ACCIDENT BENEFITS: PUNITIVE DAMAGES v. SPECIAL AWARD DAMAGES

CANADIAN DEFENCE LAWYERS
SEMINAR
By

JOSEPH J. SULLIVAN
CHRISTOPHER D. DEELEY
Barristers and Solicitors*

*CAMPORESE SULLIVAN DI GREGORIO Associates - Lawyers

Introduction

When a denial from an insurance company occurs, a Plaintiff has an option after going through FSCO Mediation to either make a claim in the Ontario Superior Court of Justice or to take the matter to FSCO Arbitration.

This decision can determine whether a Plaintiff has available to them punitive damages or a special award, how quickly a matter will be heard, and whether a judge or an arbitrator will preside over the matter.

Typically, FSCO matters are heard more quickly without the Examination for Discovery process. The Ontario Superior Court path takes one through Examinations for Discovery and Motions and normally will take longer.

There is a further impact on whether a Plaintiff or Applicant can obtain a special award or punitive damages.

A special award is available only through FSCO arbitration.

Special awards are governed by s.282(10) of the *Insurance Act,* R.S.O. 1990, c.I.8.

S.282(10) of the *Insurance Act* reads as follows:

> **Special award**
>
> (10) If the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the *Statutory Accident Benefits Schedule*, shall award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*. R.S.O. 1990, c. I.8, s. 282 (10); 1993, c. 10, s. 1.

The purpose of punitive damages is to punish the Defendant and to deter a Defendant and others from committing similar acts.

Punitive damages are normally awarded when there has been misconduct that represents a marked departure from ordinary standards of decent behaviour.

In *Ericson v. Guarantee Company of North America*, Senior Arbitrator Frederika Rotter stated that:

> I do not agree that a special award is comparable to an award of exemplary or punitive damages. Exemplary or punitive damages are awarded in addition to the usual damages in tort cases which provide compensation or restitution to an individual who is injured or harmed by the actions of another. Exemplary or punitive damages are awarded by the court when it is shown that the wrongdoers wilfully behaved in a way that is arrogant or high handed or shows a callous disregard for the rights of the victim.

It appears that a special award is awarded where it is shown that an insurer has unreasonably withheld payments that they should not have otherwise done, while punitive damages seem to have to be a more flagrant violation of bad faith.

As we know, contracts of insurance are peace of mind contracts and regardless of whether a Plaintiff or Applicant goes to FSCO or the Ontario Superior Court, the obligation of the insurer to the insured remains.

As you will see through the cases, the train of thought of the judges and arbitrators are pretty similar in determining punitive damages and special award damages.

In this paper, the prominent cases for punitive damages and special awards are outlined for you.

In these case summaries you will notice the tests for punitive damages and special awards.

I have also included for you as a bonus a summary of the two new LTD offset cases which are *Cromwell v. Liberty Mutual Insurance Company* and *Vanderkop v. Personal Insurance Company of Canada.*

Punitive Damages Cases

Clarfield v. Crown Life Insurance Co. (2000) 50 O.R. (3d) 696 (Ontario Superior Court of Justice)

Facts

- In 1992, the Plaintiff Clarfield was earning an income of over $200,000.00 per year and purchased income replacement plus disability insurance policy from Crown Life Insurance.

- In September 1996, Clarfield started a business that failed and became depressed.

- In September 1997, the Plaintiff completed a claim for disability insurance benefits.

- Clarfield had no income for the year ended September 19, 1997.

- His family physician completed a Statement of Disability wherein she described him as being incapable of working and diagnosed him as suffering from a major affective disorder.

- The doctor indicated the illness began in February 1997 and Clarfield was incapacitated in July 1997.

- In October 1997, the psychiatrist stated that he had high anxiety, disassociation, and restricted working at that time.

- In November 1997, the Plaintiff elected to have his prior average monthly income calculated according to his two best consecutive years in the previous five years as entitled under the policy.

- In December 1997, a psychiatrist provided a full medical report indicating that the Plaintiff had entered into a training program in financial planning.

- Crown Life delayed consideration of Clarfield's claim and in January 1998 denied the claim on the grounds that he was not totally disabled and he did not earn income in the months before his claim.

- This letter enclosed a cheque of $4,800.00 for the period ending January 24, 1998. It explained that the Plaintiff was asked to sign the bottom of the letter indicating his agreement with the terms. There was no mention of his residual disability benefits.

- The policy allowed an insured to be employed for the final three years of the previous five.

- Crown Life had a general policy not to pay disability benefits to claimants who had no income at the time of their disability; however they had paid Clarfield some benefits but warned him that he might have to pay some benefits back.

- After the claim was denied Clarfield put his home up for sale and was anxious to return to work.

- This reimbursement, stated the Plaintiff, was paid on an extra-contractual basis and the Defendant reminded the Plaintiff that he might have to pay those benefits back.

- Clarfield's doctor told him to do less stressful work.

- In February 1998, he obtained work with Nesbit Burns and commenced a six month training course.

- The Plaintiff brought an action on the policy and claimed for aggravated and exemplary damages. The Defendant relied on two things, first the psychiatrist GAF scores in concluding that the Plaintiff was not disabled, second they focused on the fact that the Plaintiff was earning no income when he made the claim and that the claim, if allowed was likely to be a large one.

Issues

- Was Clarfield entitled to aggravated and punitive damages based upon the conduct of Crown Life Insurance.

Held

- Clarfield was awarded benefits under the policy and aggravated damages of $75,000.00 and punitive damages of $200,000.00.

- It was found that Clarfield was totally disabled within the meaning of the policy from August 1997 until the commencement of his training program and that he continued to be continually disabled at the time of the trial based upon the medical evidence.

Commentary

- Justice Juriansz stated at paragraph 22:

> The thorough cross-examinations of Crown Life's staff made it abundantly apparent to me that they did not entertain the prospect that Mr. Clarfield might have a claim for residual disability benefits because he was earning no income in the months preceding his disability claim.

- This seemed to coincide with the letter dated October 1, 1997 which Crown Life sent to Mr. Clarfield which made no mention of residual benefits.

- The claims adjudicator seemed quite unaware that under the policy an insured could be unemployed for the final three years of the previous five years and still have a prior average monthly income that should be used to determine an entitlement to residual benefits.

- The judge highlights some of the claims handling at paragraph 40 which states:

> The claims adjudicator and her supervisor were not medically trained. The supervisor said, in discovery testimony read in at trial, that the claims adjudicator may not even have had the in-house course on medical terminology at the time she processed this claim. It seems to me that they simply and unduly focused on the GAF score, without an appreciation of the nature and duration of the illness and the fluctuating course of recovery from it. They did not seek to understand the doctors' reports as a whole. For example, while Dr. Birnbaum's report dated

> December 22, 1997 indicated a GAF score of "80," a good score, it also indicated significant findings on three of the other four axes."

