STUDY PAPER

ON

THE LEGAL ASPECTS OF LONG-TERM DISABILITY INSURANCE

ONTARIO LAW REFORM COMMISSION

1996

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THE LEGAL ASPECTS OF LONG-TERM DISABILITY INSURANCE

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A Study Paper prepared for the

Ontario Law Reform Commission

by

MARVIN BAER

1996

The Ontario Law Reform Commission was established by the Ontario Government in 1964 as an independent legal research institute. It was the first Law Reform Commission to be created in the Commonwealth. It recommends reform in statute law, common law, jurisprudence, judicial and quasi-judicial procedures, and in issues dealing with the administration of justice in Ontario.

The Commission's office is located on the Eleventh Floor at 720 Bay Street, Toronto, Ontario, Canada, M5G 2K1. Telephone (416) 326-4200. FAX (416) 326-4693.

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Ontario
Law Reform
Commission

The Honourable Charles Harnick
Attorney General for Ontario

Dear Attorney:

I have the honour to submit the Ontario Law Reform Commission's *Study Paper on the Legal Aspects of Long-Term Disability Insurance.*

December, 1996

John D. McCamus
Chair

STUDY PAPER ON THE LEGAL ASPECTS OF LONG-TERM DISABILITY INSURANCE

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PREFACE

This study paper on the legal aspects of long term disability insurance has been prepared for the Commission by Professor Marvin Baer of the Faculty of Law of Queen's University. The Commission had decided to mount a project on this topic for two reasons. First, we had been persuaded by representations made to the Commission by members of the legal profession to the effect that the law relating to long-term disability insurance appeared to be deficient in a number of respects and was therefore a suitable subject for study by a law reform agency. Second, the Commission thought that a project on this topic would provide a window on the general private law of insurance and permit us to consider whether a larger project on the general law should be undertaken by the Commission. It is my view, at least, that Professor Baer's study confirms the correctness of the first proposition and provides a compelling argument for a broader project on the private law of insurance.

Professor Baer is a widely respected expert on insurance law, a subject which he has taught at Queen's since 1966. He is a graduate in law of Queen's (LL.B.) and of the University of California at Berkeley (LL.M.). He was an editor from 1984-1994 of the annotated law reports, Canadian Cases on the Law of Insurance, and a spokesperson for the Consumers Association of Canada at the Annual Conference of Canadian Insurance Regulators from 1980 to 1985. He has written numerous articles on insurance matters and is a co-editor of a widely used volume of teaching materials, Cases on the Canadian Law of Insurance (5th ed., 1995).

This study paper contains a number of recommendations which have been summarized at the end of the paper. In addition, the paper contains a number of tentative recommendations in Part 9 on specific issues relating to the coverage under a Long Term Disability Policy which have not been included in the summary. On these matters, Professor Baer recommended further input from the public and industry before a final decision is made.

The work undertaken by Professor Baer was initially intended to be the first step in the development of a Commission Report on long-term disability insurance.

As the Government of Ontario has determined that the Commission is to cease operations at the end of this month, however, no final report on this subject will be issued by the Commission.

December 1996

John D. McCamus

STUDY PAPER ON THE LEGAL ASPECTS OF LONG-TERM DISABILITY INSURANCE

1. INTRODUCTION

Disability insurance administered by private insurance companies has expanded considerably over the past fifty years.[1] While some of this insurance is provided under individual policies, most of it is provided under group policies organized by employers or other organizations.[2] In spite of this expansion, disability insurance is far from universal and there are large segments of the population which are not covered, nor are they likely to be covered under the existing scheme of voluntary private insurance.[3] Moreover, private disability insurance is only one part of a complex array of public and private schemes designed to compensate for disability and premature death.[4]

This study assumes that no universal plan of compensation for disablement and premature death will be adopted in the immediate future. The relative advantages and disadvantages of such a scheme have been extensively studied in several jurisdictions, but they raise questions of a general economic and political nature which are beyond the scope of this study.[5]

This study also assumes that any further expansion of private disability insurance will occur voluntarily. That is, that there will be no mandatory requirement for employers or other organizations to arrange group coverage. However, it should be observed that some existing plans involve a coercive element since participation (often at their own expense) is compulsory for the employees or members of the group.

However, this study does assume that further expansion of private disability insurance is socially beneficial and that no unnecessary legal impediments should be put in its way. Given

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1 In 1939 there were 1,676 employers in Canada who covered approximately 240,000 persons by group accident and sickness insurance plans. By 1992 the Canadian Life and Health Insurance Association reported that its members administered plans that covered 10,365,000 persons for both long term and short term benefits and paid more than $2.7 billion in claims. See Life Insurance Facts, 1993 published by the C.L.H.I.A.

2 Group insurance has accounted for over 80% of the total premiums earned by accident and sickness insurers in recent years.

3 The failure of the industry to reach all segments of society is a long standing concern. See the Fifth Report on Accident and Sickness Insurance of the Ontario Select Committee on Company Law, 1981, at 151.

4 The Select Committee's Report contains a summary of the public and private programs. See also the description in H. Beatty, "Comprehensive Disability Compensation in Ontario: Towards an Agenda" (1991), 7 J.L. & Social Pol. 100.

