation rights are not as fundamental as IC historically thought**
- **Commentary (Dissent – Binnie/Major)**
    - Majority is making many assumptions unsupported by evidence:
        - tortfeasor's supposed incapacity to compensate insured
        - whatever capacity existed has been "exhausted"
        - insurer appears to have suffered no real loss as a result of inability to subrogate

- especially concerned with commentary on limited value of subrogation to insurance companies: wouldn't pursue these claims if they weren't financially valuable
- rejects assertion that limits agreement made based on lack of money as would go to SEF 44 first even if F had money
    - **since there is no evidence, court shouldn't presume insured acted in good faith**
- upholding limits agreement basically allows the insured to cut off insurance company's right of subrogation

Zurich Insurance v. Ison Toronto Honda Auto Sales Inc **[2011 OnSupCt]**

- **facts:** explosion damaged Insured's cars so that they could not be sold as new; claimed under its policy an recovered $1.9M from IC which was the factory invoice price of the vehicles less a deductible of $10k; insured retained an uninsured claim for the loss of profits, lost ability to serve and resell trade-ins plus loss of good will and a claim for the deductible and commenced an action against third party for its own claim *and that of its IC;* insurers were able to get $900k in salvage for the cars so have a subrogated claim of $1m against third party; wanted to have carriage of action that insured commenced against third party asserting its own claim and that of insurer; **policy contained a "Subrogation Clause" which altered common law in two ways:** i) permits insurer to bring action against third party even before loss has been fully indemnified, as long as has paid part of the loss or assumed an obligation to do so, and ii) modifies the insured's CL right to a complete indemnity for all insured and uninsured losses before the insurer is entitled to recover anything; **insurer argued that subrogation clause gave them control of litigation commenced against third party** (suggested that "partial indemnification" piece gave them control); insured argued *it had control of litigation* as it had not been fully indemnified
- **Issue:** Who has right to control litigation against third party responsible for insured loss? Does the insurer's contractual entitlement to be "subrogated to all rights of recovery of the Insured" and to "bring action in the name of the Insured" to enforce such rights, carries with it the right to *control* litigation?
- **Decision**: No - Insured remains in control of litigation
- **Reasoning:**
    - Principle of subrogation stated to be 'one of four cornerstones of insurance law'
        - The other three being insurable interest, good faith and indemnity
    - At common law, well-settled that until insured fully indemnified for all losses, the insurer had no rights of subrogation
        - court notes that this has been softened by contract, statute or by both
    - **Court adopts *Somersall* methodology - Court should consider:**
    - **1. Plain language of insurance contract**
        - contains no express provision about the right of either party to *control* litigation
    - **2. In relation to terms of contract**
        - **a) Special principles of interpretation**
            - any ambiguity is to be construed against insurer
        - **b) General principle of law re: insurance contracts**
            - Nothing in plain language of subrogation clause to alter insured right to control litigation until insured fully indemnified **- no reason for us to imply a term into the provision**
            - No reason to imply provision giving insured right to control to give business efficacy to contract nor did control of litigation follow from insurer right to be subrogated to insured's rights and to bring action in name of insured
    - **3. Views of other courts**

- nothing from neither the majority or dissenting opinion in *Somersall* that suggests the SCC considered the issue of the insurer's right having provided an indemnity to control the prosecution of an action against a third party for recovery of both insured and uninsured claims - question was <u>not</u> at issue
- weight of authority confirms insured in control of litigation or *dominus litus* until insured fully indemnified for insured and uninsured losses

- **4) Wisdom of policy that would result from interpretation adopted by court**
  - Effect of subrogation clause coupled with duty of good faith would required insured to consider insurer's interests etc.
  - Not necessary for court to consider discretionary issue
    - **Insurers delayed and Insured acted right away**, **Insured has expelled more effort**, no **suggestion that Insurer's position has been/will be prejudiced by not being in 'control'**
  - Not a regulated contract so Iacobucci's policy considerations from *Somersall* are not particularly relevant
  - Simple matter for insurer to <u>amend</u> subrogation clause to alter common law position and give carriage to insurers

- **Ratio:** in an absence of a contractual provision to the contrary, insured retains "control" of subrogated litigation; 4 factors *(Somersal* methodology)

C. Contribution

<u>Principle of Indemnity</u>

- Possible for Insured to have more than one policy covering same subject matter and same risk of loss
- Principle of indemnity remains applicable where loss is covered by more than one policy of insurance
- Insured not entitled to recover more than value of loss despite multiple sources of recovery potentially being available **(because not entitled to claim anymore or any less than your loss)**
- **SCC in *Family Insurance v. Lombard*:** "It is a well-established principle of insurance law that where an insured holds more than one policy of insurance that covers the same risk, <u>the insured may never recover more than the amount of the full loss</u> but is entitled to select the policy under which to claim indemnity, subject to any conditions to the contrary. <u>The selected insurer, in turn, is entitled to contribution from all other insurers who have covered the same risk</u>. This doctrine of equitable contribution among insurers is founded on the general principle that parties under a coordinate liability to make good a loss must share that burden pro rata."

<u>Doctrine of Contribution</u>

- **= <u>Equitable</u> doctrine that requires payment of loss to be *shared* by insurers**, where there is more than one insurance contract covering same risks
  - Common Law contribution requires insurer to reimburse another insurer for some of the value which the latter was required to pay to the insured
  - **Contribution = Equitable Doctrine** (*Continental v. Prudential*)
    - Relies on fairness and natural justice
- Concerned with
  - a) **over-indemnification**: sharing of loss ensures Insured not over-indemnified by recovering full loss from multiple sources
  - b) **fairness:** each insurer fulfills its indemnity obligation and is not relieved of its payment obligations that they made individually made with the insured

- Example: insured has loss of $100,000 that is covered by 2 contracts with policy limits of 100,000
    - Result: each contributes a particular amount to the insured's loss so they receive $100,000 in total but no more
- May occur by design where duplicate coverage purchased from different insurers
- May also occur unintentionally where insured obtains policy without realizing same coverage provided by another policy

****Statutory Changes****

- **General - IAA s. 544**: where contribution arises, each insurer is liable for pro rata formula unless insurance companies make inter-company agreements stating otherwise
    - each IC made liable to insured for only rateable proportion of loss vs. whole of the loss (at common law)
    - **Some parameters** on circumstances or types of insurance coverage which will or will not give rise to overlapping coverage and contribution principles **- s. 544(6)**
    - **Formula** for allocating amount of loss payable to each insurer **- s. 544(4) and (5)**
- **Auto - IAA s. 596**: do not default to pro rata as specifically defines ratable portion; if policy limits are equal they share equally however if unequal then you go to equal sharing & pay dollar for dollar up to policy limits
    - each IC made liable to insured for only rateable proportion of loss vs. whole of the loss (at common law)
    - **Some parameters** on circumstances or types of insurance coverage which will or will not give rise to overlapping coverage and contribution principles - **s. 596(1)**
    - **Formula** for allocating amount of loss payable to each insurer **- s. 596(3)**

Contractual Modification

- See *Family Insurance Corp. v. Lombard Canada Ltd.*
- attempt to modify equitable contribution because of the two provisions that were dealing with the "other insurance clauses"… (?)

Two issues:

- **1) Are there two or more identical policies of insurance covering the loss in question?** (*Family Insurance Corp)*
    - contribution only arises where there is more than 1 policy that covers the **same** risk
    - people buy identical policies (i) due to desire to not buy up to policy limits on one, (ii) to protect themselves against insurance companies going bankrupt, or (iii) unintentionally (don't realize risk is already covered under another policy)
    - ****must look to contract****
    - **Policies must be identical on certain features** (*Family Insurance Corp v Lombard Canada Ltd.*)
        - (i) All policies concerned must comprise same subject matter
        - (ii) All policies must be effected against same peril
        - (iii) All policies must be effected by or on behalf of same insured
        - (iv) All policies must be in force at time of loss
        - (v) All policies must be legal contracts of insurance
        - (vi) No policy must contain any stipulation by which it is excluded from contribution
    - **Note: Policy limits do not have to be the same!**
- **2) Apportionment: Assuming you have duplicate policies, how much does each policy contribute?**
    - ****Determined by statute & common law only (not contract itself)****
    - No pre-determined formula at common law – each insurer pays what is fair

- Default is generally **pro-rata** formula as equal policy limits is rare
    - Pro Rata = (policy limits of insurer/combined policy limits of all insurers) x value of loss
- Pro Rata becomes problematic where there is a specific insurance policy and a more general larger policy:
    - if only item damaged is one where there is specific coverage, pro rata apportionment would be unfair as specific insurer gets to share costs with other insurer
- always governed by policy limits so there is never a danger of insured being over-indemnified

Apportionment Methods

Policy Limits & Loss Amounts	Pro Rata (Maximum Liability Formula)	Equal Sharing to Policy Limits	Independent Liability
Equal Limits / Loss within Limits: Policy A $10,000 Policy B $10,000 Loss $6,000	10000/20000x6000= $3000 for each A & B **same result	A pays $3000 B pays $3000 **same result	6000/12000x6000= $3000 for each A & B **same result
Unequal Limits / Loss within Limits: Policy A $10,000 Policy B $20,000 Loss $6000	10000/30000x6000= $2000 for A 20000/30000x6000= $4000 for B	A pays $3000 B pays $3000	6000/12000x6000= $3000 for each A & B
Unequal Limits / Loss Over Limits of One Policy: Policy A $10,000 Policy B $20,000 Loss $15,000	10000/30000x15000= $5000 for A 20000/30000x15000= $10000 for B	A pays $7500 B pays $7500	10000/25000x15000= $6000 for A 15000/25000x15000= $9000 for B

- **Pro Rata** = (policy limits of insurer / combined policy limits of all insurers) x value of the loss
- **Equal Sharing** = each insurer contributes dollar for dollar up to the value of the loss or to policy limits
- **Independent Liability** = (amount the insurer would pay toward the loss as the ONLY insurer / total amount all available insurers would pay toward the loss if each was the ONLY insurer) x actual amount of the loss
- **NOTE: If loss exceeds the policy limits of BOTH policies, then each policy pays its limits.**

****Leading Canadian Case****

Family Insurance Corp. v. Lombard Canada Ltd. **[2002 SCC]**

- **Facts**: case dealing with overlapping excess coverage, both contract contained an "other insurance" clause declaring policies to be 'excess coverage' to primary coverage held by insured; Y was insured who owned riding stable; someone riding at stable was injured and sued Y; settled for $500k; Family Insurance contract was Residential Liability Policy with limit of $1M; Lombard contract was Commercial General Liability Policy with limit of $5M; Each insurer relied on its 'other insurance' clause to shield itself from primary liability
    - ***Family* policy**: "If other insurance exists which applies to a loss or claim ….this policy will be considered excess insurance and the insurer is not liable for any loss or claim until the amount of such other insurance is used up."

- ***Lombard* policy**: "If other valid and collectible insurance is available to the insured for a loss we cover … our obligations are limited as follows: …This insurance is excess over other existing

- **Issue:** to what extent are insurers liable to pay the insured's claim when there are overlapping policies limiting liability where the other insurer covers the same loss? who is primarily responsible?
  - Trial court: policies equivalent & negate each other so both contribute on equal sharing basis
  - BCCA: examines nature of contracts to say that residential contract is primary as more *specific* based on evidence that insured only
- **Decision:** identical competing excess clauses cancel each other out so equal sharing applies
- **Reasoning: 3 KEY POINTS FROM THE CASE**
- **POINT 1: clearly sets out principles of contribution**
  - 'well-established principle of insurance law' that where insured holds more than one policy of insurance that covers same risk, insured may never recover more than full loss but is entitled to select policy under which to claim indemnity, subject to any conditions to contrary
    - 'Selected' insurer entitled to contribution from all other insurers of same risk
    - **Doctrine of equitable contribution** among insurers **founded on general principle that parties under a coordinate liability to make good a loss must share burden *pro rata***
  - Overall analysis looked at general principles behind contribution (see above)
- **POINT 2: intention is irrelevant for contribution as it only affects relationship between insured & insurer**
  - proper instrument to determining liability of each insurer is the **policy**
  - properly determine the parties' intentions, looking at how each insurer sought to limit its liability to the insured when insured bought other policies covering the same risk
  - **BUT due to privity of contract**, **intention can't affect rights between two insurers**
    - limited to insurers' intention *vis a vis* the insured
  - **Here** both Family's and Lombard's intentions were clear = intended to provide primary coverage *unless* other insurance available, in which case intended to provide excess cover
    - Lombard policy went further: expressed intention to be "excess" to any "excess" policy as well as to be "excess" to any "primary" coverage
  - Family's and Lombard's intentions are 'irreconcilable': intention of each insurer was to limit its liability to excess coverage in the event that other insurance covering same risk was available
- **POINT 3: Endorsed an approach of EQUAL SHARING (not *pro rata*)**
  - Without limiting intentions or where the same could not be reconciled, ***as here,*** principles of equitable contribution demanded that parties **share burden equally** to make good a loss
  - Court examined and rejected 'Minnesota' approach which advocated using a 'closeness to the risk' test to resolve overlapping coverage disputes
    - critical because it results in preference or endorsement of the intentions of one insurer over another, which does not accord with equitable principles
  - 'Mutually repugnant' and 'inoperative' clauses effectively cancelled each other out**, so both found to provide insured with primary coverage**
    - **=** Each insurer found to be fully liable to insured for full loss as if the other did not exist
  - Where liability is shared among insurers covering same risk, loss borne equally by each until lower policy limit exhausted with policy with higher limit contributing any remaining amounts
    - **This is now deemed the "Independent Liability" Approach to apportionment:** Equal sharing of liability to policy limits represented fairest method of apportionment and accorded with principles of equitable contribution
- **Ratio**: where you have identical competing excess clauses, they cancel each other out & equal sharing applies

- **Commentary:**
    - Contribution is <u>not</u> a defence to limit payment obligation to insured
        - Contribution refers to right of insurer, upon indemnifying insured up to limits of policy, to seek reimbursement from other insurers for portion of $ paid to insured
        - Insurer entitled to bring such action against other insurers in its own name against other insurers
    - Courts will typically use pro rata as default and will particularly rely on it where 1 policy is more directly applicable to the loss in comparison with a larger more general policy as it wouldn't be fair to hold otherwise (ex. piece of art vs entire house)
    - **Court also mixes up equal sharing by calling it independently liability**: in this case the remedy is equal sharing but because loss falls within the policy limits it doesn't really make a difference (would if loss was outside policy limits)
    - **Binnie J miscalculates pro rata coverage** – should add up insurance then look at coverage but he doesn't do this

Continental v. Prudential **[1965 ManQB]**

- **facts:** Insured had property policy with Prudential which insured building against loss or damage by fire ; He was persuaded to replace Prudential policy with Continental policy; Purported to cancel Prudential policy but didn't follow mandated procedure of using registered mail and the cancellation notice was not received; Building damaged in fire and both Continental and Prudential had a policy in force insuring the loss; Continental paid out loss, and in the action, sought contribution from Prudential for their pro rate share of the loss;
- **Issue:** Should Prudential be required to contribute to the loss, despite Insured's intention to cancel the policy?
- **Decision:** No
- **Reasoning**
    - Court examined **Section 135 of Ontario Insurance Act**: "Where … there is in force more than one contract covering the same interest, the insurers under the respective contracts shall each be liable to the insured for its rateable proportion of the loss unless it is otherwise expressly agreed in writing…."
        - made each insurer responsible only for a given portion of total insurance on described property
        - Insurer could only be sued for its rateable proportion
        - <u>No question of contribution</u>
        - Purpose of Section to limit original liability of insurers instead of requiring them to seek contribution from one another
        - Section did not give one insurer who had paid an amount more than his pro rata share the right to claim contribution from another insurer who has not - **thus didn't really give the court an answer**
    - **Because statute was no help, the only way to collect would be via common law**
        - acknowledged existence of equitable right to claim contribution at common law and examined doctrine of equitable contribution
    - **BUT due to 'intention' of insured vis a vis Prudential, it would would be violation of natural justice and equity to permit Continental to recover part of loss from Prudential**
        - Not insured's intention to have double insurance
        - "A party seeking to have equity done to him must do equity" - would be inequitable to allow Continental to take advantage of insured's failure to cancel to recover part of the loss from Prudential = <u>estopped from claiming contribution</u>

- Continental's claim **also failed** because insured, at the instigation of Continental, terminated the Prudential policy by exercise of his common law right to abandon, disclaim and renounce

- **Ratio**: (i) points out difference between common law & statutory contribution (ii) emphasizes that contribution is an equitable doctrine: need clean hands to use it

Clarke v. Fidelity-Phoenix Insurance Co. **[1926 ONCA]** *clarifies what constitutes overlapping policies capable of raising contribution*

- **Facts:** Homeowner purchased a policy on her house from Fidelity Phoenix; Mortgagee of house also purchased a policy on same house; Loss occurred and Fidelity pays but seeks contribution from mortgage's insurer
- **Issue:** Do the policies meet the requirement of overlapping coverage for the purposes of contribution?
- **Decision:** No - Policies found to be distinct, Doctrine of Contribution **not** applicable
- **Reasoning/Ratio**
    - **Doctrine of Contribution applies where different insurers insure the same interest in respect to the same property and perils**
    - Here:
        - Two distinct insureds
        - Two distinct proprietary interests although in same subject matter

Musca v. Wawanesa **[2004 ABQB]**

- **Facts:** 2 policies on same vehicle – one issued by Wawanesa and one by Axa; both policies have over $1M liability limits; Owners ***intended*** to cancel Axa coverage but ***cancellation did not occur*** before motor vehicle accident (Axa didn't receive notice of this cancellation until the day after); Insured is involved in mva and injures someone who makes claim for personal injury against them in excess of $1M; Axa receives cancellation after mva so returns premiums to date of accident & claims policy wasn't in effect this day - argues they aren't liable as M intended to cancel coverage and never intended more than $1M coverage; Wawanesa says Axa's policy wasn't cancelled & each policy was an owners policy insuring identical interests as first loss insurance making each insurer liable for ratable portion of loss no more than $1M; Insured says contract wasn't cancelled & 2 valid owner policies existed so each insurer liable to pay up to its limits
- **Issues:**
    - 1) whether Axa policy had to respond by defending and indemnifying insureds re: MVA
    - 2) If so, were both policies first loss policies, or was Axa policy excess?
    - 3) Were both policies exposed to full face value of $1m or pro rata share?
- **Decision:** Axa policy not cancelled at time of MVA, based on the court's finding that Insured "would have been aware" that they needed coverage during the "transition period"
    - **** similar circumstances to *Continental* but very different result, seems to hinge on this finding****
- **Reasoning**
    - "Public policy" served by short term overlapping coverage
    - Insured did not intend to have 2 policies but <u>would have been aware that insurance cover had to be secured from one or both sources during transition period</u>
    - Intent of insured to cancel Axa had no legal effect until communicated
        - requirement for termination upon 'request' interpreted to imply that request must be communicated to other party and can't occur unilaterally; intent of M has no legal effect

- Insured actions did not cancel Axa policy because policy still in effect at time the accident happened
- policies were identical as each owners policies with equal obligations to indemnify and both 1st loss insurance = **Axa and Wawanesa each liable to respective limits**
- **ISSUE 3:** Whether insured entitled to total of $1m divided between 2 insurers, or $1 m from each insurer?
    - States general principle that where insured holds more than one policy covering the same risk, can never recover more than the full amount of the loss - must select the policy under which he claims indemnity and that insurer becomes entitled to contribution
    - Indemnity Analysis
        - Third party claimed damages exceeded $1m but no suggestion insured seeking double indemnity = no risk of double recovery
        - **Insured entitled to $1m worth of cover from each of Axa and Wawanesa:**
        - **keep in mind court is also trying to protect 3rd parties so interpret policies with this aim in mind as well**

- Ratio:

- **Commentary: really can't be reconciled with *Continental* - treat as 2 lines of authority, distinguish?**

D. Subrogation VERSUS Contribution

Distinguishing the Concepts

- Central purpose of both = ensure insured isn't over indemnified
- Both allow ICs to re-coup some of its money from another source (ie. Subrogation from 3rd party; contribution from another insurance company covering same risk)
- Subrogation allows IC to stand in place of insured & recover from someone legally responsible for loss whereas under common law contribution gives IC its own right to collect from another insurer

***Cameco Corp. v. Insurance Co. of State of Pennsylvania* [2010 SkCA] ****action really should have been brought under contribution than subrogation* **READ - figure out why Global is denying coverage yet ends up indemnifying**

- **Facts**: helicopter crash kills miners working for Corp; families of deceased miners sue Corp in tort action (nothing to do with insurance); C turns to liability insurers (G, ICSP, AH) who all provide some sort of liability insurance **but all deny coverage**; Global denies coverage, however decides to defend C anyways & act like there is coverage because if they are wrong in denying coverage they don't have any right to be involved to try to keep judgment against C low affecting how much they would have to pay for claim;
    - **Lawsuits leading up to Global's Claim -** 2 lawsuits are going on at same time:
        - (i) C sues ICs for coverage – Cameco v ICSP & AH
        - (ii) 3rd party families v Cameco with Global participating in defence
            - 3rd party v Cameco (Global) settles to pay amount of damages just over 6 million – G pays full value of judgment on behalf of C so C isn't out any money in defence costs or judgment and **C is fully indemnified**
            - G was told by one lawyer that he could have sued original insurers for contribution prior to settlement however limitation period had run out
            - G tries to add itself as a Plaintiff in Cameco v ICSP & AH suing for contribution from insurers

- SKCA rejects this as they are trying to get around a limitation period by amending an existing action to slide theirs in which isn't fair (note: this would probably be ok under AB Rules of Court)

- **Issue:** Where there is 1+ insurance policy in place and one of the ICs fully indemnifies the insured, can that IC maintain a subrogate action against the other insurer in the name of the insured?
    - ***essentially trying to subrogate for contribution money….***
- **Decision: NO**
- **G pursues 2 alternative claims to try to recover**
- **i) Subrogation**: court considers whether G can get C to amend its pleadings to specifically indicate it is a subrogated claim for G (unnecessary as subrogated claims aren't disclosed in pleadings) this is the claim in the casebook!!
    - G argued it had fully indemnified C so it had the right to pursue a subrogated claim
    - ICSP & AH argued that C had no valid claim against them as they were fully indemnified; argued that G had no rights against them to actually pursue contribution under a claim of subrogation; only claim available would be contribution action in its own name & any claim by the insured against non-paying insurers ceases to exist once fully indemnified
    - **SKCA says no**: **subrogation allows insurer to pursue anyone who is legally obligated to pay for the loss of the insured but ICs are only legally obligated to pay where an insured isn't fully indemnified yet (can't step into insured's shoes because they've already collected)**
    - **this is different than contribution where once insured has been fully indemnified by one IC, it can pursue the others**
    - subrogation is different because it gives insurer a right to all the amount recovered by the insured against a 3rd party to the extent they are liable; contribution is based on proportionate liability of insurers
    - to allow the insurer to subrogate the insured's right against the other insurers after it indemnifies would allow them to recover the whole amount it paid, putting the entire loss on the 2nd insurer
    - action should have been brought for contribution because in subrogated action, the insured seeks recovery on behalf of the paying insurer of the whole amount and not just a proportion
    - in this case, the IC has fully indemnified the insured so the insured has no cause of action available against anyone!
    - **key point: G can't stand in position of C because there isn't anything left for them (C) to recover as subrogation right has been extinguished!**
- **ii) Contribution**: G finds out that contribution claim *actually isn't time-barred* so they can sue other insurers on their own for contribution so launches a new & separate action directly against insurers for equitable contribution
    - ICSP & AH argued this wasn't allowed as the limitation period applicable had expired and the issue was res judicata (had already been decided)
    - court never hears this or determines whether G is out of time as this was an 'abuse of process' – G was trying to sneak in contribution claim in many different ways
    - Babs: decision unfair to G as they are the only insurance company that has attempted to honour its contract
- **Ratio:** Distinction between subrogation and contribution
    - Subrogation is device which gives effect to contract of insurance protecting insurer by permitting it to pursue claims against third party in name of insured in respect of losses that have been indemnified
    - Contribution is a device for relief of an indemnifier where others have undertaken to indemnify for the same risk described as a case of double insurance

- **Commentary:** *case made a huge difference to Global: lawyers lack of understanding about difference between subrogation & contribution cost them over 6 million dollars!!*

CHAPTER 3: THE INSURANCE CONTRACT

A. Uberimma Fides - The Insured's Duty of Disclosure

1. Common Law Principles

Uberrima Fides

- It applies at common law (unless altered by legislation or contract) to all insurance contracts
    - Could be altered by statute or contract - E.g. Insurance Act
- It exists apart form the express terms of the contract;
- It applies to both the insured and the insurer; and
- It lasts for the duration of the insurance contract.
- Principle of utmost good faith is important b/c it imposes heavy burdens on insured/insurer and b/c it frames the way the courts view the obligations of insured & insurer
    - Treat each other with total honesty and treat each other with fairness. Each party should consider the interests of the other party equal to their own
- **Obligation on INSURER**
    - Insurer must respond to an insured claim in a timely and reasonable manner;
    - On a liability policy, an insurer must settle with the Plaintiff within the policy limits when it is reasonable to do so, to avoid exposing the insured to an uninsured judgment; and
- **Obligation on INSURED**
    - Insured is required to be completely honest, forthright and forthcoming in providing insurer with information relevant to coverage – **DUTY OF DISCLOSURE**

Duty to Disclose

- under normal contract law, a fraudulent statement by one which induces the other to enter into a contract always entitles the latter to repudiate the contract ***however mere nondisclosure isn't enough***
    - **concealment *OR* mere non-disclosure is effectively the same as fraud in regular contract law**
- common law imposes heavy burden on insured for full & accurate disclosure for matters important to risk assessment **because insured has full knowledge whereas underwriters know nothing**
    - makes insurance contract of 'utmost good faith'
    - insured strictly held to their obligations including duty to disclose based on understanding that insurer relies heavily on insured when deciding: (i) whether to take a person on as insured and (ii) decides what to charge for premiums
      these decisions are made based on perception of risk and likelihood of having to pay for loss: must be able to determine with some degree of accuracy the risk because it is central to their agreement to enter into the contract
- **Insured is required to be completely honest, forthright and forthcoming in providing insurer with information relevant to coverage**
- **Very heavy duty**
    - Holds insured responsible for **OMISSIONS** (failure to reveal information) and **COMMISSIONS** (misrepresentations)
    - **Intent to mislead the insurer NOT required**

- **A breach of this duty means that the contract was not properly FORMED**

Parameters of the Insured's Duty to Disclose

Common Law principles arose in ***Carter v Boehm*** **(1766) 97 ER 1162 (KB)**

Carter v Boehm **(1766 Eng KB)**

- **Facts:** Carter took out indemnity insurance against their Fort being taken over by "foreign entity." Made claim against policy, insurer denied it. Stated that he declined to inform them that the Fort ***was not built properly to withstand enemy attack*** and ***that he had anticipation of a French attack*** (new that a claim was likely)
- **Issue:** Do common law contract principles apply for duty to disclose or is something **more** required for insurance?
- **Decision:** Special duty to disclose in the case of insurance contracts; Court held that Carter had no duty to disclose as the formation of the Fort was **irrelevant** to whether there would be an attack **(**professor thinks this is questionable**)** and that his anticipation of a French attack was mere speculation/opinion with no factual basis
- **Reasoning:**
    - the special nature of insurance contracts & duty of utmost good faith requires strict obligations for duty of disclosure: ***every material fact must be disclosed regardless of intention***
    - Because the assessment of risk is based upon information provided by the insured and because the insurer relies on the insured to provide this info, **the insured entering into a insurance contract owes an absolute duty to an insurer to fully disclose all material facts within the insured's knowledge**
        - requires the insured to disclose info which the insured knows or ought to know, ***even if the insured does not realize it is material to the insurance contract***
    - **BUT** insured doesn't have to disclosure
        - things the underwriter knows
        - things the underwriter *ought* to know
        - what the underwriter takes upon himself to know
        - what the underwriter waives obtaining knowledge about
        - or what impacts the degree of risk
    - at CL, non-disclosure by insured is *deemed* to be fraudulent (insurer does NOT have to prove intent)
        - *one reason why court did this is because of the difficulties in proving fraud: since insured obtains a significant benefit from policies you shouldn't burden companies by requiring proof of fraud*
    - court also ***suggests*** that the duty
        - only exists until the contract is formed ("at the time the policy was underwritten")
        - applies only to facts *not opinions* (**seems like a dumb distinction in this case…)**
- **Ratio:** Insured required to disclose **every material fact that the insured knows or ought to know, even if they don't realize it is material to the contract;** failure to do so will be deemed fraudulent, regardless of insured's intention; however insured does **not have to disclose** info they don't know or which the insured reasonably ought to know
- **Commentary:**
    - Doesn't matter why the insurer did not hear about a particular fact; if the insurer has calculated risks on wrong facts, then the contract that exists is not the contract that was intended, and this is voidable. We are concerned with FACTS, not opinions.
    - Leaves two questions unanswered
        - 1) What is a "material fact"?

- 2) What is a fact "within the insured's knowledge"?

Material Fact

- Duty to disclose applies only to facts that are **material** to the contract
    - not all facts are relevant, including those based on opinion or what insured thinks the likelihood of loss is
- Common Law definition of material fact comes from ***Mutual Life Ins. Co. v. Ont. Metal Prod*. [1925 PC]**
    - **Common law test**: a fact is material if it would cause a ***reasonable*** insurer to refuse coverage or to charge you a higher premium
    - **Doesn't matter what insured thinks is material**: applicant shouldn't be making judgment calls about questions asked
- since IC assesses risk factors at start, **it does NOT matter what ultimately leads to the loss**: **can be unrelated to material fact not disclosed**
    - ex. material fact not disclosed was existence of fireplace in home but property actually destroyed by arson **--> doesn't matter**

***Mutual Life Insurance Co. v. Ontario Metal Products* [1925 PC]**

- **Facts:** S obtains life insurance with OMP as beneficiary; application asks him to list every doctor who has treated him during period but he fails to list doctor who made a house call for his wife and ended up giving *him* tonic injections; **S had no intention to mislead but didn't consider it to be treatment as he wasn't the one who sought the help** of the doctor; contract itself said inaccurate statement *wouldn't* void policy unless it wasn't material; Ultimately died of an unrelated cause
- **Issue:** Is it "**material"** that he failed to disclose the treatment?
- **Decision:** No the injections were not material facts because if they had been disclosed, they would not have impacted the insurer's decision to enter into the insurance or the terms agreed upon; therefore no breach of S's duty of disclosure
- **Reasoning**
    - It is not what a reasonable insured would have considered material, instead 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 information requested by the insurer
    - **Test for whether something constitutes a material fact = Reasonable Insurer Test**
        - **Whether if the matters concealed or misrepresented had been truly disclosed, they would, on a fair consideration of the evidence, have influenced a reasonable insurer to decline the risk or to have stipulated for a higher premium.**
            - **WOULD HAVE TURNED THEM DOWN OR CHARGED MORE**
            - **THUS: if it premium decreases, stays the same, or formation of the contract is merely delayed then non-disclosure is not material**
    - in this case, key was that insurer produced its own medical doctor as a witness who said that had he have known this fact, he still would have recommended S as a candidate under contract
        - *not to say this will always be enough to establish what a reasonable insurer would do - just enough based on the circumstances of THIS case*
    - **NOT** concerned with whether fact misrepresented caused the loss: **don't need to draw link**
    - discussion of warranty: court discusses situations where contract guaranteed everything the insured said; under statute this isn't allowed in insurance as this could get around material fact test

- **Ratio:** determination of material fact depends on whether if the matters concealed or misrepresented had been truly disclosed, they would, on a fair consideration of the evidence, have influenced a reasonable insurer to decline the risk or to have stipulated for a higher premium.
- **Commentary:** Reasonable Insurer Test also referred to as the Decisive Influence Test (***Pan Atlantic Insurance v Pine Top Ins*urance [1994 HL] at para. 7)**

Reasonable Insurer Test

- This is and was an attempt to create an objective test, because it:
    - 1) Requires a court to view non-disclosure through the eyes of a reasonable and prudent insurer, not the actual insurer; and
    - 2) Provides clear criteria for determining whether non-disclosure was critical to formation of the contract (ie. Coverage would be refused or the premium would have been higher)
        - reasonable, prudent insurer would have declined coverage or increased premium
- Non-Disclosed information is **not material** if it would have:
    - Resulted in a ***decreased*** premium;
    - Had **no affect on the premium** or **decision to provide coverage**; OR
    - Merely **delayed** the formation of the contract.
- Pursuant to this test, the time for assessing materiality **is at the formation of the contract**
- At common law, the relationship between the subject of the non-disclosure and the cause of the loss claimed is **NOT IMPORTANT**
    - E.g. Failure to disclose that you were taking blood pressure medication and you died by being hit by a car is irrelevant. Would the premium have been higher at the time of contract formation if you had disclosed the information? If so, then you had a duty to disclose that.
    - If the insurer asks "What meds are you taking," you say none, but you really are, for blood pressure. If you told them this, you would have had higher premiums. This is a failure to disclose risk. If you die from a car accident, they can still say breach of disclosure, even if they are unrelated.
    - At common law, if you didn't know you were going to be on medication, and the next day, after getting insurance, you found out you had to take meds, common law didn't treat this differently. However, this has been changed in statute, we will discuss this later.

What is fact "within the insured's knowledge"

- The Insured's obligation to disclose applies only to facts which the insured knows OR WHICH THE INSURED REASONABLY OUGHT TO KNOW.
    - The insured can be completely unaware that it is important that the insurer knows a fact, but they still should do it. Was a case in NB that said that if the insurer did not reasonably know that something was relevant (insured has appreciation that they need to know, or insurer tells them they need to know), they don't have a duty to disclose that (contrary to the rest of the law in Canada). Interesting to see if this goes to the SCC and what the ruling would be.
    - Very difficult to know all the things that insurance companies use to determine premiums.
- The duty of the insured is limited by the knowledge of the Insurer. No duty to disclose facts:
    - Already known to the Insurer;
    - Matters of common knowledge/general facts related to the nature of the insured risk; and
    - Matters of which the insurer has waived knowledge or undertaken to find out by other means;
- What knowledge are you entitled to assume the insured has? When can it be presumed that the insured ought to know something?
    - p. 129 of casebook: recently ON courts have taken insurer's obligation to ask for material facts even further by holding that an insurer breaches its duty of good faith by failing to ask as the

insured for particular information and then later denying coverage on the basis that the information was not disclosed by the insured

- still law is not very clear in identifying the extent of knowledge which an insurer is reasonably expected to have and, more particularly, the extent of information the insurer is obliged to search for or investigate material facts beyond the information supplied by the insured

Canadian Indemnity Co. v. Canadian Johns-Mannville Co **[1990 SCC]**

- SCC :The presumed knowledge of an IC **includes matters known by the general public** and **"facts available and customary or well-known in the filed which it insures"**
- Insurer is presumed to have the knowledge of a "reasonably competent insurer". No requirement beyond that.
    - *completely different from what happens in *Taku…**

Taku Air v. Coronation **[1991 SCC] **goes the opposite way of *Johns-Mannville***

- **facts:** Taku asked about accident history and seating configuration in plane, misrepresented both. There was another accident; Coronation said they shouldn't have to pay; Taku argued there was no duty to disclose problem, because Taku used to have a policy w/Coronation before switching to another insurance co (and then back) and they had all the necessary information on file - if they really wanted to check they could have. **CHECK TIME DIFFERENCE**
- **Issue:** Did Taku breach the duty to disclose?
- **Decision {unanimous}:** Yes- SCC concluded that the contract was void due to Taku's failure to disclose **the accurate seating configurations**, a fact solely within Taku's knowledge; therefore, no coverage
    - **Seating Arrangement** was breach of duty to disclose
    - **Accident Record -** IC presumed to know, had it on file
    - **Ultimately contract is voidable because of seating arrangement**
- **Reasoning {OBITUR –** commented on the incomplete disclosure of the accident record}
    - 4/7 judges – insured had not breached the duty of disclosure **re: accident data** was available to the insurer by other means {**STUDY GROUP - clarify)**
        - where insurance coverage is statutorily required for the benefit of innocent third persons, a reasonable incremental change should be made to the common law to **limit the insured's duty of disclosure by imposing an obligation on an insurer to obtain, by due diligence, material information available from sources other than the insured**.
        - insurer failed to meet due diligence, and accordingly could not complain of insured's failure to disclose accurate accident record.
        - Insurer was "presumed to know" because a reasonably competent underwriter working in aviation would know Taku's accident record.
    - 3/7 judges – **insurer has no obligation to inform himself of Taku's record**
        - Any change to the common law duty of disclosure should be left to the legislature; and
        - The insured breached its duty to accurately disclose its accident history
        - **why are we placing an obligation on IC to *double check* applicant's answers?** probably has to do with fact that coverage was for innocent third parties….
- **Commentary:** In cases where the coverage is in place for the benefit of third parties, SCC suggests that the common law has changed and requires the insurer to do their due diligence to obtain material information available from other sources other than the insured.
    - ***policy for benefit of third parties - don't want to IC to be able to void contract and screw over innocent passenger***

- Prof thinks they didn't need to do this shift from the common law (which is obiter, so it's not really binding), since they could have just said that the insurer should have known because a reasonably competent underwriter would know the accident record.
    - What about driving tickets?

Sagl v. Cosburn, Griffith and Branham Insurance Brokers **(Ont CA 2008/2009)** **takes insurer's obligation of due diligence *even further***

- **Held:** an insurer breaches its duty of good faith by **failing to ASK the Insured for particular information**, and then later denying because that information was not disclosed.
    - "If they never asked you for your driving record, they can't say there was a breach of disclosure of you not providing your driving record"
    - Limited to Ontario right now – Prof doesn't know if this will ever be followed in AB

THREE Options for the insurer in discovering a breach

- 1) **Repudiate** the contract (**voidable** contract at instance of the insurer);
- 2) Treat the contract as **valid and subsisting** despite the breach;
- 3) Treat the contract as valid despite the breach, but **cancel** the contract:
    - Unilaterally (pursuant to the statutory provisions); or
    - By mutual agreement.
- If there were premiums involved, these half to be paid back for voidable contracts (where voiding is chosen), but if cancelled, don't have to.
- *GO OVER WHEN CHOOSE TO CANCEL, WHEN CHOOSE TO VOID*
    - IC should cancel contract when insured hasn't suffered any losses (no money has been paid out)
    - IC should void contract when money has been paid out - both parties are entitled to be put in the position they started in
- **note**: Breach of duty of utmost good faith will/can generate punitive damages (see ***Andrusiw v. Aetna***)

The IC's ability to void the contract is subject to:

- Any **obligation owed by the INSURER to a third party** (ie: mortgage clause);
- The insurer must **refund the premiums from the date of the breach**; and
    - Some case law says they don't have to return premiums, even if repudiating, if the duty breach was fraudulent
- The insurer must **advise the insured of his decision to repudiate**
- **Note:** Insurer can be estopped from repudiating (voidable contract) if they know about it and don't do anything within the year.