- Paragraph 41 stated "The claims adjudicator relied strongly on the statement in Dr. Birnbaum's report dated March 9, 1998, that Mr. Clarfield's "current mental status is recovered and normal with a GAF score of 90." Ms. Walker testified that Dr. Birnbaum, in a telephone conversation on April 20, 1998, said Mr. Clarfield was "totally recovered". Dr. Birnbaum did not recall the phone call, but explained that "total recovery" from a major psychiatric illness does not mean one is ready to return to work. He compared Mr. Clarfield's recovery from his disassociated state to a patient who has come out of a coma. In both cases they have recovered but require convalescence, and are not ready to return to work.

- Justice Juriansz commented on the claims handling with respect to medical reports at paragraph 42 when it was stated,

> It seems to me that if an insurer wishes to focus on one aspect of medical reports in assessing claims, that aspect should be the doctors' opinion as to whether the insured is medically capable of returning to work. If the defendant is skeptical of the insured's doctor's opinion, then it may have its own medical experts review the medical files and examine the insured.

- Paragraph 63 stated:

> I have indicated my finding that the medical information was clear that Mr. Clarfield was totally disabled at the end of the elimination period and at the time Crown Life refused his claim on January 9, 1998. As well, Crown Life's failure even to consider Mr. Clarfield's entitlement to residual disability benefits was not based on a reasonable interpretation of its obligations under the policy. There was no evidence to support Mr. Clarfield's counsel's argument that Crown Life would not have been as skeptical of a claim for residual benefits for a physical illness, such as cancer or heart disease, as it was of this claim based on a mental disability. However, this does not detract from the fact it processed the claim with complete disregard for the policy's express provisions.

- In looking at claims handling, it was noted at paragraph 68, Ms. Walker agreed that she overrode the claim adjudicator's recommendation that benefits be paid as she expected that Clarfield could return to work shortly. This was a handwritten response that was dated December 12, 1997 which makes it clear that as of the date of the note, she was satisfied that Clarfield could not work which was after the end of the elimination

period. Yet, she instructed the claims adjudicator to “only issue an extra-contractual payment right now”.

- The judge had problems with the January 9, 1998 letter which stated that medically there were no objective findings to support total disability. The judge felt that it was unfair in several respects. First, the statement that the medical evidence was not accurate because as of that date the insurer had no medical certification that the insured was able to return to work. Second, when Clarfield was asked to indicate by his signature not merely that he acknowledged the insurer’s position but that he agreed with the terms of the letter, which stated that there was no entitlement to benefits and there was no medical to support total disability. This was done despite the fact that there was no evidence of that that Crown Life had.

- Counsel for Crown Life attempted to create distance between the claims adjudicator and her supervisor on the one side and the company on the other by squaring them as “fairly unsophisticated ladies from Regina”. The judge did not buy this and stated at paragraph 72 that “However, I find their confidence that they were acting in accordance with the company's approach was warranted. In any event, the company is responsible for the decisions made by the staff it hires, trains and supervises.”

Damages

- Aggravated damages were paid as Mr. Clarfield suffered increased anxiety, stress, and financial pressure, both from the rejection of claim and from the delay in dealing with it. Mr. Clarfield while in dire need of money was afraid to cash cheques because he would not be able to afford to pay the money back if reimbursement was demanded and the January 8, 1998 letter confused him and he suffered great anxiety over whether he should sign it. He needed the money but he did not cash the payments until the insurance broker assured him that Crown Life would not seek reimbursement.

- Looking at punitive damages, the judge outlined paragraph 94-100:

Insurer's Conduct

It is an insurer's duty to act in good faith in its handling of its insured's claim. The claims handling of an insured's file with disregard for acting in good faith can contribute aggravated damages. This was shown in paragraphs 94 to 97 where it stated:

> [94] All the matters which I discussed above in concluding that the insurer breached its duty to act in good faith, and in the assessment of aggravated damages, are relevant here. The defendant did not make a decision on the insured's claim in a timely fashion, even though the medical information on file clearly indicated he was totally disabled. The insurer did not arrive at its decision in a balanced and reasonable manner. The memos between Ms. Folk and Ms. Walker indicate they were unduly concerned about getting Mr. Clarfield "off-claim," should they recognize his claim.
>
> **[95] The defendant not only failed to consider a claim for residual benefits, but failed to inform the insured of its decision or of its reasoning for the decision. I find this significant because an insured who is not given notice of an adverse decision cannot contest it. If Crown Life had advised Mr. Clarfield that it had decided he was not entitled to residual benefits, he may have been prompted to look at his policy or consult a lawyer. An insured who is not advised of the reasoning for a decision cannot mount an argument against it. Whether by design or not, Crown Life's conduct had the effect of concealing from Mr. Clarfield its interpretation and application of the Prior Average Monthly Income provision of the policy.**
>
> [96] I agree with Mr. Clarfield's counsel that Crown Life's mode of making payments "extra-contractually," requiring the insured agree to the terms of its letter as a condition for receiving those payments, and reminding him it could seek reimbursement when he raised questions about its decision, constituted a "condemnable form of negotiating with a disabled person." Counsel argued that Crown Life used the payments as a "bargaining chip" to intimidate Mr. Clarfield from advancing his claim. There was no misunderstanding, as Ms. Walker admitted that Mr. Clarfield was asked to sign away rights. It is reprehensible for an insurer to insist that the financially vulnerable insured compromise his claim under the policy as a condition of receiving the benefits to which he was entitled.
>
> [97] Furthermore, there was evidence that can only lead to the conclusion that the insurer's deleterious conduct is not confined to this case.

Judicial Commentary on the Testimony of Claims Adjuster

The preparation of an insurance adjuster for testimony at trial is vital and will have an impact on whether punitive and aggravated damages are awarded to an insured.

Justice Juriansz commented on the adjusters' testimony at paragraphs 98 through 100.

[98] The claims adjudicator said she could not recall "ever, ever paying any benefit to someone who wasn't working at the time and became disabled because the whole intent is of this policy is income replacement for your work if you can't work." [sic] She was evasive and equivocating when cross-examined at length as to whether there were any company instructions or directives that said there could be no entitlement to residual disability benefits if the claimant had not been earning income in the six months or 12 months before becoming disabled. She sidestepped several versions of this question. One version made the compound inquiry whether that was the philosophy of the company and whether there was something in writing that said that. She replied "nothing in writing, no." I understood her to affirm that indeed it was the philosophy of the company. She finally did say that there was no internal memorandum directed to her as a claims adjudicator stating Crown Life would not pay residual disability benefits in such circumstances. She was adamant that it mattered if claimants do not earn income in the months before becoming disabled. She said she was not the only one to whom this mattered. She said her supervisor felt the same way. She was so confident of her understanding that she testified that it was pointless to calculate the insured's Prior Average Monthly Income because he was not earning income at the time he became disabled.

[99] The supervisor, in her long and torturous cross-examination, was extremely hesitant and unforthcoming. She often remained silent for long periods while she pondered her answers to questions. Her view was the same as the claims adjudicator's, and it was entrenched and confident. The viewpoint of the claims adjudicator and the Senior Supervisor of Individual Claims must be attributed to the company. If the testimony of the claims adjudicator is to be taken literally, the defendant's conduct is as frequent as the submission of any claim of an insured who was not earning income at the time he or she became disabled.