5 Some of these studies were considered by the Select Committee in its 1981 Report.

these broad assumptions, the primary focus of this study is whether there are any changes in the law which would make the present system of private disability insurance more efficient and equitable.[6]

The terms "disability" or "long term disability" insurance are somewhat ambiguous. In some jurisdictions disability insurance is used as a generic term to cover all forms of accident and sickness insurance, including insurance which indemnifies the person insured against medical expenses. In other jurisdictions, such as Ontario, disability insurance refers to a rider written as part of a life insurance contract, and "accident and sickness insurance" is the more generic term used in non-life insurance contracts. Moreover, for many legal purposes it is important to distinguish between insurance designed to cover medical expenses and insurance which is designed to replace lost income or to compensate the person insured for the loss of enjoyment.

In this study the term disability insurance is used to refer to insurance against the inability to pursue a livelihood arising either from accident or illness, that is, insurance which provides benefits to replace lost income, including the payment of fixed sums which are not directly linked to prior earnings.[7] Such insurance is often combined with other types of coverage, particularly insurance covering medical and rehabilitation expenses. These combinations raise the question of whether any proposed regulation of disability insurance should extend to other types of coverage. This might create two different types of medical coverage: one which is regulated as part of a disability insurance contract and one which stands alone and is regulated differently.

2. THE NATURE OF EXISTING REGULATION

The existing law regulating private disability insurance is made up of a combination of case law, statutory law and regulation and administrative rulings by the Commissioner of Insurance. Several features of these various forms of regulation are significant. First, there is no general codification of the law in this area. In fact there is no general codification of the law of insurance, even though the industry has been economically and socially significant and extensively regulated since Confederation. Instead many of the basic concepts and principles that regulate insurance are found in the common law and the legislation tends to be of a piece-meal nature. Moreover, the primary legislation which regulates the insurance product (the contract between insurer and insured), the Ontario *Insurance Act*, has tended to fracture the subject, regulating different types of insurance in different ways.

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6 The Select Committee considered a proposal from the Canadian Association of Accident and Sickness Insurers (merged, with the Canadian Life Insurance Association in 1981 to form the Canadian Life and Health Insurance Association) for a standard voluntary plan available to everyone at reasonable rates with a pooling mechanism for high risk individuals. Such a plan would be consistent with many of the recommendations in this report for more standardization and public or administrative control over policy terms and underwriting criteria. See the 1981 Report, *supra*, note 3, at 150-57.

7 This is often referred to as income protection.

This disintegration of insurance law has occurred for a number of historical reasons including the division of the industry between property and casualty insurers, on the one hand, and life and health insurers, on the other. Throughout most of the industry's history there were in effect two separate industries with separate organizations and different marketing and underwriting concerns. This division in the industry has diminished and many insurers now operate in both fields. Moreover, many academic commentators and public officials have recognized the need for greater harmonization of various types of insurance law.

A separate study of the legal aspects of disability insurance may contribute to this disintegration of insurance law. In relation to several issues, such a study may be too narrowly focused. This should be a real concern to the Commission which may be in a better position, with more relevant expert advice, to rationalize and harmonize insurance law than provincial insurance regulators who are preoccupied with the financial integrity of insurers.[8]

I believe that the Commission should undertake a study of insurance law with a view to the reform and restatement of basic concepts common to all types of insurance and greater harmonization of existing parts of the statute. However, it does not seem reasonable to postpone any improvements in the law in relation to disability insurance until after such a task is completed.

RECOMMENDATION

That the Commission undertake a study of the law of insurance with a view to the reform and restatement of basic concepts common to all types of insurance and greater harmonization of the existing parts of the Insurance Act.

The second feature of the law regulating disability insurance is that it has been partially codified in two separate parts of the Act. The Act distinguishes between disability insurance that is undertaken as part of a life insurance contract and other policies. The former is regulated as life insurance under Part V of the Act and the latter is regulated under Part VII covering Accident and Sickness Insurance. Only disability insurance that is undertaken as part of a life insurance contract is called "disability insurance" in the Act; other policies are called "accident and sickness insurance".[9] This language is confusing and inconsistent with industry and public usage and the division seems no longer to serve any functional purpose. In fact in many instances the rules are similar, being simply repeated in both parts of the Act.[10] I recommend that the Act be redrafted to apply one set of rules covering disability insurance whether it is undertaken as part of a life insurance contract or provided separately.

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8 There have been few modern studies of insurance law. Perhaps the most comprehensive study was done by the Australian Law Reform Commission which issued its Report No.20, Insurance Contracts, in 1982.

9 In addition the Act distinguishes between "accidental death insurance" and "accident insurance". The former is regulated by the Life Part and the latter by the Accident and Sickness Part. Many common death and dismemberment policies are regulated as "accident insurance" and not "accidental death insurance".

10 There are, however, some significant anomalies.

Ideally this should be done in a way that prevents different aspects of a single contract from being treated differently. However, this may not be possible without completely harmonizing the law applicable to life insurance with the law applicable to disability insurance. In a less than ideal world, I recommend that the division be drawn between life and disability insurance coverage.