Andrusiw v. Aetna **[2001 ABQB]**

- Fraud in claiming disability benefits
- Decision: Breach of duty of good faith (not duty of disclosure), punitive damages awarded to insurer
    - Punitive damages could potentially we awarded against insured for fraudulent breaches of duty to disclose – have not done so yet.

Proof of Breach of Insured's Obligation to Disclose

Henwood v. The Prudential **[1967 SCC]** **how to prove an disclosed fact is material**

- **Facts:** Very thin, frail woman. Emotional crisis 2 years earlier due to religious differences with fiance, broke up. Went to psychiatrists, got meds, returned to normal. Decided to take out insurance 3

months after going back to normal (no more depression). Question asked on sheet was whether she had visited physician in last 5 years. She said yes, but didn't count seeing a doctor about her mental condition. Died later a car accident. Insurer said breach of disclosure; In this case a senior officer of the IC, who was also a medical doctor, testified that if the true information about the Applicant's medical history had been available, the premium would have been much higher.

- **Issue:** is it sufficient to accept the Insurance company's own evidence as what the reasonable insurer would have done when determining whether it is a material fact?
- **Decision:** Majority held that in the **absence of evidence to suggest that any other insurer would have thought differently**, they will **ascribe** the conduct of *this insurer to the reasonable insurer*
    - ~ *kind of like a reverse onus:* insured would have to find other IC who have disagreed
- **Reasoning:**
    - since there was no contrary evidence raised re: reasonability of qualified doctors position, the court accepted this as an adequate representation of the reasonable insurer's position
    - however, court made it clear that IC is not relieved of burden of proving practice of other insurers in most cases **simply due to absence of alternative evidence** – ultimately court considers what is reasonable
- **Ratio:** if there is no evidence to the contrary raised, a court may accept the evidence of a reasonably qualified doctor employed by the insurance company as a representation of the reasonable insurer's position
    - ***In effect, allows the court to decide on case-by-case basis whether their evidence is enough. Still, best for insurers not to take a chance and raise both subjective & objective evidence***
- **Commentary (dissent):** can't sufficiently prove objective evidence by leading subjective testimony, need positive evidence of what other insurance companies would do – in this case it wasn't sufficient as only called physicians who worked for company who explicitly testified that they wouldn't know what other insurers would do
    - onus of establishing the misrepresentation AND the MATERIALITY of the facts is on the insurer.
    - The insurer had admitted they were unaware of the practices of other insurers.
    - Therefore, the Insurer's practices could not be equated to the reasonable insurer.

Modification of the Common Law By Statute

- Parts of the test that are often changed by statute: (inter alia)
    - When can an insurer void a contract for breach of a duty to disclose?
    - Who is bound by the duty to disclose?
        - Largely arises in life insurance cases
    - What intent is relevant?
        - Intent element has been modified in almost every case by statute
    - At what point is disclosure required?
        - Case law seems to suggest that the only point that is relevant is when the contract is formed. But what about if the day after the contract was formed, someone took medication? At Common Law, would not have to disclose, but the statute has changed that a little bit.

2. Property Insurance: Misdescription, Non-Disclosure, Misrepresentation & Changes Material to the Risk {3 Instances Where Property Insurance is Void}

Property Loss/Fire Insurance

- **When can an insurer void a contract for breach of a duty to disclose?**

- **s. 540 IAA - SC 1 and 4**
    - An insured can only repudiate the part of the contract (the property insured) relevant to the misrepresentation.
    - E.g. Someone misrepresented materials that comprise the house, and then there was a theft and the representation was material to whether the house would catch fire. **You can ONLY void the portion of the insurance that relates to that misrepresentation** **{**Especially important for multi-peril policies - can only void limited part of contract that contains that misrepresentation)
- **What intent is relevant?**
    - **s. 540 IAA - SC 1**
        - If any person applying for insurance **falsely describes** the property to the prejudice of the insurer, or **misrepresents or fraudulently omits** to communicate any circumstance which is material to be made known to the insurer in order to enable it to judge of the risk to be undertaken the contract shall be void as to any property in relation to which the misrepresentation or omission is material.
    - ***Taylor v. London Assurance Corp*. [1935 SCC]**

(i) Property insurance policy is void if insured falsely describes the property; misrepresents a material circumstance; or if the insured fraudulently omits a material circumstance [IAA s. 540 SC 1]

- since it is a SC, it must be in the contract however IC can always ignore the breach (really means that the insurance is voidable if the IC enforces this provision otherwise nothing happens simply based on misrepresentation)
- insurance company must prove the breach if they will rely on it
- **Cases on Material Misrepresentation versus Fraudulent Non-disclosures**
    - show that requirements for proving misrepresentation or fraudulent non-disclosure under SC 1 are separate things so IC should be careful which they try to rely on to deny coverage
    - may be better to argue non-disclosure in both ways as although almost every non-disclosure can be characterized as a material misrepresentation, you don't want to leave yourself with just 1 argument
    - to rely on fraudulent non-disclosure, the insurer must prove fraud (actual intention to mislead)
    - for a misrepresentation, the insurer **doesn't have to prove intention** but must prove materiality
    - for an omission, **have to prove fraudulent intent**
        - if you can't prove omissions was done fraudulently, can't void (***Taylor*)**

Taylor v London Assurance Corp* [1935 SCC] **omissions*

- **Facts**: Forest fires in area, Mrs T phoned insurer to request fire insurance. Insurance person asked if there were any fires, she said yes, all over the country. Failed to tell them there was a fire in the next county, ***but she didn't know that there was a fire in the next county***. Got insurance, ended up being fire and demolished the house.
- **Issue:** what intent is relevant under the Insurance Act?
- **Decision/Ratio**: Insurance Act alters the common law - insured is only culpable for non-disclosure **IF the information was withheld PURPOSEFULLY -** insured not culpable here
- **Reasoning:**
    - If you fail to tell the insurer something, it alters the common law so that ONLY voids the contract if the omission was made fraudulently.

- This section in the Insurance Act DOES change the common law – requires purpose and intention for omissions.
- **But did <u>not</u> say if fraudulent intention requires applies to <u>*misrepresentations*</u>**
    - This is determined in ***Bowes***
- Narrows the common law duty in the required intention.

Bowes v. Fire Insurance of Canada* (1936 ONSC) **misrepresentation*

- **Facts:** P was manufacturer of trophies & shields who obtains business fire insurance policy from D; question on application asked about previous coverage and **insured disclosed all previous policies had expired** - **in actuality the policies previously existing were cancelled by the ICs as the insured didn't pay the premiums**; P indicated that **'metal patterns'** must be covered however these were **actually molds made of wood & plastic (more flammable)**; insurer denied coverage due to 2 material misrepresentations: (i) previous policy was cancelled; (ii) metal patterns; insured argued it wasn't his intent to mislead .
- **Issue:** What is the relevance of an insured's intent in a misrepresentation?
- **Decision/Ratio: Intent not relevant to a misrepresentation.** 'Fraudulent' requirement from SC 1 only applies for an omission, not required for a misrepresentation. Insurer can deny coverage based on a misrepresentation *without having to prove any intention to mislead* - simply needs to prove inaccuracy in information relied upon by insurance company to determine premium and coverage
- **Reasoning:**
    - court concludes misrepresentation doesn't have to be intentionally fraudulent but simply material: <u>the reasonable insurer would have increased premiums or denied the risk</u>
    - court is careful in saying that materiality must be weighed on a case-by-case basis
    - on the facts of this case, both misrepresentations were material
- **Commentary:**
    - The duty on the insured is different depending on how you categorize:
        - **For misrepresentation = same as common law**
        - **For Omissions = Common Law has been modified - "fraudulent" intent required**
    - Biggest problem to tell what is an omission and what is a misrepresentation.

(ii) Contract rendered void if the insured fails to promptly notify the insurer of <u>any change material to the risk</u> which is within knowledge & control of the insured [IAA s. 540 SC 4]

<u>At what point is disclosure required?</u>

- **s. 540 IAA, SC 4**
- Insured must report:
    - Change in facts
    - Known or reasonably ought to be known to the insured
    - Within the insured's control: either brought about by the insured OR could have been prevented by insured
    - Which could cause a reasonable insurer to refuse to issue coverage or increase the premium; and
- Where there's a failure to uphold this duty and the loss occurs later, the IC can void the contract back to the date of material change this means that the IC must cover any loss prior to the date of the material change but none after this so long as premiums are refunded
- **critical question:** when the material change occurred

- no requirement for the change to be causally related to the cause of loss
- Two things Insurance Company can do if it finds out about failure to notify about material change prior to loss:
    - void the contract in accordance with statutory termination OR
    - raise the premiums
- **knowledge** is not necessarily an addition to the common law duty of disclosure as this duty only applies to things the insured knows about anyways, element of '**control**' is the key requirement
- Note: condition in insurance contract is not binding upon insured if held "**unjust or unreasonable by the court before which a question relating thereto is tried**" – see **s. 545 IAA**
- SC says that after formation there is an ongoing continual duty to promptly notify of any changes material to risk in knowledge and control of the insured
    - insurance company must prove the breach to rely on it
    - where there's a failure to uphold this duty and the loss occurs later, the IC can void the contract back to the date of material change this means that the IC must cover any loss prior to the date of the material change but none after this so long as premiums are refunded
    - **critical question tends to be when the material change occurred**
    - no requirement for the change to be causally related to the cause of loss
    - 2 things IC can do if it finds out about failure to notify about material change prior to loss: void the contract in accordance with statutory termination or raise the premiums
    - knowledge is not necessarily an addition to the common law duty of disclosure as this duty only applies to things the insured knows about anyways, element of 'control' is the key requirement
    - **2 Cases Dealing with 'Knowledge & Control'**

Nahayowski v. Pearl Assurance **(1964 ABSC)**

- **facts:** N bought policy on his store from P; policy had a term that said if the building is vacant for more than 30 consecutive days there is no coverage (common clause as empty buildings more at risk); N sells the store but agreement for sale says he remains owner until all payments are made & that purchaser will be a tenant in the building in the meantime; if purchaser defaults then N can terminate the tenancy; purchaser defaults & N brings an action to cancel the agreement; tenants leave in March/April making premises sit empty; N boarded broken windows in June/July but otherwise didn't go to property; Fire in August; The Insurer denied on two basis: **(1) The Plaintiff had breached her continuing duty to disclose a change material to the risk, by failing to disclose that the property was vacant and (2) There was an exclusion for property "vacant" for more than 30 days.** P argued that SC 4 required that the P have "control and knowledge" over the change material to the risk, and that the P in this case had no control over the purchaser's decision to move out of the premises
- **issue:** whether the vacancy was within the "control" of the P, **which would go to the duty to disclose material change in risk?**
- **decision:** P had both control and knowledge of the change material to the risk. Therefore, Plaintiff was in breach of her duty to disclose a change material to the risk - no coverage
- **reasoning**
    - ample evidence that vacancy was in the control of the insured:
        - made arrangement to board up the windows
        - could have taken possession at any time as tenant was gone & no one would interfere
        - could have proceeded with action & gotten possession order
        - agreement for sale allows insured to take over premise upon default

- key was that property was unoccupied due to abandonment
- = ultimately had control and the legal & actual ability to take over the premise

- court also considered vacancy term in relation to unreasonability provision: said it wasn't unreasonable to deny coverage for vacancy as this impacts risk however this is a case-by-case conclusion that depends on circumstances

- **ratio:**
- **Commentary:** factual evidence as to her ability to 'control differentiates this case from *Watkins*

***Cody v Beaver Insurance* (1964 ABCA)**
- **Vacancy** = no inanimate objects in the premises
- **Unoccupied** = no people in the premises

***Watkins v. Portage La Prairie Mutual Insurance Company* (1986 BCCA)**
- **Facts:** P owned house leased to tenant who was an alcoholic prone to violence; she issued a notice to vacate then the next day she goes to insurance company to buy house insurance; claims she told the insurer that there was a tenant who had been told to leave; **insurer claims there was no reference to the tenant**; tenant doesn't leave until over 1 month later; **once tenant leaves the P finds out $30,000 of fixtures & possessions were missing so claims for theft**; insurer argued that P had control over material change to risk (ie. tenant staying) because she had the legal right to apply for an order of termination or court order for possession or simply could have physical removed the tenant; **furthermore, even if possession was outside of her control, she still had an obligation to notify the insurer that tenant failed to vacate due to common law duty to notify insurer of any material change even if not in control**; P argued that she had knowledge of change material to risk but no control; The Trial Court dismissed P's claim - found that the P's failure to notify the insurer that she could not take possession as contemplated was a breach of the duty to disclose of a material nature.
- **Issue:** was the tenant's behaviour was within the "control" of the P, **which would go to the duty to disclose material change in risk?**
- **decision:** No. She had knowledge but not control. SC 4 makes it clear that insured must have both to make out breach. **Ability to apply for order of termination is not sufficient for control**
- **Reasoning:**
  - **Control in this case, means actual physical control, legal means not enough** (**seems like legal was sufficient in the last case**)
    - fact that she had the right to apply to court for order of termination & possession isn't sufficient control of the risk as she had tried to get him to leave on many occasions and based on history of assaults
  - different from last case as court considered **legal abilities** to evict someone but this was keeping in mind that the building was unoccupied so she could just move in

(iii) Any other term/condition that the insurance company might insert into the contract about a material circumstance is not binding if the court thinks it is unjust & unreasonable [IAA s. 545]

- Any other term/condition that the insurance company might insert into the contract about a material circumstance is not binding if the court thinks it is unjust & unreasonable [**IAA s. 545**]
  - **IAA s. 545** – condition in insurance contract is not binding upon insured if held unjust or unreasonable by the court before which a question relating thereto is tried.
- **Example**: insurance company insures vehicle but has term you can't drive more than 5 blocks from house – this would be unreasonable so court would say it isn't binding

    - This provision operates as a defence for the insured: can't be bound to this term as it is unreasonable; up to the insured to prove unreasonableness
- **Example**: insurance company insures vehicle but has term you can't drive more than 5 blocks from house – this would be unreasonable so court would say it isn't binding
    - this provision operates as a defence for the insured: can't be bound to this term as it is unreasonable; up to the insured to prove unreasonableness

***Marche v. Halifax Ins Co* [2005 SCC]**

- **Facts:** Insured's purchased a home on Cape Breton, NS and it converted into two apartments, insured under fire insurance policy. For a period of 4 months, left house empty while going to BC to find work. While they were in BC, one of the insured brothers moved into the property. 1 month later, he was behind in rent, refused to vacate. Disconnected water and electricity to get him out. 1 month later, he vacated, but he left his stuff behind. Shortly after that, house lit on fire. **IC denies coverage on the basis that the four month vacancy constituted a change material to the risk that they were not told about** (which was a breach of Nova Scotia's SC #4). **Insured argued that it was unreasonable to apply SC 4 to this situation because vacancy didn't contribute to the event, they didn't know they had to report it, and the temporary vacancy had been rectified with a renter** (brother).
- **Issues**: (i) does this unreasonability provision even apply to SC 4? (ii) if so, does SC 4 apply to a breach that has been rectified (outside of unreasonability considerations) (iii) if the reasonability applies to SC 4, what would be the result?
- **Decision:** 5/7 (McLauchlin J.) – ruled in favor of insureds. The unreasonability provision relieved the insured of the breach because the vacancy was not causally related to the loss IN COMBINATION with the fact that it had been rectified prior to the loss. (suggested one alone not enough..)
- **Reasoning:**
    - (i) Would unreasonability provision apply to SC 4?
        - **YES -** difference between saying a condition is unreasonable and it being unreasonable when applied to these facts
        - it is reasonable to do the latter because it corresponds with remedial objectives of the provision but not the latter because the legislature would never want mandatory conditions it requires to be considered unreasonable
        - court can grant relief under unreasonability provision where application of statutory provision produces unjust or unreasonable results
        - note: Very little discussion on why in this case the reasonable condition was unreasonable in this situation….
    - (ii) Does SC 4 apply to breach that has been rectified?
        - Insured argued that prior vacancy shouldn't disallow their claim for coverage as there is no concrete evidence linking it to the fire and the contract doesn't auto cease to exist due to change, to do so where it has been rectified would be unreasonable
        - insurer argued that lack of notification of change cost it an opportunity to cancel the contract prior to the loss & it is not essential for the breach to be causally connected to the loss
        - majority unsure whether SC was meant to apply in this situation: **left issue to be resolved in later case or by legislature**
        - in this case it was said that SC 4 can't be relied upon b/c it would be unreasonable to apply it in situation like this where change was rectified and loss had nothing to do with the change (unrelated to vacancy)
- **Ratio:** The unreasonability provision should be read to apply not only to contractual provisions that are unjust/unreasonable on their face, <u>but also to statutory conditions that are prima facie reasonable</u>, **<u>but lead to unreasonable/unjust results</u>** when applied to particular cases

- **Commentary (Dissent)**: stresses legal policy rather than individual facts
    - s. 171(b) cannot apply to statutory conditions: can not use one section of the IA to negate another
    - Insureds had breached SC 4 – did not advise insurer of vacancy to property
    - Insureds had a duty to report a change material to the risk – it is not unfair where the change is unrelated to the loss because the purpose of the obligation is to assist the insurer, who had NO CHOICE but to rely for its risk assessment on information provided by the insured
    - Ignorance of the obligation to disclose (which insured ought to have known) or failure to appreciate its materiality will not excuse the insured.
    - Nothing in the SC that is unreasonable because duty to disclose is a strict duty unrelated to cause of loss
- **Prof thinks this majority decision is very results orientation and thinks that the dissent makes a lot more sense.**
    - case created uncertainty re: in what circumstances a court analyzes reasonability of SC – opens the door for insured who violate SC that is unreasonable to be held to the statutory condition
    - essentially an example of court bending over backwards to help the insured: suggests unpredictability of insurance law

3. Auto Insurance: Non-Disclosure, Misrepresentation and Changes Material to the Risk (Three Instances Where Insured's CLAIM is Invalid)

Duty of Disclosure

- duty to disclose arises at the time the contract is formed
- common auto non-disclosure problem is where owner of vehicle tries to register it under *someone else's name* in order to pay lower premiums (this is also an insurable interest problem)
- statute changes common law duty to disclose because at common law any failure to disclose/misrepresentation renders the contract void: this section explicitly states that it is only the insured's claim under the contract that is invalid and the right to be indemnified forfeited
    - **hence, auto is unique because contract itself continues in place** (due to legislature's concerns about people not having insurance) **but claims prior to loss are forfeited**: key difference significant because they don't have to pay for the loss however once they find out the info, they must pay for any subsequent losses
    - **SO in the context of auto, the failure to disclose and report material changes only affects the CLAIM but not automatically the contract as a whole**
- ****IAA s. 554****
    - Breach of Duty renders the insured's claim under the policy invalid and the insured forfeits its own right to recovery, but there is no right of repudiation.
    - IOW, insured's claim under contract is invalid and the right of the insured to recover indemnity forfeited if the insured gives inaccurate info

i) Gives false particulars to the prejudice of the insurer (IAA s. 554 (1) (a)(i))

- Does not contain any intention – but does limit this to being a breach only in cases where the false particulars **prejudice the insurer**.
- Another way to describe the material fact test [see ***Merritt***]: must be one that the insurer would have increased the premium or refused the contract
- Need proof that the insurance company is actually prejudiced/actually cares about this information

Merritt v Merit Insurance **(1963 ABSC)**

- **Facts:** P was buying policies on 11 vehicles, including 2 Mack trucks; IC asked for descriptions & serial numbers of all insured vehicles but P misdescribes truck by giving serial numbers based on the wrong year of one of the trucks - was actually a 1956 model but ended up paying more expensive premiums based on fact that IC thought it was a newer truck; when truck damaged in accident, IC denies claim as truck wasn't described properly in policy;
- **Issue:** Was the incorrect serial number to the detriment of the insurer?
- **Decision:** Court concluded no – IC had admitted that they really paid no attention to the year of the truck, so that did not act to the prejudice of the insurer – in this case – only to the detriment of the insured with higher premium.
- **Reasoning**
    - The insured insured two Mack trucks– the insurer clearly knew which one the 1955 one was – they paid out a claim on it.
    - The second one was the second Mack truck. They had all the information they needed that might have affected their risk, including the amount of the liens and the lien holders in respect of those liens.
    - **The S/N error was not prejudicial to the insurer, and the court found coverage**
    - Rejected that there was a material misdescription in the application as it was only a partial mistake that didn't affect whether the truck was insured or prejudice the insurer: **{when determining whether misrepresentation is *prejudicial}***
        - (i) calculation of premiums based on year given were actually higher than it would have been if correct year given so it actually benefitted the insurance company
        - (ii) inaccurate year didn't prejudice the insurer as they don't even use this info to identify the vehicle
        - (iii) serial number makes no difference to the insurer for premiums but it does for identification: either way the parties knew what they were insuring under the policy and the error didn't mislead the company so there was no prejudice
        - (iv) truck had a lien which was accurately quoted {goes to accurate calculation of premiums}
            - this is an important fact because if it was for a larger amount or with a company the insurer doesn't like, it would have been an item material the risk
    - ****note: fact that there was a first truck that was properly described was really important in this case****
        - because then they prove how much the premiums would have been
- **Ratio:** case shows how 'false particulars' operates similarly to the material fact test as you are looking at the **impact of the false information in terms of the loss: 'false particulars' must operate to the *prejudice* of the IC to invalidate insured's claim**

(ii) Knowingly misrepresent any fact that is asked for in the application (IAA s. 554 (1) (a)(ii))

- The insured breaches a duty to disclose if he "**knowingly misrepresents or fails to disclose**" information requested on the application form
- If you have knowingly misrepresented any facts, **these facts are deemed to be material** and the insurance company does not have to prove it impacted their decision to give you insurance in any way

Sleigh v. Stevenson **[1943 ONCA] **what intent is necessary?****

- **Facts:** son tells agent that his mom is the owner of a vehicle when it is actually his; mom signs the form which states she is the owner *without reading it*; IC later denies claim, saying insured (mom) knowingly misrepresented material facts; insured argued that she didn't knowingly misrepresent because she didn't read the completed form
- **Issue:** what is meant by "knowingly" misrepresents? Do you have to *knowingly* try to mislead the IC or simply know that the factual information is incorrect?
- **Decision:** the insured could not avoid her disclosure duty by relying on her own failure to read the completed application form
- **Reasoning:**
    - ON Insurance Act had provision similar to our **s. 554 IAA**
    - **Court held that misrepresentation was made 'knowingly'** – person who signed the application form was aware of the true facts, had she read what was on the form she would have been aware it wasn't accurate
    - **'Knowingly'** means that the person is in possession of info that is untrue or doesn't disclose the truth
    - **No requirement for intention to mislead**: simply need an awareness that the info isn't true
    - The fact she didn't read it is irrelevant as she had a chance: once she signs it the court is unwilling to determine whether or not she actually read it because she had the opportunity to do so her signature was authenticating
- **Ratio:** no intention to mislead - just need to know that information is not true.

***Moxness v. Cooperative Casualty Co*. [1979 ABSC] **AB case that goes the other way {because of the assurances of the agent}**

- **Facts:** P was buying a new car, and had no prior insurance. Salesman put P in touch with local agent, reaching him by phone at home. Agent asked about P's age, residence, etc. and then asked him about **accidents in past three years and driving record**; The papers he had signed had not revealed his car's 1968 accident (though he hadn't been driving) or all his *HTA* offences (couldn't remember details - agent assured him they would get info from MVA) and his license suspension; P is involved in MVA and injures 3rd party who successfully sues him so P wants to be indemnified by insurer; insurer denies claim and argues that communication of true facts related to driving record would've influenced its acceptance of risk
- **issue**: Is the insured responsible for **knowingly misrepresenting** the info because he signed the application form that contained the wrong info ***even though he didn't read it***?
- **Decision:** No
- **Reasoning**
    - Court goes back to fact that duty to disclose is one of utmost good faith so the question becomes one of whether the insured acted in bad faith not in this case because he gave all the info he knew
        - **only bound by his signature to the info he actually knew**: since insured disclosed everything it knew to the insurer and was clear in telling them about the info he didn't know (ie. tickets), then the insurance company can't rely on this as a non-disclosure
    - **Held that P had "innocently" misrepresented the facts because he did not recall the dates of his tickets and said so**, and was then assured by the agent that the same was unnecessary as they'd be checking it with the MV Branch in Edmonton
        - P entitled to rely upon the agent's representation that his driving records would be checked with the MV Branch in Edmonton - Insurer had undertaken to get this info by some other means than from the insurer, and therefore, were unable to rely upon the omission of the insured.

- Targeting back to the common law duty. Duty to disclose is limited by the knowledge of the insured and when they undertake to determine the knowledge by other means, you are relieved of your duty in that respect to disclose.

- **Ratio:** "knowingly" misrepresents implies *bad faith* - if insured gives all the information they can recall, but misses something, it can be considered an "innocent misrepresentation" incapable of invalidating prior claims
- **Commentary:** case is different from ***Sleigh v Stevenson***: this case suggests that while signature on the application form is **necessary** for the insurance company to rely on a misrepresentation, **it isn't sufficient to deny clam**
    - **court must be satisfied the insured knew facts different from what was stated on the application**
    - here insured might not have read the form but *even if the info re: the tickets was on the form*, they wouldn't have known if it was correct or inaccurate so the signature wouldn't be binding on these answers
    - additional waiver component not addressed in case: IC essentially took it on themselves to find out info
    - Prof guesses that the volunteered undertaking is what makes this case different from the previous one...

iii) Ongoing to duty to disclose material changes (IAA s. 556 SC 1)

At what point is disclosure required?

- **Ongoing Duty to Disclose Material Changes [IAA s. 556 SC 1]**: once an insurance contract is in effect, the insured has a duty to disclose any change material to the risk within the insured's knowledge (different from property provision as no reference to 'control')
    - statute specifically states that a material change includes certain things like changes to insurable interest of the vehicle, damage to the car, someone else taking a financial interest to the vehicle, purchasing additional insurance on the vehicle, etc (this list isn't exclusive but only provides specific examples deemed to be material changes)
    - in actuality, they are still within the broader scope of the material fact test anyways
    - Requires an insured to report "**any change in the risk material to the contract and within his knowledge".**

Thompson v. Allianz Insurance Co of Canada (1996) **[1998 ABCA)**

- **Facts**: B sells car to T in exchange for cows (argument there is no insurable interest due to this exchange, rejected by the court); T obtains an owner's policy; T lends B the truck saying he will pick it up when visits next & gives him permission to drive the vehicle to/from work; **B becomes regular driver in different town for 1 - 2 month window**; B gets into MVA; IC denied coverage arguing that B's possession and use of vehicle as primary driver was a change material to the risk which was unreported by T; **T was older man with poor driving record and B was 25, which affects risk assessment**; B is technically covered under the policy as the insurance covers not only the owner but anyone driving it with his permission: *temporary risk* was contemplated by policy however it depends on the circumstances whether use of auto by unnamed insured falls within risk originally contemplated by contract or whether it is a change
- **Issue**: was there a breach of contract for a failure to disclose a material change to risk (ie. That someone else is the regular driver of the vehicle)?
- **Decision**: yes

- **Reasoning**
    - insured's obligation to notify of a change material to the risk (after formation of the contract) does not stem from the common law but from **SC 1**
    - **Court said Insurer has onus of proving:**
        - that there was a **change of the risk material to the contract** (YES)
        - the circumstances giving rise to the change were within the insured's **knowledge** (YES)
    - **Court found change to the risk *did occur* when B took the car to other town for use in work and pleasure**
        - change in risk was in T's knowledge although he didn't know B's driving record
    - **T argued that because policy applied other drivers of his vehicle - and as a general rule this is true**
        - **but** IC called evidence that they would have investigated age, record etc and in fact they would have *denied* coverage based on his age, past insurance claims and driving record
        - ***although this was not objective evidence*** **(raising evidentiary problems)** court accepted this un-contradicted evidence as evidence of what a reasonable insurer would have done to satisfy the material fact test
    - T argued he didn't think it mattered that B was driving the car
        - Court says doesn't matter if insured knew the change was *relevant*, just need to *know of the change*
            - "If the insured has knowledge of a change in circumstances which, if notified to the insurer, would allow the insurer to investigate, develop further relevant underwriting information and then make a prudent assessment of the risk arising from the changed circumstances, the insured must notify the insurer"
        - **Emphasizes that the insured does not need to know that this is a material fact** (it makes no difference that he didn't know young males are at a higher risk or about T's poor driving record) he only needs knowledge that there was a change in circumstances that would allow the insurer to investigate to assess risk
        - insurer is obligated to disclose facts within his knowledge but the insurer assesses the materiality of the facts
    - **Ultimately while the statute changes the common law, it still reflects the common law's requirements that materiality is weighed on an objective basis**
        - **CHECK statute versus CL here**
    - Suggestion that if someone else is going to become the primary driver, when someone else is represented to be the primary driver, and you don't inform the insurance company, they may be able to void your policy
- **Ratio:** example of SC 1 applied - once an insurance contract is in effect, the insured has a duty to disclose any change material to the risk within the insured's knowledge; doesn't matter if insured knew the change was *material*, just need to *know of the change*

Heon v Insurance Corporation of BC **(1985 BCSC)**

- **Facts:** insured brought claim against IC for property damage to her van; she had plans to use van as mobile concession unit and had made extensive changes to carry out hotdog business; drives to calgary in van to discuss business plan but gets in accident on the way; vehicle only insured for pleasure; IC says that she failed to report a material change to the risk (ie. Van used for business)
- **Issue:** was there a breach of contract for failing to report a change material to the risk?
- **Decision:** No - she didn't breach her duty because she hadn't used it for business purposes **yet**
- **Reasoning**

- whether or not the IC is liable to indemnify or not turns on question of fact: **for what purpose was the vehicle being used when the loss occurred?**
    - although she had *intention* to use it for business, she had yet to so
    - her journey was 9 days instead of the 2 it would normally take so it was also for pleasure
    - she was going to obtain info which may or may not have solidified her opinion of using for business
    - accident occurred before she even made it to calgary anyways
    - ****emphasizes this is a fact-specific decision!!****

- **Ratio:** whether or not IC is liable to indemnify depends on what purpose was the vehicle being used for when the loss occurred; very fact specific exercise
- **Commentary:** Case is interesting for what it doesn't say:
    - (i) while there were significant changes made to her vehicle, they didn't see this as a material change
    - (ii) court doesn't consider driving to CG for business meeting a 'business use'
        - raises question of what would have happened if she had sold one hotdog prior to leaving Edmonton but didn't notify insurer that it was used for business: echoes property insurance question (ie. Halifax case) whether the insurance company can rely on a material change that happened once but was changed back to avoid coverage? **court doesn't answer this question**
        - under strict common law principles, insurer should be able to deny coverage for future loss based on failure to report material change even if unrelated to loss however Halifax suggested this was unreasonable …. open question as to how this would be decided in auto context

4. Life Insurance

Who is bound by the duty to disclose? (IAA s. 652)

- **Imposes a duty to disclose material facts on BOTH the life insured** and **the party applying for the insurance** *(if different*), but only to the extent that **the information has not been disclosed by the other**.
    - ie: employer may apply for life insurance on employee's life, husband on wife's life etc.
    - duty to disclose only applies insofar that the insurer doesn't have already have that information
- Applies to the application, a medical exam, and in any written statements or answers
- Similar to common law as no intention to mislead or issues of control requirement for IC to rely on a misrepresentation
- ****unlike other types of insurance, there is no ongoing duty to report changes****
    - logical because every day the statistical probability of your death changes
    - ultimately life insurance is highly constrained by statute so if you know what the statute says, you will know what happens in a life insurance situation

What is the relevant intent? (same - IAA s. 652)

- Requires that EVERY MATERIAL FACT within that person's knowledge be disclosed
- **Codifies common law**, which requires the insured to disclose all relevant info the insured knows or ought to know.

- **Irrelevant whether the breach was innocent, negligence, or due to forgetfulness or mistake - simply every material fact that either insured or applicant knows must be disclosed to insurance company**
- **Pretty harsh standard….**

***Murphy v. Sun Life Assurance Co*. (1964 ABCA)**

- **Facts**: P beneficiary of life insurance policy on husband who had suffered a fainting spell a month before; had cardiograms done in response to fainting but turned out to be nothing; insurance agent filled out application but didn't write in info so application form contained 3 errors: (i) didn't mention loss of consciousness; (ii) no disclosure of heart test; (iii) no mention of treatment he received after fainting; died of natural causes 1 year after policy issued; IC denies coverage based on 3 misrepresentations; beneficiary argued errors in transcription of the info but rejected by court who heavily relies on 3 separate errors in the application form
- **Issue**: Was there a **material** misrepresentations or omission?
- **Decision:** Yes
- **Reasoning:**
    - **Misrepresentation/Omission?**
        - did not matter that the misrepresentations were innocent with no intent to defraud.
        - did not matter that applicant might not have considered answers material did not excuse him.
        - **balance tipped in this case because there was more than 1 error**: it was unrealistic agent made this many separate mistakes
            - held it was relevant that doctor had filled out the application, not the applicant himself, in a confusing, busy and rushed setting - strangely suggested that 2 questions being answered incorrectly wouldn't have been enough but ***3 was sufficient* to establish misrep/omission**
            - if there was only 1 or 2 errors, wouldn't have been able to speculate whether these errors occurred because applicant misrepresented/omitted info or whether doctor made mistake
                - ****has been used to argue that just "few" errors doesn't prove misrep****
                - can try and rely on it but doesn't seem to make a lot of logical sense: saying intention is irrelevant but then they count the number of errors….
                - Prof doesn't agree with this reasoning but still says it could be useful….
    - ***Material* misrepresentation/omission: Reasonable Insurer Test (*Mutual Life v Ontario Metal Products*)**
        - emphasized that burden of proof is on IC: **must prove misreps were about a material fact on BOP**
        - IC took the risk and relied on its own evidence to say it was material in this case - however in this circumstance it was sufficient as evidence of what the reasonable insurer would do
            - Actuary said that he thought that if Dr Howard's report had been received, then either the term policy would not have been issue, it would have been issued at a higher premium, or it would have been issued as a "liened policy" =
                - **Liened Policy =** if a death occurs before a certain time frame stated in the contract, instead of paying the full face value of the policy, the insurer pays a portion of the face value.

- **No inquiry into whether *another insurance company would have done the same thing?* Say they are using the "reasonable insurer test" but wording suggests otherwise...**
    - Court just found that this was sufficient to show that if the true state of matters had been disclosed to them, there was a good probability that they would not have issued the policy or would have done so at an increased premium
    - **Seems to be a subjective test, not an objective one….**
- Ultimately: insurer only had to demonstrate that *had matters been disclosed*, there was a good probability that they wouldn't have issued the policy OR would have done so only at increased premiums
    - as 2 year **statutory window** wasn't over, didn't matter if they intended to mislead the insurer or that the misreps were innocent {**IAA s. 653(2)**}
- Beneficiary argued that there was no link between the omission/misrep and cause of death
    - rejects argument: there is no causal link required to cause of death to make a fact material
        - this is a strict duty - subsequent events do nothing but provide confirmation of reasonableness of attitude of insurer

- **Ratio:**
- **Commentary:** do cases of this set a standard that is too onerous?
    - is it really reasonable to expect applicants to remember every doctor they've been to? Or to expect them to answer intrusive questions truthfully in certain settings (ie: in front of your husband?)
    - Incontestability Clause - how life insurance mitigates these concerns, see below

Misrepresentation as to age (everything other than age falls under *Incontestability Clause*)

- **IAA s. 655(2) and 653(2)**: If the misstatement is in relation to **age**, **the insurer is limited to adjusting the insurance proceeds to award the amount that would have been insured at the true age** and premium of the life insured.
    - **not allowed to void contract**
    - can only adjust proceeds to the benefit that would have been at that age and that premium (ie: benefit for a 56 year old at a $500 premium, based on actuary tables)
- **Exception where the contract limits insurable age**: if the age is above the age cap, the insurance company can only void the contract for the next 5 years but after this period they can't void it so long **(s. 655(3))**
- ****DIFFERENCE IN NEW ACT: IAA s. 652(3)****: A failure to disclose (or misrepresentation) ***of any material fact*** with respect to an application for additional coverage, an increase in insurance or any other change in coverage after a policy is issued, **renders a policy voidable only in relation to the addition, increase or change.**
    - **Mitigates harshness of omission/misrepresentation requirement**
    - **RE ADJUSTMENTS ONLY**

Incontestability Clause

- **IAA s. 653(2): After two years, the insurer cannot repudiate the contract at all for a breach of the duty to disclose, *UNLESS* the misrepresentation or non-disclosure is fraudulent.**

- in the case of a simple error, *negligent misrepresentation or innocent misrepresentation*, after two years the insurer cannot void contract

- Key change re: implications of a breach are changed by statute
- Essentially the insurer can rely on an innocent disclosure to get out of the contract for the first 2 years but after this they must prove fraud
- **NOTE: this provision doesn't apply to misrepresentation of the age of the insured!**
- Cases deal with meaning of 'fraud' as an exception before they can rely on a material non-disclosure:

***Bureau v. Manufacturers Life* (1936), 3 ILR 433 (QCSC)**

- **facts:** Boy applied for life insurance at age 15, the adopted son of beneficiary; application says he is in good health except for some persistence tenderness in his heel which mother thought it was from hockey; shortly after application made, but before policy delivered, boy went to doctor who said he needed to have all his upper teeth removed - so he did; no mention of disease or problem; policy delivered; lower teeth removed during the summer; died of rheumatism related to problem with teeth; IC denied coverage because (i) on the application boy represented to be in good health when he had really been ill for several months with a sore heel and (ii) policy not effective until delivered and boy had already been already sick and seen doctor
- **Issue:** could the insurer repudiate the contract?
- **Decision**: no - policy is considered incontestable because it was in place for over 2 years and nondisclosure was not fraudulent
- **Reasoning:**
    - Policy became incontestable in June, 1934
        - Can only be cancelled by the insurer in 1935 when the boy died if the misrep was fraudulent
        - Court heard evidence that insured believed illnesses were passing due to statements made by doctor, felt like he was in otherwise good health etc = not fraudulent because insured honestly believed condition was a passing condition
        - even if the insured could be said to have concealed facts learned between the application and delivery of the insurance policy – must consider whether than concealment was intentional.
            - boy and parents **never** made aware of diagnosis or reasons for treatment
    - Case didn't deal with when policy took effect:
        - Insurer had a good argument that the policy *never* was in effect in the first place as he went to see doctor before policy delivered making the 2 yr incontestability period not start
- **Ratio:** May well have been unreported change in circumstances but because the policy had been in place for two years, it could not be voided

***35445 Alberta Ltd. V. TransAmerica Life Insurance Co of Canada* (ABCA 1988)**

- **Facts**: insured applied for life insurance; one of the questions on the application was whether he had flown in a plane other than as a passenger in the last 2 years; insured lied about the fact that he was a pilot of ultra light planes and had been in some accidents where he had sustained injuries; after application process IC hired Hoover-Holme Bureau to go ask applicant more detailed questions, though they did not formally form part of application process; also hired doctor for medical history report who didn't mention that insured was pilot or his past injuries; insured died **after** contestability period had lapsed so **IC had to prove fraudulent misrepresentation/omission;** Trial judge found based on answers that insured gave to the Bureau he must have been fraudulent at the time the answers were given;
- **Issue:** was the insured's failure to indicate he was a pilot fraudulent?