[100] The supervisor said claims adjudicators are trained to obtain signatures of the insured as a condition of receiving extra-contractual payments. She said there was a written memorandum from the company's legal department that required that this be done. She said the claims adjudicator had made a mistake by not insisting on a signature for the payment made on December 12, 1997. She described obtaining signatures as a "formal procedure" based on precedents in the claims department. I took this to mean that the format of such letters in other cases is much like the one in this case, which required the insurer to sign away rights.

Whiten v. Pilot Insurance Company 2002 S.C.C. 18 (Supreme Court of Canada)

Facts

- Daphne Whiten and her husband discovered a fire in their house in January 1994.

- Her husband gave slippers to his daughter and suffered frost bite to his feet as it was -18 degrees Celsius outside.

- The fire destroyed their home.

- Pilot Insurance made a single payment of $5,000.00 for living expenses and covered the rent of a cottage for $650.00 per month for a few months and then cut them off without telling the family.

- The origin of the fire was never discovered but everyone who investigated the fire in the six months after it occurred concluded it was accidental.

- The first persons to investigate the fire were the fire chief and the fire fighters called to the scene.

- The fire chief thought, and was eventually shown to be correct, that the fire was caused at a single point of origin by a malfunctioning kerosene heater in the porch of the addition to their house.

- An experienced independent insurance adjuster, Derek Francis, was brought in to investigate the loss and he interviewed the Whitens who admitted that they were unemployed and had financial difficulties.

- Francis interviewed the fire fighters about the fire's speed which is a key indicator of arson.

- Both the physical evidence and the Whiten's conduct satisfied Francis that the fire was accidental and on February 3, 1994 he reported to Pilot "there is no suspicion of arson on behalf of the insured's or any members of their family".

- Francis made further investigations in which he determined the Whiten's mortgage payments were in arrears and refinancing was being arranged.

- It appears that the senior claims examiner, Chris Porter, was already moving towards the conclusion that the claim should be disputed based on suspicions of the family's financial problems.

- In a letter dated February 25, 1994, Francis wrote to Pilot Insurance:

> As outlined in my 2nd report with the physical evidence we have and the fact that the insured was attempting to arrange financing through another source and pay off the existing mortgage, there is little or no base [sic] to deny this claim. I certainly agree with your train of thought and if we did not have the physical evidence and the information from the insured's solicitor that he was arranging financing for the Whitens, then my recommendations would certainly be opposite to what they are today. Unfortunately we must deal with the facts on hand and proceed with the adjustment accordingly in my opinion. [Emphasis added.] (Para 7)

- Pilot did not agree that there was little or no basis to deny this claim although at this stage they had no evidence to support a defence of arson. They refused to accept Francis' recommendations and decided to deny the claim.

- Pilot did not tell Francis why they would not pay the claim and Francis in turn did not advise the Whitens of what was happening.

- It appears that Pilot requested the Insurance Crime Prevention Bureau to review the analysis of Pilot's investigator.

- On February 25, 1994 the Bureau reported that "we wouldn't have a leg to stand on as far as declining the claim".

- In March 1994, Pilot's head office instructed Francis to tell the landlord of the cottage that the appellant was renting that they were no longer going to pay the rent. He communicated this to the landlord but never told the appellant.

- It also appears that Francis, on April 28, 1994, stated that the Whitens came unannounced and unexpected to scene of the fire to sort through debris to see if they could salvage anything which was out of character for someone who might be involved in a suspicious fire.

- Pilot also retained an engineering expert, Hugh Carter. In his initial report of January 28, 1994 he concluded that the fire was accidental. He gave two further reports in which he stated the same opinion.

- Carter then received a letter dated May 4, 1994 from Pilot's counsel, Donald Crabbe which adverted to the arson theory:

> One wonders whether the Whitens, even if they did not set the fire, sat back and allowed it to achieve a level that was convenient to them.
>
> We need to be on top of this matter and to do it quickly. The other side has retained a lawyer and they are making noises of bad faith. The matter has to be revisited in its entirety, stripped down to the bare facts and rebuilt. (Para 13)

- The Statement of Claim was issued on May 27, 1994.

- On June 7, 1994, after a further site investigation, Carter did meet with Donald Crabbe, and after the meeting he reclassified the fire as "suspicious, possibly incendiary".

- He stated at paragraph 15 that Pilot now concedes that Crabbe likely influenced Carter to influence his opinion.

- It appears that there was a reference in one letter to two previous fires, one that occurred at a cottage owned by the Whiten's son-in-law and rented out to a Mrs. Titro and one in another house previously occupied by Mrs. Titro. There was no apparent connection to the appellant or her family.

- At the Court of Appeal, Pilot conceded the evidence about the two fires was irrelevant and inadmissible.

- It appears that on June 9, 1994 a letter written by Pilot raised concerns about the Whitens hiring competent counsel. It was pointed out as opinion by the Supreme Court Justices that “the jury must have asked itself why an insurer dealing in good faith with a policy holder would express “concern” to its own lawyer that she had hired competent counsel”.

- With respect to Pilot and counsel’s conduct comments were made in paragraph 21 and 22:

> **21** Thereafter, Pilot retained a forensic engineer, a fire investigator and a firefighter. Pilot did not disclose Francis's exculpatory reports to any of these individuals, but instead, through Donald Crabbe, furnished them with information about the speed of the fire that the trial judge characterized as misleading if not inaccurate. The firefighter insisted that the fire was likely accidental but the other two experts gave opinions that provided some support for an arson defence. One of them, Richard Kooren, based his opinion on the existence of signs of a fire accelerant. Crabbe wrote on May 11, 1995:
>
> Aside from the burn pattern under the washer, Richard Kooren sees liquid accelerant burn patterns on the annex floor which are not innocent. However, these observations are not made by [Pilot's initial expert] Hugh Carter.
>
> Pilot also conceded at the Court of Appeal that these inculpatory opinions were influenced by Crabbe.
>
> **22** The trial judge commented unfavourably about Crabbe's role in this litigation. He felt that his "enthusiasm for his client's case appears to have caused him to exceed the permissible limits which ought to confine a lawyer in the preparation of witnesses". At the Court of Appeal and in this Court, Pilot conceded that these comments were justified, but added:
>
> ... Pilot, not its counsel, made the decision to deny the claim and Pilot was fully aware, because it was a recipient of the letters, of counsel's "enthusiasm". Pilot recognizes that it bears the responsibility for what occurred.

- The jury awarded compensatory damages and $1,000,000.00 in punitive damages. A majority Court of Appeal allowed the appeal in part and reduced punitive damages awarded to $100,000.00

Issue

- Were the Whitens entitled to punitive damages?

- Should the jury award of $1,000,000.00 in punitive damages be restored or should any award of punitive damages be dismissed?

Held

- The Supreme Court of Canada judgment restored the $1,000,000.00 jury verdict.

Commentary

- The claims handling in the matter and the steps that were taken by the adjuster and the retention of experts were focused on by the judges at all levels in this matter.

- It was found that the denial of the claim was forced onto the insured's in an attempt to try to make an unfair settlement.

- Conduct was planned, deliberate and continued for over two years while the Whiten's financial situation became increasingly desperate.