RECOMMENDATION

That all disability insurance whether undertaken as part of a life insurance contract or not be subject to a single set of statutory rules.

The third feature of the law regulating disability insurance is that it distinguishes between individual and group insurance contracts. Much of Part VII of the Act applies to both individual and group insurance contracts, but the Statutory Conditions do not apply to group insurance contracts. The reasons for this omission are not clear. In any event the Act authorizes the Lieutenant Governor in Council to make regulations governing "group insurance contracts or schemes, or any class thereof including prescribing and regulating their terms and conditions, qualifications for membership in groups and regulating the marketing of group insurance contracts or schemes".[11]

The fourth feature of the law regulating disability insurance is the extent of informal regulation by the Commissioner of Insurance. The Act does not make clear the extent and form of the Commissioner's rule making authority. In fact much of the Commissioner's activity occurs in private without formal participation by groups representing the insuring public. Moreover, the resulting standards are not necessarily known by the public including potential claimants. This is a problem with the regulation of insurance that extends beyond disability insurance, but it is particularly acute here because so much of the insurance is sold under group policies.

I recommend that more careful consideration be given to which matters should be included in the statute and which matters should be left to regulation by the Commissioner of Insurance. I also recommend that the Commissioner's rule making authority be made subject to more formal and open procedures allowing input from groups representing the insuring public, which in the case of disability insurance, is likely to be primarily union or other employee groups.

RECOMMENDATIONS

That more careful consideration be given to which matters concerning the regulation of disability insurance should be included in the Insurance Act and which matters should be left to regulation by the Commissioner of Insurance.

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[11] Section 121, para. 29.

That the Commissioner's rule making authority be made subject to more formal and open procedures allowing input from groups representing the insuring public.

The existing Act does not distinguish between temporary and long term disability. However, many insurers do attempt to have different definitions of disability for short and long term and this is reflected in the case law. Many policies combine occupational coverage for short term disability with general disability coverage for long term disability. That is, to receive short term benefits claimants must be disabled from performing their usual occupation, but to receive long term benefits they must be disabled from performing any occupation. While such combinations have been criticized as being deceptive, and American courts have tended to ignore or soften the distinction, most Canadian judgments have accepted the distinction.

In addition many disability policies provide for no coverage until after a person insured has been disabled for a fixed period of time. Often, as in the case of group policies arranged by employers, short term benefits are provided as part of the employer's sick leave policy. Perhaps for this reason, there is a common practice of referring to the disability insurance as long term disability or LTD, even though it combines the different types of coverage described in the last paragraph.

For most legal purposes, there is no reason to distinguish between short and long term disability insurance. Hence this study covers all disability insurance provided by insurers. It does not, however, consider any short term disability or sick leave benefits provided by an employer as part of a contract of employment.

3. ISSUES RELATING TO THE APPLICATION FOR COVERAGE

(a) THE INSURED'S DUTY TO DISCLOSE MATERIAL FACTS

Disability insurance contracts like other insurance contracts are said to be contracts of the utmost good faith. This phrase was originally applied to the bargaining process where it was thought (at least by the latter part of the nineteenth century) that the underwriting needs of the insurer required the insured to be more forthcoming than persons bargaining in other contexts.[12] Utmost good faith involves not only an obligation on the insured not to misrepresent his or her situation, but also a positive obligation to volunteer information which the reasonable insurer would consider relevant in assessing the risk. In spite of its name, the requirement goes beyond a general standard of honesty and fair dealing. Over the years it has developed into a requirement which extends beyond the actual or reasonable expectation of the insured and failure to meet it results in the severe penalty of forfeiture of any claim under the policy.

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[12] Reuben Hasson, "The Doctrine of Ubirrima Fides in Insurance Law: A Critical Evaluation" (1969), 32 Mod. L. Rev. 615 and (1975), 38 Mod. L. Rev. 89. See also the Law Commission's Report on Insurance Law, Non-disclosure and warranty, Law Com. No. 104, 1980.

There are several aspects of the requirement of the utmost good faith which requires further examination, namely:

- The type of information that must be disclosed by the insured.
- The knowledge of the insured.
- The relationship between the insured's failure to disclose and the loss.
- The consequences of the insured's failure.
- The court's power to relieve against forfeiture.

The requirement of the utmost good faith requires the insured to disclose to the insurer all material facts. The onus is on the insured to disclose these facts on his or her own initiative whether or not the insurer has inquired about them. The test for what is a material fact was authoritatively stated by the Privy Council[13] and recently reaffirmed by the Supreme Court of Canada.[14] The Privy Council defined a material fact as any fact that would have influenced a reasonable insurer to decline the risk or to have stipulated for a higher premium.

This is essentially a question of fact based on the current underwriting practices of reasonable insurers. In Canada at least, the test remains whether the information would have actually led the insurer to either decline the risk or stipulate for a higher premium. The more recent variation of the test adopted in England is whether the fact would have been considered along with other matters by the insurer in making an underwriting decision even though the fact alone would not have been decisive in arriving at any decision.[15] So far the English variant has not been considered or adopted in Canada.[16]

In order to fully understand what type of facts might be material, one needs to know something about underwriting practices in Canada. These have varied over time, so strictly speaking a judicial determination that a fact is material should have little weight in

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13 *Ontario Metal Products Co. v. Mutual Life Ins. Co.*, [1925] 1 D.L.R. 583, [1925] 1 W.W.R. 362 [1925] A.C. 344 (P.C.).