- **Decision:** Yes
- **Reasoning**
    - Fraud on BOP based on both the way he behaved when filling out the application AND in the information he gave to others
    - "insurer will not use any statement in defence of this claim unless its used in the application…" - suggests that the IC will not raise a brand new alleged misrepresentation (based upon answers given outside the application process) unless that same misrepresentation is **contained** in the application attached to the policy.
        - IC couldn't have solely relied on answers given by insured to Bureau - only as corroboration
        - **insured made fraudulent statements in application so nothing wrong with court going outside the application for evidence**
        - So considered evidence outside the contract itself that insured gave to an independent investigator that suggests he purposely misled when filling out the form
    - Insured's argument was that doctor became *agent* of the Insurance company and hence insurance company was taken to have the same knowledge and thus their was no fraudulent misrep
        - **Court held Insurer had hired Dr. for very limited purpose – medical history**
        - The topic of whether the applicant flew ultra light planes was outside the doctor's retainer and thus Dr's knowledge ≠ insurer's knowledge
- **Ratio:** example of fraud vitiating life insurance contract after the 2 year incontestability period; case shows that the insurer can look at outside evidence of misrepresentation & intention to prove fraud (not limited to time they filled out the form)

When the Contract Takes Effect [IAA s. 649]

- ability of IC to rely on misreps is time contingent, this raises the question of when the time period begins to run
- **provision says that life insurance contract doesn't take effect until 3 things happen**
    - **(i) policy is delivered to insured/beneficiary AND**
    - **(ii) first premium payment is made AND**
    - **(iii) no change in insurability of the life to be insured between the time of application and the time the policy is delivered after this, the time starts ticking**

****SEE JANELLE'S CAN SUMMARY****

B. Formation of the Contract

Ordinary Principles of Contract Law

- Ordinary principles of contract law applicable to formation of enforceable insurance contract = **Four Requirements**
    - (1) Offer
    - (2) Acceptance
    - (3) Valuable Consideration
    - (4) Parties must be in agreement as to essential terms of contract

Need Agreement as to Essential Terms

- i) Subject matter of Insurance (ie: House, Building, Jewelry)

- ii) Duration of the Coverage
- iii) Deductible
- iv) Amount of Premium Payment Required
- v) Policy Limits
- vi) Whether Endorsements will be Added

Limitations on Freedom to Negotiate Contractual Terms

- Legislative direction as to **form** and **content** of insurance contracts
    - By inclusion of specified terms and conditions
    - ie: "**statutory conditions**" mandated for **general/fire**, **accident and sickness**, and **automobile insurance**
- By deeming **specific coverages** to be included in insurance contracts
- By requiring insurers to have their standard policy wordings approved by the government (in AB by the Superintendent of Insurance) - ie: **IAA s. 551**
- Wording of standard form policies may also be **voluntarily agreed on by insurance industry associations** to maintain competitive advantage by making them comparable

Purpose of Legislative Provisions = **Consumer Protection**

- Recognition that insurers are sophisticated as opposed to insureds who are less knowledgeable
- Even more provisions recognizing this disparity in bargaining power, sophistication in *Insurance Amendment Act*

Standard Form Insurance Contracts

- Insurers and insureds *usually* do not negotiate terms and conditions
- Focus tends to be on:
    - Premium Cost
    - Limits
    - Duration of coverage
- Result: shop around

Policy vs. Contract

- As contracts of adhesion, *policies themselves* are not a contract but simply evidence of a contract because they require agreement on central terms in order to form the body of the contract
    - Courts focus on whether a contract has been formed & whether the parties intended it to be formed
- **Contract:**
    - **Section 1(j) IA** defines '**contract of insurance**' as 'any policy, certificate, interim receipt, renewal receipt or writing evidencing the contract whether sealed or not, and a binding oral agreement'
    - 'Legally binding agreement by an insurer to indemnify a particular insured against specified risks'
- **Policy:**
    - **Section 1(uu) IA** defines '**policy**' as 'an instrument evidencing a contract of insurance'
    - *not a very helpful definition in terms of differentiating it from contact*
    - **Essentially:** 'Recitation of terms and conditions which do not attach to a particular person, item or interest'
    - **Section 513(1) IA** – "all the terms and conditions of a contract of insurance must be set out in full in the policy …"

Offer and Acceptance

- Offer of essential terms made by one party and acceptance of offer by other party
- ****Modification by Statute: Section 518(1) 'Delivery Provision'****
    - **IAA s. 522(1)** – 'when the policy has been **delivered** the contract is as **binding on the insurer as if the premium has been paid**'
    - **Applicable to all types of insurance except life {SEE THREE REQUIREMENTS}**
    - Prevents insurers from making existence of insurance contract conditional upon receipt of premium payment
    - Simplifies common law, normal contract offer and acceptance as actual payment of agreed premium not required element for formation of insurance contract
    - Also complicates process as does negate usual common law requirement that parties agree to fundamental terms of insurance contract (see *Patterson v. Gallant* – and Court's comments therein)
- **But s. 522 'Delivery Provision' only applies to Premium Non Payment**
    - Modifies "consideration" requirement but should not be interpreted as nullifying offer and acceptance as requirement for insurance contract
    - If insurer delivers policy to signify intention to be bound, insurer cannot avoid contract later on basis that contract never formed b/c insured had not paid premium agreed

Consideration

- No exchange of money/items is required - **a promise to pay a premium is enough**
    - Insurer promises to indemnify insured for loss falling within coverage outlined by insurance contract
    - Insured promises to pay insurer the premium for the promised coverage
- **s. 522 IAA** – contract takes effect whether premium actually paid or not (not required for a contract)
    - ****exception for life insurance**** [**s. 649 IAA**] – payment of 1st premium before contract deemed effective

Focus of Jurisprudence: Policy versus Offer

- Whether document delivered to insured was a 'policy' of insurance (**captured by s. 522**) or a mere offer of insurance (**not subject to provision**)
    - once its found to be a policy, have to follow all statutory provisions (ie: cancel according to necessary procedure etc.)
- Focus on *****intentions of insurers*****
- Lack of jurisprudence in Canada = lack of certainty
- **Fact-specific determination what courts will consider offer/acceptance**
    - key: complete offer/acceptance requires some sort of discussion & suggestion of acceptance of **premium**
    - i) Default Approach
        - offer: IC giving insured an application
        - acceptance: insured filling out application
            - appropriate because insured would call up agent and explain what they needed, then would go about filing app
    - ii) Where insured pays prior to knowing price (given estimate in advance of app or pay at time you apply)
        - offer: Insured filling out application
        - acceptance: IC gives you policy & agrees to insure you at rate

- iii) Renewal:
    - offer to renew: contract is already in place & insurance company issues a reminder to insured prior to expiration
    - **acceptance: paying the premium**
- iv) 2-Step Renewal:
    - where there is an offer to renew, insured pays premium, then insurer issues certificate
    - acceptance is paying premium
- **Grace Period**
    - for renewals, though not required, IC will give a grace period where coverage is still in place after termination date
    - for life insurance, statute requires a mandatory 30 day grace period after the policy would otherwise expire or after the date the premium was due **[SECTION #]**

Davidson v. Global and Ocean **(1965 ON HighCt) *demonstrates need for agreement on essential terms***

- **Facts**: P owned clothing store; Ocean's agent solicited P's insurance business and submitted a letter which described coverage (policy limits, subject matter) but did not quote a premium and did not mention duration **(TWO ESSENTIALS IN FORMATION OF INSURANCE CONTRACT)**; Agent phones P to discuss premiums but P thinks they are too high; P obtains policy from **Global;** Fire occurs and P makes claim against **Global, who admits liability but tries to seek contribution from Ocean for proportionate amount;** Global submitted that the letter was a binding contract and that it was never terminated**;** Ocean contented that letter was only a proposal, that it was never accepted and according to the P, he never intended to accept it because premiums too high and thus parties were never *ad item* **-** Offer argued to have been good only during negotiations & lapsed upon P obtaining policy from Global
- **Issue**: whether Ocean was bound by paragraph stated that the letter was 'evidence that coverage as outlined is in force with Ocean'?
- **Decision:** No - may have been an offer but there was never valid acceptance & parties never in agreement on essential terms
- **Reasoning**
    - Was of the view that 'by delivery of policy', 'doing nothing more than making a **continuing offer to the Plaintiff** which was open for acceptance by the Plaintiff'
        - 'delivery of replacing policy, insurer doing nothing more than making a continuing offer to the insured which was open for acceptance by the insured'
    - No contract of insurance unless there is an acceptance of a proposal which, whether it be by the issue of a policy or by letter, is in terms of the proposal
    - First essential to binding contract is that parties must be agreed upon every material term, which include:
        - Definition of risk
        - Duration of risk
        - Premium
        - Amount of insurance
    - **As to all of these, there must be a consensus *ad idem* – express agreement or circumstances where agreement can be reasonably inferred**
        - **Parties *never* agreed on premium**
- **Ratio:** must be an explicit/implicit consensus of the mind (*ad idem*) about the essential terms of the contract for it to be formed which include the definition of the risk, the duration of the risk, the amount of coverage to be provided and the amount of the premium

- Court will evaluate it on a case-by-case basis - if it is implied, you need to be able to reasonably infer from the facts that the parties were ad idem

McCunn Estate v. CIBC **(2001 ONCA) *illustrates how key the intention of parties is***

- **Facts:** Life insurance policy where premiums automatically deducted from insureds' credit line; policy stated that coverage provided was provided "subject to the age 70 limit" ; Insured turned 70 but bank continued to debit monthly premiums for a further 16 months until she passed away; Estate then sought life insurance payment under policy of amount appropriate to reduce **any** outstanding indebtedness under credit line at date of death; Request rejected by bank which pointed out that coverage had been terminated on 70th birthday and that premiums continued to be debited as a result of "administrative oversight"; Premiums were reversed by bank **{STUDY GROUP: argument was that 'consideration' constituted renewal}**
- **Issues:** Was the insurance contract still in place due to automatic withdrawals of premiums? (essentially whether estate could take advantage of CIBC's mistake) Whether **Certificate of Life Insurance evidenced a binding contract between deceased and CIBC and Mutual Life** (thus whether deceased entitled to benefits defined in Certificate)
- **Decision:** No contract - would need **express** agreement to extend that contract beyond age of 70
- **Reasoning:**
    - Would have had to have been a new contract formed because old one terminated at at 70
    - For parties to have created a new contract of insurance, necessary that bank with requisite knowledge and intent, make offer to provide insurance, and Mrs. M, with requisite knowledge and intent, accept offer
    - **As always,** would need agreement upon every material term of the contract (**reiterates the 4 material terms** = Definition of risk to be covered, Duration of the insurance cover, Amount and mode of payment of the premium, Amount of insurance payable in the event of loss)
        - As to all of the material terms, there must be a consensus *ad item*
        - ***reiterates general principles from previous case***
    - To extend insurance contract beyond termination date, necessary that there be **express agreement** to do so
        - Oversight stated to be an inadvertent omission or error - not intentions of parties for coverage to exceed 70yo
        - **An act which is the result of administrative oversight not an intended act**: can't be elevated to knowing intention to extend coverage to unspecified future date, particularly as M neither relied to her detriment or formed a reasonable expectation that her life would be insured after 70
        - As bank was in error in debiting premiums, ***it cannot be said that bank intended to extend the contract*** **(FOCUS ON INTENT OF INSURER)**
            - To act erroneously is inconsistent with acting knowingly - Bank could not be seen to have knowingly intended to make an offer to extend the contract or enter into a new contract
            - No evidence that it was accepted by Mrs. M
                - No evidence that Mrs. M was ever aware that policy was still in effect although premiums remained the same
            - Case came down to a mistake by the bank which was not relied on by Mrs. M and Insurer's duty to pay was discharged on 70th birthday
            - Court viewed the Estate as attempting to take advantage of bank's mistake to demand payment of insurance

- Where a party knows of another's mistake or should reasonably know of it, **law will not permit the taking advantage of it** particularly where there was no detrimental reliance nor where there was a reasonable expectation that coverage had not come to an end

- **Ratio:** where a party knows of or should reasonably know of another's mistake, she/he can't take advance of it, particularly where he/she didn't rely on it or act in reasonable expectation of it - need express agreement to continue or extend an expired insurance policy
    - courts look carefully at circumstances to determine existence of intention to be bound by BOTH parties
- **Dissent**: tried to benefit insured by saying auto withdrawals was a continuing offer, silence was acceptance
    - reference automobile policies
    - <u>but not the same type of contract- not in the reasonable contemplation of both parties - not the same sort of third party consideration</u>

C. Cover Notes (Interim Receipts)

<u>Cover Notes, Interim Receipts or Temporary Binder</u>

- = **immediate but temporary insurance contract that is issued to potential insured while application is processing**
    - (before policy delivered which satisfies statutory formation requirements - except life insurance)
- Designed to prevent agent from losing business by not being able to give coverage right away: can issue short-term coverage whether or not they agree to long-term coverage in the end
- Insurance Act includes 'cover note' aka 'interim receipt' <u>within the meaning of an 'insurance contract'</u>
- Somewhat dated but unique feature of insurance contracts: not as relevant today due to faster underwriting period

<u>Issues that arise:</u>

- i) what coverage do they provide? (whole/limited) interpret what is written
- ii) what terms/conditions are attached to the cover note? interpret what is written
- iii) did the agent that issued the cover note have the authority to do so? focus in casebook

<u>Applicable Principles</u>

- Duration generally less and premium charge less than charge for full policy
- Terms and conditions of usual policy typically govern interim coverage cover {see SCs}
- Insurer <u>not</u> legally obligated to provide full policy by providing interim cover
    - Distinct from circumstances where the full policy is being delivered
- Interim cover effective until one of three things happens
    - (i) Full policy issued
    - (ii) Temporary agreement terminated (Insured/Insurer agrees they no longer want to be bound)
    - (iii) Agreed upon term expires
- Where no time-limit is specified in cover note, <u>courts will imply a reasonable time</u> however the courts <u>will not do this for a long-term policy</u>
- Problems can occur where there is a problem with longer-term policy: insured would argue either is in place

Buske v. Potter* (1966 Ontario County Court)** ***Prof says seems more like an agent's liability case, not necessarily the best example of Interim Coverage

- **Facts:** B went to Potter (agent) seeking (6 month) car insurance; Potter quoted him at $160 which Buske paid and received a receipt and a certificate covering liability insurance on his car from Potter; No policy number shown on certificate but it did say 'held covered, effective (date)' and it did give an expiry date; Agent sent the application in, *but failed or forgot to send along the $160 he received from Buske*; IC tells Potter that premium is actually higher and full amount must be paid within 15 days - debate on the facts whether Potter passed this information on to B, however full amount was not paid; **B reports a MVA and tries to claim on terms of interim policy but IC denies coverage;** Potter argues he was not not negligent (advised Buske that application was **subject to acceptance by IC and did not represent that B obtained a policy of insurance <u>but that he was only submitting one for approval</u>);** also claimed that he told B that he would be covered for a 15 day period, **pending acceptance/rejection by IC of application**; and claimed he told B $160 was only an **estimate** of policy cost; IC denied that it issued an automotive liability insurance policy and denied that any contract of indemnity existed - If full premium was paid, policy would have been issued - otherwise company policy is to cover applicant for 15 days and send notice called a 'automobile insurance binder';
- **Issue**: (i) if agent was only expressly authorized to issue interim receipt for 15 days, is the IC bound by the terms in the cover note? (ii) Was the act of giving notice to the agent equivalent of giving notice to the Insured due to legal agency relationship?
- **Decision:**
- **Reasoning**
    - <u>i) If agent was only expressly authorized to issue interim receipt for 15 days, is the insurer bound by the terms in the cover note?</u>
        - agent argued he advised the P that application was subject to acceptance by LM & that he didn't represent that the P had obtained a policy at this point, simply temporary insurance for 15 days pending approval at estimated cost
        - IC deny issuing auto insurance: argues agent only had the authority to issue interim coverage for 15 days & since offer for coverage wasn't accepted there was none in place
        - B argues that he never heard anything from IC & that agent told him he would be covered that date without an indication that it was limited coverage for limited time
        - **HELD: IC was bound to provide coverage according to terms in cover note {which was longer than 15 days}**: strong presumption in place that insurer has accepted the risk where they accept premium & application form
            - accepted B's evidence that he was never told about 15 day period or increase in premium "estimate" - as far as he knew there was no reason not to rely on 6 month period as agent was clothed with authority to issue temporary coverage
                - **Potter held to be ostensible agent for IC extent of having the right to issue the insurance liability certificate**
            - In absence of cancellation of coverage, B entitled to assume that he had, having been issued this certificate, and having paid his premium, and filed an application, coverage against the collision according to the terms of the application for a period expiring on the noted date
            - = **contract of insurance once application and premium received by Potter**

        - Prof says right result but seems to sort of stretch what was meant to be interim coverage into a full policy -- different than other cases on this topic we will be looking at
    - ii) Was the act of giving notice to the agent equivalent to giving notice to the insured due to legal agency relationship?
        - IC argued that Potter was *acting as a legal agent for the principal B*, so the act of giving him notice was legally equivalent to giving notice to the insured
        - **HELD:** court rejected this argument - here insurance agent was only an agent of IC
            - where company issues pink card, it suggests an intention on the part of the insurer to provide coverage at least for a limited time = suggested intention for it to remain in place until insurer communicated decision
            - courts rely on fact-specific determination of agency to determine whether knowledge of agent is imputed on principal
                - since premium was given to him, that is deemed acceptance and
            - note: agency is important in the context of disclosure b/c the court deems knowledge of the agent on its principal
- **Ratio**: where insurance agent is clothed with authority to issue an interim receipt, the insurer may be bound by what is on this interim receipt in terms of coverage & duration

'Pink Cards in Auto Insurance

- ***Patterson v. Gallant* (1994 SCC)**: 'Pink card by itself does **not** constitute a binding policy'
    - '…. Only an administrative requirement … does not bind the insurer in the absence of an underlying insurance policy'
    - *Highway Traffic Act* requires you to have the card but not a "policy" inandofitself and can not bind an insurer in the absence of a valid policy

***Patterson v. Gallant* (1994 SCC)**

- **Facts:** G insured under auto policy with Cooperators; One month prior to expiry of insurance, Co-op mailed G a document consisted of 4 detachable sections - **one of those was a copy of the pink card** (which attests to there being insurance in place); Gallant did not pay renewal premium due by time specified in "Automobile Premium Notice/Offer to Renew" ; ***G is arguing that because he *accepted* the renewal policy, it didn't matter if he had paid the premium (offer to renew + pink card = policy);** Co-op claimed that *if Gallant paid renewal premium*, Coop would have issued him a document entitled "Automobile Renewal Receipt" along with a **SECOND pink slip/card identical to the first one sent with the Notice/Offer to Renew - effectively a two step renewal process**; Renewal Receipt would have functioned as a renewal certificate or receipt within meaning of Section 218 of Ontario Insurance Act - would have been equivalent of a policy such that insurer would not have to issue a complete copy of the standard owner's policy upon each renewal; G involved in MVA where he injured 3rd party who then sues Cooperators; Co-op denies liability on the basis that policy had expired; G argued that renewal was a one step process so offer to renew and issuance of pink card was equivalent to a policy under IA
- **Issues**: Should a pink card be construed as a binding policy of insurance? Did the two step renewal process utilized by Co-op cause it to incur an obligation of coverage, even if premium not paid?
    - IOW: what is the meaning of '**renewal**' of an auto insurance policy and what documents constitute renewal
- **Decision:** Pink card not a binding policy - just an administrative requirement - by issuing it, IC is not communicating an intention to be bound - *could* be evidence of an existing policy but on its own, not sufficient

- **Reasoning:**
    - Two meanings that could be ascribed to "renewal"
        - 1) first meaning results from <u>continuous policy</u> {provides for further extensions of term of existing contract subject to rights of parties' to terminate}
            - questions of formation, material term are answered by reference to initial offer/acceptance
        - 2) second meaning involves situation where <u>separate and distinct contract comes into existence at each renewal</u>
            - ****ALL AUTOMOBILE INSURANCE falls under this category****
                - own offer/acceptance
                - makes sense: this year IC might be asking for x dollars more in terms of premium and x less in terms of coverage - insured would consider these terms and either accept or decline = new contract
    - True that IA has altered common law principles of offer and acceptance: even if not a contract in the strictest sense, if the insured issues a doc that *could be construed as a 'policy'* IC can not avoid liability
        - respondent argues that renewal documentation was in effect a policy and thus IC is bound by IA despite the fact that he did not pay
        - contention is that IC used a **one step process and that offer to renew along with pink card** functioned as the equivalent of an insurance policy
        - **Court does not agree:** clear that Co-op had mailed an **<u>offer to renew</u>** and the docs made clear that **<u>contract would be renewed if premiums paid on time</u>**
            - didn't purport to be binding insurance policy regardless of payment
            - *probably not *ad idem* as to fundamental terms - premiums change with age, record etc.*
            - **hence, did not fall within defn in ON IA of a policy**
                - just because forms were *similar* didn't make them the same thing
    - court recognizing the commercial reality of how people buy policies
        - mail pink card as a marketing technique
        - and good thing for consumer because they get their pink card right away - **<u>practical</u>**
        - would be impractical to request premiums upfront
    - But reiterates pink card not a binding policy, **rather an administrative requirement for insurers under provincial *Highway Traffic Act***
        - Leg would have included pink car in defn of contract under IA if they had intended it to count
- **Ratio:** pink card is not a binding policy but simply an administrative requirement so by providing it, the insurer isn't indicating any intention to be bound to the contract; *even for a cover note/interim receipt to be in effect, you must have agreement on essential terms (*without payment there is no agreement on essential terms)

D. Duration of Cover

<u>When does the contract take effect?</u>

- Agreement will generally take into effect upon **offer & acceptance** unless contract states otherwise
- **s. 522 IAA** – contract binding **<u>upon delivery</u>** whether or not premium paid
    - exception of life insurance [s. 564 IA / s. 649 IAA] – need payment of 1st premium before contract effective

When does the contract end?

- **i) Contract expires based on natural expiry of terms**
- **ii) Contract ends by mutual Agreement:** both parties agree they no longer want to be in contractual relationship
    - so long as they are ad idem, the parties can end the contract early (same as other types of contracts)
- **iii) Contract ends by unilateral termination:** allowed in statute though can also be written into contract
    - insurance contracts are unique because unilateral termination is generally not allowed for contracts
        - SCs of **property section** [**IAA s. 540 SC 5 and 14**}
        - SCs of **auto section** [**IAA s. 556 SC 8 and 9**]

Effect of Termination

- Brings end to mutual obligations of insured and insurer under contract
- Insurer no longer responsible for any losses suffered by insured and insured no longer obliged to pay premiums
- Note for **Life Insurance:** (**s. 651 IAA**) contract builds on 30 day grace period after expiry date for renewal that allows original contract to continue to exist unless IC gives notice they don't intend to renew

Reasons for Termination

- No requirement in statute for parties to give reason for termination
    - **with the exception of auto due to adverse contract provisions** [**IAA s. 555**]: IC can't terminate auto insurance unless the reason is recognized by statute/regs (ex. non-payment of premiums)

(ii) By Mutual Agreement

- Duration of coverage can be changed during contract by mutual agreement of parties
- Insurer and insured can agree to terminate contract earlier than anticipated
- as long as *ad idem*, can end contract

***Ellis v. London Canada Insurance Co* (1954 SCC)**

- **Facts:** Ellis recovered judgement against Gillan; Then brought action under IA against Gillan's IC to recover unsatisfied Judgment**;** IC resisted claim on grounds that policy was void because of fraudulent misrepresentation of insured; **Alternatively, IC claimed that if not void, policy had been cancelled by insurer prior to MVA'** Unnecessary to deal with question of misrepresentation - had recognized errors in info given by insured so IC inspector **"picked up" policy {and G "surrendered it"}**, returned it to head office for cancellation, and refunded premiums; Ellis argued that Gillan's IC didn't follow statutory obligations re: notification
- **Issue:** Was the policy terminated by mutual agreement?
- **Decision: Yes -** Gillan voluntarily surrendered his policy so contract not in force between parties on the date of MVA
- **Reasoning:**
    - IC did not need to comply with statutory requirements because they didn't unilaterally terminate
        - by surrendering policy & accepting full premiums, there was a voluntary agreement to rescind the contract - Gillan can't claim benefit of SC which only applies to unilateral cancellations

- simply because IC ***initiates*** termination **doesn't mean they are unilaterally terminating**
- **note**: this situation will rarely come up because **unilateral termination is easier & doesn't require discussion**; mutual termination may occur where parties are agreeing to replace contract with a new one

- **Ratio:** insurance contract can be cancelled effectively by mutual agreement, in which case SCs will not apply

(iii) By Unilateral Procedure

- No common law principle which permits party to unilaterally terminate contract
- Only permissible if unilateral termination expressly permitted by contract or by legislation:
  - **General - IAA s. 540 SC 5**
  - **Auto - IAA s. 556 SC 8**
  - **Accident & Sickness - IAA s. 705 SC 4**
- 671 SCs #5 & 6 for accident and sickness
- **Statutory Conditions {all of the provincial legislation have some versions of these} = REQUIREMENTS FOR UNILATERAL CANCELLATION PROCEDURE**
  - Permit insured to unilaterally and **immediately terminate contract on notice to insurer**
  - Insurer required to give insured specified period of **advance written notice**
    - 5 days notice if personally delivered or 15 days if sent by registered mail - **General s. 540 SC 5(1)**
      - **IA**: receipt is determined by the day it goes to the **central post office**
      - **IAA**: receipt determines by day it is **received at the house of the insured**
  - Gives insured opportunity to obtain alternate cover
  - Insurer must return premium
    - return unexpended portion of premium at the time or 'as soon as practicable' – allowed to withhold amount of premium as an administrative fee when they calculate unexpended portion
- **courts hold insurance companies tightly to time & notice requirements under the Act since they do not have to provide reasons for termination**
  - up to insurance company to prove it was delivered to address in question
- Note: statutory provisions allow **INSURED** to unilaterally terminate upon request **{no procedural requirements}**
  - no risk to the IC due to lack of coverage (unlike reverse situation) so no time limits for notice required

Krupich v. Safeco **(1985 ABQB)**

- **Facts:** IC intended to terminated fire insurance and sent notice of cancellation to Plaintiff by registered mail on February 25th; Refund cheque was not mailed until five weeks later on April 4th; Evidence showed that Notice of cancellation was never actually reached insured, as it was returned to the insured unopened; Fire loss occurred on April 26 and Plaintiff notified insurer's agent of loss; IC declined coverage on the basis that it cancelled the policy of insurance 2 earlier and therefore there was no policy of insurance in effect at time of loss
- **Issue**: was the policy properly terminated by the insurer in compliance with the statutory requirements?
- **Decision**: No - IC didn't return unexpended portion of premium with the notice of cancellation '**within reasonable or practicable time'** as required under statute - therefore policy was still in place when loss occurred
- **Reasoning:**

- Requirements set out in SC 5 - Insurer found not to have complied with 5(2)(b) in that refund of excess premium did not accompany notice as required
- Forwarding of refund cheque some 5 weeks after purported termination did not meet requirement of 5(3) that insurer refund 'as soon as practicable' the excess premium to the insured
- Court found that contract of insurance was subsisting between the parties at the time of the second fire loss
- **Doesn't define reasonable time however in this case it <u>wasn't</u> 5 weeks**
    - Clearly struggled with notion that it can't rely on fact that notice wasn't opened by insured as there was nothing in <u>statutory provisions</u> requiring this & based on authority of *Lumbermen*

- Ratio:

E. Interpretation of Terms

1. General Principles

<u>Two Issues</u>

- 1. Coverage – Was the risk which occurred the risk that was insured?
- 2. Causation – Even if the risk that was insured occurred, did the losses claimed flow from the risk?

<u>Guidelines of Interpretation</u>

- Not an exact science: court uses various techniques to give <u>logical sense</u> to finding, tend to agree on what guidelines are however debate over its application
- **Goal** = to reflect the intention of the parties somewhat artificial goal in context of insurance as they are contracts of adhesion so insured simply wants coverage for loss (different intention than insurance company)
    - Heavy burden on IC to prove the intention of the parties where the wording of the contract is unclear as they are the ones who drafted the contract: <u>courts will construe ambiguous wording against them</u>
- <u>Be mindful of purpose of insurance contract as a whole:</u> **don't interpret word in a way that gives a windfall or profit to insured or negates purpose of coverage altogether**

<u>*TWO PART INTERPRETATION PROCESS*</u> {*Consolidated Bathurst Export,* SCC 1979}

- **1) Interpret contract in a way that reflects reasonable INTENTIONS of parties at the time it was entered into**
    - **(i) if term is defined in policy, give the word the definition it was given**
    - **(ii) if term is undefined, give plain & ordinary meaning to words**
    - **(iii) if plain & ordinary meaning can lead to more than one interpretation, chose the meaning that most reasonably promotes the intention of the parties**
- **2) If still AMBIGUOUS**
    - **(i) Interpret contract <u>against party who wrote it</u> (contra proferentem) as they are at fault due to drafting**
        - doesn't apply to pre-approved policies or statutory conditions
    - **(ii) Interpret <u>coverage provisions broadly and exclusion provisions narrowly</u> (benefits insured)**

- **(iii) Interpret in a way that fulfills reasonable expectations of the parties without reading in windfalls in favour of either (windfall for insured or excuse insurer from anticipated coverage)**
    - *unclear how this should be used*: seems to be the same as step 1 as courts use 'reasonable intentions' and 'reasonable expectations' interchangeably
    - also problematic because different parties have different expectations (why they are in court in the first place) so questionable whose expectations we are talking about & what time period we are talking about (only makes sense it is at the time contract is formed as once they are in court they have different expectations)

Three Problems in the Case law

- sub-context in interpretation cases is **fairness in results**
    - what the type of insurance is ***usually expected to do*** (intention of the parties entering into this type of contract), **subject analysis versus exact science**
- SCC has outlined a two step procedure and series of basic principles but application to the facts has proven much more difficult
    - Following are examples of cases where Courts divided over agreement on intentions of contracting parties, or or ambiguity of insurance terms
- **THREE MAJOR PROBLEMS**
    - **1) How much do external public policy considerations play a role in interpretations?**
    - **2) How do you determine if there is ambiguity?**
    - **3) How do the principles play into interpretation of ordinary words?**
        - Example: 'use/operation' or 'accident' are basic words however the courts struggle in interpretation
            - what is use & operation of an auto?
            - what is an accident in terms of property insurance or Section C of auto insurance?
            - at what point does an activity become so reckless that it is no longer an accident?

Issue 1: When does the court take into account external factors such as insurance being a public service?

***Jesuit Fathers v. Guardian* [2006 SCC] --> Sets out rules of interpretation for insurance policies**

- **Facts:** Policy specifically covered liability arising out of operating Indian Residential Schools; Jesuit fathers seeking coverage for costs arising out of class action litigation; coverage specified for 'claims made' during the policy term; insurer is notified that there is a claim being made against JF (falls within policy) and about potentially others to come, **and refuses to renew contract**; after expiration further lawsuits are filed about the abuse - INSURER argues they aren't liable because it was a 'claims-based' policy so only applies to claims filed during policy term; INSURED argued that the court should interpret the contract in light of the ****public policy**** served by the liability policy (not to protect the insured but to make a pot of money available to compensate injured 3rd party claimant)
- **Issue/Decision: SCC agrees with INSURER**: wording of contract makes it clear coverage was only for claims filed during policy term and when the contract is clear, you should interpret it on its terms because this reflects the intention of the parties
- **Reasoning:** court adheres to 2-step process making it clear that **ambiguity must exist prior to taking into account public policy**
    - Terms of policy must be examined in light of surrounding circumstances to determine intent of parties and scope of their understanding

- Insurance law has given rise to number of principles specific to interpretation of insurance policies
- Principles stated to apply where there is ambiguity
- **1) Courts need to be aware of unequal bargaining power at work in negotiation of insurance contract**
    - Done in 2 ways:
    - **i) Through application of *contra proferentem* rule; and**
    - **ii) Through broad interpretation of coverage provisions and narrow interpretation of exclusions** {coverage clause delineates what is insured under the agreement}
    - = These rules require that ambiguities be construed against the drafter
- **2) Courts should try to give effect to *reasonable expectations* of parties without reading in windfalls in favour of any of them**
    - without permitting IC to collect a premium and not compensate a loss
    - and not permitting insured to collect for a loss they didn't incur
    - neither party should benefit unduly
    - = terms must be examined in light of surrounding circumstances to determine intent of parties
- **3) Finally, context of particular risk must also be taken into account**
    - what kind of risk is being covered, what is the context in which it is being covered
    - public policy here?
- Using an unprincipled approach, as advocated by the Insured, would be problematic to future victims obtaining coverage & compensation and both parties are entitled to expect that well-established principles will be reflected in interpretation as this is in public interest as well

- **Ratio:** Reaffirmation and consolidation of some broad principles from previous - **ambiguity must exist prior to taking into account public policy**
- **Commentary**: it is possible that the court would interpret the liability contract to benefit an insured or 3rd party because this is done all the time however the court refuses to do it in this case because there is a competing need to make sure well-established insurance principles are adhered to (ie. Principle that you clear the 1st hurdle of ambiguity prior to interpreting the contract against the insurance company)
    - Note: will learn more about reasonable expectation test with *Progressive Homes*

Issue 2: How do you determine if there is ambiguity?

***Brisette v. Westbury* [1992 SCC]**

- **Facts:** Husband murdered wife; tried to recover life insurance proceeds but this failed [because he intentionally caused the loss - public policy doctrine] so assigned action to wife's estate; wife's Estate sought proceeds of life insurance policy
- **Issue:** how should the joint policy be interpreted (to determine the effect of husband's conviction for the murder of his wife on the liability of the insurance company?)
- **Decision:** SCC divided 4 to 2 in its interpretation of policy
- **Reasoning [Majority - Sopinka J]**
    - Proceeds not payable as could not be made within policy terms **because policy clearly stated payment to be made to surviving spouse**
        - no provision for proceeds to be paid to estate
        - this contractual intention not affected by intervention of public policy
        - it was never the intention of the parties that the money would be paid to the deceased's estate as the terms of the policy were clear & unambiguous that money is only paid to survivor

- **Just because public policy prevents this intention from coming into fruition does not mean there is ambiguity**
    - nothing unjust about applying the policy on its terms where the situation was not contemplated
    - the only way you'd have a constructive trust is if there was something unjust about not doing it (unlike Dissent, doesn't look at implications on anyone else in accessing the money)
- **outlines interpretation guidelines:**
    - i) interpret whole contract in a way that promotes full intention at time contract was formed
    - ii) if capable of more than one meaning, pick one that reflects intention
    - iii) ambiguities construed against insurance company
    - iv) achieve interpretation that doesn't result in windfall for insured or excuse insurer from anticipated coverage

- **Reasoning [Minority - Cory J]**: do find ambiguity
    - **Policy ambiguous because it did not specify whether or to whom proceeds ought be payable if surviving husband killed his wife**
    - applies principles if interpretation differently: **intention of parties was key**
    - **i) in considering contract as a whole, it is clear that parties reasonable expectation is for coverage upon death of spouse so insurer still obligated to pay**
        - IC takes into account spousal homicide when calculating risk & premiums so irrelevant how insured died unless it fell within exemption, which it didn't
    - **ii) in considering policy as a whole, finds ambiguities as policy doesn't specifically deal with spousal homicide**
        - compared to other parts of the policy that specifically stipulate exemptions (ie. Suicide & acc death)
    - **iii) since insured drafts contract, it is just to interpret ambiguities in favour of the insured**
        - refuses to sympathize with IC because they failed to anticipate situation & address it in contract
    - **iv) principle of public policy should be strictly interpreted**
        - no reason why IC should benefit by failing to compensate when it was never intended that this policy would be used to avoid contractual obligations
        - since death resulted from murder of one joint owner by other, it is contrary to public policy to allow survivor to benefit so proceeds should be held in constructive trust for estate of murdered spouse as this is fair & ensures contract complies with intent of parties
        - court also goes through US approach to show how far some jurisdictions will go when giving effect to reasonable expectations of parties
    - **Principles:**
        - Courts to search for interpretation from whole of contract which promotes true intent of parties at time of entry into contract
        - Where words capable of 2 or more meanings, most reasonable in promoting parties' intentions to be selected
        - Ambiguities to be construed against insurer
        - Interpretation must avoid windfall to insurer or unanticipated recovery to insured
- **Ratio:** Shows that interpretation is not clear - we have a fundamental basis but appears to be very case specific
- **Commentary:** Prof suggests that Dissent used 'fairness' interpretation to benefit children via estate

Issue 3: How do the principles factor into this analysis?