- Whiten upheld the test in *Hill v. Church of Scientology of Toronto [1995] 2 S.C.R. 130 at para. 190* which stated that the test thus limits the award to misconduct that represents a marked departure from ordinary standards of decent behaviour.

- In paragraph 94 Justice Binnie appears to summarize where punitive damages against insurers can be awarded.

- With respect to the investigation to the claim Justice Binnie stated at paragraph 102:

> The respondent claims that an insurer is entirely within its rights to thoroughly investigate a claim and exercise caution in evaluating the circumstances. It is not required to accept the initial views of its investigators. It is perfectly entitled to pursue further inquiries. I agree with these points. The problem here is that

> Pilot embarked on a "train of thought" as early as February 25, 1994 (see para. 7 above) that led to the arson trial, with nothing to go on except the fact that its policy holder had money problems.

- **Justice Binnie focused on the "train of thought" that was mentioned in the letter to Pilot from Derek Francis located at paragraph 103 and noted that there was a difference between due diligence and wilful tunnel vision. Justice Binnie stated that an award of punitive damages, leaving aside the issue of quantum was a rational response on the jury's part to the evidence.**

- Justice Binnie stated that the more reprehensible the conduct, the higher the rational limits to the potential award.

- The level of blameworthiness may be influenced by many factors but some of the factors noted in the selection of Canadian cases include:

    1. **Whether the misconduct was planned and deliberate.**
    2. **The intent and motive of the Defendant.**
    3. **Whether the Defendant persisted in outrageous conduct over a lengthy period of time.**
    4. **Whether the Defendant concealed or attempted to cover up its misconduct.**
    5. **The Defendant's awareness that what he or she was doing was wrong.**
    6. **Whether the Defendant profited from his misconduct.**
    7. **Whether the interest violated by the misconduct was known to be deeply personal to the Plaintiff or a thing that was irreplaceable.**

- Justice Binnie stated at paragraph 82 that an independent actionable wrong is required but it can be found in breach of a distinct and separate contractual provision such as fiduciary obligation.

- At paragraph 73 it stated that when allocating punitive damages one must focus on the Defendant's misconduct not on the Plaintiff's loss.

- The contractual obligations that Pilot had were to pay the claim and Pilot was also under a distinct and separate obligation to pay or to deal with its policy holders in good faith.

- A breach of contractual duties of good faith was thus independent of and in addition to the breach or contractual duty to pay the loss.

- It was agreed by Justice Binnie that the jury, with the $1,000,000.00 verdict, decided a powerful message of denunciation, retribution and deterrence had to be sent to Pilot.

- The obligation of good faith dealings means the appellant's peace of mind should have been Pilot's objective and Whiten's vulnerability ought not to have been aggravated as a negotiating tactic. (Paragraph 129)

- The reasons for an award of punitive damages is outlined in the facts with the multiple reports sent to Pilot, stating that there was little or no basis to deny the claim, the fact that they did not follow the independent adjuster's advice and the Insurance Crime Prevention Bureau investigator who also stated that there was no claim.

- There is no doubt that an insurance company such as Pilot does have any obligation and right to investigate all claims however they have a duty to investigate claims in a fair and diligent matter.

Fidler v. Sun Life Assurance Co. of Canada, [2006] S.C.J. No. 30 (Supreme Court of Canada)

Facts

- This was an appeal decision by Sun Life Assurance Company from a Court of Appeal decision upholding the Respondent's award of damages for mental distress, awarding an additional $100,000.00 in punitive damages.

- Fidler worked as a bank receptionist who became ill and was diagnosed with chronic fatigue syndrome and fibromyalgia.

- Fidler was covered by a group policy that included long term disability benefits.

- The policy that Fidler had stated that she would only receive benefits after a period of two years if she was unable to perform any job.

- The test for ongoing entitlement changed from her job to any job test.

- In May of 1997 Fidler was informed that her benefits would be terminated due to video surveillance which revealed activities that showed she was capable of doing some light and sedentary work.

- One week prior to trial the insurer reinstated benefits and paid arrears.

- The issue at trial was for aggravated and punitive damages for bad faith.

- The trial judge awarded the Respondent $20,000.00 in aggravated damages for mental distress and dismissed the claim for punitive damages and on appeal the aggravated damages was upheld and the court awarded an additional $100,000.00 in punitive damages.

Issue

- Was Fidler entitled to aggravated and punitive damages?

Held

- The appeal was allowed in part and the aggravated damage award was upheld and the award of punitive damages was set aside.

Commentary

- In this matter the Supreme Court stated that to attract punitive damages "the impugned conducted must depart markedly from ordinary standards of decency/the exceptional case that can be described as malicious, oppressive or high handed in that it offends the court's sense of decency". (paragraph 62)

- The court also followed the *Whitten v. Pilot* decision which stated that punitive damages are designed to address the purposes of retribution, deterrence and denunciation.

- An Insurer will not necessarily be liable for such damages by incorrectly denying a claim that is eventually conceded or judicially determined to be legitimate. The question in each case 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.

- In order to be successful in damages for mental distress or breach of contract a Plaintiff must prove his or her loss and the court must be satisfied that the degree of mental suffering caused by the breach was of a degree sufficient to warrant compensation.

- The Supreme Court of Canada accepted the 'peace of mind exception" to the general rule against recovery from mental distress and contract breach. The court indicated that the court must be satisfied that:

    1. That an object to the contract was to secure a psychological benefit that brings mental distress upon breach within the reasonable contemplation of the parties and,
    2. That the degree of mental suffering caused by the breach was of a degree sufficient to warrant compensation.

Special Awards Cases

Erickson v. Guarantee Co. of North America [1992] O.I.C.D. No. 27 (Ontario Insurance Commission File No. A-000560)

- This was a decision on special awards where it was found that the Applicant's benefits had been unreasonably withheld by the insurer and the Applicant was entitled to a special award.

- Senior Arbitrator Frederika M. Rotter stated that "I do not agree that a special award is comparable to an award of exemplary or punitive damages. Exemplary or punitive damages are awarded in addition to the usual damages in tort cases which provide compensation or restitution to an individual who is injured or harmed by the actions of another. Exemplary or punitive damages are awarded by the court when it is shown that the wrongdoers wilfully behaved in a way that is arrogant or high handed or shows a callous disregard for the rights of the victim."

- To summarize, punitive or exemplary damages are awarded in a case of wrongdoing or breach of contract where an individual has acted deliberately or in bad faith so as to injure another.

- In contrast, a special award in the *Insurance Act* is payable when an arbitrator finds that an insurer has acted unreasonably in withholding or delaying a payment of a benefit.

- A special award does not require these types of findings but only requires the insurer acted unreasonably.

- The criteria for punitive damages go considerably beyond unreasonableness and conduct may be unreasonable notwithstanding that it is not deliberate or wilfully injurious motivated by bad faith.

- The arbitrator stated that a special award must be substantial enough to have a deterrent effect and should be more than nominal which could be viewed as a license to act unreasonably.

- The arbitrator stated that the special award should take into consideration the time and resources expended by the insured person in asserting and securing their rights. Nevertheless a special award is not an award of damages or costs and cannot be expected to fully reimburse or compensate an individual for his expenses or losses.