14 *Canadian Indemnity Co. v. Canadian Johns-Manville Co.* (1990), 50 C.C.L.I. 95, [1990] I.L.R. 1-2650, [1990] 2 S.C.R. 549, 72 D.L.R. (4th) 478, 115 N.R. 161, 50 B.L.R. 1, 33 Q.A.C. 161 (S.C.C.).

15 *Container Transport International Inc. v. Oceanus Mutual Underwriting Association (Bermuda) Ltd.*, [1984] 1 Lloyd's Rep. 476 (C.A.); *Highlands Insurance Co. v. Continental Insurance Co.*, [1987] 1 Lloyd's Rep. 109; Pan *Atlantic Insurance Co. v. Pine Top Insurance Co. Ltd.*, [1993] 1 Lloyd's Rep. 443. See also Brooke, "Materiality in Insurance Contracts" [1985] L.M.C.L.Q. 437 and Clarke, "Failure to disclose and failure to legislate: is it material?", [1988] J.B.L. 206, 298.

16 *Container Transport* was considered in *Amo Containers v. Drake Ins. Co. Ltd.* (1984), 8 C.C.L.I. 97 (Nfld. T.D.) and *Bradbury v. Cabot Insurance Co.* (1988), 30 C.C.L.I. 172 (Nfld T.D.), but the distinctiveness of the English test of materiality was not considered.

subsequent litigation.[17] Underwriting is not an exact science. Underwriters rely both on actuarial evidence and experience. They base the likelihood of loss on both the physical and the moral hazard.[18] In the life and health insurance field, the physical hazard includes all those medical, occupational, and vocational factors which the underwriter decides would affect the risk. The moral hazard includes those factors associated with the individual insured's personality which the underwriter decides would or might affect the risk. Here the term moral hazard is used in a slightly different way than in other contexts. It means more than just the fact that insurance might tend to increase the likelihood of an event happening by removing some of the financial incentive for carefulness. It includes all those factors which are hard to quantify which the underwriter has learnt through experience might affect the risk.[19] Of course, insights which are gained from expert or professional experience may be hard to distinguish from attitudes which are prevalent in society based on stereotype or prejudice.[20]

Premiums are not based on an assessment of the risk alone. They must also include the administrative costs of selling and servicing the policy. How such costs are allocated is an internal business decision of the insurer and may reflect its marketing strategy.

In applying the test of materiality, Canadian courts have not often examined the question of what amounts to reasonable underwriting practice. The more careful judgments make clear that it is not the underwriting practice of an individual insurer which is relevant, although many courts have followed the lead of the Supreme Court of Canada[21] in assuming that, in the absence of any other evidence, industry practice is similar to the practice of an individual insurer. However, few Canadian courts have probed the evidence of underwriting practice to see if it is based on marketing factors rather than an assessment of the risk, whether the assessment of the risk is based on actuarial or other probative evidence and whether in any event, the underwriting criteria is unreasonable because it is inconsistent with modern notions of human rights.[22]

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17 However, in determining whether some fact is material, some courts do refer to prior decisions which have considered similar facts. Similarly text writers often refer to judicial decisions as having determined that particular facts are material. See Winsor & Radomski, The *Insurance Act* of Ontario Annotated, 1987, at p. 452. Moreover, some courts occasionally determine that a fact is material based on their own views of the world.

18 The underwriting criteria used by various branches of the insurance industry was described in the various Reports of the Select Committee on Company Law. See in particular the First Report on Automobile Insurance (1977), at 87-113 and the Fourth Report on Life Insurance (1980), at 221-224.

19 The assessment of the moral hazard was described in some detail by the Human Rights Board of Inquiry *in I.C.B.C. v. Heerspink*, March 8, 1979. See Marvin Baer, "A Famous Victory: I.C.B.C. v. Heerspink and Director, Human Rights Code" (1983), 17 U.B.C. Law Rev. 299.

20 See B. Underwood, "Law and the Crystal Ball: Predicting Behaviour with Statistical Inference and Individual Judgment" (1979), 88 Yale L.J. 1408.

21 *Henwood v. Prudential Ins. Co. of America*, [1967] S.C.R. 720, 64 D.L.R. (2d) 715.

22 For an example of a more critical attitude towards the insurer's evidence of materiality see *Doherty v. Home Ins. Co.* (1987), 19 C.C.L.J. 314 (Ont. Div. Ct.).

Whether underwriting criteria are based on actuarial evidence or experience, they are not known in any detail by the insuring public. Yet the requirement of the utmost good faith at common law requires the applicant for insurance to disclose all material facts whether the applicant knows the facts are material or not. Moreover, the applicant must disclose material facts even if no reasonable insured would appreciate their materiality. However, the applicant is required to disclose only those facts which he or she actually knows rather than what a reasonable person in the applicants position would know. At the same time the insurer is under no duty to inquire. Moreover, when the insurer does inquire about some matters, the applicant is not entitled to assume that other information is immaterial.