- ie: How do you interpret the exclusions against the insurance company to benefit the insured?
- Significance of these cases is that they never get to 2nd step as both decided based on intention of the parties

***Engle v. Aviva* [2010 ABCA]**

- **facts:** commercial building insured; lot being excavated next to a building; building sustained damage to its foundation and structure because of excavation next door; court had to look at **settlement exclusion clause** ("form does not insure against loss or damage caused directly or indirectly by… iii) settling, expansion, contraction, moving, shifting, or cracking unless concurrently and directly caused by a peril not otherwise excluded); IC denied coverage relying on exclusion based on loss/damage caused by settlement; insured argued that exclusion doesn't apply as it was only supposed to apply to damage caused by 'naturally occurring settling'; insurer said that exclusion wasn't specifically defined so it should apply broadly to both types; chambers judge held exclusion clause not to apply as loss was not inevitable - exclusion clause interpreted to only apply to settlement caused by natural forces;
- **issue**: Does exclusion clause exclude coverage for loss/damage from settlement regardless of cause?
- **Decision:** Found in favour of insured - exclusion clause only applies to **naturally** caused settlement and since this was man-made, the insurance company is liable for the damage
- **Reasoning:**
    - Looked at other Settlement Cases: most settlement exclusion clauses exclude settlement regardless of cause
        - **but** most do not contain words "caused by" **and this settlement exclusion** specifically said "**caused by" so it was distinct** from those that exclude settlement without regard to cause
    - So referred to principles that govern interpretation of insurance contracts (p. 195)
        - court must search for an interpretation from the whole of the contract that promotes the parties' true intent at the time of entering into the contract
        - where words are capable of two or more meanings, the meaning that is more reasonable in promoting the intention of the parties will be selected
        - ambiguities will be construed against the insurer, often by use of *contra preferentem* rule
        - an interpretation that will result in either a windfall to the insurer or an unanticipated recovery to the insured should be avoided
        - coverage provisions should be construed broadly and exclusion clauses narrowly
        - the desirability, at least where the policy is ambiguous, of giving effect to the reasonable expectations of the parties
    - Step 1) Intention of parties: **court felt that wording of clause was instructive as to parties' intent**
        - i) looked at language of exclusion itself & find that it shows intent of parties:
            - specific terms used re: 'expansion, contraction, moving, shifting, cracking' suggest it was meant to exclude damage for **gradual, natural events**
            - Settlement stated to occur in two ways:
                - 1) Almost inevitable settling or shifting of structure brought about by its construction and its foundation
                - 2) Consequence of accident or misadventure, and results from unexpected and unnatural force to building or erosion to its foundation

        - Settlement exclusion clause made no attempt to specify that damage arising from settling, whether natural or man made, intended to be excluded
    - ii) looked at language used in rest of policy which specified coverage re: natural or man-made
        - language shows drafters could reflect intent to exclude natural events via precise language but this clause does not
        - Drafters could have reflected an intent to exclude both natural and fortuitous events by precise language such as "whether natural or man made" - **would have been easy to do if they were trying to exclude this**
        - ****remember exclusion clause so being interpreted as *narrowly* as possible****
    - iii) looked at general intentions of all-risk policies:
        - consistent to interpret exclusion as applying only to natural settlement because all-risk policies are not in place to cover inevitable or natural settlement but accidental events
            - Reasonable intention of parties to policy was that settlement exclusion clause applied to naturally occurring settlement, but not to settlement that occurred otherwise
        - in addition, insurer under all-risk policy would agree to cover fortuitous events because they have right of subrogation to recover from wrongdoer (not under natural so makes sense it would be excluded)
    - **ultimately if parties intended different results, they should have said so in contract**
- Ratio: under step one the courts consider the language of the exclusion, the language used throughout the rest of the policy, and the context of the contract overall

Scott v. Wawanesa [**1989 SCC]**
- **Facts:** Insured home damaged by fire deliberately set by the 15 year old son of **named insureds**; Policy contained exclusion clause for "criminal or willful act" of **insured** and contained many defns for the word "Insured", including relatives living in the house; intention of broad exclusion was to cover possessions of person who owned the house & those who lived within it; insured argued that ***they* didn't intentionally cause the loss or mean for the son to do it so exclusions don't apply**
- **Issue**: was the son the "insured" for the purposes of the exclusion clause? IOW, does exclusion clause only apply to the insured *responsible* for the act or omission, or does it apply to *innocent insured* as well?
- **Decision {Majority - 4}: Yes - loss not covered because policy exclusion captured son**
- **Reasoning {Majority - 4}**
    - court interprets contract on its face & find that it clearly excludes coverage in these circumstances
    - policy specifically does not cover type of risk that occurred & that definition of insured clearly includes son
        - = clear wording that boy was an insured under the policy and that coverage was excluded by his criminal and willful act **{defined in the policy, so not ambiguous}**
        - note: much more simple reasoning than that of the minority
    - rejected argument that son's insurable interest was limited to his personal property as he had directly relationship to family home & its contents as they were his source of accommodation & support so his interests were inseparably connected to that of parents
- **Reasoning {Minority 3}:** Exclusion ambiguous and applied *contra proferentem*
    - **unfairness** in application causes them to find ambiguity
    - acknowledges that courts have used two different approaches in these situations:

- (i) make recovery dependent on whether interests of co-insured were joint (misconduct of one=misconduct of other) or several
- (ii) considers language in contract & whether reasonable person would view obligations as the same as co-insured

- takes **contextual approach** to interpreting contract to find that the exclusion is ambiguous as insured ***could*** mean the person who committed the criminal act: applied *contra proferendum* to find coverage
  - reasonable person would expect that policy naming them as insured would insure extent of their interests unless they are the one who wilfully destroyed property
  - parents didn't take out insurance to insure son's possessions but to protect their house so unreasonable to assume that this marginal consideration would prevent recovery – policy should be construed in way that reflects **ordinary intentions of parties** in this type of commercial transaction
  - if insurer wants to draft policy contrary to these reasonable expectations, it must put it in clear language
  - if fire destroyed house & insurer was presented by claim by son that he be treated as an equal to named insured for value of whole property, this would have been rejected as not jointly insured with inseparable interests to named insured (unreasonable to hold this in one context but not reversed)
  - harsh result to punish parents who have major interest under policy for wrongful act of child
  - **public policy concerns shouldn't come into play because it wouldn't be covering the wrongdoer** but his parents & the reasonable intention of insured homeowner was for house to be protected despite intentionally caused loss by their children *(Babs says that this may be confusing the reasonable intention of the parties on the face of the contract with the reasonable expectation test that is applied for ambiguity)*
- **Ratio:** where wording of contract is unambiguous, courts shouldn't give it a meaning different from that expressed in its terms unless it is unreasonable or has an effect contrary to intention of parties
- **Note: s. 541(1) IAA** imposes statutory interpretation where similar exclusion clause is in question to ***Scott***
  - = exclusion for criminal act of one insured doesn't apply to an innocent co-insured

Court divided on definition but neither majority or dissent are arguing under ambiguity principles {ironic that they can be divided over meaning but say there is no ambiguity}

***Canadian National Railway v. Royal and Sun* Alliance [2008 SCC]**

- **Facts:** loss caused during construction of railway tunnel when drill stalled due to dirt build up; insured claims for loss of time & cost of repairing machinery; insurer says they don't have to cover the loss as there is **exclusion associated with "faulty design"** of tunneling project (in hindsight, it is clear that there was a problem with the design of the drill which allowed for dirt to fall in - however this was a novel project so no one knew this at the time of design as used state of the art technology)
- **Issue:** Does loss fall within exclusion such that IC can avoid paying?
- **Decision {Majority - 4}:** No
- **Reasoning {Majority}**
  - no ambiguity in exclusion clause: idea of faulty design must mean one that doesn't comply with state of the art technology
    - perfection in design not required - it simply must be as good as it could be given whatever information was known at the time of the design

- narrow interpretation appropriate as best accords with intentions of parties based on plain meaning of words used
- all-risk policy taken out in recognition of risk based on lack of knowledge about project due
    - this is a manuscript policy meaning one of exceptional expensive projects where insured/insurer negotiated terms of the contract including coverage & exclusions important because it isn't a contract of adhesion so any of the policy reasons for interpreting it against the insurer do not apply
- court takes into account burden of proof: court is satisfied of coverage on BOP so turns to basis of exclusion, since insurer didn't meet onus of proving exclusion applies then their argument fails (can't rely on hindsight to prove it)

- **Reasoning {Minority}:**
    - no ambiguity found
    - arrive at a different defn of 'faulty design' – should be capable of withstanding reasonably foreseeable risks
    - risk that materializes in this case is foreseeable so the exclusion applies
- **Ratio:** stands for issue that has arisen out of general principles and "guidelines" that SCC has given us that in their application are much more difficult to apply
    - ***prof not very interested in the reasoning here***

2. Interpretation of Common Terms - "Use and Operation" of Motor Vehicle

<u>The Standard Auto Policy – made up of 3 sections</u>

- Policy approved by Superintendent to make sure all government interests are covered
- AB has fault-based insurance meaning it operates under tort law principles (not all provinces are like this)
- **Section A: Liability Insurance Coverage**
    - IC will provide coverage that will indemnify driver for any judgments against them OR for loss or damage to others arising from '**use or operation**' of car
        - where vehicle owner or anyone driving it with their permission causes loss/damage to someone else, the insurance company pays the judgment entered against you (only when you are be sued)
    - mandatory provision with a min $200,000 under Traffic Safety Act to ensure the injured are compensated
- **Section B: Accident Benefits – Medical payments, Death & Total Disability, Uninsured Motorist Cover**
    - Every time you buy section A, you get Section B: not designed to provide complete compensation but an **immediate source** to help you cover disability benefits, injury, etc.
    - coverage for death/injury of person that arises directly or independently of all other causes by accident arising out of '**use or operation**' of car
    - Definition of insured is different under this section – includes pedestrians
    - Medical: up to $50,000 available to pay for sickness where you are injured in a car accident
    - Disability: time off work
    - Death benefits: funeral, payment to family members
- **Section C: Collision Coverage**
    - optional coverage, though contained in standard auto policy: declaration page says whether you have it
    - covers accidental damage to **<u>own</u>** vehicle (not intentional harm): premiums/limits depend on value of car

- coverage to vehicle does **NOT refer to use and operation**

- SEF 44:

- accident must arise from '**use & operation**' of car
- courts use the same guidelines & principles to interpret however there is some discrepancy in results where phrase used

"Use and Operation"

- Arises in insuring agreements of automobile insurance policies; and
- In exclusion clauses of general liability policies
- Term has lead to significant litigation {See p. 48 Janelle's CAN for examples}
- **2 Factors the Courts Look at when Analyzing meaning of 'Use and Operation'**
  - 1) Meaning/Purpose
  - 2) Look to facts to find causal connection

Amos v. ICBC **[1995 SCC] *Leading Case: "no fault"***

- **Facts**: A attacked by gang while driving his van in California; Assailants attempted to break into his van; A shot while trying to get away, effectively leaving him a paraplegic; Returned to BC and made Section B claim for no fault accident/disability benefits from ICBC {**note:** different test that is applied when court is looking at ****no fault compared to third party liability**** - be mindful of what kind of case you're dealing with}; At issue was interpretation of Section 79: "benefits in respect of death or injury caused by an accident that arises out of the **ownership, use or operation** of a vehicle"; BCCA held A wasn't entitled to benefits because his loss didn't meet these requirements

- Issue: Did A's loss arise out of 'use and operation' of vehicle?

- Decision: Yes - A was entitled to no fault disability benefits sought

- Reasoning:

- court tries to avoid overly technical definition of 'use and operation' that defeats purpose & intent of legislature to provide coverage where there is some connection between ownership/use/operation of vehicle & injuries
- **Develops: Two Part Test ("Amos" Test)**
- **1) PURPOSE: Did the accident result from the ordinary and well known activities to which cars are put?**
  - A was driving the van when assault occurred and was using vehicle for its ordinary purpose = **YES**
  - ***Most of time this first requirement is met*** - basically satisfied where you can show transportation was involved
    - all accidents which the common judgement in ordinary language would attribute to the utilization of an automobile as a means of different forms of accommodation or service
- **2) CAUSATION: Is there some nexus or causal relationship between the appellant's injuries and the ownership, use or operation of his vehicle?** or is the connection between the injuries and the ownership, use or operation of the vehicle merely incidental or fortuitous?
  - *more contentious part of the test*
  - Doesn't require a direct or proximate connection, or for MV to be direct instrument of the injury
    - phrase 'arising out of' is broader than 'caused by' so should be interpreted more broadly
  - **But requires MORE than vehicle just being the site of the loss**

- must be possible to trace a **continuous** chain of causation unbroken by interposition of a new act of negligence and stretching between the the negligent use and operation of a motor vehicle on the one hand and the injuries sustained by the claimant on the other
- **Here:** Van was *more* than just the site of the shooting because the shooting resulted from the assailants' attempts to gain entry to the van

- **Commentary:** uncertain after this case - test was being interpreted very broadly, courts weren't distinguishing Amos on the basis that the case dealt with "no fault" benefits - were using it third party liability cases
  - further cases (*Vytlingham* & *Herbison*) *apply the test to find no coverage because they say that the causal test must be narrowed where you are talking about coverage under Section A*

Citadel General v. Vytlingam* [2007 SCC] * narrows Amos' causation test for liability insurance

- **Facts:** Vs were traveling on a highway in North Carolina when their vehicle was **struck by a boulder** launched from an overpass by Farmer (tortfeasor); Michael V sustained catastrophic injuries and his mother and sister suffered psychological injuries; Vs received no fault benefits from their own insurer in Ontario **as per the *Amos* test**; (court agrees this is a good application) **but also seek their same IC to pay under the inadequately insured motorist coverage pursuant to Family Protection Endorsement 44 {ie: to stand in the shoes of Farmer and pay the amount he ought to pay by way of damages};** Farmer's insurance policy limits were $25K; Michael's damages alone were assessed at $960K so tortfeasors' limits insufficient to satisfy Judgment; **SEF 44 provided that:** "insurer shall indemnify …for the amount … legally entitled to recover … from inadequately insured **motorist** … **arising directly or indirectly from the use or operation of an automobile**"
- **Issue**: whether the tort that caused the injuries was sufficiently connected to the **use and operation of Farmer's car** for it to be concluded that the claim was based on a tort committed by a **motorist?** [IOW, whether the chain of causation linking the claimed loss to the use and operation of the motor vehicle is broken (by boulder launching)?]
  - "Courts below thought Vs were entitled to compensation {because of trend under *Amos* test that *anything* involving car would be covered
- **Decision: No coverage - Amos test doesn't apply this far:** policies must be interpreted to give effect to reasonable expectations of the insured and the insurer
- **Reasoning:**
  - Did not feel CA had addressed issue of whether or not Farmer`s tort **was committed as a motorist**
    - Farmer may be a motorist and may be at fault for the injuries but the question arises as to whether the claim can be said to arise from the ownership, or directly or indirectly from the use or operation of an automobile
    - Cause of V's injuries arose from boulder launching - **not a tort committed as a motorist**
  - **Amos not a template to resolve indemnity coverage**
    - **Motorist"** issue does not exist in "**no fault**" coverage: in *Amos* focus was necessarily on claimant's car but here we are dealing with tortfeasor's car
      - ie. The motorist issue because the type of insurance and coverage requirements in Amos did not require the presence of an at fault motorist
    - In this appeal, Court not concerned with no fault statutory accident benefits payable to an insured
      - *Amos* – focus was necessarily on use of claimant`s car
      - Here – focus on use of tortfeasor`s vehicle

- **Forces court to <u>distinguish and adapt</u> the *Amos* test = MODIFIED TEST**
- **1) PURPOSE: does the claim arise from the tortfeasor using the vehicle ***<u>as a vehicle</u>*** and not for another purpose? (ie. As a diving platform)**
    - IOW was V's claim was in respect of an inadequately insured tortfeasor whose fault occurred in course of using a motor vehicle as a motor vehicle and not for some other purpose?
    - IC argues that Farmer used " vehicle for the purpose of getting weapons to the scene of a crime" and this doesn't fall within meaning of "ordinary and well-known activities"
    - Court disagrees: transportation is what cars are used for - the fact that it was for criminal purpose is irrelevant, as it is still being used as a car
    - Purpose of SEF 44 is to sell piece of mind to insured & will often be invoked where criminality is involved due to the nature of coverage so unfair to deny claim here (ie: drunk driver)
- **2) CAUSATION: is the chain of causation linking the claimed loss or injuries to the use and operation of the MV unbroken? {the TORTFEASOR's USE & OPERATION}**
    - **Elements of tort need to be non-severable**
    - Insured argues car was integral to the entire operation so if not for transportation it would not have occurred
        - court disagrees: car-related activities are severable from tort
    - Test is concerned with elements of the tort itself and in this case liability comes from dropping rocks and not transporting them
    - While the **use of Farmer's car "in some manner" contributed to his ability to commit the tort** that caused V's injuries, such contribution does not mean the tort was committed ***in his capacity as an at fault motorist*** **within the meaning of the SEF 44**
        - Farmer's car was used to transport boulders/people to scene: this activity is severable from the rock throwing
    - CA erred in transferring without modification the discussion of causation in *Amos* into different context of determining whether the liability established here on the part of Farmer arose directly or indirectly out of the use of the Farmer vehicle
    - **Essentially reining in *Amos* test: narrows 'but for' test for liability coverage because to use it in these type of cases would mean that anytime anyone takes a car anywhere and then causes harm, it would trigger liability coverage**

- **CONCLUSION:** The 44R requires the tortfeasor whose conduct is the subject matter of the indemnity claim be at fault as a motorist
    - 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
    - Claimant must implicate the vehicle in respect of which coverage is claimed on a manner that is more than merely incidental or fortuitous
    - While use of Farmer`s car in some manner contributed to Farmer`s ability to commit the tort that caused the injuries, such contribution does not mean the tort was committed in his capacity as an at fault motorist within the meaning of the 44R
    - Rock throwing was an activity entirely severable from the use or operation of the Farmer vehicle
- **Ratio:** Case stated to turn on question of causation - to suggest that any time a car is used to transport people to the scene of a tort or a crime is sufficient to engage inadequately insured motorist coverage stretches the intended coverage until it snaps

Lumbermens v. Herbison **[2007 SCC]**

- **Fact:** Wolfe driving to hunting stand when thought he saw deer; stopped and shot at flash of deer but hit another member of the hunting party H; Wolfe found civilly liable, and damages assessed at $832K; **Wolfe policy provided coverage for loss or damage arising from the ownership, or directly or indirectly, from the use or operation of an automobile owned by the insured**; H sued Wolfe's IC seeking to have it satisfy their Judgment*;* Ontario *Insurance Act* required victim to demonstrate that liability imposed by law upon the insured Wolfe is for **loss or damage arising from ownership, or directly or indirectly, from use or operation of automobile**; ONCA holds that reference to 'indirectly' effectively removed requirement for unbroken chain of causation
- **Issue**: was W's negligent shooting <u>fairly within</u> the risk created by the use or operation of the insured vehicle, or did the use of the vehicle merely create an opportunity in time and space for the damage without any causal connection to the tort?
    - **third party liability coverage, not "no fault" benefits**
- **Decision:** No coverage based on application of *modified* Amos test
- **Reasoning**
    - Court distinguished *Amos*, noting that Court was not concerned with no fault statutory accident benefits payable to insured and focus in Amos was on the use of the claimant vehicle, whereas here concerned with use of tortfeasor vehicle.
    - **Applied *Amos* test and failed on step 2 causation test**
        - i) Purpose: purpose of use was for transportation which is in usual & ordinary use of vehicle so first step is met
        - ii) Causation: intervening tort of negligence (via shooting) breaks chain of causation between use of vehicle and injury
            - *Vytlingam* applies in cases of liability coverage to **require court to go beyond merely finding that use or operation of the MV 'in some manner contributes or adds to the injury'**
            - Wolfe interrupted motoring to start hunting **= <u>No causative link</u>**
- **Ratio:** modified *Amos* test for third party liability coverage requires a causative link between the 'use and operation' of the vehicle, beyond just that it adding or contributing to the injury

ING v. Manuel* (2008 ABCA) *third party liability

- **Facts:** deceased driving, took out a gun; shot his child and himself; mother sought recovery under liability insurance which covered 'loss or damage arising from the ownership, use or operation of the automobile'; trial judge found coverage
- **Issue:** Was shooting fairly within the risk created by deceased's use or operation of the insured truck, or did the use of the truck merely create an opportunity for the damage to be inflicted without any direct or indirect causal connection to the basis for liability?
- **Decision:** Causative requirements not met
- **Reasoning:**
    - i) Purpose: car being used so this is satisfied
      ii) Causation: court said use of car <u>not</u> ***causally*** related to loss as there is a broken causal chain between the operation of the vehicle and the shooting (vehicle is simply incidental site)
        - **liability flows from shooting**: mother isn't claiming about deceased's use and operation of vehicle but about the gunshot
        - Truck was simply the place that the shooting happened
        - Did not show unbroken causal chain connecting operation of truck to shooting
- **Commentary**: this would have been different if put exhaust pipe in car to kill son instead of using gun as would have been from use & operation of car

Arruda v. Allstate **[2007 ABCA] **no fault liability case: Section B, but different wording that *Amos*****

- **Facts:** A stabbed after MVA; wife and estate trying to make claim under "no fault" Section B benefits; Section B wording included the words "**directly and independently of all other causes by an accident arise out of use and operation of a motor vehicle**" {note: worded different than *Amos* cases}; wife argued that wording of Section B is similar enough to *Amos* so 2-part test should be broadly interpreted to find coverage; Insurer argued that 'directly and independently' narrowed the meaning of the term 'arising out of use an operation'
- **Issue:** Do the circumstances of A's death within wording of the Section B coverage?
- **Decision:** No
- **Reasoning:**
    - Upon strict application of Amos, coverage would be found because there is a sufficient nexus - he died as a result of injuries sustained while complying with his duty as a motorist involved in accident
    - **But additional wording** required that the use of the motor vehicle be the **DIRECT** cause of the injury or death, and that the chain of causation be unbroken
        - this wording narrowed interpretation of 'arises out of' to require use of the vehicle to a proximate and direct cause of injury and death (unbroken chain)
        - **Result of wording is to apply modified Amos test to Section B in the same was it is applied for Section A coverage**
    - Injury didn't result directly out of use of MV but out of assault so there was no unbroken chain
        - Because he had been stabbed after road-rage incident occurred = broke chain of causation
- **Ratio:** specific wording of IA Section can alter the application of the *Amos* test

Derksen v. 539938 Ontario Ltd*. [2001 SCC] **different from other cases because looking at 'use and operation' as an exclusion changes burden of proof to require insurer to prove exclusion, interpreted narrowly*

- **Facts:** Employee left steal plate unsecured in truck; flies off back & hits school bus, injuring 3 & killing 1; employee sued on several grounds including negligence based on unsecured plate; employee had auto insurance as well as **general liability insurance which excluded coverage** for 'bodily injury or property damage arising out of ownership, use or operation of auto and for bodily injury or property damage with respect to which any motor vehicle policy is in effect'; court said there were 2 potential causes of loss: negligence in cleaning up work site (non-auto related) & negligence in operation of car by improperly securing plate; insurer argued that where loss is caused by two concurrent causes, **one of which is included and one of which is excluded, and the excluded cause is *essential* to the chain of causation, there is should be no coverage at all**. Trial judge held that general liability policy provided coverage despite exclusion clause
- **Issues:** Did loss arise out of one auto related cause, or two concurrent causes? If loss arose out of two concurrent causes, is coverage under general liability clause excluded by automobile exclusion clause in that policy?
    - ****decided prior to *Amos* etc****
- **Decision:** Two concurrent causes - exclusion clause was ambiguous as to what occurs where 2 concurrent causes, so principles of interpretation require the court to interpret exclusion narrowly in favour of insured = coverage
- **Reasoning:**
    - Court said that if the insurer wanted to limit coverage in these circumstances, it should have expressly stated this

- Nothing to indicate there was no coverage at all if excluded risk was an additional cause of injury so held that general liability policy only covers portion of loss attributable to non-auto-related negligence
- Where both auto related negligence and non-auto related negligence of same person contribute to same bodily injury, there must be ***percentage apportionment of fault to each type of negligence.***
- Exclusion clause stated not to totally exclude coverage under CGL policy, but rather only that portion of loss that is attributable to auto related negligence is excluded
    - **remember: point is General Liability insurer is trying to get out covering *both***
    - would not read in another intention

-**Ratio:**

McEvoy v. McEachnie* [2010 BCCA] - *actually a vicarious liability case

- **Facts:** F's Jeep involved in single vehicle accident; Appeal from TJ's holding that McEachnie was driving vehicle with F's consent resulting in F being vicariously liable for McEachnie's negligence; And appeal from finding that F's daughter was driving or operating the Jeep again resulting in Forster being found vicariously liable; **Two versions of the facts:** Trial judge found that daughter's intoxication led her to believe that hazard existed where there was none, or to think it would be humorous to give the Jeep a shake by grabbing the steering wheel - found that daughter engaged in deliberate act to exert force on steering wheel and that daughter was 'driving' and 'operating' the Jeep within the meaning of those words as set out in Section 86 of the relevant legislation (s. 86: "… every person driving or operating the motor vehicle … with the consent … of the owner ….")
- **Issue**: Was daughter driving or operating the Jeep at the time in question for purpose of Section 86
- **Decision:** Yes
- **Reasoning:**
    - Court did look at a BCSC case where Amos was applied and Looked at Vytlingam which limited 'relaxed causation' test in Amos to situations of no fault insurance benefits = <u>not</u> determinative
        - Court of view that conclusion that daughter was driving Jeep was in accord with grammatical and ordinary meaning of Section 86 - so Amos, Vytlingam, et al not considered to be 'determinative'
    - Applied principles of statutory interpretation to conclude that even though daughter had just reached over from the passenger seat, she was "driving" the jeep
- **Ratio:** passenger in a motor vehicle who suddenly reaches over and grabs steering wheel is "operating" the vehicles for the purpose of insurance coverage

***Hannah v. John Doe* [2010 BCCA]**

- **facts:** H brought action against ICBC under unidentified motorist provision of relevant legislation claiming damages for injuries sustained in an accident in supermarket parking lot; Passenger in van came up beside Hannah, reached out, snatched her purse and drove off; H was thrown backward and dragged until her purse ripped; Driver/passenger of van never identified; H relied on s. 24: "**if bodily injury … arises out of the use or operation of a motor vehicle … any person who has a cause of action … in respect of bodily injury … may bring an action against the corporation as nominal defendant …"**
- **Issue:** did H's inures arise out tortfeasor's 'use of operation of vehicle'
- **Decision:** Yes
- **Reasoning - not very important**

- Examined *Chan v. ICBC* [1996 BCCA] = Passenger injured when struck by brick thrown from unidentified oncoming vehicle, where issue was whether brick throwing fell within unidentified motorist provision
    - CA relied on Amos and held that brick throwing broke the causative chain
    - **but this case is no longer good law: *Vitingham* narrowed *Amos* test and stated to overrule *Chan* on the question of causation**
- Here, ICBC argued that intentional torts and criminal acts do not come within Section 24: **ICBC trying to use *Amos* arguing that did injuries didn't "arise out of the use of the vehicle"**
    - Court **disagreed**: **noted that ICBC did not distinguish between cases where claim advanced against 'at fault' motorist, and those where insurer seeks to recover from insured the damages paid to a claimant based on an insured's policy breach involving intentional or criminal acts**
    - Like underinsured coverage in *Vytlingam*, an "at fault motorist" required to permit recovery in Chan
    - In action brought under the unidentified motorist provision, requirement in Vytlingam for an 'at fault motorist' makes clear that words 'arising out of' must be taken to mean 'caused by' and vehicle must be implicated in a manner that is more than merely incidental or fortuitous
- **Note** that Court discusses Section **19.1 of BC legislation** added to exclude damage caused by shootings (ie. "use of any weapon or any object other than a vehicle used as a weapon")
    - another "twist" of this case
- **Court then looked at Vytlingam**
    - it was reasonable to infer that driver and passenger were engaged in joint enterprise of robbery using their vehicle to effect their purpose
    - Found that it was the driver's acceleration of the vehicle while the passenger had hold of Hannah's purse that caused Hannah to fall and be dragged = **Case of continuous chain of causation**
        - **more than just incident scene of tort - integral - car was used to commit tort**
- **Ratio:** injuries suffered by pedestrian when passenger in van tried to grab her purse and ended up dragging her, arose from the 'use and operation' of the vehicle - without an exclusion to the contrary, **criminal acts can fall under Section A coverage.**

Russo v. John Doe* [2008 ONCA] *same wording under consideration as in *Vytlingam*

- **Facts:** Appeal considered scope of 44 Family Protection Coverage; R was victim of drive by shooting that left her paraplegic; R went into restaurant to get snack and shots fired from stolen van driving by in the parking lot; under consideration, s. 239 of ON Insurance Act and wording of Ontario SEF 44 = same wording as considered in Vytlingam
- **Issue:** did R's injuries arise from the "use and operation" of motor vehicle?
- **Decision:** No - *Vytlingam* applied
- **Reasoning**
    - **purpose test** was met as van used to transport shooters and guns to front of restaurant – stated to be a well known and ordinary use of an automobile (maybe a stretch but still using it to "drive"…)
    - **but causation test not met**
        - R's injuries did **not arise from driver's driving** but rather from **the passenger's shooting** = a distinct and intervening act completely independent from use or operation of van
            - = severable intervening event

- **Ratio:** personal injuries arising from drive-by shooting did not arise from 'use and operation' of motor vehicle because the shooting was an intervening act

Letkeman v. Ouellette **[2010 ABCA]**
- **Issue:** Did personal injuries suffered by police officer when he was assaulted by a driver while attempting to arrest the driver after a chase, arise from "use and operation of vehicle"?
- **Ratio/Reasoning:** injuries were caused by assault not by driver's use of car - assault was the intervening act that broke the chain of causation.

3. Interpretation of Common Terms - 'Accident'

Scale of Culpability
- **i) Fortuitous loss** – no human interaction (ie. Lightening)
- **ii) Negligence** – don't intend or expect loss but is foreseeable by reasonable person **{accident falls within the red}**
- **iii) Gross negligence** – you are foreseeing the loss yourself
- **iv) Recklessness** – it is foreseeable and on reasonable standard you would expect it
- **v) Intentionally caused loss** – on purpose – will never be an accident

Issue = where to put 'accidental loss'
- **issue** = where insurance provides coverage for '**accidental loss'**, how far down the continuum do we go before we can say that loss is *effectively intentional*?
    - ie: things become so reckless that there is no difference between insurer saying they want the loss to occur or that they knew it would occur
- "A century and a half of insurance litigation has failed to produce a bright line definition of the word 'accident'. **Insurers have consistently declined to attempt to define the term in their policies."** (*Co-op v Gibbons* SCC)
    - "One of the most philosophically complex simple questions" = what is an accident
- Case law says that for intentionally caused loss, you don't need to have intended the loss that actually occurred but you must intend some harm
- **accident falls around negligence, gross negligence, and recklessness**
    - case law we are talking about is contracts where IC provides coverage for only accident: designed to say it is NOT fortuitous or intentionally caused losses
    - cases deal with unintended losses resulting from intentional acts or disease – probably fortuitous as not usually seen as accident however difficulty where human activity leading up to illness pushes it into definition of accident
    - if you can classify the human activity that leads up to disease as negligence or gross negligent, you can probably define it to be an accident
- **Examples:**
    - anthrax attack – intentional
    - rape – not an accident
    - unprotected sex that leadings to illness – fortuitous as normal activity you would expect to lead to particular disease
    - drunk driving – did not intend to cause a loss
        - courts have said this is gross negligence which would constitute an accident so it would be covered under Section C of SAP except where insurance contract specifically excludes coverage for loss/damage to vehicle if you are driving impaired

- but Section B provides coverage even though accident was caused by impaired driving

Martin v. American International **[2003 SCC] *drug overdose***

- **Facts:** Life insurance policy provided specific benefits if death '**effected through accidental means';** Doctor suffered from morphine & Demoral addiction and died of overdose after he injected himself with Demoral; Evidence did not suggest he was suicidal as he (i) was happy/planning for future and (ii) low level of drug was injected; insurer argued that there was no coverage under accidental death benefits since death was caused by purposeful injection of drugs with the knowledge that the risk of death was possible in doing so; beneficiary argued death was accidental as he mistakenly miscalculated how lethal the dose was
- **Issue:** what is the proper interpretation of '**accidental death**' benefit provision in life insurance policy? was the Doctor's death effected through "**accidental means**?"
- **Decision:** Yes - circumstances surrounding death supported inference that death was accidental - consequences of his action of injecting the drug was unexpected since it was caused by a miscalculation
- **Reasoning:**
    - Death occurred by accidental means where chain of events as a whole suggests insured did not expect death to be a consequence of actions and circumstances
        - **Death by "accidental means" = death that had been brought about unexpectedly**
    - Coverage for intentional act that leads to unexpected result is fair because:
        - i) accords with ordinary meaning of the phrase
        - ii) accords with the principle that insurance contracts must be interpreted in a manner that gives effect to the reasonable expectations of the parties
        - iii) almost all accidents involve some deliberate action as an immediate cause
    - Whether death was expected is determined through **2-Step Contextual Objective Test**
        - **i) did the insured *subjectively* expect to die as a result of his actions?**
            - need proof that the insured actually expected death to be likely:
            - **not sufficient** to prove there are risks involved, that the death could have been prevented by taking greater care or that mishap was reasonably foreseeable
            - may be proved by circumstances of the death, what insured said, did, did not do
            - **here:** the court determined that Doctor didn't expect to die (arrangement of body, planning for future, injection partly due to pain, minor amount)
        - **ii) To extent that it is unclear what the insured subjectively expected, would a *reasonable person in position of insured would have expected to die***
            - limiting willing participation in inherently risky activities without regard to their personal safety (ie. Russian roulette versus rescuing which has social value & where death isn't expected when considering larger context of triggering events)
            - insurer could have drafted contract to narrow coverage via specific exclusions for death resulting from deliberate or voluntary actions so long as it does so explicitly & clearly which isn't unfair to insured
            - **Beneficiary must prove accidental death on BOP, tactical burden shifts to insurer to displace inferences**
            - **Here:** someone who injects this level of dose wouldn't necessarily believe it would cause death even if experienced physician and drug-user

- **Ratio:** court unwilling to define accident so broadly that any death resulting from purposeful actions of insured wouldn't be considered an accident

Co-operators v. Gibbens* [2009 SCC] *sexually transmitted disease

- **Facts:** Claim under accident insurance policy by G, who had unprotected sex with three women; acquired genital herpes, which caused rare side affect of inflammation of spinal cord, resulting in total paralysis from mid-abdomen down; Claimed compensation under group insurance policy on basis that paralysis resulted "**directly and independently of all other causes from bodily injury occasioned solely through external, violent and accidental means**", without negligence on his part; case law up until this point says that bodily infirmity caused by diease contracted in ordinary course of events is <u>not</u> accidental; insurer argued that sex with willing partner is an ordinary part of life so not an accident
    - *Note: fact that sex was unprotected was irrelevant to decision*
- **Issue:** was paraplegia caused by **accidental means** or did it occur in the ordinary course of events?
- **Decision: <u>not caused by accidental means</u> -** paraplegia is a normal incident of contracting herpes and in order for accident policy to apply, bodily injury must arise from a mishap of some sort and not simply natural causes
- **Reasoning**
    - IC tried to argue that *Martin* applied but distinguished by the court:
        - (i) didn't deal with disease at all
        - (ii) court could infer accident based on circumstances as there was a miscalculation involved
    - G contracted sexually transmitted disease in **ordinary way** through intercourse
        - Paralysis was tragic and unexpected, but not caused by **external violent and accidental means** within wording of the policy
    - **Policy excluded bodily injury from processes that occur naturally within the body in the ordinary course of events, and as well, from diseases that are transmitted in the ordinary way without any associated mishap or trauma, except the spread or inception of the disease itself**
        - person would never said 'I had an accident' when coming down with virus/flu as they are contracted in ordinary course of events – parties wouldn't expect disease contracted in ordinary way to fall under accident coverage
            - "world is full of pathogens"
        - to say that contracting herpes was an accident would simply add STDs to 'critical diseases' in group policy and this was not the intention of the policy
            - such a conclusion would stretch the boundaries of an accident policy beyond the snapping point, and convert it into a comprehensive insurance policy for infectious diseases contrary to the express intent of the parties and their reasonable expectations
        - **Fact that outcome was unexpected doesn't mean an accident has occurre**d
    - <u>Court came to conclusion by relying on principles of interpretation</u> (tried to achieve result reflecting the atmosphere in which insurance was contracted)
        - i) Words like 'accident' should be given their ordinary meaning: as they would be understood by average person applying for insurance (ie. Picking up disease in ordinary course of events not ordinarily seen as accident)
        - ii) Generous interpretation of coverage term 'accident' unless policy restricts it: should take care not to convert accident policy into general health, disability or life insurance policy

- iii) Where ambiguous, words should be construed against drafter & effect should be given to reasonable intention of parties: doesn't apply in this case
- iv) Continuity of interpretation among jurisprudence to promote certainty & predictability

- **Ratio:** fact that an outcome was unexpected doesn't mean an accident has occurred - accident policies exclude bodily injuries due diseases that are transmitted in the ordinary way without any associated mishap or trauma other than the spread of infection/disease itself

Nelson v. Industrial-Alliance **[2010 ABQB] *important summary of principles on what constitutes an accident***

- **Facts:** insured with heart condition suffers heart attack & dies after swimming in cold water; death benefits provided coverage for **accidental death**; beneficiary argued it was an accident because he did not expect to die in doing this activity & death was a result of a mishap (swimming)
- **Issue:** was the death accidental? what constitutes an 'accident'
- **Decision:** No - death arose from deceased's inherent congenital heart condition = natural causes in the ordinary course of events not from disease or illness associated with the trauma or mishap
- **Reasoning:**
    - Accident benefit policies do not generally define the word "accident": guidance as to what constitutes an accident is to be found in the two SCC cases of *Gibbens* and *Martin*
    - <u>General principles of interpretation from *Gibbens* to be applied when considering the term "accident":</u>
        - 1. to be given ordinary meaning;
        - 2. generous interpretation to be given to term "accident" unless policy clearly restricts it;
        - 3. words of contract, when ambiguous, should be construed against drafter;
        - 4. when policy ambiguous, effect to be given to reasonable expectations of parties; and
        - 5. there should be continuity of interpretation.
        - Further guidance from SCC
            - Expectations of both parties to be taken into account
            - Balance to be struck btwn expectations of both parties
            - Care not to convert accidental benefits policy to general health, disability or life policy
            - Chain of events as a whole must be examined
    - **WHAT IS AN ACCIDENT?**
        - **i) Antecedent mishaps external to the person of the insured**
            - **= where bodily injury or death results from an external force or impact on the body of the insured**
            - includes unexpected bodily injury or death that arises from disease or illness that was caused by a mishap
            - examples: injury arising from MVA, slipping on ice, tripping while going down stairs, died from prolonged exposure to wet & cold due to shipwreck, fell off horse onto wet surface & contracted pneumonia, fell in hospital & needed surgery which led to death, involved in MVA which triggered pre-existing heart condition leading to death
        - **ii) Antecedent mishaps internal to the person of the insured**

- **= where mishap involves a voluntary act/movement of insured which is a normal day-to-day action but due to a bodily malfunction of the insured, bodily injury results (aka body contortion)**
- may have had pre-existing condition but this could not have caused the damage itself (required mishap as trigger)
- examples: insured suffers hernia from violently swinging golf course although pre-disposed to hernias, occlusion occurred after insured assumed awkward position & extended neck although had protruding disc which may have contributed, twisted his neck while playing basketball which caused stroke & paralysis

- **iii) Antecedent mishaps due to the miscalculation by insured of risk involved**
  - **= where intentional act by insured results in bodily injury or death due to events outside insured's control, insured having made a miscalculation, mistaken belief in circumstances, failure to perform action in timely manner, miscalculation of effects of intentional action on his body**
  - determined by consideration subjective & objective intentions of insured
  - court said that this test would also apply for intention consumption of drugs or alcohol leading to death/injury
  - examples: drove off ferry thinking it had reached pier, failed to notice ongoing train when crossing railway track, mistakenly inhaled more chloroform than expected during regular procedure, failure to remove mask in timely fashion
    - *Martin*: no intention to die, simply miscalculates risk associated with deliberate act

- **WHAT IS NOT AN ACCIDENT?**
  - **i) Disease or illness of the insured that arises from processes that occur naturally within the body in the ordinary course of events or from diseases that are transmitted in the ordinary way without any associated mishap/trauma**
  - examples: *Gibbens*; death via C-section from amniotic fluid embolism which is rare but natural consequence during child birth
  - ****CASE HERE** -** this as this was a pre-existing condition that unfolded in an ordinary and natural course of events (natural death) and not a result of an accident or mishap
    - swimming itself as a natural and common event, particularly for the insured
    - confirmed by medical reports which determined he died of 'natural causes' related to his inherent vulnerability due to his heart condition
    - relied on tools of interpretation to give effect to reasonable expectations of the insured & insurer who would not expected the circumstances of the insured's death to give rise to a claim under accident benefits policy; to do so would turn it into a general health policy
    - court distinguished this case from ***Martin***: while it is true that Nelson's act of going for a swim was deliberate and that the results were neither expected nor designed from his perspective, this is not the same as *Martin*
      - analysis in *Martin* related to determining whether death brought about by deliberate act would be considered an accident through miscalculation or whether it would be considered a suicide
  - **Note**: court still has problems determining what's a sufficient triggering event to entitled death/injury to be considered accidental (ex. contracting west nile from mosquito bite considered accidental & not a natural/ordinary event)

- **Principles**

- **1) Accident occurs where:**
    - **Prior unanticipated mishap or occurrence external to insured body causes BI or death**
    - **Disease or illness attributed to prior unanticipated mishap or occurrence external to insured body causes BI or death**
    - **Prior unanticipated mishap or occurrence due to deliberate action of insured results in BI or death due to bodily malfunction peculiar to insured**
    - **Deliberate action on part of insured causes BI or death due to insured's miscalculation or mistaken belief about circumstances**
- **2) Accident does not occur where disease or illness resulting from natural causes or bodily infirmity in the ordinary course of events causes BI or death**

F. INSURANCE AGENTS AND BROKERS

Broker vs. Agent

- historically: broker independent person with expertise who would consult public about their insurance needs and provide them with multiple quotes to get best possible deals
    - and agent worked for insurance company
- simplistically could say brokers are agents of individual applicant
    - complicated because interests of brokers are different - work on commission!
    - compared to IC who just want facts so they can't accurately assess risk
- because of these differences, body of law has arisen to deal with agency issues
    - agent of IC or agent of individual?
    - not always easy to determine and may change

Critical Pieces of Information

- 5 pieces of information that make the difference in the case law
    - 1. Whose agent is he in the circumstances?
    - 2. Is he an employee of an insurer or an independent agent?
    - 3. Did he act within his actual authority from the insurer?
    - 4. Did he act within his ostensible (or apparent) authority from the insurer?
    - 5. To what extent did the Plaintiff rely on the agent or broker?