Persofsky v. Liberty Mutual Insurance Co. [2003] O.F.S.C.I.D No. 11, Appeal P00-00041 (Ontario Financial Services Commission)

Facts

- This was an appeal from an Arbitration Order dated June 23, 2000. This decision gave Persofsky payment for caregiver benefits, housekeeping and various other supplementary and med/rehab benefits.

- The focus of the appeal was on the Arbitration Order that Liberty Mutual pay a special award of 40% plus the 2% compounded monthly interest rate for the housekeeping amount. On the swimsuit claim Liberty Mutual should pay 50% for a special award. On all other amounts owing Liberty Mutual shall pay 30%.

- Liberty Mutual did not challenge the imposition of a special award however did object to the amount.

- On March 18, 1992 Persofsky was involved in an automobile accident where she tore her rotator cuff in the left shoulder and sustained soft tissue damage in her lower back. The impact on her life was particularly serious due to a pre-existing medical condition where since birth she had a shortened right arm and minimal use of her right hand which means she used her left arm for everything.

- Persofsky was working as a computer installation and support supervisor at the head office of Shoppers Drug Mart.

- Liberty Mutual accepted that she was unable to return to work and paid her IRBs because Persofsky was also entitled to benefits from a group disability plan and CPP her IRBs were reduced to approximately $150.00 per week. There was never any dispute about IRBs.

- Six months after the accident Persofsky retained counsel and they presented claims for personal care, housekeeping and home maintenance services dating back to 1992 totalling $103,226.18. This was for attendant care and housekeeping services provided by her adult daughter who was living with her but did not have a job.

- It was the view that Liberty Mutual never properly implemented its role as Persofsky's SABS insurer and did not make her fully aware of the benefits available to her.

Issue

- What special award should be awarded in this matter? (There are numerous other matters that were heard in this case that I will not go over. I will just focus on the special award and not the apprehension of bias argument in this matter)

Held

- A special award should be paid in this matter.

Commentary

- Special awards were authorized under s.282(10) of the *Insurance Act*.

- The arbitrator found that a plain reading of s.282(10) supported Liberty Mutual's position that the arbitrator is to award a lump sum if he or she finds the insurer has unreasonably withheld or delayed payments.

52 I would not suggest that punitive damages and special awards are directly comparable. The former is a common law remedy that is integrally connected to other

common law remedies. In contrast, special awards are defined by legislation and are capped. However, the purpose of a special award, like punitive damages, is to punish the insurer for its misconduct and to deter it, and others, from acting similarly in the future. Or, as Binnie J. described it - retribution, denunciation and deterrence. In my view, the percentage approach to calculating special awards is subject to the same criticism Binnie J. levelled against ratios - they are easy to apply, but may not serve the purposes behind the order. To borrow another term from Whiten, what is needed is a "nuanced" analysis aimed at determining an appropriate penalty, within the maximum, that is sufficient to penalize the insurer for its misconduct, and to serve as a deterrent, but no larger than is needed for these purposes.[25] The considerations that go into determining the appropriate amount of a special award are discussed in more detail below.

53 In summary, I conclude that the proper approach to special awards under s. 282(10) of the Insurance Act is as follows:

1. Determine the benefits owing to the insured person, including interest calculated under the applicable version of the SABS;[26] Decide whether the insurer unreasonably withheld or delayed the payment of these benefits. If so, the insurer will be ordered to pay a lump sum amount in addition to the benefits and interest calculated in #1;
3. If the insurer did not act unreasonably in respect of all the benefits owing under #1, determine the amount of the benefits that were unreasonably withheld or delayed, and the interest payable on these benefits under the applicable version of the SABS.[27]
4. Determine the maximum special award that can be awarded under s. 282(10), or at least a reasonable approximation. This is done by taking the amount in #1 or #3, whichever is applicable, and adding the additional interest component in s. 282(10) - two per cent per month, compounded monthly. To be clear, this calculation includes interest on the unpaid SABS interest. The maximum special award is 50 per cent of this total. Expressed as a formula, the calculation is as follows:

   Maximum special award = 50% x (benefits that were unreasonably withheld or delayed + interest on these benefits calculated under the SABS + compound interest calculated according to s. 282(10))[28]

5. Consider all relevant factors (discussed below) to determine an appropriate lump sum special award, not a percentage, that responds to the facts of the case and bears a reasonable

relationship to other special awards, and does not exceed the maximum.[29]

6. Provide reasons for concluding that the special award is payable, and for the amount of the award.[30]
7. In the order, express the special award as a specific, lump sum amount. No interest is payable on this amount, except as part of the enforcement process.

- The arbitrator in this matter further relies on came out of *Whitten* and this was stated at paragraph 73 which stated the following:

73 Proportionality refers to the need to ensure that the consequences imposed on the insurer are rationally related to the misconduct at issue. The Supreme Court of Canada identified various dimensions of proportionality for punitive damages, which I find relevant to special awards. To paraphrase, the award should be proportionate to: (i) the blameworthiness of the insurer's conduct; (ii) the vulnerability of the insured person; (iii) the harm or potential harm directed at the insured person; (iv) the need for deterrence; (iv) the advantage wrongfully gained by the insurer from the misconduct; and (vi) should take into account any other penalties or sanctions that have been or likely will be imposed on the insurer due to its misconduct.

- The arbitrator has also included a list of things that should be considered for special awards in paragraph 74 which are as follows:

* The amount of the benefits unreasonably withheld or delayed.

  This is clearly a major factor in calculating the maximum amount that can be ordered. In my view, it is also an important consideration in fixing the size of the special award. However, the amount of the claim is not an absolute measure of the gravity of the insurer's conduct. The refusal of a large claim is not necessarily more blameworthy than a small, but essential claim.

* The time the benefit is withheld or delayed.

  Again, this is clearly a factor in calculating the maximum, and generally will be an important consideration in the size of the award. However, it is a factor that must be carefully considered. Due to the double interest component in the calculation under s. 282(10), particularly now that interest under the SABS is compounded, the potential size of a special award increases quickly with the passage of time. While timeliness is a high value under the SABS that arbitrators should enforce, arbitrators

should take a hard look at the period over which the delay was unreasonable.

* Failing to respect important obligations under the SABS.

  The SABS include important procedural and other protections, including notice requirements and pay-pending-dispute provisions. The failure to respect these obligations, particularly if the failure is persistent, undermines the system. Therefore, a higher special award may be required to serve the goal of deterrence.

* Other factors that increase the gravity of the insurer's conduct.

  Bad faith is not required for a special award and, therefore, is not the focus of the inquiry. However, evidence of bad faith may increase the amount of the special award. As set out in Whiten, the degree of blameworthiness may be influenced by various factors. For example, a higher special award may be justified if the insured person is especially vulnerable, particularly if the insurer is aware of the likely impact of its actions.

* Mitigating factors

  Even where the insurer has acted unreasonably, other factors may reduce the size of the special award. For example, any actions by the insured person that make the claim more difficult to determine, or delay the process, may be relevant considerations.

* Other penalties

  Arbitrators should consider the whole picture. If the insurer will suffer other consequences as a result of its misconduct, that should be taken into account. Investigation and prosecution by the Superintendent is a possible example, but only if it is likely to occur.