The insured's failure to meet the requirement of the utmost good faith results in the forfeiture of any claim under the policy, whether or not the loss is related to the information withheld or misrepresented, and whether or not the insurer would have declined the risk. This result is in stark contrast to other areas of contract law where an actionable breach requires actual damage and where only a substantial or major breach by one party provides the other with an excuse not to perform.

The courts have seldom explained the justification for such a unique and harsh remedy. The general notion of freedom of contract is not a satisfactory explanation, since the requirement of the utmost good faith is one which has been imposed by the courts (although based on their notion of the social requirements and the presumed intention of the parties). An explanation for the remedy has been suggested by American writers, who have identified the problem of the undisclosed freeloader.[23] Under this explanation, the remedy is necessary to set an example and frighten others into compliance. A simple adjustment of the premium to reflect the information that should have been disclosed would not be sufficient. Unless an insured had a loss, it would be unlikely that a failure to disclose would be discovered. So an insured would have an incentive to conceal or misrepresent information and would suffer no real adverse consequences if this was discovered.

In other contexts where contracts provide for the remedy of forfeiture regardless of the nature of the breach, the courts intervene in appropriate circumstances to provide relief.[24] In the past, Canadian courts have held that their ability to provide relief from forfeiture of insurance claims was limited to the express and limited provisions of the *Insurance Act*.[25] Appellate courts have recently reconsidered this matter and the Supreme Court of Canada has recently held that the courts' general equitable jurisdiction to relieve against forfeiture extends to insurance contracts.[26] However, the precise reach of the courts' jurisdiction remains unclear. In particular it is unclear whether the courts would relieve against forfeiture for breach of the obligation to disclose all material facts.

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23 Patterson, Essentials of Insurance Law (2nd ed, 1957), at 278.

24 See Fridman, The Law of Contract (3rd ed., 1993), at 774-75.

25 The leading case was *Johnston v. Dominion of Canada Guarantee & Accident Insurance Co.* (1908), 17 O.L.R. 462 (C.A.).

26 *Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance Co.*, [1994] 2 S.C.R. 490, [1994] I.L.R. 1-3077, [1994] 7 W.W.R. 37, 23 C.C.L.I. (2d) 161, 20 Alta. L.R. 295, 155 A.R. 321, 115 D.L.R. (4th) 478, 168 N.R. 381.

The common law obligation of the utmost good faith is widely recognized to be too onerous and unfair.[27] It places too little obligation on the insurer to solicit relevant information and treats minor breaches by the applicant too harshly. On various occasions since Confederation, the legislature has intervened in various parts of the *Insurance Act* to correct the balance between the parties. This intervention has taken various forms, including:

- restricting the open-ended nature of the obligation by requiring any concealment to be fraudulent[28]
- requiring that any application form used be approved by the Commissioner of insurance.[29]
- giving the courts authority to disregard any stipulation that is thought to be unjust or unreasonable in its application.[30]
- providing that after two years any concealment or misrepresentation is no longer relevant in the absence of fraud.[31]

Other jurisdictions have adopted other methods to redress the balance between applicant and insurer.[32] The most common method is to prevent the forfeiture of any claim where the insurer would have insured with accurate information, but at a higher premium. In such circumstances, the laws of many jurisdictions require either the adjustment of the premiums or more commonly, the adjustment of the benefits payable under the contract.[33] The latter solution may have the advantage of providing less incentive to freeload.[34]

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27 See e.g. The Australian Law Reform Commission Report No. 20, Insurance Contracts, at 105-112, English Law Commission, Working Paper No.73 Non-disclosure and Breach of Warranty, para. 66. and Report No. 104, Non-disclosure and Breach of Warranty, para. 458. Hasson, "The Doctrine of Uberrima Fides in Insurance Law - A Critical Evaluation" (1969), 32 M.L.R. 615.

28 See *Insurance Act*, R.S.O. 1990, c.I.8, s.148, Stat. Cond 1, (Fire).

29 Section 228 (Automobile).

30 Section 151 (Fire).

31 Section 184 (life) and s.309 (accident and sickness).

32 See the Australian Law Reform Commission, Report No.20, Insurance Contracts, at 106-114.

33 The proportionality principle has been adopted in some European countries and in the E.E.C. Directive on the Co-ordination of Legislative, Statutory and Administrative Provisions Relating to Insurance Contracts. (see Law Comm. Report No.104, Appendix C for the draft directive).

34 However the Australian Law Commission rejected the principle in relation to "general insurance" (property and casualty) but accepted its application in life insurance. They als accepted its application as the appropriate remedy for breach of warranty in all insurance contracts. The Commission believed that the principle would be too difficult to apply to general insurance because of the difficulty of establishing the effect on premiums of all the many facts that might be material. The argument seems to be that while an insurer might have charged more if they had known the material facts, it would be extremely difficult to establish how much more, if the insurer's judgment was not based on statistical or actuarial evidence.