ISSUE 1: What are the obligations or legal rights that arise in regards to insurance agents conveying info between the insured & insurance company?

- are misrepresentations made by insured and transferred through agent things the IC is deemed to know?
- where IC tries to prove it relied on wrong info at later point, the question is whether the wrong came from the insured or whether the agent is responsible?
- **Key question: is the agent acting as an agent of the insured or the insurance company?**
    - ***whoever the principal is, they are deemed to know everything that the agent knows***
    - ie: agent given correct info by insured but relays wrong info to the IC…
        - if s/he is an agent of the IC, the IC is deemed to know the truth because the agent knew it
        - if s/he is the agent of the insured, the agent might have breached their obligations to the insured by giving the IC the wrong info however it doesn't mean the IC is deemed to know the information because it is not the principal

- **<u>Basic Principles</u>**
    - **i) If insured fills out application form & signs it, they are bound by what is on the form**
        - remember ***Sleigh v Stevenson*****:** ONCA found that the insured could not be absolved of the disclosure duty by signing a completed application form without reading it. By signing the application form, the insured authenticated the contents of the form and was bound by the representations made on the completed form
    - **ii) Where the agent fills out the form & gives the insured the opportunity to read & sign it, there is a rebuttable presumption that the insured is bound by the contents of the form, even if the agent wrote down something wrong UNLESS you can show special circumstances why they shouldn't be bound**
        - once insured signs the form, the burden is on the insured to establish why the IC shouldn't be able to rely on that form (ie. Insured was illiterate, language difficulty)
    - **iii) Prima facie presumption does <u>not</u> apply if insured doesn't have the chance to read the answers or sign them** (*Blanchette*)

Blanchette v CIS Ltd. **(1973 SCC)**

- **Facts:** in course of brush-clearing work, individual sued for starting a fire which spread to another property; was aware he was being sued and applied for greenery insurance and public liability insurance; agent filled out form as per company policy; **one of the Qs in public liability section was whether insured had been subject to any claims and he said "no"**; insured told by agent that insurance would be in place immediately; few days later he sought to add tractors to insurance and agent said over the phone that he would fill this section out too - only asked him for serial #s **but** question on form was whether they would be used for brush clearing and agent filled out form to say no (factual dispute - insured said he was never asked about this and it was agent's mistake but agent argued he wrote down what insured said); **insured tractor destroyed by fire in brush-clearing**; IC denied on basis of misrep and because no policy had been issued; Trial judge ruled in favor of the insured; CA overturned decision saying that the agent who completed the form was the agent of the insured, not of IC, and therefore, the insured was responsible for incorrect statements on the form
- claim re: damage on tractor under fire insurance policy; insured (B) phoned agent & asked for fire insurance on property; question on app about past losses; agent fills in answer as no but this was inaccurate as there was legal action by the insured over previous fire; insured reads & signs it; after coverage put in place, insured phones to
- **Issue:** is the IC bound to provide coverage for damage to tractor?
- **Decision:** Yes - IC cannot rely on the erroneous answer written by its agent
- **Reasoning (Majority): agent was acting as agent of the IC**
    - Error re: intended use of tractor "could not be attributed to B in these circumstances" because
    - **1) The agent was more than just a soliciting agent**. He had the companies' rate manuals, could accept money on behalf of the company and could issue receipts on behalf of the company. He could make an agreement and bind the company. If he did not have actual authority to bind the coverage, he had ostensible or apparent authority to do so.
        - clothed with authority by IC to accept policies - even if he didn't have actual authority to bind coverage on the date of the application (as IC maintained) ***he had apparent authority*** **and thus policy was in force as of date of application**

- the agent was not merely trying to solicit business for the IC, he had authority to make the contract binding so IC should be held to whatever authority he professed to exercise & was reasonably believed to have

- **2) Agent's actions in filling out the form over the phone denied the insured the opportunity to verify the contents of the application form** – distinguished this case from those where the applicant signs the form without reading it.
    - general rule is that if someone signs form they haven't read or sign blank form in advance, the insured would be liable but this is different because agent had proposed a particular plan of action ("ill just fill it in over the phone") which made it impossible for insured to verify the information
- **3) The insurance company should bear the burden of the inaccurate information because the insurer had charged the insurance agent with the duty of filling in the application form**
    - by allowing form to be filled out this way, IC took the risk of receiving misinformation - to hold insured to incorrect answers would be unfair because he had no chance to review answers entered by agent

- **Dissent:** agent was acting as **agent of the insured**
    - By signing the application form and subsequently authorizing the insurance agent to add the tractor related information to the application form above his signature, ***the agent was acting as the agent of the insured***, and the insured bound itself to all information contained in the form
        - first coverage void because B signed below statement saying that signature meant all info in application was true
        - IC not liable for second coverage for tractor because agent was acting for B making the misrep made on the form a failure to disclose a material risk on behalf of the insured
        - Insured gave the agent permission to complete the form without him reviewing it
    - The Agent had no actual binding authority - could not bind IC to issue policy, and no policy was ever
    - **Prof says this makes more logical sense:** Insured is in the same position as if he signed a form without reading the answers filled in by agent
- **Commentary: see *Newshome* case** - proposer himself signs proposal form, he adopts whatever answer the agent has filled in; doesn't matter if he signs without reading or signs a blank form
    - based on this - how do you distinguish this case
    - **majority says he signed it believing it to be complete and *then* came back with a second application**

Current State of the Law

- **To avoid a policy on the ground of the misrepresentation of one or more material facts in the application or other written material, the IC must show:**
    - a) that the applicant himself filled out the form inaccurately or incompletely and signed it, in which case the applicant is bound by the answers; OR
    - b) that the agent, being required by the Company to fill out of the form, did so and correctly recorded false or incomplete answers given to him by the applicant and verified by the applicant's signature, in which case the applicant is bound by the answers, whether or not the applicant read the document; OR
    - c) that the agent, being required by the Company to fill out the form, did so and incorrectly recorded the true and complete answers given by the applicant, **who then verified the form by signing it**, in which case the applicant is bound by the answers, whether or not he read them; provided, however, that the applicant may be able to show special circumstances

sufficient to relieve the applicant of the consequences of his negligence or to disentitle the insurer from relying on the applicant's signature.

- if applicant gives right answers correctly but agent rights them down wrong, he is bound if he signs it unless he can prove **unfairness** or fit himself into one of the **exceptions**
  - **one of the exceptions**: when by the action of the agent the applicant is denied the chance to read over the form - *Blanchette*
  - **IA s. 606** - deems agent to be agent of IC (**is there an IAA equivalent?)**
    - could you use this section to suggest that agent was agent of IC and IC can not rely on misrep

- **what if court deems agent to be *agent* of the insured and he messes up answers, does individual have a remedy?**
  - sue agent in his personal capacity - if he is your "agent" he has certain responsibilities to you - to make sure the info is filled out completely and correctly
  - next few cases: in what circumstance can you sue an agent or broker
- **where problem arises as to existence of adequacy of Insurance contract, Canadian courts have generally held that agent can be personally liable**
  - thats why independents often have error or omission coverage
  - agents who are employees of corp may also in some circumstances be personally liable because they may be found to be *your* agent (corp would be vicariously liable because agent would have been acting in scope of duties)

ISSUE 2: Does the agent have to provide insurance coverage consistent w/ the insured's circumstances?

- ***TJR Interprovincial Projects Ltd. v. Wilford Agencies (1994) Ltd*, [2001 ABQB]**
  - agent liable for failing to obtain coverage for collision for insured's towing business because it was a known risk of the business (foreseeable loss)
- ***CIA Inspection Inc v Dan Lawrie Insurance Brokers* [2010 ONSupCt]**
  - broker liable for failing to obtain coverage for specialized piece of equipment required for the insured's business and for failing to advise insured of the gap despite specific request for coverage
- ***Beck Estate v. Johnston Meirer Insurance Agencies Ltd*, [2011 BCCA]**
  - broker liable for failing to discuss possible changes in coverage with insured who advised the broker that she had separated from husband (posed foreseeable risk of harm to property)
- Cases show us an **increasing** duty - as insurance gets more and more complex, there will be more reliance placed by insured on brokers, esp independent broker

***Fine's Flowers Ltd v General Accident Assurance Co of Canada* (1977 ONCA)**

- **Facts**: The insured corporation suffered a loss of horticultural products when the heating system failed in several of its greenhouses. The heating system failure had been caused by a water pump bearing, which burned out as a result of ordinary wear and tear. IC denied coverage because policy expressly denied coverage for loss due to "wear and tear" and insured sued their agent C who had arranged for all the coverage on the greenhouse; argued that he had instructed C to obtain full coverage and this clearly didn't happen; **insured had over many years established a close and continuing relationship with agent's company**; C argued that he could not obtain the required insurance from any insurer & that he never made representations that he obtained blanket coverage but simply what was asked for; also argued the insured had the policy in his possession so he could have read it to see what coverage he had; TJ found as fact that insured had relied on agent to cover him for all normal, foreseeable risks

- **Issue**: is the IC liable in contract or negligence to the owner by reason of is failure to arrange insurance protection against this event?
- **Decision:** Yes - agent liable for failing to obtain the requested coverage & for failing to tell the insured about the exclusion (had an obligation to tell them he couldn't get coverage for wear & tear)

  Reasoning (Majority - Wilson JA) : Liability in Contract
    - When asked to obtain specific coverage, agents must use reasonable degree of skill and care in doing so and inform the principal promptly if such coverage is not available.
    - If the principal gives no specific instructions, but relies on the agent to see that he is protected, then the agent – ***if he agrees to act on such terms***, must inform himself of the principal's business in order to assess the foreseeable risks and to insure his client against them.
        - allows plaintiff to rely on him to provide coverage, then he has to make sure he understands enough about P's business to obtain the nec insurance coverage (reliance was proven at trial)
    - **Therefore, C breached the terms of contract when he failed to obtain the necessary insurance coverage**
        - loss in this case was very predictable for this type of business however agent made no inquiries about it & obtained no coverage for parts in question at all
        - contract existed between principal & agent for obtaining full coverage of his properties & business, burden of introducing evidence to show coverage was not available was on agent but was not met so breach of contract established that led to principal's loss
    - C argued that it would be impossible to provide wear and tear coverage - if the requested coverage was unavailable, then Mr. Campbell breached the contract in failing to advise the insured about the gap in coverage.
        - Breached contract by failing to advise client (who could have looked else where, paid more etc.
        - Court found that C hadn't done any research into importance of pumps or looked into insuring them
        - Had been a letter from the IC who had done quick audit of greenhouse that pointed out pumps, would be important, and this is the amount etc.
    - Could also be held "negligent" in tort as a result of the special duty of care which agent owed the Plaintiff.
- **Reasoning (Dissent - Estey J): Liability in Equity/Negligence**
    - Not liable in contract as Insured didn't show contract was breached by C in that loss was suffered by an insurable risk under which the D should have obtained coverage
        - no evidence that there is any insurance on the market that would provide coverage in this circumstance so P can't prove loss arose out of 'insurable' risk
        - **no contract in first place because no "meeting of the minds" as to what 'full coverage' entailed**
            - did not agree on what constituted "coverage"
    - **Relationship between agent and insured gave rise to a tort duty of care.**
        - duty arose by virtue of the **reliance** placed upon the agent to **obtain adequate coverage against foreseeable loss** by the insured, and the acceptance of that reliance by the agent.
        - duty breached in failing to obtain insurance coverage against this reasonably foreseeable loss OR for failing to advise insured that coverage could not be obtained/ was subject to wear & tear exclusion.
        - **Test in *Hedley-Byrne v Heller*: an insurance Agent owes a duty of care in providing information to its customers if:**

- **1. The customers rely on the advice and information provided by the agent;**
- **2. The reliance is reasonable; and**
- **3. The agent knew or ought to have known of the customer's reliance.**

- Also found a breach in equity because the relationship gave rise to a ***fiduciary relationship*** under which C was obligated to arrange full insurance coverage or to advise the insured of any gaps in coverage.
    - breached duty in this case because he knew this was the most obvious risk that would face the business & about the lack of coverage
    - P was entitled to think his instructions were followed unless he was corrected
    - Prof thinks argument is perhaps going too far but ***maybe acceptable*** in these certain circumstances, because of their history of dealing
        - *better argument: reasonable reliance giving rise to tort duty of care that was breached*

- **Ratio:** agent has duty to provide coverage as requested or against all foreseeable risks & if this can't be done, they must inform the insured about the exclusions or gaps in coverage
    - **key is that agent is represented to insured that they can find a product to suit their need**

Fletcher v Manitoba Public Insurance Co **[1990 SCC] **lessens standard for public insurance agents****

- **Facts**: The insured, F was in a car accident and left a paraplegic. The driver of the other vehicle was 100% at fault and F was awarded over $1.3 million in damages. However, the other driver's insurance limits were only $500,000, leaving over $800,000 in damages unsatisfied. F and husband had auto policy which did not include equivalent of Alberta's SEF 44; F sued IC for breach of contract, misrepresentation, negligence & breach of duty arguing that he relied on the expertise of the agent when he obtained the policy - **had asked for maximum coverage available & had assumed he got it**; also that there was **no mention of SEF 44 when he got policy**; IC argued that they sent out flyer along with renewal certificate that mentioned Under-Insured Motorist Coverage (though did say 'not applicable under it); Trial judge found MPIC liable in tort and contract; Majority CA found IC owned no duty to ensure that its customers were aware of all available coverage - no breach because F received a flier about UMC and didn't read it; Minority CA found MPIC was liable in tort - given the almost complete monopoly enjoyed by Autopac, it was reasonable to assume at least as much of a duty as would be the case with a private insurance agent (Declined to rule on whether there was a contractual basis for the claim)
- **issue:** did government insurer have a duty to advise its customers about the existence of underinsured motorist coverage?
- **decision: Yes - SCC unanimously follows CA DISSENT and finds IC liable in <u>tort</u> -** F gets coverage for amount of loss he would have been covered for as if he was advised about UMC
- **reasoning:**
    - insurance applicants reasonably rely upon information provided by public insurance employees in order to make insurance decisions, these employees have a **<u>tort law duty</u>** to advise applicants about all available coverage options, including the purpose and cost of endorsements.
        - duty breached here because IC made minimal effort to inform F & public about existence of SEF 44
        - evidence suggested he would have purchased it had he known
        - forms simply cause confusion and any ambiguity must be resolved in favour of insured
            - communication by mail required them to make sure written materials were very clear, but flyer was not
    - This case and previous one consider **test from *Hedley Byrne v Heller***

- **An insurance Agent owes a duty of care in providing information to its customers if:**
  - **1. The customers rely on the advice and information provided by the agent;**
    - F relied on expertise of employee as source of info re: insurance and coverage
  - **2. The reliance is reasonable; and**
    - F could reasonably expect that insurer would tell them what was available
  - **3. The agent knew or ought to have known of the customer's reliance.**
    - employee should know that most customers are not knowledgeable in this area
- **Agrees with *Flowers* and previous cases re: Duty on Private Insurance Agents =** stringent duty to provide info & advice appropriate b/c they are licensed professionals who specialize in helping client with little knowledge of subtleties of coverage with risk assessment & tailoring policies to their needs
- **The Duty on Public Insurance Employees =** Limited to advising applicants in a reasonably intelligent fashion about all available coverage. Here the MPIC failed to inform the Fletchers about all available coverage, and therefore breached the duty.
  - **Thus Duty on public insurance employees *less* than on private IC**
  - Difference in the duties imposed upon a private agent and a public insurance employee (the private agent having a much more onerous obligation) turns on the degree of reliance reasonably and expectedly imposed upon the agent.
    - Lesser standard is appropriate because of institutional setting in which public insurance is sold (less individualized attention), qualifications of employees (more clerical than experts in risk assessment), options available are simple & straightforward to explain
- **No finding on MPIC's possible exposure in contract or equity**

- **Ratio:** public insurers have a duty to inform customers of available range of coverage so they can make an informed choice: *where additional optional form of coverage is available due to risk foreseeable to insurer in situations where standard coverage would be inadequate, insurer has a duty to make this known to insurer*
- **Commentary:**
  - **Miller V Guardian Insurance of Canada (ABCA 1997):** court found that agent was negligent in failing to advise purchaser of auto insurance of availability of family protection endorsement
    - **= adopted same "public law" duty placed on employees for all insurers in AB**
  - ***Fichtner v. Johnston Meier Insurance Services Ltd.*, [2001 BCSC]:** didn't advise as to expiry date - but no evidence of reliance
    - = **tort duty only arises where there is evidence of some reliance**
  - ***Sportsman's R.V. Resort Blind Bay B.C. Ltd. v. Capri Insurance Services Ltd*. [2003 BCCA]:** not liable for failing to explain concepts of "full replacement cost" etc because insured already understood these concepts
    - **= duty may be less when dealing with more sophisticated or experienced individuals compared to more vulnerable, inexperienced individuals etc**

G. CLAIMS ON THE POLICY

Steps to Payment of a Loss

- Once a loss has occurred, how does insured go about getting paid by IC

- **1. Insured must provide Notice of Loss and Details of Claim advanced to insurer;**
    - **a) notice**
    - **b) proof**
    - **c) cooperation**
- **2. Insurer must investigate, verify and respond to claim. Includes:**
    - **a) Confirm validity of Insurance policy**
    - **b) Confirm applicability of policy to loss**
    - **ci) Assess amount of compensation owed**

Insured's Duties upon loss

- **A. Provide Notice of Loss**
- **B. Provide a proof of loss; and**
- **C. Cooperate with the Insurer;**

1. Duties of the Insured (STEP 1)

(a) Notice of Loss

A) Notice of Loss

- Most insurance policies do include **'Notice of Loss Clause'** which typically require insured to report losses within a specific time period.
- **Timely notice** important because allows them to investigate while loss is still fresh and has the chance to step in and mitigate the loss if possible
- Makes providing notice of the loss a **condition precedent** to the insured's right of recovery under the policy
    - if insured doesn't provide ***timely notice*** they forfeit their rights under the policy
    - seems a little draconian, courts have noted this - duty relieved in certain circumstances:
        - **Insured can argue (if not fulfilling notice or other duty)**
            - **a) relief against forfeiture**
            - **b) waiver**
            - **c) estoppel**
    - 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.

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

- **1) What is the triggering event?**
    - often arises in liability claims where insured fails to report accident & only tells IC after they are sued
    - courts have said that the **duty to report a loss is triggered as soon as the reasonable person in the position of the insured would have thought that a loss occurred**
    - ultimately depends on **what statutory provision** applies (ex. for property you must report it as soon as you know about it)
- **2) Was the loss reported within a certain time frame of that trigger.**
    - insured must be told that a loss has occurred – not necessarily making a claim, z simply advising
    - duty is put in place because the information is only known by the insured making the insurance company heavily reliant upon the insured to allow them to collect fresh evidence etc

- legislation/contract require insured to provide insurance company with notice of insured loss 'promptly,' 'immediately' or 'as soon as practicable' prior to making a claim – question of fact whether this has been done - though case law tries to distinguish these words

How Can Insured Give Notice

- **General - IAA s. 530(3)** = subject to statutory conditions (**540 SC 14**), insured can give notice by **delivering it to chief agency of insurer in province**, **sending it by registered mail or to the authorized agent of insurer in any manner**
    - in general, ICs don't care if it is in writing so long as they have been given actual notice

Provisions Governing Notice {DIFFERENCES BETWEEN IA AND IAA}

- **IA s. 549, SC #6(1) (Fire Insurance)**: requires that notice be given "**forthwith**"
    - **IAA s. 540, SC #6(1) (General)**: applying to property losses only (**s. 540(3)**) – "**immediately**" give notice in writing to the insurer
- **IA s. 614 (Auto)**: "**promptly**" give notice.
    - **IAA s. 556 SC 3(1)(a) and 4(1) same wording**
- **Note: no statutory requirement to give notice for Life Insurance**
    - different because people don't always realize immediately after death that policy exists
    - must look at terms of contract itself - usually they require notice 'as soon as practicable'

Other Notice of Loss Provisions

- "as soon as practicable after learning of a claim or of the circumstances which would likely give rise to a claim"
    - particularly problematic in liability policies because someone may be aware that something has happened but not aware that a claim will be brought or believe that a claim will not be brought
    - what is the trigger? when do they have to start looking at providing notice to IC?
- "written notice within 30 days of the occurrence of any accident within the meaning of the policy"
- "as soon as possible"
- **Difficulty interpreting what these mean - not objective time frames…s**

Marcoux v. Halifax Fire Insurance Co. **[SCC 1948] **not in casebook = leading case for "triggering event"****

- **Facts**: auto policy claim similar to AB in that notice of loss clause required insured "promptly notify" IC of any loss causing bodily injury; Insured hit pedestrian August 24, 1940; Pedestrian refused medical attention and insisted he was fine so insured did not give notice to IC. On October 24, 1940, pedestrian sought damages from the insured; Insured ***then*** reported claim to insurer; IC refused coverage based on the fact that insured did not "prompty" notify the IC of any loss; Insured argued clause should be interpretted in regard to his knowlege (thought pedestrian was fine)
- **Issue:** When was the triggering event for the purposes of the "promptly notify" clause?
- **Decision:** Insured's duty to notify triggered by accident - no coverage
- **Reasoning:**
    - Agreed that the Notice of Loss clause must be interpreted in regard to the surrounding circumstances.
    - **Objective/subjective test: look to the knowledge of reasonable man in the position of the insured.**
        - **TEST TODAY: A reasonable person, standing in the insured's shoes, would have concluded that bodily injury most likely had been suffered from a car hitting a man**

- Therefore, the triggering event occurred on the date of the accident
- **Ratio: unless** clause worded to be relative to objective event, in which case the trigger would be in accordance with this test; insured not relieved of duty to report unless his belief was ***reasonable in the circumstances***

Glenburn Dairy Ltd. v. Canadian General Insurance Co **[1953 BCCA]**
- **Facts:** Policy required the insured to report the occurrence of an "accident" "as soon as practicable". A third party **stubbed her toe** at the insured's premises (= the accident); The insured was unaware that the third party was hurt until she claimed damages 10 months later at which time insured reported incident to IC
- **Issue:** Did ensured meet her duty to notify IC?
- **Decision:** No, insured failed to fulfill this duty
- **Reasoning**
    - 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".
        - focused on the fact that **accident is an objective term**
    - **Even if insured thinking potential claim is frivolous, vexatious, they won't be held liable or the third party won't actually bring a claim - DOESN'T MATTER**
- **Note**: depends on what policy says!

Fulfillment of the Obligation to Give Notice
- courts have only given relative instruction as to notice
    - "Immediately" is sooner than "promptly".
    - "Promptly" is sooner than "as soon as possible or practicable"
    - "As soon as possible" is sooner than "as soon as practicable"

North Lethbridge Garage v. Continental Casualty **[1930 ABCA]**
- **Facts:** Auto policy requiring **"immediate"** written notice of accident (**note: SC required notification of loss to be made "promptly" but IC had *substituted* this for "immediate" -** there is a mechanism under Act where you can change this notice provision but they had not used it)**;** On July 28, 1928, child injured by Insured's auto (driven by its employee). Manager of Insured learned of accident a few days later – he investigated and was told that the child was hanging on the car, had been ordered off, and got on again without the knowledge of the driver, and had fallen off. Police investigated a few days later, and said it was nothing important, but he was to tell his employees not let kids hang on the trucks when in use. 2 months later, Insured received a notice from a lawyer making a claim on behalf of child. Insured couldn't find his policy, so his lawyers wrote to IC advising of the claim, the facts they knew of it, and asking for the policy. Insurer then hired an adjuster who investigated the accident and concluded that he wouldn't be liable, and also indicated that the loss had not been reported for a period of two months. On October 23, 1928, the Statement of claim was served; Insured forwarded it to his IC for defense and coverage
- **Decision: court ruled 2 months later = "prompt"**
    - **compare *Duchene v. General Accident Assurance Co*** [1926 Ont HCJ): 5 weeks delay was found to violate the requirement for prompt notice.
- **Ratio**: if acting for insurer and notice hasn't been given right away might be able to raise issue of prompt notice; if you're acting for the insured, may be able to avoid issue of prompt notice - case law is all over the map, very fact specific

(b) Proof of Loss

INSURED must prove claim

- Proof of loss requirement requires an insured claiming recover to show that **(IAA s. 540 SC 6(1)(b), s. 556 SC 4 & 5, s. 705 SC 5, s. 674)**
    - a) a valid insurance policy exists;
    - b) a loss has occurred;
    - c) the loss occurred during the time period covered by the policy;
    - d) the loss falls within the coverage of the policy; and
    - e) the amount of the loss.
- Like the Notice of Loss Clause, the insured's obligation under the Proof of Loss Clause is a condition precedent to the insured's right to recovery under the policy.

Not the same as Notice

- **Proof of Loss might = Notice of Loss**
- **Notice of Loss ≠ Proof of Loss**
    - proof is always in writing, usually sworn under statutory declaration (notice can be oral)
    - matter of fact whether proof of loss has been made out is Question of Fact

Time for Proof of Loss

- **Insurer** has obligation **within 60 days of receiving of notice of loss**, to furnish insured (or person to whom the insurance money is payable) forms on which to make the proof of loss required under the contract (**IAA s. 523 (General)**)
- **Insured's time lines**
    - **Fire**: "deliver **as soon as practicable** to the insurer a proof of loss verified by statutory declaration" setting out specified information regarding the loss - **IAA s. 540 SC 6(1)(b)**
        - **Note:** fraud on proof of loss form invalidates the **entire claim** [**IAA s. 540 SC 7**] - issue in ***Swan Hills***
    - **Auto**: deliver to the insurer **within 90 days after the date of the loss** or damage a statutory declaration stating, to the best of his knowledge and belief, the place, time, cause and amount of the loss or damage" -**IAA s. 556 4(1)(c)**
    - **Accident and Sickness: within 90 days from the date a claim arises** under the contract on account of an accident, sickness or disability, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening…and the loss occasioned thereby." - **IAA s. 705 SC 5(1)(b)**

Issues for the Court:

- **1) Was the Proof of loss Provided within the time frame**
    - Fairly straightforward matter once the date of the triggering event under the proof of loss clause has been identified (ie: fire)
    - Where the time deadline is prescribed in more general terms (ie as soon as practicable), courts have to evaluate that requirement as a question of fact in all of the circumstances.
        - Look to what has insured gone through, could they have potentially gotten information to IC more quickly given their losses
        - Again no real rules...
- **2) Was the information in the proof of loss sufficient to satisfy the proof of loss requirement?**

- Whether the insured has provided sufficient information to satisfy the Proof of Loss requirement is determined based upon a standard of reasonableness.
- Requires the insured to provide whatever information it has in its possession, or could be reasonably obtained by the insured - may have to go outside and obtain info from 3rd party sources to prove their loss
- *part of the insured's duty of utmost good faith*
    - underlies court;s assessment of what information should be provided by by insured: info that "might reasonably be expected by the insurer to evaluate insurance claim"

Swan Hills Emporium & Lumber Co v. Royal General Insurance co of Canada **[1977 ABSC]**

- **Facts:** Fire Policy covering stock in the building ($30,000) and the building ($29,000); December 18, 1968 – fire destroyed the building and its contents; Fortunately the week before a Sheriff had effected a seizure of the Insured's stock and had prepared an inventory. Insured signed a proof of loss (under oath) that proof of loss was accurate even though it included items that were not destroyed in the fire; **Even without these added items, loss exceeded policy limits;** IC denied refused to pay due to fraud on proof of loss form, arguing that it vitiated the entire claim under SC#7; Insured claimed he thought he was required to list *all his inventory on the proof form*; [note: Insured provided notice within 1 month - no issue here]
- **Issue**: What is the effect of the false statements when even the true loss exceeded the policy limits? (IOW: does it matter that the false statements were not <u>material</u>)
- **Decision:** False statements breached the duty of utmost good faith and vitiated policy
- **Reasoning**
    - even though higher amount wouldn't be paid as outside limits, claiming higher amount puts insured in <u>better bargaining position</u> and <u>claim might not receive same scrutiny</u>
        - court will not separate true statements from false ones as fraud taints the whole
    - can not claim equitable relief with dirty hands
    - court found there was fraud & that wording of SC 7 is clear that the insurer is excused from the entire claim even if the fraud had no material impact on the claim or the policy
    - strict rule in place because insured has an absolute duty of utmost good faith
- **Ratio:** intentional fraud on proof of loss form means insured forfeits right to claim on policy **{BUT SEE MODIFICATIONS TO THIS RULE}**

<u>Modifications of this principle by statute (or contract):</u>

- **Fire/General and Auto** – typically provide that fraud by the insured with respect to a claim forfeits the insured's right to recover **<u>FOR THAT CLAIM</u>** (not from all contractual obligations).
    - **Fire - IAA s. 540 SC 7**
    - **Auto - IAA s. 554 (1)(c)**

<u>Burden of proof</u>

- Balance of probabilities is the technical burden for proving fraud
    - However, burden is a heavy one because of the **serious nature** of the allegation.
    - The insurer must prove fraud to a "**higher degree of probability that that which it would require for negligence**"

(C) Duty to Cooperate

<u>The insured has a duty to cooperate</u>

- notice of loss & proof of loss are essentially examples of requiring insured to cooperate with insurer
- however, ultimately a separate obligation, particularly relevant to liability insurance policies as it is impossible for the insurer to defend a claim without the cooperation of the insured
    - requirements put in place because where IC takes over liability claim, the insured has been paid & no longer has any stake in the outcome of the lawsuit
- May include requirement to:
    - produce all records that are relevant
    - give evidence under oath
    - secure the attendance of witnesses
- Most modern liability policies typically include express provisions:
    - Prohibiting the insured from assuming liability for any claim
    - Imposing a general duty on the insured to cooperate with the insurer in the defence of the action (except, insured doesn't need to pay for anything).
- **Canadian courts have found that the insured's conduct (or lack of it) must be material and substantial in order to constitute a breach of the insured's basic duty to cooperate. (Must be more than trivial)**
    - courts say that they won't rely on the insured's breach of this duty to deny them coverage unless it is clear that the insured acted in bad faith or maliciously
        - *example: insured can't sign affidavit because on holidays – not flouting obligation in bad faith*
    - but insured **must** take same position as IC: breach of duty if you go against this
        - **Auto - IAA s. 556 SC 3(2) and 3(3)** state that insured must cooperate with insurer & cannot voluntarily assume liability or interfere in legal proceedings/negotiations

Thorsen v. Merit Insurance **(1963 Alta SC) *court takes narrow view of duty to cooperate to protect 3rd parties***

- **Facts**: Insured reports loss relating to Section A coverage then moves away without notifying the insurer of their forwarding address. 3rd party sues IC directly who refuses to provide coverage because insured left breaching their duty to cooperate;
- **Issue:** Did insured breach duty to cooperate?
- **Decision:** No - failure to alert IC to move was merely due to ignorance, inadvertence and mistake - not bad faith or wrong motive **[don't think this would apply today]**
- **Reasoning:**
    - Didn't breach duty because he *did* communicate with insurer and provide them with info pre-move
    - Declined to follow *England v. Dom. of Canada Gen Insur Co*. [1931 OntCA] – which found that moving and failing to leave a forwarding address did constitute a breach of the failure to cooperate
    - Gives examples of activities that **would** breach duty to cooperate, aka considered to be malicious or in bad faith:
        - arbitrary refusal to act (failure to sign affidavit, appear in court)
        - having friendly relations with injured 3rd party
        - giving false testimony
        - interposing over insurer's obligations
        - confessing, varying testimony or willfully falsifying facts

Other Cases where there HAS been a breach of duty to cooperate

- 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 v. ING Halifax*** [**2006 OntCA]**)
- Insured, without involving the IC, investigated and settled a claim brought against him (***Colliers McClocklin Real Estate Corp v. Lloyd's*** **[2004 SaskCA]**)
- Insured paid the judgment on a claim while IC was still deciding whether to appeal (***Fidelity & Casualty Co of New York v. Marchand*** **[1923 SCC]**)
- 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. v. Kansa General Insurance Co*** **[1966 ONCA]**
    - *depends on liability policy: sometimes Insured retains the right and duty to defend policy claims but still have to let IC know*
- Insured intentionally failed to attend hearings, provide evidence or assist in obtaining witnesses in the course of a lawsuit commenced against the Insured **(*Satter v. Pafco Insurance Co*** **[1993 SaskQB]**)
- Insured promoted the action brought against him **(*Walters v. Ocean Accident and Guarantee Corp*** **[1935 BCCA]**)
- Insured lied to the IC about the circumstances of the accident for first 2-3 months following accident **(*Provident Assurance Co. v. Adamson*** [**1938 SCC**])

(d) Limitations

Two points where Insured might face limitation

- **(1) After Proof of Loss**
- **(2) To bring an action on the policy**

(1) After Proof of Loss

- Insured can't sue IC until they actually respond to the claim
    - IA puts moratorium on ability of insured to sue in recognition that insurer can't be obliged to pay for a loss the day it occurs: **need time to decide whether particular loss is covered**
- Total time range tends to be 90-180 days after loss, the IC must provide proof of loss form, proof of loss must be given by insured (up to 120 days), then insurer has from 30-60 days depending on contract to respond
- **General**
    - **IAA s. 524**: No action lies for the recovery of money payable under a contract of insurance until the expiration of 60 days after proof:
        - of the loss OR
        - of the happening of the event on which the insurance money is to become payable OR
        - or a shorter amount if prescribed in the contract of insurance itself.
    - **= can not bring an action until you've filed proof and 60 days has passed: basically giving IC 60 days to decide if they are going to pay, can't sue them during this period**
    - This 60 day window can be shortened by contract) [IA 549 SC 12/IAA 540 SC 12]
- **Auto**
    - **IAA s. 556 SC 6(2)** = Repair or Replacement Provision: 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.