  Interest has been a matter of some debate. While I agree with the Arbitrator in Graper that interest and special awards are distinct responses, I conclude that the insurer's obligation to pay interest at the high rate imposed by the SABS may be a factor in assessing the proportionality of the award.

Safi v. Sovereign General Insurance Co. [2008] O.F.S.C.D. No. 7 (FSCO A04-001121 Ontario Financial Services Commission)

Facts

- Safi was injured in a motor vehicle accident on November 6, 2002.
- He received SABS from Belair Insurance Company.
- Belair terminated IRB benefits in the summer of 2003.
- Later as a result of a priority regulation Sovereign became the insurer.
- Safi claimed to suffer from chronic pain or fibromyalgia and depression and other psychological problems as a result of the motor vehicle accident.
- Sovereign's argument was three pronged, first that Safi was not credible in the presentation of his pain symptoms and the psychological problems his experienced and therefore he was not disabled. Second, the alternative position was that even if Safi was credible in his presentation of chronic pain, fibromyalgia and psychological conditions they were not causally linked to the motor vehicle accident. Thirdly, Sovereign argued that even if the accident had been the cause of these conditions he was not disabled to the extent that he was eligible for the benefits sought.
- Prior to the accident he was employed on a full time basis as a shipper, handler, truck driver and delivery man for $12.50 per hour and worked for 40 to 55 hours per week.
- He claims that he can now walk for 20 to 30 minutes maximum when he feels well and he can stand for no more than 20 minutes and can lift 8 to 10 lbs at most and can drive for half an hour to 50 minutes.
- It should be noted that five to six hours each day was spent loading and the rest of the time was used in delivery and some unloading. He also drove vans to the delivery point and had to lift weight to as much as 30 lbs.
- He was diagnosed by his own physiatrist to have chronic pain syndrome. Dr. Dubeau and Dr. Kahn in insurer medical examinations both felt that he was not disabled.

- There was also an issue of credibility in this matter where Safi was described as having multiple or exaggerated pain responses exhibiting voluntary inhibition of effort and inconsistency, disproportionate syndrome or displayed numerous non-organic findings and inconsistencies.

- Despite this, the arbitrator ruled that Safi was credible in the medical and pain complaints he was making and that he did develop chronic pain syndrome and fibromyalgia.

Issue

- Was Mr. Safi entitled to a special award?

Held

- Safi was entitled to a special award and arguments would be made at a later date.

Commentary

- Paragraph 1 of 7 stated that “arbitrators upheld the special award determinations based on a factual examination of each case. Unreasonable behaviour by insurer in withholding or delaying payments can be seen as behaviour which was excessive, imprudent, stubborn, inflexible, unyielding or immoderate.”

- The first four steps determine the maximum special award and the last three determine how the appropriate award should be determined.

- The arbitrator did not feel that the DAC doctors or the adjuster acted unreasonably in this matter.

- The arbitrator focused on the fact that the insurer withheld two Treatment Plans which were never made the subject of a DAC or other assessment. The adjuster admitted that the plans for injections and acupuncture were clearly unlike other plans previously submitted. There was no evidence under which to base a refusal and substantial evidence that might have led to their approval.

- The arbitrator stated that the adjuster acted imprudently and excessively in denying them and the insurer unreasonably withheld or delayed the payment and that merited a special award (paragraph 110).

- Sovereign argued that the special award should not be made against them as they were not the ones who were adjusting the files at the time however s.282(10) of the *Insurance Act* does not make a note of who is adjusting the file at the time of the impugned conduct.

Michalski v. Wawanesa Mutual Insurance Company [2007] O.F.S.C.D. No. 217 (Appeal P06-000030 Ontario Financial Services Commission)

Facts

- Special Award was granted with respect to a motor vehicle accident on October 24, 2001.

- The first decision the arbitrator found that a special award was warranted and in the second set the amount at $150,000.00.

- The arbitrator found that a special Order was payable because Wawanesa failed to advise Michalski of the benefits she was entitled to improperly reduced them and delayed arranging assessments to determine her attendant care needs and whether she was catastrophically impaired.

- A key aspect of the special award was the arbitrator's finding that from the onset Wawanesa knew that Michalski was catastrophically impaired as it hired a case manager. Payment for a case manager is only a benefit for the catastrophically impaired.

- It received an OT report which stated 24 hour monitoring.

- The arbitrator also found that Wawanesa failed to follow s.40 of the SABS for determination of catastrophic impairment.

- Despite numerous reports, Wawanesa failed to provide the proper attendant care amount for Michalski.

- The arbitrator held that the insurer owed nearly $179,000.00 in attendant care benefits and made a special award of $150,000.00. The insurer appealed.

Issue

- Should the $150,000.00 special award be upheld?

Held

- While the arbitrator considered the proper factors in deciding to make special awards she erred in setting the proper amount. The award was reduced to $50,000.00.

Commentary

- Arbitrators should focus on the amount of the special award, not the percentage of it.

- The arbitrator here chose the high end of the scale as referring to the percentage of the maximum that was awarded instead of the actual dollar amounts of the special awards.

- She also took as her starting point the highest previous awards instead of the contents of special awards in general.

- The award that was made by the arbitrator in this matter far exceeded any other special award granted.

- The arbitrator determined that the award should be proportionate to the blameworthiness of the insurer's conduct, the vulnerability of insured person, the potential harm directed at the insured person, the need for deterrence, the advantage wrongfully gained by the insurer for misconduct and should take into account any other penalties or sanctions that have been or likely will be imposed on the insurer due to its misconduct.

Henderson v. Lombard General Insurance Company of Canada [2000] O.F.S.C.I.D. No. 64 (File No. FSCO A97001019 Ontario Financial Services Commission)

Facts

- Ryan Henderson sustained serious injuries in a work related truck accident in Minnesota.

- Initially he applied to the Worker's Compensation Board which paid medical and rehabilitation expenses as well as wage losses through August 1996.

- When Henderson decided to claim accident benefits under the *Schedule* in 1996 instead of Worker's Compensation benefits, Lombard denied his right to switch systems.

- In 1998 Lombard conceded Mr. Henderson's entitlement to claim accident benefits.

- A claim was made for special award for Lombard's unreasonable delay in withholding accident benefits.

- Mr. Henderson stated that he acted on the advice of Lombard's adjuster in filing for worker's compensation benefits.

- Lombard acknowledges that it has never sent Henderson any claim forms or brochures about his available accident benefits.

- The arbitrator has found that the insured person can make a binding decision on which type of benefits to go with the insurer is obligated to assist the insured person in making an informed decision.

- It was found that Lombard ignored its obligations to the applicant.

- Lombard relied on Commission decisions to defend its position in 1997 and 1998 where in early 1997 Lombard used the Davis arbitration decision to argue that Henderson could not switch from the Worker's Compensation system. This case dealt with the proposition that once an insured becomes entitled to Worker's Compensation benefits he or she cannot switch.

- However the evidence is that Lombard did not change its position respecting Henderson's entitlement after the Davis arbitration decision overturned an appeal by the Director's Delegate.