There are some functional and historical reasons why the common law requirement of the utmost good faith has been modified in different ways for different types of insurance. For instance, in automobile insurance, the Commissioner's authority to control forms is just part of a broader scheme to standardize and control the contents of automobile insurance policies in Ontario. In the case of life insurance, there was a widespread use of incontestability clauses in the industry before the legislature made them mandatory. However, these functional and historical reasons for the different approaches may no longer be compelling and they have created anomalies which have been exaggerated by the courts. Nevertheless, the *Insurance Act* and the reforms in other jurisdictions do suggest different models which could be used to define the appropriate disclosure requirements for disability insurance.

As we have seen, disability insurance is regulated by two different parts of the *Insurance Act*, but in both parts the legislature has adopted a similar modification of the requirement of the utmost good faith. This modification occurs in two ways, although one is not as clearly stated in the legislation as the other. The first modification is to mandate a two year incontestability clause.[35] That is, after a period of two years a claim cannot be avoided on the basis of concealment and misrepresentation in the absence of fraud. There is an exception for misrepresentation concerning age. In that case the two year incontestability period does not apply, but instead the Act provides for an adjustment of the benefits payable under the policy.[36] The second modification which is not so clearly stated, but is adopted by inference, is that the disclosure obligation is limited to information solicited in the application form or in any required medical examination.[37]

Against this background, the fundamental question in relation to the requirement of the utmost good faith as it applies to disability insurance is whether the Act has struck the right balance between the interests of the parties, whether some other approach such of those found in other parts of the Act might be more appropriate, and whether the Act covers all of the unusual aspects of the common law doctrine which are discussed above.

- Does the Act clearly limit the obligation of the insured to disclose information to that which is asked?

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35 There is one apparent anomaly. Section 184 does not apply to "disability insurance" (i.e. disability coverage which is part of a life insurance contract). See *Taylor v. National Life Assurance Co. of Canada*, [1990] I.L.R. 1-2646, 7 C.C.L.I. (2d) 146 (B.C.C.A.). The insurer may, however, lose its right to rescind the contract after two years if the policy so provides. See *Bogh v. National Life Assurance Co. of Canada (1990)*, 43 C.C.L.I. 262, [1990] I.L.R. 1-2576, 42 B.C.L.R. (2d) 249, 65 D.L.R. (4th) 736 (S.C.) affirmed (1991), 3 C.C.L.I. (2d) 132, 54 B.C.L.R. (2a) 79, 78 D.L.R. (4th) 444 (C.A.).

36 Sections 186 (life), and 312 (accident and sickness). Neither section applies to group insurance. While in theory this may leave group insurers free to avoid claims for misstatement of age, the authority of the commissioner to regulate group contracts may prevent them from doing so.

37 Sections 183 (life) and s.308 (accident and sickness). See also s.300 Stat. Cond 2 of the Accident and Sickness Part. While Stat Cond. 2 makes it clear that the insurer cannot rely on oral misrepresentations, the Act is less clear about whether the duty to disclose is limited to the information actually requested. The text authorities are divided. Compare Winsor and Radomski, The *Insurance Act* of Ontario Annotated, at 450 and 452 with Norwood and Weir, Norwood on Life Insurance Law in Canada (2nd ed.) at 307.

- Even if the insured has only to answer the questions asked, should the insured have to know what is material?

- Should there be any control over the type of information that can be asked? Should the insurer be allowed to avoid the claim only if the concealment or misrepresentation is related to the disability or loss?

- Should group insurance contracts and individual policies be treated in the same way? What is the risk of adverse risk selection with group insurance? In the case of group policies, should the group insured be responsible for any concealment or misrepresentation by the insured?

- Is the two year incontestability clause too crude a device? What besides its historical use in life insurance suggests it's a better device for alleviating the common law than other devices? It may be a crude device for preventing adverse risk selection while at the same time protecting the vested rights of insured. But is it necessary to guard against adverse risk selection with group insurance?

- Should the courts' power to relieve against forfeiture be clarified? Or at least specifically mentioned?

Generally, apart from the question of regulatory control over the type of information that can be requested, these questions can be summarized as what should be the appropriate disclosure requirement and what should be the remedy for its breach.[38] In relation to the first question there are three main possibilities: (1) requiring the insured to act in good faith and to avoid intentional concealment (deliberate concealment or culpable indifference), (2) requiring the insured to disclose what a person in the circumstances of the insured could reasonably be expected to know to be material, (3) limiting the existing duty to disclose to questions that are asked. The Australian Law Reform Commission rejected the first option on the grounds that it "might give rise to unwarranted difficulties of proof and might conceivably make dishonesty more difficult to detect".[39] Instead the Commission recommended the adoption of the second option with the addition that where a person gave an obviously incomplete or irrelevant answer to a question included in a proposal (application) form about a matter, the insurer should be deemed to have waived compliance with the duty of disclosure in relation to that matter.

It should be noted that the Commission's concern about the difficulty of proving fraud has not deterred the Ontario legislation from adopting (in part) fraud as the appropriate standard in the Fire Part[40] or as the standard after the two year incontestability period in the

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38 In the following discussion "the disclosure requirement" or "duty to disclose" refers both to the insured's obligation to avoid misrepresentation and concealment of material facts.