- **Life Insurance**
  - **IAA 674**: within 30 days of receiving required evidence, insurer must pay claim

2) Of Actions {CHANGES WITH IAA}

- when you **MUST sue by,** once your ability to sue has crystallized
- In general, the date of loss is when the limitation period starts: when you consider how you can't sue within 90-180 days based on limitation period after proof of loss, the time period to make a claim is relatively short
- *Limitations Act* states that person has 2 years to sue subject to other statute
  - but says that limitation period in statute can't be shorted by contract
- **UNDER CURRENT IA: 1 year limitation period due to provision in IA (makes them diff from other contracts)**
- **ONCE IAA PUT IN PLACE: limitation period extended to 2 years for almost all insurance claims**
- **General**
  - **IA s. 549, SC 14 (Fire)**: Every action or proceeding against IC for recovery of any claim under or by virtue of this contract shall be absolutely barred unless commenced within **one year after the loss or damage occurs**.
  - **IAA s. 526**
    - **Property – two years after reasonably knew of loss or damage**
    - **Other – two years after cause of action arose** (same as Limitation Act)
- **Life**
  - **IA s. 590 (1)**: within **one year of the proof of loss** OR **6 years after the death**, whichever expires first
  - **IAA s. 677**: **within 2 years of the proof of loss** OR **6 years after death**
- **Auto**
  - **IA s. 614, SC 6(3)**
    - **Damage to Auto**: Within **one year after the happening of the loss** and not afterwards,
    - **Damage to persons or property – one year after cause**
      - **=** 1 year limitation period for certain causes of action (ie. Where 3rd party claimant sues the insured, insured must seek protection from auto coverage within 1 year of being sued)
  - **IAA s. 588(1)**
    - **Auto damage – 2 years after loss or damage arose**;
    - **Personal Property or Injury – 2 years after cause of action arose** (same as Limitation Act)
  - Note: auto insurance gives innocent 3rd party a direct statutory cause of action to sue insured's insurance company where they refuse to provide coverage
- **Accident & Sickness**
  - **IA s. 671, SC 12**: **1 year after date insurance money became payable** or would have been payable if it had been a valid claim.
  - **IAA s. 708(1): two years after knew or ought to have known about loss {and if death, then same requirements as life insurance}**
- **Hail**
  - **IA s. 728 SC 16: one year after occurrence of damage**
  - **IAA s. 636 SC 16: 2 years of the loss or damage**
- **OVERALL: IAA amendments trying to bring sections more into line with *Limitations of Actions Act* (2 year period, but *varying starting events*)**

- **Pay attention to when limitation starts to run**: Date of Loss? Date that Cause of Action arose? Or some other Date?

Smith v. Cooperators General Insurance Co* (2002 SCC) **shows importance of wording of statutory limitation period to determine trigger event*

- **Facts:** Insured injured in car accident. Claims and receives **statutory accident benefits (**Section B Disability Benefits); May 8, 1996, IC advised that they were terminating the benefit payments because report suggested Insured was doing better; advised insured of statutory right to pursue mediation if she disagreed (IC required by Act to notify its insured of the termination of benefits and to inform them of the procedure for resolving disputes); Only advised of mediation – did not advise of procedure for bringing an action. Insured pursued mediation but it was unsuccessful. September 8, 1998, she commenced an action against IC Insurer seeking ongoing benefits; IC argued that the claim was time barred; Ontario IA required action be commenced within 2 years of "the insurer's refusal to pay the benefit claimed"; Trial judge dismissed insured's claim, holding that limitation began running May 8, 1996 when benefits were refused; **Ontario CA Majority** dismissed the appeal, holding that limitation started to run when IC met requirement to advice insured of method for dispute resolution (expln of whole procedure not nec - just the first step which was the right to request mediation; plus insured was advised of 2 year limitation in the report of the mediator) **Ontario CA: Dissent** finds insufficient compliance with this requirement – advising of the first step not sufficient and thus limitation did not begin to run.
- **Issue:** Did IC fulfill its obligations under statute to inform insured of procedure for resolving disputes, thus prompting proper refusal and triggering 2-year limitation period?
- **Decision: Majority adopts ONCA dissent** - rejected the insurer's limitation defence and found for plaintiff
- **Reasoning**
    - Claim is not time barred because the insurer had not properly terminated benefits in accordance with the statutorily mandated procedure.
    - Had only advised of the first step in dispute resolution (mediation): **<u>were required to tell the insured about the limitation period – since they didn't do that, the Limitation Period was not triggered</u>**
    - IA is a piece of consumer protection legislation: legislature intended insurer to inform claimant of full dispute resolution process in clear & straightforward language so without this being done there is no valid refusal
        - in this case, there was no indication of anything beyond mediation which misleads the insured
- **SCC Dissent** – Bastarache J. – held that the benefits had been properly terminated as of May 8, 1996, because he did not interpret the legislation as requiring the insurer to advise the insured of the appropriate limitation period.
- **Commentary:** case is relevant only for question over limitation period - doesn't mean P now has valid claim - would still have to prove that loss fell under policy
- **But see *Golic v. ING Insurance Co of Canada:*** ONCA found insurer sufficiently complied with statutory termination requirements by advising insured of dispute resolution process & relevant statutory sections
    - But key to court's finding was fact insured had been involved in mediation twice before

(e) Exceptions

Exceptions/Excusing Breach

- Exceptions that can be relied upon by insured to get around duties related to post-loss conduct (aka: mechanisms available to allow insured to get out of strictly complying with particular conditions & obligations)
    - **1) Relief from Forfeiture**
    - **2) Waiver**
    - **3) Estoppel**

1) Relief From Forfeiture

- Where insured fails to uphold post-loss obligations, the insured forfeits coverage - **however relief of forfeiture allows court to grant insured relief in certain circumstances**
- **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.
    - **an equitable remedy** pardoning insured for failure to meet legal obligations
        - so *discretionary* and will only be awarded insured acted in good faith with clean hands
- **Key question**: in all of the circumstances, is it fair that the insured should be denied coverage for failing to comply with a particular activity or condition?
    - **However, in order to grant relief, the insured must satisfy the court that:**
        - **1) As a matter of law, the doctrine of relief against forfeiture can be applied to the case at bar = three relevant factors:**
            - **i) the source of the court's power to grant relief;**
            - **ii) the type of insurance involved; and**
            - **iii) the nature of the insured's breach**
        - **2) The facts of the case merit the application of the doctrine = case law says court must be satisfied that:**
            - **i) the insured's failure to do something was incomplete/imperfect compliance and not non-compliance**
            - **ii) the insured was acting reasonably in its imperfect compliance**
            - **iii) there is no (substantial) prejudice to the insurer**
- Example of typical situation where relief would be provided:
    - Insured has duty to promptly report loss from car accident but insured was in coma as a result of the accident & reports loss after months once wakes up - (i) this is imperfect compliance as reported loss but simply late, (ii) insured acted reasonably as they reported it as soon as they were capable; (iii) no obvious prejudice to the insurer
- **No relief from forfeiture where:**
    - insured intentionally or maliciously breached obligation, or
    - insured's unreasonable conduct led to the breach; or
    - where insured lied about the circumstances giving rise to the breach; or
    - where insurer is unduly prejudiced by the breach
        - eg. – insured's delay in notifying the insurer of a loss substantially impaired the insurer's ability to investigate or mitigate the loss
    - these factors would weigh the balance in favour of the INSURER (not granting forfeiture)

Statutory Sources:

- **1) Insurance Act**
    - IA s. 515 & 521 consolidates in **IAA s. 520** = **Specific Relief Section**
        - **IA s. 521**: when there has been **imperfect compliance with a condition or term of the contract as to proof of loss** to be given by the claimant and a consequent forfeiture or

avoidance of the insurance, in whole or in part, and Court considers it inequitable that the insurance be forfeited or avoided on that ground, it may relieve against forfeiture or avoidance on any terms it considers just

- **IA s. 515**: when there has been **imperfect compliance with a statutory condition as to the proof of loss** to be given by the insured or another matter or thing required to be done or omitted to be done by the insured with respect to the loss and the consequent forfeiture or avoidance of the insurance in whole or in part and the Court considers it inequitable that the insurance should be forfeited or avoided upon that ground, the Court may relieve against the forfeiture or avoidance on any terms in considers just.
- ****IAA s. 520****: If the Court considers it inequitable that there has been a forfeiture or avoidance of insurance, in whole or in part, on the ground that there has been imperfect compliance with
    - (a) **a statutory condition**, **or**
    - (b) **a condition or term of a contract**
    - as to the proof of loss to be given by the insured or the claimant **or another matter or thing** done or omitted to be done by the insured or the claimant with respect to the loss, the Court may relieve against the forfeiture or avoidance on any terms it considers just.
- **New provision thus far broader**
    - Includes **statutory conditions and terms of the contract**
    - Not restricted to proof of loss breaches (though related to obligations with respect to loss generally).

- **Exclusions {DIFFERENT BETWEEN IA AND IAA}**
    - **IA s. 512:** this part (**including s. 515 and 521**) does **not** apply to life insurance contracts.
    - **IAA s. 513** – this part (**including s. 520**) does **not** apply to life insurance **OR accident and sickness**
    - **Note**: only talking about specific "Relief from forfeiture" Provision of IA **{Judicature Act provisions might apply - see below}**
- **Specific Relief Provisions in the Insurance Act are only available where:**
    - 1) There has been **imperfect compliance** (NOT complete non-compliance) **AND**
    - 2) With a **statutory condition** or **contractual term AND**
    - 3) Where the imperfect compliance **relates to the insured loss**

- **2)** ***Alberta Judicature Act***, **RSA 2000, c.J-2**,
    - **General Relief Section - s. 10** : **"Subject to appeal as in other cases, the Court has power to relieve against all penalties and forfeitures and, in granting relief, to impose any terms as to costs, expenses, damages, compensation and all other matters that the Court sees fit."**
    - = allows court to provide relief against forfeiture for any contract
    - unanswered question is whether insurance contracts are limited to IA provisions or whether they can rely on judicature act which is worded more broadly?
        - case law says this can not be applied where limitation period is missed, where there was a failure to pay premiums resulting in lapse of policy or for misrepresentations pre-loss
    - **SCC** (*Saskatchewan River Bungalows Ltd. v. maritime Life Assurance Co* [1994]) – **Judicature Act can apply to life and accident and sickness insurance** (*but an obiter statement….*)
        - leaves questions unanswered: could specific IA provision and general judicature provision apply at the same time?

- **Three Factors the court should consider in exercising discretion to grant general relief from forfeiture**
    - 1. The conduct of the claimant: Was the conduct of the plaintiff reasonable in the circumstances
    - 2. The gravity of the breaches: Was the object of the right of forfeiture essentially to secure the payment of money? And
    - 3. The disparity between the value of the property forfeited and the damage caused by the breach: Was the disparity substantial?

Short rule for BOTH general and specific relief from forfeiture: a court should only grant relief in circumstances where it would be more fair to relieve the insured from the consequences of its breach than to hold the insured strictly accountable for the breach = **Balancing act**, **which is FAIRER**

Falk Bros Industries Ltd. v. Elance Steel Fabricating Co **[1989 SCC] *Leading Decision on Relief from Forfeiture***

- **Facts:** Insurance on performance of bond owed to Falk Bros as part of debt; Elance gave notice to IC *after expiry* of the 120 day notice period required under in the contract so insurer denied coverage; Elance argued they were entitled to payment regardless of late notice, relying on relief from forfeiture; Statute provided relief where there was imperfect compliance with SC as to proof of loss
- **Issue:** Did the relief from forfeiture provision in Sask equivalent of **IA s. 515** permit the court to grant relief from forfeiture in circumstances where the claimant failed to give notice of his claim to the insurer within the required time period?
- **Decision:** Yes because insured *did* notify IC of claim - problem was timing = imperfect compliance
- **Reasoning: imperfect compliance or non-compliance?** (seems to be the helpful part of the case)**
    - IC tried to equate late notice with non-notice
    - Court compared distinction between imperfect/non-compliance with that of breach of term and breach of condition precedent
        - condition precedent is breached, it is considered to be more like non-compliance because rights have crystallized (ie: failure to bring action within Limitation Period = non-compliance & relief isn't available)
        - **unlike missing limitation period, if you're late on notice you still have rights under the law**
    - Looked to previous case law where insured's:
        - failure to provide timely notice of loss or proof of loss – **generally imperfect compliance**
        - failure to commence litigation on the contract within the prescribed limitation period – **generally non-compliance** (because more serious breach)
    - Notes that courts have allowed relief for failure to give notice in timely fashion as it is imperfect compliance
        - different from failure to <u>institute action</u> in required time which is seen as non-compliance/breach of condition precedent
    - Distinction between imperfect/non-compliance put in place because:
        - (i) failure to give notice of claim is more similar to a breach of a term versus a breach of a condition: since no rights crystallize when insured gives notice, insurance company simply has more time to investigate action
        - (ii) failure to give notice of claim is a defect in provision of proof of loss which is contemplated by statute: statute strictly specifically says that relief is only available for things insured did after loss occurred

- **Ratio: So long as question is 'when' the loss was reported, it will amount to <u>imperfect compliance</u> and relief will be granted unless it is of such a degree of lateness that it prejudices the insurer (ex. because of imperfect compliance they are completely unable to investigate the claim – this is extreme prejudice so relief from forfeiture isn't there)**

Williams v. York Fire & Casualty Insurance Company* [2007 ONCA] *prevailing wisdom in Canada, though not significant case

- **Facts:** Rollover accident on May 16 which caused serious damage to insured's vehicle and sound system (under section C); Insured timely provided notice on May 20 and sworn proof on September 29 (no issues with timing); **Insured driving with suspended license at the time of the accident *but didn't know of the suspension because hadn't received mail from Highway Traffic Commission yet;*** policy explicitly said that insurer won't pay for loss or damage caused in an accident if you drive the automobile <u>while not authorized by law</u>; Insured argued that he should be given relief from forfeiture
- **Issue:** Can TJ grant relief of forfeiture in these circumstances?
- **Decision:** No because breach is *not post-loss* - term relating to coverage that was breached **<u>prior</u>** to the loss. To allow it for a breach of condition would essentially give the court the power to alter policy terms

  Reasoning:
    - s. 515 does not give the courts a broad discretion to grant relief from forfeiture where the conditions of an insurance policy are breached – too much interference in contractual rights.
    - Relying on *Falk*, the court found that the court's power is only in relation to things or matters required to be done, in relation to the loss, that is, **after the loss has occurred.**
    - Also found breaches of the policy that relate to coverage issues are not subject to the specific relief from forfeiture found in IA.
        - Similarly – courts have found that relief from forfeiture does not apply to a failure to pay insurance premiums, as that results in the lapse of the policy (*Pluzak v. Gerling Global* [2001 ONCA]) on the basis that those breaches occurred **PRIOR TO THE LOSS**
- **Ratio**: IA is clear that relief can only be granted for post-loss aspects of non-compliance **BUT IAA s. 520 IS NOT RESTRICTED TO POST-LOSS CLAIMS**

<u>(2) Waiver and (3) Estoppel</u>

- Applies to both **pre-loss AND post-loss breaches**
- Focuses on behaviour of IC: where conduct of insurer is so bad that they are denied the ability to rely on the insured's breach to get out of obligations (ie: where limitation period missed)
- **Common foundation**: a party should not be allowed to go back on a choice when it would be unfair to the other party to do so
- Constituent elements of waiver and estoppel technically different, but in practice the facts which give rise to a waiver often also satisfy the criteria for an estoppel, and vice versa (= usually both will apply)
    - People often refer to any situation where a party, by its words or actions, foregoes its contractual rights, as a waiver (colloquially used to encompass both of these technical terms)

<u>Waiver</u>

- **Applies where**
    - **a) IC *intentionally* relinquishes a known legal right OR**
    - **b) IC *intentionally* gives up a known privilege or power**
- Can can occur before or after breach
- Can be express or implied

- **Statutory Waiver**: **compel reinstatement of Life Insurance contract although premiums not paid on time**
    - **IAA s. 651(3)**: IC must accept premium paid within 30 day grace period after it is due without evidence of insurability being required, even if person dies it is fine so long as you pay within 30 days
    - **IAA s. 658**: IC must reinstate the contract of the insured reapplies within 2 years of policy lapsing so long as overdue premiums are paid & evidence of insurability is provided (assuming no dramatic changes to health of insured

Estoppel

- Equitable doctrine that prevents an estoppel prevents an insurer from denying coverage on the basis of an insured's breach of contract **where:**
    - **(1) the insurer represents to the insured that the contract will not be enforced AND**
    - **(2) the insured relies on this representation to its detriment.**
        - Party will not able to make any claim under the contract that relates to that misrepresentation
- = if IC makes a false representation of fact by word/act upon which insured acting in good faith reasonably relies to his prejudice, no claim will be allowed under terms of the contract inconsistent to the representation
- Note: this is Promissory Estoppel - see Acquiescent Estoppel later

Non-waiver agreements {See Later}

- IC tries to protect itself from waiver/estoppel - knows these arguments can be made so often try to get insured to sign non-waiver agreement acknowledging IC isn't intending to let insured get by with less than strict compliance
- Insured gets temporary relief because insured agrees to become involved in claim in the meantime - **even though IC is going to represent the insured, doesn't mean that they concede insured has a valid claim**
- Non-waiver agreements MUST be witnessed: insured should get independent legal advice before signing it so they know this reduces the arguments they can make later on

Statutory Waiver & Estoppel {Difference between IA and IAA}

- **IA s. 517**: If IC gives **written notice** (waiver) that insured doesn't have to comply, then the insured can avoid doing something they are obligated to do under the contract = **doesn't address estoppel**
- **IAA s. 521**: **re-writes IA s. 517** and **addresses estoppel** by saying insured must be excused from contract if written waiver or if conduct leads insured to believe they are excused which they rely upon to their detriment **(representation by IC though doesn't have to be in writing)**
    - emphasis for waiver is that IC has to provide notice in writing for it to be considered a waiver however for estoppel it doesn't have to be in writing
    - says that IC doesn't waive any requirements just by participating in dispute resolution process: trying to figure out amounts of loss, delivering proof of loss form, investigating/adjusting complaints etc.

Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance Co **[1994 SCC] - Leading Canadian Case on Waiver**

- **Facts: Life Insurance Case (so specific provisions don't apply)**; policy lapses after premium was not paid within 31 day grace period but Insured applied followed procedural requirement and policy was reinstated (written application to IC, payment and submission of insurability, good health etc.); **When**

policy lapses again, insurer accepts late payment and does not require evidence of insurability or application, reinstating the policy but stating they expressly reserve the right to seek evidence on insurability ; On July 24, 1984 insured mailed a cheque of $1,316 for premium; but on August 13, 1984 IC sends 'premium due notice' requesting $1,361 so second cheque for **$45 (the difference)** which is received by IC on August 22, 1984; **BUT IN FACT, first cheque had <u>never</u> received by insurer**; After the expiry of grace period on November 28, 1984, IC wrote advising beneficiary that premium from July remained unpaid. Said that the policy was *technically* lapsed, and that they required the <u>immediate payment</u> of $1,316 to pay the July premium in which case the policy would be in force - no one was at the address to get this mail so policy lapsed; On Feb. 2, 1985 IC sends a notice of policy lapse to the insureds and invited insureds to apply for reinstatement, but that it would require evidence of insurability. Insured did not become aware of late payment offer from November, or of the lapse, **until April, 1985** at which point he began to look for lost premium cheque; Sent replacement cheque in **July, 1985 along with next years premium but both premiums were refused by IC;** On July 9, 1985, insurer was informed that insured was terminally ill and uninsurable. On August 10, 1985, insured died. IC rejected claim for benefits on the basis that the policy had been terminated

- **<u>Insured argued that</u>**
    - (i) IC had waived its right to timely payment of premiums by
        - encouraging policy holders to pay by mail;
        - requesting payment of the 1984 premium after the expiry of the policy grace period;
        - delaying issuance of the February lapse notice;
        - failing to return the partial payment
        - accepting late payment in 1981
    - (ii) none of IC's acts were sufficient to retract its waiver so the policy was still in force at the time of death
    - (iii) if there is no waiver, relief from forfeiture should apply

- **Issue: (1) Did IC waive its right to compel timely payment in accordance with the terms of the policy? (2) If there was no waiver, are the respondents entitled to relief from forfeiture under the Judicature Act?**
- **Decision:** No waiver by the IC - the policy lapsed before the insured's death.
- **Reasoning (Issue 1)**
    - November letter did constitute a waiver of the IC's right to timely premium payment but this waiver was **retracted** by the February letter (hence, waiver not in effect at the time of the insured's death)
    - Since the insured became aware of both the waiver and retraction of the waiver at the same time, there had been <u>no</u> reliance on the waiver
        - **note**: **waiver does not require reliance** - but court said if insured relied on waiver and then it was retracted, IC would have to give reasonable notice
            - doesn't matter here b/c no reliance but **remember reliance-retraction issue** in future cases
        - Thus IC not required to give any notice of intention to lapse the policy prior to the February letter.
    - **Established a strict two part test (WAIVER TEST) for determining if a waiver has occurred**
        - **TEST: Evidence must establish that the insurer had:**
            - **1. Full knowledge of rights; and**
            - **2. An unequivocal and conscious intention to abandon them**
                - **was this clear intention communicated?**

- **<u>Strict compliance</u> with test is required, because waiver amounts to an amendment of the contract, without any further consideration to the insurer for doing so.**
- **Central feature of this test = insurer's intention to give up a known contractual right.**
- ***<u>**If there has been reliance**</u>* then reasonable notice will be required to <u>retract a waiver</u>**
    - **but if no reliance, no reasonable notice is required to retract the waiver**

- **Reasoning (Issue 2) - Obiter: court didn't go into whether relief from forfeiture applied bcs insured did NOT act reasonably**
    - Respondents knew at all relevant times that the insured was terminally ill and uninsurable but did not arrange for appropriate delivery of their mail over the winter
    - When the respondent learned that the premium was 9 months overdue in April, they did not make the payment for a further three months
    - Didn't comment on the other two elements of the test – unnecessary
        - So didn't determine issue of whether RFF can apply in this circumstance of a pre-loss breach
    - Reiterates **<u>same</u>** 3 factors for relief from forfeiture to apply:
        - (i) reasonability of applicant's conduct – did the insured have a good reason for the breach?
        - (ii) gravity of the insured's breach – aka imperfect compliance or non-compliance?
        - (iii) disparity between forfeited value & value of damage caused by the breach – prejudice to the insurer?
    - **IC argued that because IA specially excludes life insurance, it was *meant* be excluded from general provision of *Judicature Act* and because the specific overrides the general**
        - Obiter: could still apply the general *Judicature Act* provision
        - IA doesn't codify the whole law of insurance but simply imposes minimum standards
- **Ratio:** Establishes what is required in order to prove waiver = evidence that (i) the insurer had full knowledge of its rights; (ii) the insurer exhibited clear & conscious intention to abandon their rights; (iii) the intention to abandon was communicated. And waiver can be withdrawn where reasonable notice is given (depends on circumstances)

***Paul v. Cumis Life Insurance Co* [2011 BCSC]**

- **Facts:** Life insurance on mortgage (secures a debt to someone else) with automatic premium withdrawals; bank account overdrawn and is frozen by bank; IC writes a letter to insured requesting outstanding premiums and stating that policy would not lapse if they were paid within 3 weeks; payment is still not made so IC writes another letter stating that policy has lapsed; friend eventually sees that premiums are owing and calls agent who tells them that they could pay a certain amount and policy would be reinstated without any evidence of insurability; **at this point, insured was dead but this wasn't asked so friend did not mention it and simply paid outstanding premiums and IC sends letter saying policy has been reinstated;** Claim is made several weeks later and IC realizes that they re-issued policy when insured was already dead - refuse to pay death benefits on the basis that policy hadn't been reinstated;
    - Claimant relies on waiver: although the insurer would have been entitled to refuse reinstatement had it requested new evidence of insurability, since it did not request that info, it has waived its right to avoid the insurance and deny coverage.
        - (i) insurance was validity reinstated when they followed instructions & paid premiums; (ii) insurer's administrative error shouldn't disentitle insured to benefits; (iii) she isn't responsible for insurer's failure to request info on insurability as condition for reinstatement

- IC relies on waiver: it had no knowledge of rights being waived because agent did not know insured had died:
    - (i) policy had lapsed due to non-payment of premiums & had not been reinstated prior to the insured's death; (ii) insured should have informed them of death & that in order to have waiver they must have full knowledge of the rights they are waiving (if they knew he was dead, the insurance wouldn't have been reinstated so w/o info it isn't valid)

- **Issue**: Was right unequivocally and consciously waived? (IOW, did waiver require knowledge of insured's death)
- **Decision**: **Yes - Waiver does not require full knowledge facts just full knowledge of right or rights being waived**. Here, the right being waived by the insurer was the right to require a new application and renewed evidence of insurability as a precondition to reinstating insurance.
- **Reasoning**
    - IC waived its right to treat the policy as lapsed as all requirements of waiver met:
    - **(i) IC must know about rights it is waiving: there is a difference between knowing facts and knowing rights & the IC knew it had a right to treat the policy as lapsed or to make reinstatement subject to evidence of insurability**
        - waiver doesn't require full knowledge of all possibly relevant info but full knowledge of rights being waived (here the right being waived was the right to require a new application, including renewed evidence of insurability)
        - agent had full knowledge of this right as he knew grace period had expired & that IC didn't have to reinstate insurance without new evidence of insurability
    - **(ii) IC must intentionally give up this right: intentionally gave up right to ask by not asking for evidence of insurability; insurance company is bound to the acts of its agent**
      (iii) Waiver must be in writing: IC wrote to beneficiary saying policy had been reinstated upon payment of premium with no mention of requiring evidence of insurability
        - At common law – a waiver can take any form as long as it demonstrates the insurer's clear intention to give up the right to enforce an insured's contractual obligation.
        - Alberta's IA s. 517: (1) No term or condition of a contract is deemed to be waived by the insurer…**unless the waiver is stated in writing**…; and (2) Neither the insurer nor the insured is deemed to have waived any term or condition of a contract by act relating to the appraisal of the amount of loss or to the delivery and completion of proofs or to the investigation or adjustment of any claim under the contract. **{note IAA s. 521 does <u>NOT</u> require waiver to be in writing}**
            - Note: Apply to waiver only – not estoppel.
        - IC argues no waiver because it was not in writing as required by s. 11 of the BC IA
        - But court says letter of December 3, 2008 was in writing **SO THERE WAS WAIVER**
    - **Obiter**: In the alternative, court would have found an **estoppel**.
        - Insurer made clear representation that the insurance would be reinstated upon fulfillment of only one condition, payment of the outstanding premiums
        - Plaintiff acted on the representation by submitting payment immediately
        - That was in the Plaintiff's detriment to the extent of $1,179.00.
        - Therefore, insurer is estopped from denying insurance.
- **Ratio:** there is a difference between knowing your rights under a policy & knowing the fact in issue – waiver only requires you to know of your rights

Abbi v. Klippert and State Farm Fire **(1969 Alta SC)**

- **Facts:** P claimed indemnity from auto insurers after an MVA; IC then realizes that P had failed to disclose two previous accidents in their application so tries to cancel policy by treating it as void from the outset; IC returned pro-rata portion of premium (*not from start of policy*)
- **Issue:** is returning **only part** of the premium waiver or estoppel? (used interchangeably but actually estoppel)
- **Decision:** No - IC had waived its right or is estopped from treatment policy as void at the outset by not returning full premiums because this was a representation that the policy was in place for at least sometime
- **Reasoning**
    - if insured makes a misrepresentation, after event has happened the insurer has the right to insist that the insured's rights have lapsed
    - However if it does any act recognizing the other party's rights, with knowledge of the facts, such act is a conclusive election no to take advantage of the clause **(here: by keeping some of the premiums)**
    - if IC wants to treat a policy as void from the start, they must return all of the premiums or else they will be held to have waived their right or be estopped from treating the policy as void
- **Ratio:** By failing to return all premiums to the insured, an insurer may be precluded from arguing that an insurance policy was void ab initio because of a non-disclosure by the insured. Electing to affirm the policy, and not return the premiums can be seen as a waiver (estoppel). It is a conclusive election not to take advantage of the clause.

Estoppel by Acquiescence

Silcock v. Cooperative Fire **(1969BCSC) - ACQUIESCENCE (sets out requirements for estoppel)**

- **Facts:** P failed to disclose previous MVA when applying for auto insurance; IC issues policy and before any loss occurs, receives driver's abstract and learns of the misrepresentation; **but IC keeps silent**; Insured tries to make claim and IC says there is no coverage due to this misrepresentation
- **Issue:** Was an estoppel by acquiescence created?
- **Decision:** No - court unsympathetic because insured intentionally made a material misrepresentation
- **Reasoning**
    - **(i) Insured must be mistaken about his own legal rights so if he is aware that he is infringing the rights of others, he takes the risk of those rights being asserted:**
        - Here, P was guilty of deceit. Was aware of his omission, and therefore had no right to assume he had indemnity to drive the car (he lied so is deemed to have been aware of no legal rights)
        - **Thus no mistake as to his own legal rights - knew he didn't have a right to drive the car**
        - Because this condition is not met, none of the conditions that follow can be met.
    - *key factor missing: no estoppel because there was no detrimental reliance by the insured as they never realized the IC knew about the misrepresentation since this wasn't communicated to them*
    - **(ii) insured must do some act in reliance on his mistaken belief**
        - not possible because didn't have a mistaken belief of his rights
    - **(iii) IC must know of its rights**:
        - no obligation on the IC to give notice of cancellation of policy, while it could have done so, it relied on the insurance act to make the claim invalid
    - **(iv) IC must know about the insured's mistaken belief making it inequitable to keep silent & allow insured to proceed on this mistake:**

- no money spent by insured on faith of mistaken belief, he was driving his car with knowledge he had in fact attempted to deceive the company
- **(v) IC must encourage insured to rely on mistake**
- IC didn't encourage insured to drive the vehicle

- **commentary:** remember Duty to Disclose case where IC said they would look up his mva record when he couldn't remember and court said they didn't rely on his misrep, they took on the responsibility to look info up themselves
- difference is here insured was guilty of deceit

(f) Enforcement Mechanisms

General Contract Principle of Damages

- The wronged party in such circumstances is entitled to be restored to the position it would have been in if the breach had not occurred.
- Generally, court will order rescission or specific performance of a contract
- Can also include a claim for punitive damages from the insurer if a breach of the duty of utmost good faith
- Basically, **punitive damages** can be awarded in contract actions where the impugned conduct of one of the parties
  - **1) Constitutes an "actionable wrong" independent of the breach of contract claim AND**
    - ***Whitten*:** in insurance context, breach of duty of good faith **is an independent actionable wrong so first criteria is automatically met**
  - **2) is of sufficiently egregious, malicious or high-handed nature as to warrant retribution, deterrence and denunciation.**
- where insured acts maliciously in attempting to defraud the insurance company on the proof of loss or application form, they are essentially taking a chance as to whether or not they will receive coverage
- where IC refuses claim, insured hasn't actually lost anything they were entitled to b/c they were taking a chance so courts go further & award punitive damages against the insured
- Punitive damage claims are grounded on the idea that disclosure on the application form or in the post-loss period is a duty of utmost good faith

***punitive damages *CAN* be awarded against the Insured* {and the Insurer, see later *Whitten*}**

***Andriusiw v Aetna Life Insurance Co of Canada* [2001 ABQB]**

- **Facts:** insured knowingly lied about his physical abilities in order to continue to collect disability insurance proceeds from his insurer; IC learns of fraud & denies coverage; court invalidates policy & says insured must forfeit all claims due to the misrepresentation
- **Issue:** Should punitive damages be awarded for misrepresentation?
- **Decision:** Yes - awarded $20,000 in punitive damages .
- **Reasoning**
  - punitive damages are imposed for an actionable wrong causing injury to other party
    - conduct must be deserving of punishment because of its harsh, vindictive, reprehensible & malicious nature
  - object of punitive damages is **deterrence, punishment, extra-compensation for harm**
    - contract of insurance is governed by principles of utmost good faith: **breach of this obligation by either party is a separate & independent wrong for which compensation is paid**

- if only consequence of his behavior would be to forfeit his claim, this is not effective deterrence because he is no worse off than if he had been truthful
- insured tried to invoke spec. relief from forfeiture
- but court concluded that willfully false statements are more than incomplete compliance so couldn't rely on this

Haiduc v. Alberta Motor Assn. Insurance **[2003 AB prov Ct]**

- **Facts:** Insured makes post-loss misrepresentation about the value of his car and is denied so brings action against IC; insurer argues insured misrepresented material facts when applying for the policy & willfully made false statements in respect of the claim which invalidates right to recover based on IA; **IC counterclaims for punitive damages for breach of obligation of good faith** & to send a message to others to deter fraudulent claims in response to increasing problem in insurance industry
- **Issue:** should punitive damages be awarded for misrepresentation?
- Decision: Yes - his action is dismissed and punitive damages ($1000) against him are awarded
- **Reasoning**
  - Plaintiff made willfully false statements to the adjuster and investigator, and provided a fraudulent bill of sale to the insurer **= guilty of deceit and breach of the obligation of utmost good faith.**
  - Action dismissed & punitive damages awarded – was trying to play a game (if he won he would be paid, if lost he wouldn't)
- **Ratio:** Punitive damages are awarded in exceptional cases **EITHER** where there is some highly reprehensible misconduct that is (i) a marked degree from ordinary standards of decent and (ii) deserving of denunciation **OR** where damages would achieve some retribution or deterrence; amount should be proportionate to any harm caused, seriousness of misconduct, any other penalties/losses suffered for misconduct

2. Duties of the Insurer

- Once a claim has been made (assuming a valid contract exists) what are the contractual & statutory duties on the **Insurer**?
- Some duties are implied in light of the duty of utmost good faith owed to the insured - due to the insured relying on the IC to provide them with coverage for loss at a stressful time
- **Insurer owes 3 specific duties to the insured:**
  - **(a) Duty to respond**
  - **(b) Duty to defend**
  - **(c) Duty to settle**

(a) Duty to Respond

What is the duty to respond?