- Lombard admitted at the hearing that it did not change its position respecting Mr. Henderson's entitlement until February or March 1998. Therefore the arbitrator rejected Lombard's submission that it relied in good faith on the case law. In that, they had no basis to deny Henderson's entitlement to accident benefits or delay payments after the Davis appeal decision in July 1997.

Issue

- Was the Plaintiff entitled to a special award for the claims handling in this matter?

Held

- He was entitled to a special award of $65,000,000.

Commentary

- The arbitrator focused on Lombard's duty to its insured despite the fact that he was entitled to Worker's Compensation benefits.

- Paragraph 70 states:

70 Lombard knew or should have known its entire defence had evaporated at the November 1997 pre-hearing, but did not change its view until February 1998. Even if I accept that Lombard, a sophisticated Insurer represented by legal counsel, did not know the ramifications of the Davis appeal decision when it came down, its continued delay and withholding of Mr. Henderson's accident benefits after the pre-hearing certainly demonstrates an inflexible and unyielding attitude.

- Henderson was awarded a lump sum special award of $65,000.00 for Lombard's deficiency in handling Henderson's claim together with a number of years over which they occurred demands significant award calculated to deter future conduct of the type exhibited here.

Thiyagarajah v. ING Insurance Co. of Canada [2007] O.F.C.D. No. 131 (File No. FSCO A05-001520 Ontario Financial Services Commission)

Facts

- The Applicant was injured in a motor vehicle accident on March 6, 2004.
- An arbitration hearing addressed the Applicant's entitlement to benefits and ING was ordered to pay the Applicant further IRBs of $353.14 per week from June 2, 2005 to March 5, 2006.
- The parties were to provide submissions regarding pre-judgment interest and the jurisdiction award of special award was sought.

Issue

- Was the Applicant entitled to interest and special award?

Held

- The Applicant was entitled to interest as per s.46(2) of the SABS and was entitled to a special award of $625.00.

Commentary

13 Mr. Thiyagarajah further argued that the legislation should be read purposively and that the clear statutory intent was that benefits should be paid on a timely basis and that unreasonable positions should be discouraged. Relying on the decisions in *State Farm Mutual Automobile Insurance Company and Lopez* (FSCO P98-00031, September 20, 1999) and *Jensen and GAN Canada Insurance Company* (FSCO P96-00079, March 31, 1999), the Applicant noted that the *Insurance Act* provides that a special award may be awarded on monies unreasonably delayed. Such wording would be rendered superfluous should special awards be restricted solely to cases where monies, withheld throughout the proceeding, were found owing by an arbitrator.

15 ING notes the comments in *Leitgeb and Allstate Insurance Company of Canada* (OIC P-012407, November 16, 1995) that:

> The focus of the arbitration, therefore, is on the applicant's entitlement to benefits, or the proper amount of the benefits. The basis for ordering a special award arises out of that inquiry. The special award provision does not expand the arbitration into a generalized inquiry into the insurer's conduct.
>
> I agree with the arbitration decisions that have held that a special award is not a claim to be advanced like a claim for benefits ... Rather, it is a statutory authority, or a direction, given to the arbitrator to make an award if he or she finds that not only are benefits owing to the applicant, but that they were unreasonably withheld or delayed by the insurer.

16 This view is echoed in the comments of Director Sachs in *Simpson and Royal Insurance Company of Canada* (OIC P-03863, August 22, 1996) that:

> A special award is not a stand-alone claim, but an amount which an adjudicator may order to be paid according to the circumstances of a case. It arises out of the insurer's conduct, as evaluated by the adjudicator. It is not a claim to be made in order to expand the arbitration into a generalized inquiry of the insurer's actions.

24 In *Prudential of America General Insurance Company (Canada) and Chafe-Moote* (FSCO P99-00044, September 8, 2000), the insurer argued that the arbitrator had erred in ordering a special award when entitlement to the benefits had never been in issue and there was no finding of entitlement to which a special award could attach. Rather, benefits had been withheld pending Mrs. Chafe-Moote's attendance at an insurer medical examination as provided for under the applicable legislation. Director Draper responded:

> With respect, I find little merit in this argument. Section 282(10) is clearly meant to encourage the timely payment of benefits, as are various sections of the *SABS-1994*. A special award is payable if the insurer unreasonably withholds or delays *payments*. The amount of the special award is based on a percentage of the amount to which the person was *entitled* at the time of the award. In this case, however, entitlement was not in issue. The only basis for withholding benefits was Mrs. Chafe-Moote's non-attendance at the two sets of examinations. It follows, therefore, that if she was not in breach of s. 65(5) of the *SABS-1994*, her entitlement continued and the special award can be calculated based on this entitlement. [emphasis in the original]

- In this matter there were multiple IRB payments. $625.00 was awarded on the August 11, 2004 IRB payment but no special award for the July 18, 2005 IRB payment.

- There was no special award on the July 18, 2005 IRB payment as the insured did not get the proper Disability Certificate forms in to the insurer. The Applicant was in violation s.34(4) of the *Schedule* therefore it is not warranted a special award for this IRB claim.

Special Case : Preserving the Collateral Offset

There are two important recent cases that deal with preserving the accident benefits' insurer's collateral offset that merit some discussion in considering trial tactics

Cromwell v. Liberty Mutual Insurance Co. 89 O.R. (3d) 352 (Ontario Superior Court of Justice)

Facts

- This was a motion by Cromwell for partial summary judgment to compel Liberty Mutual to pay IRBs which Cromwell alleged were wrongfully withheld.

- Cromwell was injured in a motor accident in 1998. Crowell had long term disability benefits with Sun Life and accident benefits with Liberty Mutual.

- Cromwell had a claim against Sun Life and the claim was settled in December 2003 for $15,000.00 representing arrears due under the policy and $160,000.00 viewed by Sun Life as representing future payments and costs.

- In July 2003, she also received an advance payment of $78,485.00.

- In July 2003, the Defendant wrote to the Plaintiff and took the position that Sun Life's advance payments were collateral benefits which resulted in overpayment which it was entitled to recoup pursuant to s.47 of the SABS.

- The Plaintiff's weekly entitlement to IRBs was $311.49 per week and payment began on December 13, 1998.

- IRBs were terminated by the Defendant on various occasions but were reinstated and the Plaintiff received benefits in the amount of $15.47 per week up to the time of the trial.

- From June 17, 2000 to May 30, 2003 the Defendant had paid a total amount of $47,971.00 in IRB payments.

- On July 4, 2003, the Defendant wrote to the Plaintiff and confirmed it was aware of the advance payment made by Sun Life on which the Plaintiff was required to pay income tax as well as the taxable amount of the LTD benefit.

- Liberty Mutual took the position that it would be entitled to deduct the net monthly LTD payment from the IRB payments pursuant to s.7 of the SABS.

- The Defendant stated that it intended to recoup all IRB payments paid now that the Plaintiff had received collateral benefits.

- The over payment claimed by Liberty Mutual was $68,708.19 and stated that they would deduct 20% of the amount of benefit from each payment and would be charging interest under s.47(6) of the SABS on the amount it was entitled to recoup until the full amount had been repaid.