39 *Supra*, note 8, at 111.

40 Section 148, Stat. Cond. 1 refers to an applicant who "misrepresents or fraudulently omits to communicate any circumstance that is material. The Supreme Court of Canada has held that the adverb "fraudulently" means actual fraud, but applies only to omissions and not to misrepresentations. Hence, an insurer can still avoid a fire

Life[41] and Accident and Sickness Parts.[42] As between the other two options, they are both designed to limit the duty to disclose to what might reasonably be anticipated by the insured. They may be substantiality similar as long as the insured is given the benefit of the doubt about any ambiguous question. The Australian Law Reform Commission preferred the second alternative for general insurance on the grounds that it would be difficult for the insurers to anticipate all the facts that might be relevant and ask appropriate questions. They recognized that this difficulty may not be so great in the life and health insurance fields.[43]

In Ontario the legislature has already partially adopted the third option for life, accident and sickness insurance. So there may be some advantage in building on this approach, by clarifying that the disclosure obligation does not go beyond answering the question asked, that the insurer is deemed to have waived compliance with the duty in relation to matters where the answers are obviously incomplete or irrelevant and that an applicant satisfies the obligation where it would have been reasonable for a person in the applicant's position to have understood the question to have the meaning that the applicant apparently understood it to have.

As to the appropriate remedy for breach of the duty to disclose, these are several possibilities. One would be the adoption of a proportionality principle similar to that found in some foreign legal systems.[44] The second would be a remedy in damages based on general contract principles. The third would be a combination of forfeiture during the initial two year period and incontestability (except in the case of fraud) thereafter.

The Australian law Reform Commission, while rejecting the proportionality principle for general insurance, recommended its adoption for life insurance (which by their definition, included a continuous disability insurance contract). They also recommended the continuation of the existing practice in Australia of incontestability after an initial three year period. In addition they recommended that the courts be allowed to relieve against forfeiture even in the case of fraudulent concealment.[45] Apart from the incontestability provision, these recommendations are consistent with their recommendations of the appropriate remedy for breach of warranty.

The adoption of these recommendations in Ontario would redress the balance between the parties, provide a suitable standard and remedy for all types of insurance (and thus facilitate the eventual assimilation of all types of insurance contracts) and provide the basis for consistent remedies for both breach of the disclosure obligation and breach of warranty.

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insurance contract for innocent misrepresentation. See *Taylor v. London Ass'c Corp,* [1935] 3 D.L.R. 129, [1935] S.C.R. 422, 2 I.L.R. 252.

41 Section 184(2).

42 Section 309(1).

43 *Supra*, note 8, at 111-12.

44 *Supra*, note 33.

45 *Supra*, note 8, at 118-19.

RECOMMENDATIONS

That the Act expressly provide that the insured and person insured's duty to disclose be confined to answering all questions asked of them in the application process to the best of their knowledge and belief.

That the Act expressly provide that the duty to disclose is met if it would have been reasonable for a person in the applicant's position to have understood a question to have the meaning that the applicant apparently understood it to have.

That the Act expressly provide that the insurer is deemed to have waived compliance with the duty to disclose in relation to matters where the answers are obviously incomplete or irrelevant.

That the Act provide that the insurer's remedy for the insured or person insured's failure to meet their duty to disclose should be an adjustment of benefits such that the person insured receives a proportionate amount based on the ratio of the premium received and the premium that would have been charged if the duty of disclosure had been complied with.

That the Act should continue to provide that where a contract has been in effect for two years, a failure to disclose or a misrepresentation of fact does not, in the absence of fraud, render the contract voidable.

(b) MISREPRESENTATION OR CONCEALMENT BY THE INSURED (EMPLOYER, ETC.)

The Accident and Sickness Part of the Act requires the utmost good faith from both the insured and the person insured. In the case of group insurance this requires full disclosure of material facts by the employer or other organizer of the group as well as the employee. Any failure by either the insured or the group person insured can lead to a forfeiture of a claim under the contract.[46] Whether the group person insured will suffer the consequences of the insured's failure to act, will depend on whether the insured is seen as the agent of the group person insured. Here, as in other insurance contexts, the law recognizes that an agent can be acting as an agent for both parties at the same time and that it is a question of fact whether the agent is performing a particular function for one party or the other.[47] In making this determination there is a tendency for the courts to place particular emphasis on the express authority given by the insurer.[48] Yet the person insured, particularly a group person insured,

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[46] In the case of a contract of group insurance, s.308(3) provides two qualifications to the duty to disclose. The duty only applies if evidence of insurability is specifically requested by the insurer and, if the duty is not met, only the coverage of the affected person insured is voidable, not the group contract as a whole.

[47] *Guardian Insurance Co. of Canada v. Victoria Tire Sales Ltd.*, [1979] 2 S.C.R. 849, 108 D.L.R. (3d) 283; *Baptist Convention (Ontario & Quebec) v. Hartford Fire Insurance Co.*, [1978] I.L.R. 1-1033 (Ont. H.C.); *Piggott Construction* (1969) *Ltd. v. S.G.I.O.* (1985), 16 C.C.L.I. 204 (Sask C.A.).