- In all insurance contracts, insurer must **investigate claim**, **communicate with insured** & **make a decision on coverage**
- An example of the duty of **utmost good faith**
  - Reciprocal obligation on part of insurers and insureds to deal with one another in "utmost good faith"
  - Extends beyond contract formation: **Insurer obligated to *respond* to insured's claim w/"utmost good faith"**

    - Insured suffering loss described as "vulnerable", "emotionally distraught" and "in financial distress"
- But a separate duty that reflects the fact that insurance contracts "**piece of mind" contracts**
    - Insureds buy insurance "to alleviate potential emotional and financial stress associated with unexpected loss" - ie: go by fire insurance so if you have a house fire, you have reassurance that everything will be ok
    - A vulnerability or reliance that gives rise to the duty
- **Key to duty**: insurance company does not have to give up legal rights **but they must treat insured reasonably when investigating the claim** (ex. can still ask for proof but must do so in a fair manner). Insurance company should:
    - (i) avoid making insured *prove* every single element of claim
    - (ii) pay the claim within *reasonable time* for a *fair value* without vindictively delaying or minimizing payment
- where there is a breach of this duty, the court orders insurer to pay the required coverage
    - but if the insurer acted maliciously or unreasonably, the insured may be awarded punitive damages (even if IC ends up paying more than policy limits)
    - **BUT** just being wrong is not enough to for damages – insured must prove the denial caused them to suffer distress for aggravated damages or that IC acted egregiously for punitive damages

Examples of unreasonable conduct that are a breach of duty to respond:
- Denying coverage for loss w/o adequate reason for doing so
- Forcing the insured to take unreasonable steps to prove the loss
- Treating the insured in a belligerent or demeaning fashion, especially where there isn't evidence of wrongdoing
- Intentionally leading the insured to miss the limitation period

Summary:
- **i) If court finds coverage where IC said there was none and that IC acted egregiously in a way that breached their duty of good faith**, IC may be liable in punitive damages
- **ii) If court finds coverage where IC said there was none but IC didn't act egregiously**, IC liable as per policy coverage
- **iii) If court agrees with IC that there is no coverage**, punitive damages may *still* be awarded against them for breaching duty to respond

Vorvis v. ICBC* {1989 SCC} *very important case re: bad faith - shows that punitive damages can be awarded for breach of contract
- **Facts:** Not insurance case but a wrongful dismissal action *against* an employer insurance company; employment contract between V & ICBC was breached as V was wrongfully dismissed so entitled to damages
- **Issue**: Should punitive damages be awarded for breach of contract?
- **Decision**: Not actually awarded here - although employer acted in bad faith, they were entitled to terminate without reasonable notice, so termination of contract is not a wrong in law entitling P to further remedy
- ****Principles****
    - **Punitive damages are available for breach of contract in rare circumstances where actionable wrong has been committed in addition to the breach of contract**
    - **Distinguishes between the different types of damages {later applied in *Whitten*}**

- **Compensatory**: compensate hurt party for something they lost
    - (a) Pecuniary/special – actual financial loss in past or future, includes compensation for something lost from breach
    - (b) Non-pecuniary/general – compensate for intangibles to provide solace for pain
- **Punitive Damages**
    - **<u>Not</u> compensatory - designed to punish**
        - an exception to the general common law rule that damages are designed to compensate the injured, not to punish the wrongdoer
    - Punitive in nature and may only be employed in circumstances where the conduct giving the cause for complaint is of such nature that it merits punishment
        - focuses entirely on behavior of offending party to determine whether they acted unreasonably & maliciously
        - conduct must be extreme & deserving of full condemnation & punishment by any reasonable standard (harsh, vindictive, reprehensible, malicious)
- **Aggravated Damages**
    - **Still mostly compensatory -** frequently covers conduct, which could also be the subject of punitive damages, but the role of aggravated damages remains compensatory
        - Awarded to compensate for aggravated damage
        - Recognizes that one party's treatment of another has resulted in that 2nd party suffering more than they would otherwise suffer
    - Take account of intangible injuries, and by definition, will augment damages assessed under general rules relating to assessment of damages
    - In Insurance, usually arises where insured suffers **mental stress from IC not promptly paying claim** or **where IC tortures the claimant via its actions**
        - not about the maliciousness of the IC's actions but ***about how the insured is affected*** (normal stress is general damages; aggravated is more about nervous shock)

- **<u>When Appropriate to Award Punitive Damages for "breach of contract"?</u>**
    - Cannot be awarded to punish "merely conduct" that the Court disapproves of
    - The only basis for imposition of punitive damages <u>is a finding of commission of an '**actionable wrong'** which caused injury complained of by Plaintiff</u>
        - "Punitive damages are not recoverable for a breach of contract ***unless*** the conduct constituting the breach is also a tort for which punitive damages are recoverable"
    - ***Robitaille v. Vancouver Hockey Club Ltd***.{1989 BCCA}: R suffered very bad hockey injury and was denied medical attention; club forced him to continue play until he suffered a more serious injury
        - **while it unusual, punitive damages may be awarded in cases of breach of contract**: offensive attitude and conduct of club in denying him medical attention and making him play was sufficient to constitute and actionable wrong
    - Rare to find a contractual breach which would be appropriate for such an award but possible
        - Punitive damages must only be awarded in respect of conduct, which is of such nature as to be deserving of punishment because of its harsh, vindictive, reprehensive or malicious nature

- Where such an award is made, conduct must be extreme in its nature, and such that by any reasonable standard, it is deserving of full condemnation and punishment

Whiten v. Pilot Insurance Co **(2002 SCC) *largest punitive damages case in Canadian history - $1M award*** **EQ**

- **Facts:** W made a claim against property insurance when their house burned down; Pilot IC forced an eight week trial on an allegation of arson when there no objective evidence of this, besides the fact that W was in financial difficulties; The trial forced her to put at risk her only remaining asset and incur approximately $320 K in legal costs; Denial of claim was essentially designed to force W to make unfair settlement for less than she was entitled to; **Conduct stated to be planned and deliberate, and continued for over two years while the financial situation of W grew increasingly desperate**; Arson defence concluded by jury to be unsustainable and made in bad faith, jury added an award of punitive damages of $1M, in effect providing Whiten with a "windfall" that added something less than treble damages to her actual out-of-pocket loss; Pilot argued that the award of punitive damages was, itself, "outrageous" (**note:** civil cases before Juries are rare in AB); Court of Appeal reduced award to $100k
- **Issue for SCC:** Should $1M punitive damage award be be upheld?
- **Decision:** Yes - on the exceptional facts of this case, there was no basis on which to interfere with the jury award. Court acknowledged that jury was "clearly outraged" by "high-handed tactics" employed by Pilot following its unjustified refusal to pay W's claim under her policy. While very high, award was rational in circumstances disclosed in the evidence, and within the limits that a jury was allowed to operate. Pilot required Whiten to spend $320k in legal costs to collect $345k that was owed to her. Combined total of $665k at risk put punitive damages award in perspective. *Everyone* at Pilot knew about this claim (not just a low level agent). W's Reputation had been damaged by Pilot's allegation of Arson because W from small community
- **Reasoning**
    - Punitive damages are awarded against a defendant in exceptional cases for "malicious, oppressive and high-handed" misconduct that "offends the Court's sense of decency" = misconduct that represents a marked departure from ordinary standards of decent behavior
        - straddle the frontier between civil law (compensation) and criminal law (punishment)
    - **<u>Comparative Survey of Jurisprudence in Other Common Law Jurisdictions</u>**
        - (1) Attempt to limit punitive damages by categories does not work, and is rightly rejected in Canada
        - (2) There is a substantial consensus that the general objectives of punitive damages are punishment, deterrence of the wrongdoer and others, and denunciation
        - (3) There is recognition that the primary vehicle of punishment is the criminal law (and regulatory offences), and that punitive damages should be resorted to only in exceptional cases, & w/ restraint
        - (4) The incantation of the time honored pejoratives provides <u>insufficient guidance</u> (or discipline) to the Judge or jury setting an amount - more principled and less exhortatory is desirable
        - (5) All jurisdictions seek to promote rationality so court should relate the facts of the particular case to the underlying purposes of punitive damages ad ask itself how an award would further the objectives of the law and what is the lowest award that would serve the purpose?
        - (6) It is rational to use punitive damages to relieve a wrongdoer of its profit where compensatory damages would amount to nothing more than a license fee to earn greater profits through outrageous disregard of the legal or equitable rights of others

- (7) None of the common law jurisdictions have adopted a formulaic approach, except by statute
- (8) Governing rule for quantum is proportionality
- (9) Evident that juries can and should receive more guidance, and help from the judges in terms of their mandate. They should be told, in some detail, about the function of punitive damages and the factors that govern both the award and the assessment of a proper amount. They should not be thrown into their assignment without any help.
- (10) There is substantial consensus that punitive damages are not at large, and that an appellate Court is entitled to intervene if award exceeds outer boundaries of rational and measured response.

- **Punitive Damages for Breach of Contract?**
  - **(i) Was a breach of an insurer's duty to act in good faith an actionable wrong independent of the loss claimed under the fire insurance policy**
    - **Breach of contractual duty of good faith is independent of an in addition to the breach of a contractual duty to pay the loss**
    - Therefore an "actionable wrong" within *Vorvis* rule, which did not require independent tort
- **Review of Jury Award - was the award of punitive damages a rational response to Pilot's misconduct?**
  - Applicable standard of review for rationality stated to have been articulated by Justice Cory in *Hill*
    - = was the misconduct of the D so outrageous that punitive damages were *rationally* required to act as deterrence (serve a **rational purpose)**
    - appellate courts have much greater scope and discretion on review of punitive damages compared to compensatory
    - agree with ONCA that punitive damages (in some amount) were justified - exceptional case that justified an exceptional remedy
- **Quantum of Award: whether jury's award of $1.0 million in punitive damages should be restored**
  - **TEST = whether a reasonable jury, properly instructed, could have concluded an award in that amount, and no less was rationally required to punish the misconduct**
    - To be reversed, award of punitive damages must be ***so inordinately large*** **as to obviously exceed the maximum limit of a reasonable range** within which the jury might properly operate (to shock the court's sense of reason)
  - **Issue of Proportionality**: what broad factors should be considered?
    - **Blameworthiness of Defendant's conduct**
      - whether the misconduct was planned and deliberate
      - the intent and motive of the D
      - whether D persisted in outrageous conduct over a lengthy period of time
      - whether D concealed or attempted to coverup its misconduct
      - D's awareness of that what they were doing was wrong
      - whether D profited from its misconduct
      - whether interest violated by misconduct was known to be deeply personal to the P or a thing that was irreplaceable
    - **Degree of Plaintiff's vulnerability**
      - highly relevant where there is a power imbalance between P and D

- but remember that punitive damages are not compensatory and emotional distress claims only relevant insofar as it helps to assess oppressive character of D's conduct
- aggravated damages are the appropriate remedy for P's emotional stress

- **Award proportionate to harm**
  - award should not be windfall to P but malicious high-handed conduct should not be excused because it fortuitously results in little harm
- **Proportionate to need for deterrence**
  - D's financial power may become relevant if (1) D chooses to argue financial hardship (2) it is directly relevant to the defendant's misconduct or (3) other circumstances where it may be rationally concluded that a lesser award against a moneyed D would fail to achieve deference
  - would be more important factor if this behaviour had happened before
  - but still egregious conduct of of *middle management*
- **Other penalties which may have been inflicted on Defendant for same misconduct**
- **Advantage wrongfully gained by Defendant**

- **Conclusion on Rationality**
  - SCC says it would not have awarded $1M in punitive damages, but in the Court's judgment, the award was within the rational limits within which a jury must be allowed to operate
  - Award not so disproportionate as to exceed the bounds of rationality
  - Did not overshoot its purpose

- **Commentary:** case stated to raise "the specter of uncontrolled and uncontrollable awards of punitive damages in civil actions

Fidler v. Sun Life **(2006 SCC)**

- **Facts:** Insured diagnosed with disease and unable to work so collecting long term disability benefits; Policy said to collect benefits for the first two years you just had to prove you couldn't do you 'own occupation' and, after two years, you had to establish you couldn't reasonably do *any* occupation; IC became suspicious and conducted its own video surveillance; terminated benefits without notice, despite the fact that there was no medical assessment and all her medical professionals said she was very ill; Insured supplies IC with evidence that she is still 'disabled' but they still deny her claim; Don't reinstate her benefits until one week before trial; She proceeded with case on basis that their actions caused her significant mental distress and were in bad faith, such that she was entitled to punitive damages; **Trial Judge found that denial caused Ms. Fiddler significant mental distress for which IC was liable in aggravated damages ($20 000), but there was no bad faith on the part of the insurer justifying an award of punitive damages; BCCA upheld the award but found that Trial Judge erred in reaching a conclusion that there was no bad faith, and awarded $100,000.00 in punitive damages to Ms. Fiddler**
- **Issue in appeal:** whether an object of the disability insurance contract was to secure a psychological benefit that brought prospect of mental distress upon breach within reasonable contemplation of parties at time contract was made?

- **Decision:** Trial Judge's finding that IC did not act in bad faith should not have been been interfered with and precluded an award of punitive damages - CA's order as to punitive damages, and restored Trial Judge's award
- **Reasoning**
    - Court noted that damages for breach of contract should, as far as money can, place P in same position as if contract had been performed {***Hadley v. Baxendale***}
    - Damages for mental distress have not been welcome in the family of remedies spawned by this principle
    - ***Vorvis*** **said that damages for mental distress and "peace of mind contracts" should be seen as an <u>expression of the general principle of compensatory damage</u> rather than as an exception to that principle**
        - Damages for mental distress for breach of contract may, in appropriate cases, be awarded as an application of the principle in ***Hadley v. Baxendale***
    - Court should ask: <u>what did the contract promise, and provide compensation for those promises</u>
        - No reason why this should not include damages for mental distress where such damages were in the reasonable contemplation of the parties at the time the contract was made
        - Conclusion stated to follow from the basic principle of compensatory contractual damages: that the parties are to be restored to the position they contracted for, whether tangible or intangible
    - **Test for Aggravated Damages Court - must be satisfied**
        - **(1) that object of contract was to secure psychological benefit that brings mental distress upon breach within a reasonable contemplation of the parties; and**
            - doesn't need to be the dominant aspect of the "very essence" - as long as the promise in relation to state of mind is a part of the bargain in the reasonable contemplation of the contracting parties
            - **Here**: bargain was premiums in exchange for payment of premiums in the case of disability not a mere commercial contract - if IC does not pay when disability occurs, the IC had breached this reasonable expectation of security; **mental distress is an effect which parties to this contract may reasonably contemplate would flow from failure to pay required benefits -** financial pressure on top of loss of work and existence of a disability is likely to heighten an insured's anxiety and stress (the very thing people enter into the contract to prevent)
            - **So yes,** P's damages for mental distress flowed from Sun Life's breach of contract
        - **(2) that degree of mental suffering caused by breach was of a degree sufficient to warrant compensation**
            - **Here:** substantial loss over a 5 year period and genuine additional distress and discomfort
    - **Discussed aggravated damages generally:**
        - **true aggravated damages:** <u>not</u> awarded under general principle of ***Hadley v Baxendale*** but rest on separate cause of action {ie: defamation, oppression, fraud. The idea that damages for mental distress for breach of contract may be awarded where object of contract was to secure a particular psychological benefit has no effect on the availability of such damages - does not arise out of the breach itself

- **mental distress damages {IN THE CONTEXT OF INSURANCE}:** which **do** arise out of contractual damages itself - these are awarded under ***Hadley v Baxendale*** principle and exist entirely apart from any aggravating circumstances; based on parties' expectation at time of contract formation

- **Court then examined Fiddler's claim for punitive damages**
  - Threshold issue = whether IC breached not only its contractual obligation to pay the LTD benefits, but also the independent contractual obligation to deal with insured's claim in good faith?
  - duty of good faith - applies to both manner in which IC investigates and assesses the claim
    - when making decision as to whether to refuse payment, must assess the merits of claim in balanced and reasonable manner = reasonable interpretation of its contractual obligations
    - must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage for a settlement
    - **question is whether the denial was the result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claims process**
  - **here:** IC's conduct was "troubling", the same was not sufficient so as to justify interfering with the Trial Judge's conclusion that there was no bad faith

- **Ratio:** IC will not nec be in brach of duty of good faith by incorrectly denying a claim that is eventually conceded or judicially determined to be legitimate
- **Commentary:** after ***Whiten***, insured's would plead bad faith right away to put pressure on IC to scare them away. Case makes it clear that punitive damages will not necessarily be awarded against IC who breaches duty of utmost good faith because it may not be sufficiently egregious. Wrongly denying coverage doesn't necessarily mean IC was malicious.
- **See *Sagl v Cosburn, Griffiths & Grandham Insurance Brokers* (ONCA 2009]:** upheld TJ's finding that insured did not breach her duty of good faith by failing to fully disclose material facts on the application form; found that **insurer** is in breach of its upmost duty of good faith where the insurer issues and insurance policy when it knows or ought to know that material information is lacking on the application form and then raises the lack of info as a defence to policy claim

General Principles from Whiten and Sun Life

- Insurer must act "fairly and promptly" in responding to an insured's claim, which means they must:
  - Investigate and assess claim objectively and on proper grounds
  - act within reasonable diligence during each step of claims process to see claim resolved in a timely way, and
  - if no reasonable grounds for denying coverage or payment exist, pay the claim on a timely basis
- Application of Principles will depend on the particular facts of each case
- In general, insurers who act unreasonably in responding to insured's claim will be found in breach of duty of good faith

(b) Duty to Defend Under Liability Insurance Policy

Introduction

- **Only relevant to Section A** (Liability: protects insureds against financial loss which may be incurred if the insured is sued by a third party) - essentially a sub-category of duty to respond
- Liability insurance policies usually require insurer to fulfill two duties:
    - 1 – to defend the insured against the third party claim & pay associated costs (**"duty to defend"**)
    - 2 – to pay any judgment awarded to the third party against the insured (**"duty to indemnify"**)
- Scopes of duties depends on wording of insurance contract but if IC acts egregiously in failing to do either of these things, they can be liable for punitive damages

What triggers duty to defend? "Pleadings Rule"

- Trilogy of SCC cases beginning with ***Nichols v. American Home Assurance Co*** **[1990 SCC]**
- Court held that an insurer's duty to defend arises only if, assuming that the facts as alleged in the pleadings were proven true, the insurer would have an obligation to indemnify the insured = **endorsement of the "Pleadings Rule"**
    - **TEST: look at pleadings filed by the 3rd party claimant & assume that everything alleged is true -would the IC have to pay the judgment?**
        - **if yes, then the IC has a duty to defend**
        - **if after the fact, they only have to partially defend claim, this would fall under duty to indemnify**
    - "the pleadings govern the duty to defend": An insurer must defend an action if the pleadings in the third party action raise the "mere possibility that a claim within the policy may succeed"
    - **So duty to defend triggered by mere allegations in the pleadings without regard to the merits of the same**
    - Application of pleadings rule to be done with the "**widest latitude**" being given to the allegations in the pleadings to determine **whether the same given rise to a claim falling within the scope of the policy**

Duty to Defend vs. Duty to Indemnify

- **Duty to defend** is broader than duty to indemnify: it involves more than simply providing payment for any judgments this means that it is enforceable immediately upon a lawsuit by a 3rd party before any judgment is made at trial (can't wait until trial & repay defence cost then)
- **Duty to indemnify** engaged where there are be no concerns about coverage – where IC denies coverage, they do not have a duty to indemnify until this issue is resolved at trial

Two issues post-*Nichols*

i) 3rd parties may intentionally craft pleadings and include negligence to trigger IC's duty to defend
Non-Marine Underwriters v. Scalera **(2000 SCC)**

- **Set out 3 Part Test Determining Whether Pleadings Triggered Coverage**
    - **1. Determine which of the legal assertions contained in the pleadings "could potentially be supported by those factual assertions"** {are the allegations properly plead}
    - **2. Where multiple claims are plead, determine whether any of the claims are entirely derivative of another** {arises from the same actions and causes the same harm}
    - **3. Determine whether the distinct** {non-derivative} **claims, IF PROVEN, would require the insurer to provide indemnity** {the third step in the *Nichols* test}
        - **= Claims satisfying this final threshold give rise to the duty to defend**
- Link between duty to defend and pleadings does not mean that duty to defend to be determined solely by reference to the words used in the pleadings

- Not "bound by the plaintiff's choice of labels, and thus defenseless against inaccurate or manipulative pleadings" **Focus on substance of pleadings - what is really being alleged**

Monenco v. Commonwealth **(2001 SCC)**

- **Issue:** What evidence can the Court properly consider when assessing **the true nature of third party claims**? Is the Court entitled to go beyond the pleadings and consider extrinsic evidence?
- **Decision: at minimum court can look at look at any extrinsic evidence <u>expressly</u> referred to in the pleadings**
- **Reasoning:**
    - SCC endorsed the Pleadings Rule as part of the 3 step process set out in *Scalera*
    - Duty to defend "requires an assessment of the pleadings to ascertain the substance and true nature of the claims" by considering whether the "factual allegations …. in their entirety …. could possibly support the plaintiff's legal claims"

ii) Where IC only has to defend 1 claim, it may affect the outcome of the 2nd claim

- 3rd party may not be faking pleadings by including claims of both negligence & intentional acts, just don't know
- Where 1 claim isn't derivative of the other, the IC only has to defend 1 claim – insured must get lawyers to defend one part of the claim where the IC will defend the other party
- Sometimes IC will try to defend both in order to get full control & say that the insured can pay them back if they are held liable or that the insured can contribute to the cost of lawyers for the uninsured portion
- Problem is that the lawyers for the IC have less of an incentive to defend against the uncovered portion – they are hired by the IC so they have motivation to push liability into something not covered under the policy
- IC must be careful because if they instruct lawyers in a way that is unfair to the insured, this is a breach of their duty of utmost good faith

Progressive Homes v. Lombard **(2010 SCC) *CHANGED THE LAW IN CANADA***

- Facts: P hired as General Contractor to build several housing complexes. BC housing sued P for breach of contract & negligence, alleging significant damage caused by water leaking in to four buildings; P relied on its **five successive liability insurance policies with Lombard** that were in place from time of construction until actions brought against P. Three versions of five successive policies that were stated to be occurrence policies, which insured P against damage caused by occurrences or accidents. **Policies required Lombard to defend and indemnity P if it became legally obligated to pay damages because of property damage caused by an occurrence or accident;** Lombard initially defended P but then withdrew form the claim alleging it had no duty to defend because claims weren't covered under policies.
- **Issue:** Does Lombard owed duty to defend claims against P Homes?
- **Decision:** Yes - upon interpreting the policy & considering the pleadings, court found L had a duty to defend
    - ****IMPORTANT:** arguments made by Lombard *were previously* the law in Canada - SCC went in a completely different direction: before they never used IC's to pay out for defective workmanship, always done through contract/tort **- this case confirmed that you can sue IC if exclusion clause doesn't cover it** - **exclusion clauses do limit your duty to defend****
- **Reasoning:**
    - Pleadings allege that P is negligent in construction of units, and that it breached contract with BC Housing - condos were inadequately constructed, resulting in significant water damage

- P asserted that inadequate construction was completed by sub-contractors
- P covered under L policies for property damage caused by an accident (subject to specific exclusions) and each policy explicitly states that L owes duty to defend
    - But contained "work performed" exclusion - precludes coverage for damage to the insured's own work once it was completed
- **Insurer 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**
    - Irrelevant whether allegations in pleadings can be proven in evidence - duty not dependent on insured actually being liable and insurer actually being required to indemnity
    - Requires mere possibility that a claim falls within the insurance policy
    - Where it is clear that the claim falls outside the policy, there will be no duty to defend
    - In examining the pleadings to determine whether the claims fall within the scope of coverage, parties to contract are not bound by the labels selected by Plaintiff - true nature or substance of the claim is determinative
- **General Principles of Policy Interpretation**
    - Court should give effect to clear language, reading contract as a whole
    - Where language of policy is ambiguous, rely on general principles of contract construction
        - prefer interpretations that are consistent with reasonable expectations of parties
        - avoid interpretations that would give rise to an unrealistic result, or that would not have been in contemplation of the parties at the time the policy was concluded
        - strive to ensure that similar insurance policies are construed consistently
    - Where ambiguity remains unresolved, construe the policy *contra proferentem* against insurer
        - corollary: coverage provisions are interpreted broadly, and exclusion clauses narrowly
- **Here Each insurance policy covered property damage caused by accident** - but question as to what the meanings of "property damage" and "accident" are in the policies
- **L argued that "property damage" does not = damage to one part of a building arising from another part of the same building**
    - Argued this was pure economic loss, not property damage and hence "property damage" within the meaning of the policy limited to third party property damage **and does not include insured's own work**
        - argument stems from distinction between property damage and pure economic loss drawn in tort law: "property damage" limited to third party property, and did **not** include damage to the insured's own work
- **Court did could not agree with Lombard's interpretation of "property damage"**
    - policy interpretation must, first and foremost, depend on the language of the policy at issue and there is no limitation to third party property in the defn of "property damage"
    - nor was plain and ordinary meaning of "property damage" limited to damage to another person's property
    - plain meaning of property damage was consistent with reading the policy as a whole
        - qualifying the meaning of "property damage" the way L wants would leave little or no work for the "work performed" exclusion

        - and second version of the policies expressly excluded coverage for defects which would be redundant if defects were excluded from property damage at outset
    - overall not obvious that defective property could not also be property damage
- **Pleadings did allege property damage**: met the low threshold of showing that the pleadings revealed a ***possibility of property damage*** for the purpose of deciding whether Lombard owed a duty to defend
    - also describe defective property which may also be property damage
    - whether specific property actually falls within defn of "property damage" is issue to be determined on evidence at trial
- **Pleadings also sufficiently allege "accident"** - alleged negligence suggesting damage was fortuitous and that damage was result of continuous or repeated exposure to conditions
    - P also had to show that the property damage described was caused by an accident
    - "Accident" defined in first policy, and, essentially, same defn applied to "occurrence" in later vers.
    - **whether defective workmanship was an accident, was necessarily a case specific determination**
    - not agree with L's view that faulty workmanship is never an accident
        - no reference to intentional conduct by Progressive
- **Because claims in the pleadings fell within the initial grant of coverage, and onus shifted to L to show that the coverage was precluded by an exclusion clause**
    - required to show that "work performed" exclusion clearly and unambiguously excluded coverage and they were not able to do this - there was a possibility of coverage under each version of policy

- **Ratio:** Insurer must defend a claim where the facts alleged in the pleadings, if proven to be true, require the insurer to indemnify the insured for the claim doesn't require insured to be actually liable or being actually required to indemnify, only need a mere possibility that the claim falls within the policy (low threshold)

(c) Duty to Settle

<u>Duty to Settle Within Policy Limits</u>

- Only relevant to Section A (liability)
- Duty of utmost good faith applies to insurer's conduct in defending insured pursuant to a liability insurance contract
- **If third party claims falls within policy limits**, **insurer's good faith obligation easily fulfilled**
    - Since insurer fully responsible for paying any judgment obtained against insured, insurer can meet its obligation by acting in its own interests in deciding litigation strategy
- **Difficulty arises when claims in exceed policy limits** {where judgement may exceed policy limits}
    - Insurer must make reasonable efforts to settle third party action <u>*within*</u> policy limits
    - Have positive obligation to pursue settlement offers within policy limits if liability against insured likely and to disclose all material information to insured re: insured's position in litigation and settlement negotiations

Dillon v. Guardian Insurance **(1983 On HC) *low court decision setting out duty of liability insurer settling a claim***

- **Facts:** 5yr old child suffered severe brain injury when struck by car owned and operated by Dillon; Dillon insured by owner's motor vehicle liability policy with $50,000 limits; Third party claiming $100k; ***Claim could have been settled for $45K or $46K prior to trial*** **but IC refuses; At trial Dillon found 100% liable for damages of $78K - of which IC pays $50k and Dillion pays the rest**; Dillon sued his IC for the $28k he was being asked to pay out of pocket
- **Issue:** Can IC be held liable to Dillon for failing to settle in policy limits?
- **Decision:** Yes - IC breached a duty by failing to settle within policy limits so they must pay the entire amount of third party claim
- **Reasoning:**
    - IC didn't have anything to lose by going to trial because they would only had to pay policy limits of $50k
    - But in refusing to pay more that $40K to settle action, **IC did not use reasonable care for protection of insured Dillon, and was thus guilty of bad faith**
- **Ratio:** IC owes a duty of utmost good faith to the insured to use its best efforts to settle within the policy limits where reasonable to do so - not a fiduciary duty that it would require them to put the interests of the insured ahead of their own, but *close* to it

CHAPTER 4: THIRD PARTY CLAIMS

What are Third Party Claims?

- Insurance contract may affect 'third parties' – ie. Individuals or other legal entities not parties to the contract
- Privity of contract prevents 3rd parties from benefitting or enforcing contractual rights but contract and legislation may give them certain rights and obligations
- Examples of 3rd parties seeking benefits:
    - unnamed insured (ex. Section A – covers anyone driving with owner's consent)
    - beneficiaries in life insurance
    - shared property interest
    - someone injured by insured

Two Issues Arise

- i) Under ordinary contracts, 3rd parties can't get benefits *directly* so the insured would have to collect & pay them
    - but terms of contract *may* allow 3rd party to sue IC and recover directly
- ii) 3rd party dependent & reliable upon the insured having an enforceable contract - if there is an issue with the contract, then no coverage for 3rd party

3 Circumstances where 3rd Parties Permitted to Make Claims

- A) Assignments
- B) Standard Mortgage Clauses
- C) Automobile Liability Claims

A. Assignees

Assignees of Insurance Contracts

- Insurance is a personal contract: decision to provide coverage based on assessment of likelihood of a particular loss occurring based on risk posed by individual qualities of insured

- Thus, contract of insurance attaches to insured not to the subject matter of the insurance
- Coverage does **NOT** automatically transfer if subject-matter of insurance is transferred (***Rayner v. Preston***)

- **If Insured assigns PAYABLE PROCEEDS OF INSURANCE CONTRACT, payment will be made to third party assignee**
  - **Contract remains between insured and insurer - does NOT result in a new contract**
  - Assignment only deals with who gets the payments of insurance funds
  - Third party's ability to recover proceeds **dependent on insurer's contractual obligation** to pay insured
  - If insured breaches contract, insurer has no obligation to pay third party
    - distinct from circumstances where dealing with **mortgage clauses**
  - Assignment of proceeds can be effected **without** insurer's advance knowledge or consent
    - because it makes no difference who they pay the money to
- **If insured assigns INSURANCE CONTRACT, third party is substituted for the insured as party to insurance contract**
  - **Assignment gives rise to a NEW contract between third party and insurer which replaces original contract**
  - **= Third party becomes the insured**
  - Substitution of third party for insured = **material change** to original insurance contract so **insurer must consent to assignment of contract**
  - Validity of replacement contract determined on its own terms
    - Validity of original contract becomes immaterial and insurer cannot challenge validity on basis of any default or breach of contract attributable to assignor

Peters v. General Accident **(1938 EngCA) *note difference between 3rd party claimant and 3rd party assignee***

- **Facts:** C has auto insurance covering people who drive with his consent; C sells vehicle to Pope requiring payment in installments; Pope gives car & insurance contract after ½ payments made; Pope injures Peters in MVA then pays for rest of car; Peter is 3rd party claimant who sues Pope (3rd party assignee) for damages seeking judgment against IC
- **Issue:** Was the contract of insurance *assigned* to Pope?
- **Decision:** No - this type of liability contract not capable of being assigned to 3rd party
- **Reasoning**
  - The effect of allowing this kind of assignment would be to impose on insurer an obligation to indemnify a new insured thereby altering the character of risk under the policy
  - Personal element stated to be inherent in policy which made it impossible to be assignable at volition of insured
- **Ratio:** Assignment of liability contract can not be done at insured's volition without consent of IC
- **Note**: Pope could have been covered as unnamed insured but this was never argued

Springfield Fire and Marine Insurance Co v. Maxim **(1946 SCC)**

- **Facts**: Fire insurance policy issued to Mr. Maxim; Mr. Maxim materially misrepresented his fire loss history to insurer when he took out the original policy - came to light when claim made for fire loss; but prior to fire loss Mr. M transferred property to Mrs. M and asked agent to assign policy to her **{wife is 3rd party assignee}**; Agent did so issuing an endorsement substituting Mrs. For Mr; After fire destroyed insured property, IC refused Mrs. M's claim alleging that contract void due to Mr. M's misrepresentations
- **Issue:** What is the affect of a material misrepresentation on assigned policy?

- **Decision:** New contract created when insurer agreed to transfer policy to Mrs. M - New contract replaced the old and since Mrs. M not guilty of the misrepresentations, IC could not deny cover on basis of breach committed by Mr. M under old contract
- **Reasoning:**
    - Insurance contract stated to be 'a personal contract of indemnity against loss or damage to the interest of the insured in specified property'
    - 'Insurance against certain risks and among them, what is called the moral risk of the insured'
    - Limited to 'interest of the insured in the subject matter'
    - Would be unfair to hold assignee responsible for original misrepresentation because they are innocent and paying premiums
    - If IC was concerned, could have asked assignee to fill out a new app or answer Qs before approving assignment
- **Ratio:** where IC consents to an assignment, a new contract is created & the IC can no longer rely on the breaches that occurred prior to the assignment
- **Note**: Court doesn't refer to this as waiver but it has the same affect – they are waiving their right to rely on past breaches in doing the assignment

B. Mortgagees

Standard Mortgage Clause

- Lender who takes security interest in debtor's property (mortgagee, ie: bank or other lenders) will want to have property insured against damage or destruction and have any proceeds payable for a loss paid to them first
    - **protects their right to recover their loan where there is damage to the property**
- **Mortgage clause provides mortgagee with full protection of its insurable interest,** irrespective of any breach or default of the insurance contract by the mortgagor
- **= Express term in insurance contract between mortgagor and insurer of mortgaged property**
- Usually follows standard wording of Insurance Bureau of Canada (IBC) – **p. 375** - but not dictated by statute
- **Creates a SEPARATE INSURANCE CONTRACT between mortgagee and insurer of secured property**
    - Even though mortgagee is not signatory to contract and mortgagor arranges/pays for mortgage clause
- **So single insurance policy stated to give rise to 2 contracts**
    - **main** contract between mortgagor and insurer for unsecured interest AND
    - **another** contract between insurer and mortgagee for secured interest
- **Contractual relationship created between insurer and mortgagor**
    - Mortgagee becomes party to insurance contract and has direct contractual **right of action** against insurer to enforce coverage claim - instead of simply being added as a loss payee
- IC only has an obligation to the lender under standard mortgage clause so long as there is a mortgage: if it is foreclosed, they are free of obligations as there is no longer any debt owing
- **Contribution still applies** if lender takes out its own insurance policy against the property as well

***Cooperators v. National Bank* (1988 ABCA)**

- **Facts:** Bank contended that when Coastal Cedar's principal dealt with insurance agent, and stipulated for the fire insurance coverage contained in the Continental policy, two contacts were made; First contract stated to be between Coastal Cedar and Co-operators for fire insurance coverage on its property; Second contract was an independent contract between bank and Co-operators containing

terms of mortgage clause - which was inadvertently omitted from first contract. At trial, TJ ordered rectification of insurance policy, and gave Judgment to mortgagee against insurer

- **Issue**: whether a mortgagee of land **whose mortgage clause was omitted from the fire and insurance policy by error** may recover for a loss where the insurer is not liable to the property owner
- **Decision:** Yes - **contract between mortgagee & IC was complete, even though it was only oral, so IC had to pay mortgagee *notwithstanding the insured's breach***
- **Reasoning:**
    - Concept of two independent contracts between different parties but containing the same policy of fire insurance has had difficulty gaining acceptance, even though this has been going on for a century
    - This construction of the standard mortgage clause accords with the commercial reality in Canada
        - Reality is that virtually all construction is financed by mortgage loan
        - Lenders require that the owner insure the property - all parties to the transaction (owner, lender and insurer) **know that the policy must have a mortgage clause covering the lender's interest**
            - Without it, there will be no loan, and the owner knows construction will not proceed - so acts as an agent between the mortgagee in obtaining insurance and gives consideration on its behalf as is required in the covenant between the parties
            - And the IC knows that without it, there will be no insurance policy and no premium -
            - **= two way street**
- **Ratio:** mortgage clause contains the terms of a separate independent contract of insurance between mortgagee and insurer, engrafted onto the policy delivered to the mortgagor.

<u>Effect of a Breach by the Insured on the Collateral Contract</u>

- According to terms of mortgage clause, **insurer cannot rely on insured mortgagor's acts, omissions or defaults under main contract to deny coverage to mortgagee under collateral contract**
    - Insurers acts *won't prohibit enforcement* of collateral contract between IC and mortgagee
    - Only <u>insured</u> is subject to the impact of these breaches
- = **An exception to the rule of subrogation** that you can't sue your own insured
- Not risk free for the insured to sign a standard mortgage clause: **they can be sued by the IC for the amount paid to the lender based on the contractual right of subrogation** (IC stands in shoes of lender & sues insured for money)
- Strictly enforced by courts: lender has no idea about content of original contract and hence should be protected

Royal Bank v. State Farm* (2005 SCC) **Extent of insurer's obligation to pay mortgagee under standard mortgage clause notwithstanding breach of main contract*

- **Facts**: Fire destroyed house insured by State Farm; At time of fire, house had been vacated by owners, and controlled mortgagee RBC; Neither Insureds or mortgagees notified IC that house was vacant; **Insurance policy included standard mortgage clause;** IC denies claims, asserting that vacancy of house was a change material to the risk within control and knowledge of RBC, of which it had not been notified, and that it was thus entitled to avoid payment under the policy, pursuant to SC4 {treating mortgagee as an "insured" under the policy}
- **Issues** (1) Does SC#4 permit IC to avoid coverage granted to mortgagee by standard mortgage clause in event of change of material to risk within control and knowledge of mortgagee, of which it was not

notified (2) If so, was there a change material to the risk w/in control & knowledge of mortgagee, of which insurer was not notified?