Issues

- Is the Sun Life LTD policy an indemnity policy permitting the Defendant to a collateral benefit deduction for the past Sun Life settlement under s.7 of the SABS?

- Is the Defendant entitled to deduct from the monthly IRBs an amount equal to the monthly payment due under the Sun Life LTD policy as a result of the $160,000.00 portion of the Plaintiff's settlement with Sun Life being future payments of collateral benefits within the meaning of s.7 of the SABS?

Held

- It was held that the Sun Life long term disability policy was an indemnity policy.

- Liberty Mutual was entitled to deduct from income replacement benefits the disability benefits received under the Sun Life policy.

- All benefit payments made between July 4, 2002 and July 4, 2003 by Liberty Mutual could be reclaimed. **However, Liberty Mutual was not entitled to a deduction of the $160,000.00 lump sum payment received from Sun Life as it could not be classified as a payment.**

- Sun Life was not obliged under the terms of its policy to pay a lump sum with respect to future payments.

Commentary

- It does not appear that there was any evidence that the lump sum paid was calculated to take into account the future value of those payments.

- It appears that it was arrived at on the basis of the amount of money available under the authority of the person authorizing the settlement.

- What seems to be the turning point here is the content of the releases that were completed and executed in this matter.

- The release that was executed by Cromwell from Sun Life released claims for mental stress and aggravated and punitive damages.

- As these were not income based payments, the Defendant was not entitled to do a deduction with respect to the $160,000.00 lump sum payment.

- The Full and Final Release did not include any claim for future benefits but merely claims for past benefits plus punitive and aggravated damages as

well as damages for mental distress as a result of Sun Life having refused to pay benefits under the policy.

- This would appear to bar Liberty Mutual from being entitled to this as a collateral benefit.

- It does not appear that there was enough evidence for Justice Lofchik in this case to properly determine what the long term disability benefit payment was for.

- This matter shows the importance of prior to settling an accident benefits claim of subpoenaing the long term disability benefits file to determine exactly the intentions of the parties involved when settling long term disability benefit claims.

Vanderkop v. Personal Insurance Co. of Canada [2008] O.J. No. 1937 (Ontario Superior Court of Justice)

Facts

- The Plaintiff Jokelee Vanderkop was injured in a motor vehicle accident on February 17, 1997.

- Vanderkop's accident benefits carrier was The Personal Insurance Company and she had a group policy of insurance with Manulife which included long term disability benefits.

- The Manulife LTD benefit was to pay for monthly loss of income benefits assuming eligibility entitlement requirements were met.

- Vanderkop, 52 weeks prior to the accident, earned $64,265.00.

- From 1997 to 1998, Vanderkop was off and on at work and on November 17, 1998 had used up all of her sick leave credits. She was a teacher.

- In January 2001, the Defendant was provided with a Dr. Fulton report and from this report The Personal paid Vanderkop IRB benefits overdue since

January 31, 1998 in the amount of $107,068.23 plus interest calculated at 2% per month compounded monthly in the amount of $27,292.43.

- On November 27, 2002, there was a private mediation between Manulife, The Personal and the Defendant in the Plaintiff's tort claim.

- Up to the mediation the Defendant was still paying IRB benefits in the amount of $653.90.

- At the mediation Vanderkop entered into a settlement with Manulife where she released all entitlement to past present and future benefits under the Manulife policy for a payment of $57,500.00.

- "At the mediation The Personal did nothing to encourage the Plaintiff to enter into the Manulife settlement nor anything that could reasonably be interpreted by the Plaintiff to mean that they endorsed or approved the Manulife settlement." (paragraph 54)

- "At the time the Plaintiff entered into the Manulife settlement the present value of past, present and future benefits potentially available to her under the Manulife Policy provided that she qualified and in the absence of any offset or third party liability rights in favour of Manulife was later calculated to be in excess of $700,000.00." (paragraph 54)

- The Plaintiff was unaware of this quantification at the time of the Manulife settlement and it was not disclosed by Manulife or her lawyer.

- Vanderkop also executed Minutes of Settlement with The Personal to settle the income replacement benefits in the amount of $10,000.00. This settlement was not finalized as Vanderkop voided settlement during the statutory cooling off period.

- Notice was given by The Personal to Ms. Vanderkop in a letter outlining that according to s.7(1)(ii) of the SABS, the insurer could deduct net weekly benefits for the loss of income that was not being received by the person but are payable to the person as a result of the accident under the law of any jurisdiction or under any income continuation plan.

- The Personal also warned Vanderkop that if she proceeded with the Manulife settlement it might be an improvident settlement prejudicing The Personal.

- The Personal stopped paying IRB benefits due to the settlement with Manulife.

- This notice was given in an OCF-9 on August 20, 2003, eight to nine months after the mediation.

- Vanderkop refused to carry out the terms of the settlement entered into with Manulife and commenced an action against her former counsel for damages.

- On October 31, 2005 an Order was made for Vanderkop to carry out the terms of the settlement entered into on November 27, 2002 with Manulife. The Court of Appeal refused the appeal of the Plaintiff.

Issue

- Are the settlement funds $57,500.00 recoverable?

Held

- The Personal was not entitled to the collateral benefit of the long term disability benefits pay off.

- "The Minutes of Settlement entered into after mediation provides the sum of $57,500.00 as the payment of all past, present and future claims. This would include the claim for aggravated and punitive damages and damages for mental distress claimed in the amount of $100,000.00 in the Statement of Claim filed by the Plaintiff."

- "Based on these facts I conclude that the monies paid pursuant to the settlement cannot be characterized as "*net weekly payments for loss of income that are not being received by the person as a result of the accident".* Rather, the funds represent a lump sum payment arrived at

- “There is no allocation of the lump sum as among the various heads of damage claimed. Under these circumstances I find the Defendant is not entitled to any deduction for a payment in respect of the lump sum settlement payment made by Manulife.”(paragraph 82)

Commentary

- It would be my recommendation that the Full and Final Release would have to be specific to income replacement benefits or some sort of income loss payment for it to be covered as a collateral benefit.

- It would be my recommendation for an insurance company to exercise its rights under s.33 of the SABS to get the full LTD benefit file and perhaps move for production of the complete file under Rule 30.10 of the *Rules of Civil Procedure.*

- Also, consideration should be given in conducting an Examination Under Oath of a non-party under Rules 30.10 of the *Rules of Civil Procedure.*

- Upon receipt of the file, you would want to investigate to determine conclusively how a lump sum cash out of the long term disability policy was calculated.

- This may involve more than just obtaining a Full and Final Release between the long term disability carrier and a Plaintiff as they could “allocate” the settlement as they see fit in order to prejudice the accident benefits carrier.

- It would be important to examine the reserve information and the internal calculations made by an LTD carrier as to see how the settlement lump sum was reached and determine if any legal opinions were given with respect to that issue.

- Further, you could see how the Plaintiff strategically manoeuvred to maximize LTD cash outs and not have to deduct it by the way they structure their Full and Final Release settlements

Conclusion

Overall at FSCO, the arbitrators have appeared to give out more special awards than the Superior Court in giving out punitive damage awards.

FSCO seem to be more willing to give special awards to Applicants for alleged misconduct by insurance companies compared with the courts with punitive damages.