- **Decision: No -** where terms of SMC & SC 4 conflict, SC can't be relied on to void coverage under the clause
- **Reasoning**
    - Mortgage clauses are **standard vehicle** by which mortgagees insure their interest in encumbered property
        - Allow mortgagees to piggyback on insurance purchased by mortgagors = most economical, rational and fair procedure for effecting insurance on the interest of mortgagees
    - **Wording of mortgage clause determines scope of coverage granted to mortgagee**
        - Here mortgage clause said loss under policy is made payable to mortgagee = suggests that mortgagees obtain coverage that is subject to all the terms of the policy
        - But mortgage clause also said ***its terms shall supersede any policy provisions in conflict, but only to the interest of the mortgagee***
            - **= terms and SC's of policy that conflict with clause do not effect mortgagee's coverage**
            - assuming "insured" in SC#4 means "mortgagor", this right cannot be reconciled with mortgage clause, which provides that the mortgagees' coverage shall remain in force despite any act of the mortgagor - **so there is complete and direct conflict between mortgage clause and SC#4 - but clause tells us how to resolve such conflicts and it prevails**
        - **THUS: SC#4 cannot be relied on by IC to limit scope of RBC's coverage**
        - **Even if SC #4 did not more conflict with the mortgage clause,** IC not rely on it to void the mortgagee's coverage because it would defeat the insurer's promise contained in the mortgage clause of continued coverage in the event of a vacancy
- **Ratio:** mortgagee has a specific duty to tell the IC when property is vacant under the standard mortgage clause **but failure to do so does not** disentitle them to recovery (simply impacts premiums)

Hum v. Grain Insurance **(2009 ABQB)**

- **Facts:** Insured property damaged by arson committed by tenants; **Tenant Exclusion Endorsement** excluded coverage for intentional damaged caused by tenant; H a mortgagee seeking a declaration of coverage under the standard mortgage clause under which they were named as loss payees; IC rejected claim due to tenant exclusion and argued that while MC allows mortgagee to recover despite breaches by insured, it does not allow recovery for policy exclusions/conditions.
- **Issues**: (1) Do provisions of SMC expressly supersede tenant's exclusion endorsement so H entitled to recovery under policy as mortgagees, despite fact that fire loss caused intentionally by tenant?
- **Decisions: Yes -** exclusion inconsistent with SMC so it takes precedence and mortgagee can recover
- **Reasoning:**
    - SCC *Royal Bank* appeared to conclude that SMC superseded **any conflicting exclusions:** permitted recovery by a mortgagee in circumstances where exclusion would otherwise preclude recovery by an insured
    - SMC says mortgagees are protected against "*any act...attributable to* the mortgagor, owner *or occupant of the property*" and that it "*supersedes any policy provisions in conflict therewith, but only as to the interests of the mortgagee"*
    - **tenant's exclusion clause was inconsistent with SMC and therefore unenforceable against mortgagees**

***Kelowna Realty v. Canadian Indemnity* (1978 BCCA)**

- **Facts:** Fire occurred at insured premises, destroying building and contents; Insured made declaration of proof of loss or damage in respect of contents; Insured later admitted to making a fraudulent statement in respect of declaration and it was determined that items claimed by insured were either not owned by him or not lost/damaged in fire; Insured charged and plead guilty to with criminal fraud; **Mortgagee commenced action in capacity as loss payee, even though there was no SMC**
- **Issue:** Without a SMC, does the mortgagee have a right of action against the IC?
- **Decision: NO** - no severance of the risk insured in the policy
- **Reasoning**
    - Mortgage company was a **first loss payee** based on assignment of proceeds towards them
    - **Loss payee does not have separate claim: without SMC there is no contract between a loss payee and IC and they are not protected against effect of breach by the insured**
    - General principle of insurance law that in the instance of a policy's having in it a loss payee and no SMC, and where the loss payee sues, **any defence that IC could have validly used against the insured, it can commensurately or validly be used against the loss payee**

Duration and Termination of Mortgage Clause

- **Notice Requirements** - **s. 539 IAA** applies to all policies *except life insurance* – IC can't cancel contract of insurance without notifying other payees otherwise they still have to pay

***Bonser v. London & Midland General Insurance Co* [1973 SCC]**

- **Facts:** B was a mortgagee of hotel but died, so mortgage security held in his Estate; Insured M failed to make premium payments; Notice of Cancellation issued by IC but Executrix of mortgagee's Estate was not notified; Insured hotel and contents destroyed by fire;
- **Issue:** Was IC entitled to cancel policy w/o notice to mortgagee? {IOW - did Notice of Cancellation served on insured bring the contract to an end, or did IC remain liable to mortgagee until notice was served on him/his estate?}
- **Decision:** No - original contract was cancelled but collateral contract between mortgagee and IC remained in place
- **Reasoning**
    - ON *IA* placed insurer under duty not to cancel or alter policy without due notice to mortgagee
        - IC not entitled to cancel or alter policy to the prejudice of mortgagee without notice
    - SMC construed as part of "protection afforded to the mortgagee" - when the IC cancelled the policy pursuant to the Notice, and without notice to the mortgagee, they were abridging the terms of the policy in contravention of the provisions of **SMC**, **which expressly agreed that the interest of the mortgagee should not be invalidated by any act or neglect of the mortgagor**
- **Ratio:** mortgagee remains fully protected until notice is given under the requirements of the statute

C. Auto Liability Claims

Auto Insurance in Canada

- **Tort Based** – Alberta
    - Victim of accident has right to sue wrongdoer to compensate them for their damages
    - If you crash your car and injure yourself, no one pays you
- **No Fault** – Quebec
    - If you are injured in a car accident, you are paid regardless of whose fault it was
    - Can not sue someone from being in an accident

- **Combination** – Saskatchewan
    - Can buy tort based policy and will be entitled to sue if you are in an accident
    - If you buy a no fault policy, you can't sue but get better coverage

Alberta Auto Insurance

- **Tort Based Liability Section** (**Section A Benefits**)
    - If you injury a third party
    - **s. 571 IAA: minimum mandatory limit of $200 000** {aim is to protect innocent third parites}
- **No Fault Medical and Disability Benefits (Section B Benefits)**
- **Fault-Based Property Section** (**Section C Benefits**)
    - Car accident, both driver injured, their respective ICs will compensate *them* and then IC of person at fault with reimburse other IC
    - Fault Chart Agreement between Insurers - set agreements
        - ie: if you are hit from behind, that person is 100% liable
        - intended to reflect results of tort law but not totally accurate
        - **but may still have tort liability**

Potential Actions – MVA

- 1) Action brought by the victim against the owner and/or driver of the car for damages (**Tort Action**)
- 2) Action brought by victim against the driver owner's insurer (**Rights of Creditor's Action**); and
- 3) Action brought by insurer against insured (**Contract action**).
    - **s. 635(13)** The insured must reimburse the insurer on demand in the amount that the insurer has been paid by reason of this section and that it would not otherwise have been liable to pay **{must be a judgement}**

****EXAMPLE****

Joe	IC = Y	s. A – 1 mill	s. B	s. C – 25000	SEF 44 - 1 mill
Mary	IC = X	s. A - $500,000	s. B	s. C - $20,000	SEF 44 - $500,00

Potential defenses against Mary: misrepresentation, unlicensed, loss not from use & operation

Procedure

- Joe would claim under his own s. B and s. C for damage to the car which would cover the bulk of his insured losses - **for any additional uninsured losses not covered under s. B, Joe would sue Mary and trigger her s. A liability coverage (ex. from personal injury)**
    - s. B coverage is never subrogated so it would be deducted from any judgment won by Joe
- Mary claims against her own insurance company under s. B and s. C
    - IC can raise defences against its OWN insured under s. B: would be able to deny her coverage for breaches or issues regarding coverage in accordance with the terms of the SAP
- With Joe suing her, Mary would turn to her own s. A coverage and argue that IC is obligated to defend
    - If Joe is successful, Mary's IC will have to contribute up to the policy limits
- If IC knows it has defences available, it may try to get out of paying Mary
    - However statute requires pool of money for innocent driver Joe: s. 579 put in place to allow Joe to sue Mary's liability IC directly & recover from them for his loss **where he becomes judgment creditor**

3 Causes of Action Arise re: Section A coverage under IAA s. 579:

- **1) The Tort Action**
- **2) The Right of Creditors' Action**
- **3) The Contract Action (IC Recovery Against the Insured)**

- Keep them separate as different issues raised in each!
- **s. 579** provides statutory scheme where:
  - (i) injured Joe isn't affected by the fact that Mary breached her policy, allowing cause of action 2 & 3, AND
  - (ii) Mary's IC can become involved in cause of action 1 as a third party by order

1. The Tort Action

3rd party claimant (JOE) v Insured tortfeasor (MARY)

- No insurance is argued = **purely tort issues**
- However this sets the stage for cause of action 2 & 3
- **IC will want to be involved in this action *even if there may be potential issues with Mary's coverage:* will want to keep any judgement as low as possible in case they end up being responsible**

(a) Claims for Deductibles and Premiums

***Lenkewich v. Landry* (2004) [ABProvCt 2004]**

- **Facts:** Fender bender; Victim had collision coverage – covered property damage to her car. But she ends up having to pay 50% of the deductible and higher premiums; Tries to claim against Insured
- **Issue:** Can third party make a claim for her deductible & increase in premium?
- **Decision: Yes for deductible** but not for increase in premiums as it was not proven on BOP that increase was actually *caused* by this MVA
- **Reasoning**
  - Auto policy premiums go up for certain drivers involved in accidents or making claims on their policies;
  - It was not common knowledge the guidelines for such increases (are they limited to at fault claims?)
  - Premiums were rising for everyone and after a certain number of claims, premiums might go up
  - **SO** no way of knowing why P's premiums went up - couldn't confirm her premiums went up as a result of this accident
  - **But left door open to this type of claim, if evidence showed increase was attributable to MVA on BOP**

(b) Non-Waiver and Reservation of Rights

Avoiding Waiver and Estoppel

- Important that the IC can defend the action on behalf of the Insured (right and duty), but do not give up their claim against Insurer if they detect a breach later, so use:
  - **1) Reservation of Rights Letter**
  - **2) Non-Waiver Agreement**
- Allow the insurer to suspend its decision to deny coverage for a given loss, while permitting the insurer to continue its involvement in **investigating, defending and potentially resolving the claim**
- Provide insured with confirmation that by defending the claim, they are not saying coverage exists

Non Waiver Agreement

- The insurer and the insured mutually acknowledge and agree to the insurer's reservation of rights
- **Purposes**:
    - 1) Enable IC to conduct defence of insured without the risk of being estopped from denying liability later;
    - 2) Preserve right of IC to recover any amounts paid out in settlement or in satisfaction of a judgment or claim of the third party
- **Requirements/General Principles**
    - **1. The documents must clearly set out the rights which are reserved to the IC – interpreted strictly against the IC (like the policy provisions generally)**
        - Often inadequate with respect to preserving the right of the insurer to recover any amounts paid
    - **2. The documents will not be enforced if the terms or relevance of the agreement were misrepresented by IC or otherwise misunderstood by the insured**.
    - **3. The documents are not effective once IC has denied coverage - If IC takes steps to deny coverage (ie sues their own insured) and then take steps to defend tort action – may be estopped from denying validity of policy**
- IC is essentially stepping outside the statutory scheme, but giving themselves the same rights but under contract
    - so after the conclusion of cause of action #1, they will sue Mary under contract for cause of action #3
- Advantages
    - don't have to decide the strength of the case against Mary **until later on**
    - can **essentially skip over cause of action #2 & rely on breaches in the polic**y
    - avoid claims from insured of waiver or estoppel
    - and Insured **gets benefit of representation without paying for a lawyer (ALWAYS SIGN)**
- But if they settle, there is an issue as to whether they can go to cause of action #3 – typical for IC to give themselves a right to claim back against the insured in the event they pay out a settlement

Non-Waiver Agreement Requirement 1 = Adequate Language

***Northwest Casualty Co v. Fritz* (ONCA)**

- **Facts:** IC investigating accident found evidence that the insured was intoxicated at the time of the accident and thus was in breach of the policy conditions; IC and insured then entered into **non-waiver agreement** which was very broad and provided that **IC might investigate the circumstances of the accident, carry on negotiations, make a settlement or defend the action or pay any judgment "without prejudice to the rights of any of the parties"** AND that **"the insured would not in any action brought against him plead or contend that the insurer by conducting investigations or negotiation or defences or making any settlement or payment of judgment created any estoppel or waived any of its legal rights to recover from the insured an amount or amounts paid";** Relying on this non-waiver agreement, IC conducted defence of the action; eventually negotiated a settlement of the damage claims of the third party but before doing so, wrote to insured advising him that he had been guilty of a breach of the policy and that the claims of the third party would be settled within a certain time if the insured did nothing; Insured did not answer the letter or take any of the steps requested; IC then brought action against insured to recover the amounts paid out in settlement and proved that insured was intoxicated at time of accident; insured appealed
- **Issue:** Was the IC entitled to recover about paid out in third party settlement from insured?

- **Decision: No - agreement did not give IC authority to settle the claim on behalf of insured**
- **Reasoning**
    - Normally, the liability of insured to third party must have been ascertained by judgment before IC was entitled to recover anything from the insured.
    - Notwithstanding the very broad terms of the non-waiver, the effect of the agreement was **simply to prevent insured from subsequently alleging estoppel or waiver by reason of anything done by IC**
        - agreement did **not** give the IC the authority to settle the third party claim and thus render the insured's liable to IC if he was subsequently found guilty of breach of the policy.
    - **Payment that IC made in this case was payment to 3rd party in satisfaction of their own obligation to the third party under statutory rights - not a payment on behalf of insured because didn't agree to an amount**

Canadian Mercantile Insurance Co v Clark **(ManCA**) ***IC can settle if it has been *given* authority by insured***

- **Facts:** Insured entered into an agreement with IC whereby he requested IC to settle the third party claim for a specific sum; also agreed that the sum paid out should be taken to be one determined by judgment in any subsequent action between the insured and IC
- **Issue**: Did the non-waiver agreement preserve the rights of the IC to recover from insured without the amount paid out having been ascertained by judgement?
- **Decision:** Yes
- **Reasoning: Distinguished from *Fritz* because insured was an active party in fixing the amount of the settlement and therefore the payment was made directly for the benefit of the insured** (rather than simply to discharge the statutory liability of the IC)
- **See also: *New Zealand Insurance Co v Campbell* (BCSCs):** Third party claims were paid upon the written authority of insured whose solicitor was kept informed of the negotiations; IC was entitled to maintain an action against the insured and be reimbursed without judgment if it successfully proved a breach of the policy by the insured.

Non-Waiver Agreement Requirement 2 = No Misrepresentation/Misunderstanding

Halifax Insurance Co v. Williams **(1966 Ont Co. Ct.)**

- **Facts:** unlicensed friend of the insured had borrowed car while insured was sleeping and left a note as to having taken the car. Shortly after awakening, the insured was advised by police that his car had been involved in an accident. To protect his friend from theft charges, the Insured told police that he had given the driver permission to take the vehicle. He also told this to the insurance adjuster and signed a statement to that effect. Adjuster asked insured to sign **non waiver**, **which adjuster said was a formality so they "investigate the incident without committing ourselves" without indicating any concerns about his liability**. Insured did not know non-waiver would allow IC to recover settlements from him or that non-consent was a potential defence; IC settles claim with third party then tries to claim back against Insured on basis of non-waiver agreement
- **Issue:** Can IC rely on non-waiver agreement to recover third party settlement amount from Insured
- **Decision: No -** the nature and effect of the document were misrepresented by the adjuster
- **Reasoning:**

- insured signed NWA in reliance on misrepresentation that it was nothing more than authorization for adjuster to investigate the 3rd party's claim - no one told him it allowed IC to sue him or that it would limit his defences
- IC cannot now look to the insured for reimbursement of damages for which he was probably not even liable

- **Ratio:** a non-waiver agreement will not be enforced if the terms or relevance of the agreement were misrepresented by IC or otherwise misunderstood by the insured.

Reservation of Rights Letter

- IC ****unilaterally**** informs the insured of its intention to preserve its right to deny coverage = prevents insured from raising arguments about waiver/estoppel
- seems to be useful for less *active* involvement by IC - would probably want to issue a NWA later

Allstate Insurance of Canada v. Foster **(1972 ONCoCt)**

- **Facts:** Insured involved in MVA, caused damage to third party vehicle; Insured was charged and plead guilty to drunk driving; Operating vehicle under the influence of alcohol was a breach of the his liability policy **[SC #2(1)(a)]**; No non-waiver agreement entered into between parties; **A reservation of rights letter send by registered mail to insured which said IC was investigating the accident and that in negotiating for a compromise settlement or in making a settlement - it did not waive any of its rights or admit any obligation under the policy.** IC settled third party claim despite the fact that no authority or permission to settle was ever granted by insured to IC.
- **Issue:** Is the reservation of rights letter sufficient to maintain a cause of action by IC against the Insured?
- **Decision:** No - IC's action dismissed
- **Reasoning**
  - ***Only two ways to for right to claim over is preserved*:**
    - 1) Judgment
    - 2) By express agreement between the insured and insurer (**non-waiver agreement**)
  - While the reservation of rights prevents the insured from relying on an estoppel or non-waiver argument, **it does not create a substantive right in law which does not otherwise exist**
- **Ratio:** No right to claim over exists independent of **s. 579(13)** or by non-waiver agreement - reservation of rights letter not sufficient

(c) Third Party By Order

- Statute allows IC to enter tort actions - **[IAA 579(14)/(15)/(16)}**
- **s. 579(14)**: **When an IC denies liability** under a contract evidenced by a motor vehicle liability policy, **it must, on application to the Court, be made a third party in any action to which the insured is a party** and **in which a claim is made against the insured** by any party to the action **in which it is or might be asserted that indemnity is provided by the contract**, whether or not the insured enters an appearance or defence in the action.
- **(15)** On being made a third party, the insurer may
  - (a) **contest the liability** of the insured to any party claiming against the insured,
  - (b) **contest the amount** of any claim made against the insured,
  - (c) **deliver any pleadings** in respect of the claim of any party claiming against the insured,
  - (d) **have disclosure of records and questioning** under Part 5 of the Alberta Rules of Court in respect of any party adverse in interest, and
  - (e) **question and cross-examine** witnesses at the trial,

- **to the same extent as if it were a defendant in the action.**
- = IC entitled to act as though *it is the defendant* (Mary) in the tort action
    - Can also settle the action (as long as its within policy limits)
    - Issue in case law as to whether Mary's IC can then sue Mary if they settled
- Requires IC to decide whether to deny coverage
    - Different from non-waiver where they can take a risk that they may not have to defend in the future

Giese v. Hunking **(1971 ABSC Appeal Div) *compare to *Re Perfaniuk****

- **Facts:** Third party commenced action against Insured H for death of daughter in MVA but H never tells IC; Third party gets default judgement against Insured; **IC finds out and wants to be made third party by order so the default judgement can be set aside and matter can be fully litigated;** application requires an affidavit setting out that they meet statutory requirements including that IC "denies liability under a contract"; affidavit did not deny liability to H and third party G claims this is required; IC argues that it is sufficient that it deny liability of its insured to the claimant
- **Issue:** Does the "third party by order" provision require that IC deny liability <u>to the insured</u>?
- **Decision:** Yes
- **Reasoning**
    - Provision <u>not</u> intended as a mechanism to <u>allow IC to deny liability of insured</u> ***against third party claimant***
    - If IC does <u>not</u> deny liability to its insured, then it has to defend claim in insured's name, not in its own
    - Here, H was in breach of SC 3 of the policy (requiring him to give prompt notice of the accident, immediate transmission of documents of claim, etc.) so IC may deny liability on the policy, <u>but it hasn't done so yet</u> so its application to be added as a third party is dismissed.
- **Ratio:** in order to be added as third party, **IC must deny liability to its insured** in strict compliance with statutory requirements - courts won't assume that IC intends to deny coverage.

Re Perfaniuk **(1961 ManCA)**

- **Facts:** Appellant injured as a passenger on motorcycle which collided with the D's truck. D's truck insured by Respondent IC. Appellant brought and served an action but D did not notify IC as required by the statutory conditions of his policy. No defence was filed so default judgment was entered. Shortly thereafter, Appellant's lawyer advised D's IC of judgment. IC then applied to be added as a third party by order, and asked that the default judgment be set aside.
- **Issue:** Can IC be made a third party by order after a default judgement has been entered?
- **Decision:** Yes - IC had no knowledge of action so would be a matter of grave injustice to deny them the right to be entered as a third party.
    - Court says that 3rd party by order has all the rights that an insured has but nothing more
    - Where there is a default judgment that <u>isn't a finding on the merits</u>, this action *could* be reopened by the insured (with the hope it would be set aside), <u>so this same right is available to 3rd party by order</u>
    - Where there is a regular judgment that IC doesn't know about, the IC can <u>not</u> be made a 3rd party by order because court has already decided liability
        - However the IC could be made a 3rd party by order and then appeal the judgment on its merits
    - different way of getting same result as previous case - AB Appeal Div probably uses better reasoning?
    - Insured was in breach of policy by failing to give notice, therefore coverage can be denied …

2. The Rights of (Judgement) Creditor's Action

3rd party claimant (JOE) v Mary's IC (ICX)

- Mary has already been held liable under the tort action so Joe is given a cause of action as **judgment creditor to sue her IC directly**
    - ensures protection for innocent 3rd parties
- ****Even if IC has no obligation to Mary due to breaches/coverage issues, they have obligation to Joe - s.579****
    - **Common law is altered by statute**, because under CL only parties to a contract have a right to enforce it and third party would have no direct claim against defendant's IC if D insured chose not to claim against policy or if IC denied coverage to D.
- **"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
    - **Found in all liability contracts**
        - **General Liability Provision** – **IAA s. 543**
        - ****Auto Liability Provision – IAA s. 579(1)****
    - **Provision will allow for recovery by the third party directly if:**
        - The third party obtained a **judgment** against Person;
        - Who is insured under a **liability insurance contract**;
        - Which provides **indemnity to the insured with respect to Third party claims** against the Insured.
- This is a 'class action' meaning that ***every party injured by Mary*** **in THAT INCIDENT** will be pursuing her IC together, causing policy limits to be divided between **ALL** claimants (ex. $200,000 is PER incident)
- There are restrictions on what defenses Mary's IC can raise - this is to protect Joe who is an innocent party
- **Note: IAA s. 579(2)** puts a ****limitation period of 1 year**** from the final determination of the action against the insured for the 3rd party claimant to sue the IC under the judgment creditor action

(a) Distinct From A Tort Action

Bourbonnie v. Union Insurance **(1959 ABSC)**

- **Facts:** MVA resulted in fatality of passenger; Plaintiff B recovered $14,000 against Insured for the death of her husband. B sues tortfeasor's IC in judgment creditor action; IC defended claim and relying on breach of contract by insured for driving while intoxicated & defences of volenti or contributory negligence because B's deceased husband was also drunk
- **Issue: can these defences be raised by IC against third party judgement creditor**
- **Decision: No -** these are invalid defences in a statutory action
- **Reasoning:**
    - Judgement creditors action not based on negligence or misconduct of the insured, or the policy of insurance
    - **It is an action based on a judgement previously obtained against by the P and on the right conferred by the IA to sue to have the insurance moneys applied to that judgement**
    - Therefore defendant IC can not rely on defences which would have been available to it in the tort action

- **Can only rely on defences available under the statute** - insurer was not the insurer, insured was not an insured, no judgment was recovered and/or judgment has been satisfied

- **Note: statute also sets up** a different defence. – any defence that the insured could have raised against the insured – **only in respect of insurance over and above the statutory minimum.**
    - Driving while ability to do so was impaired by alcohol – breach of a statutory condition – can be raised by the insurer as against the Plaintiff.

(b) Only Applies to a Judgment on the Claim

Bartkow and Walder v. Merit Insurance (No 2) **[1963 BCCA]**

- **Facts:** Five people suffered injuries in an MVA caused by the insured's negligence. The insured's IC settled three of the claims prior to judgment being obtained against the insured. The two remaining claimants obtained judgment against the insured and brought a Judgment Creditor Action. Policy Limits would not cover all 5 claims. **IC argued that the available policy limits should be shared amongst <u>all five</u> TP claimants** (IOW - that the settlement amounts already paid should be deduced from the $200 000 policy limit, the remainder of which would be shared by 2 judgement creditors)
- **Issue:** can policy limits be reduced the by out of court settlements?
- **Decision:** No - policy limits must be available to the **judgment creditors** to be split pro rata
- **Reasoning**
    - The parties with settled claims are not "persons having judgments or claims against" the Insured.
    - They signed releases and discharges prior to the action against the insurer. Thereafter, they had no judgment or claim as per **IAA 636**
    - Scheme is in place to ensure there is money available in the judgment creditor action - IC may end up paying more than the minimum statutory limit because the limits have to be split pro rata between the 2 claimants
    - **note:** IC could prevent this by *not* settling - make all 5 claimants judgement creditors
- **See IA IAA s. 579(7):** When a person has recovered a judgment against the insured and is entitled to bring action under subsection (1) and the insurer admits liability to pay the insurance money under the contract, and the insurer considers that (a) there are or may be other claimants, or (b) there is no person capable of giving and authorized to give a valid discharge for payment who is willing to do so, the insurer may apply to the Court ex parte for an order for payment of the money into Court, and the Court may, on the notice, if any, it thinks necessary, make an order accordingly. **= basically allows IC to pay into court and have court deal it (like normal JC situation)**

(c) Defences Available to the Insurer

- Mary's IC can't raise **ANY** defenses related to **<u>Mary's breaches for the first $200,000</u>** – **IAA s. 579(4)**
    - this is to ensure that at least the statutory minimum of $200,000 is available to Joe
    - Where the action is for MORE than $200,000, Mary's IC could raise some defenses – **s. 579(11)** - see later
- **With respect to first $200 000, can only raise arguments re: coverage because this isn't a "defence" - arguing that there was no policy in the first place**
    - **ie: argument is loss didn't arise from 'use and operation' of the vehicle - <u>because this is a question of coverage, not a question of breach</u> = SITUATION DOES NOT FIT INTO CONTRACT**
    - other examples: never had a contract with Mary in the first place, policy had been terminated before the accident, policy didn't cover the loss, any outstanding liability has already been satisfied by insured so no outstanding judgment creditor action exists

- Note: defences about coverage may have already be decided in the tort action = another reason why IC will want to be involved as finding of fact in tort action may limit ability to succeed elsewhere
- **IAA s. 579(11) pulls back from absolute liability provision s. 579(4)**
    - **(11)** When one or more contracts provide for coverage in excess of the limits mentioned in **section 556 SC#2 (minimum insurance limits of $200k)** , except as provided in subsection (12), the insurer may, despite subsection (4),(a) with respect to the coverage in excess of those limits, and (b) as against a claimant **avail itself of any defence that it is entitled to set up against the insured** other than a defence arising out of a breach of Statutory Condition 2 set out in section 614. (Prohibited use by insured).
        - = **for first $200k, IC can not raise any defence that it may have against it insured as against the injured third party claimant**
        - **Only for claims over $200k**
        - **Exception: defence of "prohibited use by the insured" can NEVER be raised**
            - ie: SC2 says driving unlicensed is a breach so if this was Mary's only breach, then her IC would still have to pay Joe the full policy limits of $500,000 as this isn't a defence

***Jivraj v. Edwards* (1999 ABCA) - EXAM QUESTION**

- **Facts:** State Farm issued auto insurance policy to Irene Edwards purporting to insure a vehicle licensed and registered in her name; but actually, car had been purchased and was solely driven by her son Gordon who had been convicted of drunk driving and was disqualified from having a license; Son gets into MVA and caused injury to third parties; third parties brought actions to recover their damages and both State Farm and Motor Vehicle Accident Claims Fund (compensates victims of uninsured or hit/run accidents); MVACF paid third party claims but reserved the right to be reimbursed by State Farm; Trial Judge found that Irene Edwards had no ownership (in fact or law) in the vehicle and thus no insurable interest = **no insurance contract ever came into existence, Gordon was an uninsured driver and MVACF should pay the judgement (based on finding that policy not an "owner's policy)**
- **Issue**: Was Gordon Edwards an 'uninsured driver' (so that the MVACF had to pay the TP's damages), or did State Farm have to respond to the claim by the injured third party?
- **Decision (Majority):** ONCA has removed basis for Trial Judge's decision - State Farm not entitled to raise issue of misrepresentation as to ownership against the third party and thus had to pay judgement.
- **Reasoning:**
    - Very often the owner of a car involved in an accident is not the named insured on the policy (usually bcs premiums would be too high or this person had license revoked etc.)
    - **Two methods of interpretation have been applied in such cases**
        - **1) *Transport et al v. London & Midland* (1971 OntCA) -** Applied by the Trial Judge
            - effect of **IAA 559** is that if policy was issued to *owner* of vehicle as the result of a misrepresentation, the fact of the misrepresentation does not provide IC with a defence against injured third parties
            - **but if the misrepresentation is to OWNERSHIP, the vehicle would not be "owned by the insured named in the contract" so coverage would not exist at all and IC could raise this defence**
                - vehicle not owned by insured named in the contract (Irene) and therefore, she could not have give permission to anyone (including Gordon) to drive the car and coverage for an unnamed insured couldn't exist

- **BUT: ONCA overruled this case in *Campanaro v Kim* (1998 ONCA) -** question is property whether IC issued an instrument as a motor vehicle liability policy
    - whether labeled/intended as an "owner's" or "non-owner's" is **irrelevant** as long as the instrument issued by IC purports to be a motor vehicle liability policy
- **2) *Marshall v. law Union and Rock Insurance* (1958 NBSCAD) -** other line of authority
    - The statutory right of recovery covers **any misrepresentation**, including a misrepresentation as to ownership of the vehicle - **misrepresentation regarding ownership is <u>no</u> different than misrepresentation regarding any other fact under s. 579(4)**
    - = Blanket prohibition on raising misrep as a defence against 3rd party claimants
- **Must follow *Marshall* and *Campanero***: no reason to treat misrepresentations differently. Once a liability policy has been issued, the IC may not *under any circumstances* rely on a defence against third party claimants of it not being a valid policy

- **Dissent:** Agreed with trial decision, but for different reasons**. {how would the law be different if this had been the majority judgement}**
    - **IA s. 1(ll)** "**motor vehicle liability policy**" insures (i) the owner or driver of an automobile or (ii) employee/agent/person using vehicle on owner's behalf
    - **but IA s. s. 1(pp)** "**owner's policy**" means a motor vehicle liability policy insuring a person in respect of the **<u>ownership</u>**, use or operation of an automobile **<u>owned by the person</u>**…
    - **and IAA s. 559** every contract evidenced by an **owner's policy insures the insured named in the contract** and **every other person who with the named insured's consent drives an automobile owned by the named insured**
        - makes everyone who drives car with owner's consent an **unnamed insured**
        - if not for this section, owner policy would only cover **named insured**
    - Can still defend the action on the basis that the policy does not provide coverage to the judgment debtor
    - Went through above IA definitions, and concluded that if you don't have owner's policy, can't give anyone permission to drive your car, and then they aren't an unnamed insured so they aren't covered
        - **IC is precluded from denying that the policy was in force at the time of the accident**
        - **<u>However</u>**, the motor vehicle liability policy <u>doesn't</u> provide indemnity to Gordon - his use of the vehicle cannot be said to have been with the consent of the named insured and is thus no more entitled to indemnity than a thief.
        - **Gordon was never covered under the policy**
- **Ratio: As against the injured third party claimant, for first $200k, IC can not raise any rely on defence of insured's misrepresentations to argue that there was not a valid policy in place.**
    - **But dissent - leaves open the issue of whether IC could argue that driver was never covered because he is not named in the policy**

(d) Defences Available in Excess of Statutory Limits {Claims over $200k - IAA s. 579(11)}

- When one or more contracts provide for coverage in excess of $200 000, the IC may, with respect to the coverage **in excess** and **as against a third party claimant** avail itself of **any defence it would have against the insured, other than a breach of "prohibited use by the insured" from IAA s. 556 SC#2 --> NEVER A DEFENCE**

- Example: if Mary's IC can prove there was misrepresentation, **they will not have to pay Joe anything beyond $200,000,** even though her policy limits are $500,000
    - Rationale: Joe can't benefit from being lucky enough to get in a MVA with someone with high policy limits
- But IC must be able to prove defence applies – outcome on this fact may affect what happens in Action #3

Markus v. Western Union Insurance **(1964 Alta SCAD)**

- **Facts**: M and Z were passengers in Insured N's car who were injured in an accident that was the fault of N; M sues N on behalf of himself and Z but N does not report action to IC; IC finds out before trial and successfully applies to become a third party by order; M gets judgement against N and sues IC in a judgement creditor action; **IC argued that coverage in the policy for passengers was "excess insurance" and Insured N had not properly reported claim when made, failed to cooperate in the defence of the action, and therefore forfeited right to recovery**. **Third party argued that insured N would be entitled to relief against forfeiture to prevent IC from relying on N's breach and denying them their money**; Trial judge awarded M judgement amount against IC
- **Issue**: What defences can IC raise? Can a 3rd party claimant rely on relief from forfeiture in a judgment creditor action?
- **Decision/Reasoning:**
    - Third party creditor can raise argument that would have been available to the **insured** which includes relief from forfeiture
    - Relief from forfeiture **applied** because the IC didn't suffer any harm due to the non-notice and thus could not rely on the insured's breach to deny coverage
    - **BECAUSE WE'RE DEALING WITH EXTENDED/EXCESS COVERAGE, the insurance company can avail itself of any defence it can raise against the insured**
        - just turned out to be unsuccessful in this case

MacKinnon v. Canadian General Insurance Company **[1976 SCC]**

- **Facts:** P in tort action recovered judgement of $67 000 against Insured; Insured had two liability policies (owner - first loss; and drivers - excess insurance); P commence judgement creditor action against both ICs; Each provided minimum limits of $35,000.00 (the statutory minimum at the time); First loss IC paid $35,000 and P sued for balance of $27 00 against driver's IC; Driver's IC argues it should be able to raise any defences it had as against its own insured (because P had already received $35k)
- **Issue**: Could the excess insurance company (Canadian Genera) raise the issues that it had against its own insured as defences (because third party had already received $35k) or was it was still within absolute liability provisions?
- **Decision (Majority): IAA s. 579(11) applies to each IC individually**
    - Each insurer may only raise these defences after **it** (not another insurer) has paid out the statutory minimum {IOW, must pay out the minimum themselves in order to raise defences on the policy}
- **Dissent (Pigeon J and Ritchie J):** - Once coverage of $35,000 has been provided by a policy, any excess coverage, **whether by that insurer or another**, the insurance company may set up as against the third party, all the defences that the insurance company could have raised as against the insured.

Schoff v. Royal Insurance Co of Canada **(2004 ABCA)**

- **Facts:** Insured Mrs. Goyan made several fraudulent misrepresentations on her application for auto insurance; in addition to misrepresenting her own accident history an the number of cars she owned,

she said she would be the only driver of the car as the only licensed driver in her household; in reality she lived with her 4 sons who were all licensed drivers; After policy issued, IC learned that her driving record was not accident free like she indicated but chose not to inquire further; Son Charles was driving the car when he caused a MVA that insured Schoffs; S obtained judgement of $500 000 against Charles (Mrs. Goyan's third party liability limits were $500k); S claimed IC is obligated to satisfy their judgements; IC argues that (1) Charles was not driving with Mrs. Goyan's consent and therefore was not insured, and (2) if he was driving with consent, IC is entitled to deny liability to S for any amount in excess of $200k;

- **Issue**: Could Royal Insurance deny coverage to third party claimants for all of insurance or the portion exceeding the statutory minimum?
- **Decision:** Could rely on fraudulent misrepresentation defence against third party **but only for coverage over $200k**
- **Reasoning:**
    - Charles was driving with the consent and was therefore an unnamed insured under policy because of finding of fraudulent scheme which necessitates "consent"
        - **therefore IC is on liable for *at least* minimum statutory limits {can't raise issue of non-coverage}**
    - Trial judge found that IC could not use misrepresentations to deny coverage for amount over $200k
        - **Relied on the "notorious information exception" to the duty to disclose**: IC should have been put on notice because it learned of her misrepresented driving record and this in combination with the fact that that she claimed to have 3 cars of which she was the only driver, should have put IC on notice to investigate
            - Could not rely on the misrepresentations because of this knowledge which it had prior to the accident, and the choice not to make further inquiries.
    - **Court of appeal finds that IC was entitled to rely on Ms. Goyam's representations:** only knew about her accident record being misrepresented and the fact that she was insured for 3 cars was not *that* unusual - the other facts were entirely within knowledge of insured
    - **Allow IC to rely on defence of fraud on the basis that if Ms. Goyan had made a claim in these circumstances, it would have been denied**.
        - trial judge incorrectly concluded that "Royal cannot now rely on those misrepresentations to as against innocent third parties"
        - this conclusion overlooks the fact that legislation has addressed this with absolute liability provision covering up to $200 000 = legislative bright-line rule for public protection where coverage denied
            - plus public can protect itself further with SEF44 endorsement
        - **beyond $200 000, the basis upon which IC can deny coverage to third party judgement creditor is the same as a denial to the insured**
            - This was a fraudulent scheme: no principle that a fraudster, having obtained the contract by fraud, can succeed in enforcing it on a doctrine akin to contributory fault.
- **Ratio:** IC entitled to rely on any defence it would have against the insured to deny coverage to third party judgement creditors for amounts over $200k

3. Recovery from the Insured

- **Where contract has been breached, Mary's IC has cause of action against Mary herself, allowing them to recover any amounts they had to pay Joe in the judgement creditor action**

- **Cause of action arises from either**
    - a) non-waiver agreement
    - b) **IAA s. 579** = statutory right of action
- If there was no issue of coverage, IC would have to pay Joe under cause of action #2 & wouldn't be able to sue Mary because an insurer can't subrogate against its own insured
    - ie: if loss resulted out of 'use and operation' of the vehicle, Mary's IC has agreed to provide coverage for this risk so they would have no reason to sue Mary
- Issue in case law where IC involves itself in Action 1 without a NWA and achieves a settlement with the 3rd party claimant: statute allows them to recover for any 'judgments' but question is whether they can sue to recover for settlements? Case law is conflicted
    - Ultimately it seems to depend on whether there was some sort of involvement by the tortfeasor in the settlement (participation, endorsement, acquiescence)

Peace Hills General Insurance Co v. Terringno **(2009 ABPC) - OVERTURNED ON APPEAL IN 2011, DON'T FOLLOW IT**

- **Fact:** Son was in accident while driving insured mother's vehicle with her permission. At time of accident, son's licence to drive was suspended for unpaid fines in Ontario; Son denied liability for accident; IC advised son to get liability issue settled or it would settle third parties' claims as it saw fit; **Insured did nothing so IC settled third parties' claims** and brought action against son for reimbursement of $14,400 paid to third parties on basis that son breached statutory condition of policy; Policy contained **SEF 8(a) – Property Damage Reimbursement for Operating by Named Person Endorsement** = Undertaking that certain persons will not drive vehicle, but if they do and accident occurs, and the insurer is required to compensate a third party for property damage, then the insurer is entitled to reimbursement from its insured. IC sued on endorsement for property damage and sued son on amounts paid out for personal injury. Defence = endorsement had not been signed by insureds as required .
- **FOLLOW QB: In order to claim over against son, IC needed a "JUDGMENT" under IAA s. 579 = a hard and fast rule**
    - Trial Judge was of view that there was no "hard and fast rule requiring a judgment" — In fact, there was such hard and fast rule — It was set out in legislature of **IAA s. 579** — No authority holding that insured's acquiescence, doing nothing, was sufficient to permit insurer to reimbursement in absence of judgment against insured — In holding otherwise, learned trial judge erred in law.
    - court acknowledged there are exceptions to this rule where the insured **agrees** that the issues of liability & damages in the 3rd party claim may be determined by means other than a 3rd party judgment
    - But acquiescence or doing nothing isn't sufficient to allow an insurer to be reimbursed absent judgment against the insured

Lockhard v. Quiroz **(2006 ONCA)**

- **Facts:** Q driving L's car with permission and was involved in single vehicle accident. L sued Q for damages to car. Q's IC was added as a third party by order. IC and L settled without involvement of Quiroz - provided him with notice, but didn't get his consent or authorization. As part of settlement, L and IC entered into consent judgment but no judgment obtained against Quiroz.
- **Decision:** Court held that because the Plaintiff had not obtained judgment against Quiroz, (and because it had not properly obtained the Plaintiff's consent to the settlement), the Insurance company could not sue Quiroz for reimbursement.
- **Reasoning:**

    - insured can only be sued where there is an actual judgment
    - only circumstance where this wouldn't be required is where the insured participated in the settlement discussions OR authorized the IC to enter into settlement on their behalf understanding they would be sued later (aka NWA)
- **Commentary:** policy reasons for this decision: statute doesn't permit IC to bind insured to judgment against them at the instance of the IC itself, so similarly IC shouldn't be able to enter into settlement without any involvement by the insured in determining the amount
    - while case is often used to support that there must be a judgment, there isn't enough discussion about what the rest of the judgment says as the court does leave room for exceptions where there is participation

Exam

- 100 marks, 12 Qs, 2.5 hours
    - 6 -7 Qs worth less than 5 marks
    - 3 x 10 mark Q
    - 2 x 10+ marks
- marks correspond to points - mostly hypotheticals - ¾ of the Qs
- one is a quote from case decision and request for your comment (5 marks)
- some straight forward: how did a particular case change the law?, what are factors did the court consider in X case?