[48] This is particularly true where material facts are communicated to the insurer through a written application form. In completing the application form the agent will be held to be the "amanuensis" of the insured unless the insurer has expressly authorized the agent to complete the form. See Baer & Rendall, Cases on the Canadian Law of Insurance, (5th ed., 1995) at 433-465.

has little opportunity to select or monitor the form and content of any communication between the employer and the insurer. The existing law is at best uncertain and at worst unduly protective of the insurer.[49] The group person insured should not be prejudiced by the misrepresentation or concealment of the insured, unless he or she has participated in misleading the insurer.

RECOMMENDATIONS

That the Act be amended to provide that a (group) person insured's claim will not be affected by the misrepresentation or concealment of the insured unless the group person insured has participated in misleading the insurer.

4. CHANGE MATERIAL TO THE RISK

At common law the requirement of full disclosure was a pre-contractual duty. There was no continuing obligation to communicate material facts after the contract was formed.

Such a continuing obligation is imposed in several parts of the Act, but not in the Life or Accident and Sickness Parts. This does not mean, however, that changes in the person insured's circumstances after the contract is formed have no effect on disability insurance coverage. Insurers have several ways to control the risk after the contract is formed. These include the use of promissory warranties, exclusions or restrictions to the definition of the risk, the unilateral right to terminate coverage and, as a result, the unilateral right in practice to vary the terms of coverage.

At one time, omissions, variations or additions to the Statutory Conditions imposed by the Accident and Sickness Part were expressly authorized, subject to a special notice requirement and judicial vetting to determine whether they were just and reasonable.[50] Similar judicial scrutiny was and is provided in the Fire Part of the Act.[51] The older provisions have been replaced by a more limited provision allowing some statutory conditions to be varied or omitted.[52] Such variations or omissions are no longer subject to any special notice requirements or judicial control. At the same time, it is no longer clear whether insurers are permitted to add other promissory warranties or conditions, such as a general requirement to disclose any change material to the risk, or a more limited requirement to disclose change in occupation, health or other matter. Such a requirement might seem anomalous if it were not subject to the same limitations as those put on the disclosure

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49 Manitoba Law Reform Commission's Report on a Review of Certain Aspects of Fire Insurance Law in Manitoba (1976) at 52-57, and English Law Reform Committee, Fifth Report (1957).

50 See *Insurance Act*, S.O. 1922, c.61, s.12.

51 Section 151.

52 Section 301.

obligation before the contract is made. However, such anomalies exist in other parts of the Act.[53]

In any event, insurers do not have to rely on promissory warranties to protect themselves from changes in the risk. They can often accomplish the same goal by carefully defining the risk. The courts recognized that insurers were free to do this, even when additions, omissions and variations of the statutory conditions were expressly controlled, and even in relation to matters that were closely related to a Statutory Condition. For example in *Curtis' and Harvey (Canada) Limited v. North Br. & Mercantile Ins. Co.*, the Privy Council[54] held that the Fire Statutory Condition only dealt with an explosion *originating* a fire and the insurer was free to exclude loss from an explosion *incidental* to a fire. And in *Continental Casualty Co. v. Casey*,[55] the court recognized that an insured over a particular age could be excluded from coverage under an accident and sickness insurance policy even though misrepresentations about age were covered by the Statutory Conditions. The present Act has no control over the definition of the risk or exclusions in the policy other than two apparent integration clauses that require exceptions or restrictions to be set out in the policy.[56]

Hence, even though Statutory Condition 3 expressly provides for an adjustment in recovery where the person insured has changed occupations, an insurer may be able to exclude coverage for particular or other occupations in any event.[57] Moreover, if the insurer is free to add promissory warranties to the policy, it may require the insured to give notice of change in occupation, with a right to terminate or charge a higher premium where there is compliance, and to avoid liability where there is non-compliance.

The similarity between promissory warranties and the definition of the risk and the need for legislative, administration, or judicial control over either is considered further below. Apart from more general reform, there should be more specific control over the rights of insurers to require further disclosure of material changes to the risk after the contract is formed. Ideally the requirement for disclosure and the consequence of non-compliance should be no greater after the contract is formed than before. However, there are two difficulties with the existing legal controls over the pre-contractual disclosure obligation which makes them unsuitable for controlling any post-contractual disclosure obligation. First in the pre-contractual context, the open ended nature of the obligation can be restricted by reference to the information specifically requested by the insurer. Assuming the application process is conducted appropriately, the importance of these matters should be fresh in the mind of the person insured. However, after the contract has been in force for some time, the

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53 For instance compare s.148, Stat. Cond. 1 and 4 of the Fire Part and s.233 and s.234, Stat. Cond 1 of the Automobile Part. In both instances the obligation to disclose a material change in the risk after the contract is formed is greater than at the time of the original application for insurance.

54 [1921] A.C. 303 (P.C.).

55 [1934] S.C.R. 54, [1934] 1 D.L.R. 577.

56 Section 300, Stat. Cond 1, and s.299.

57 This is the view of Winsor and Radomski, The *Insurance Act* of Ontario Annotated, at 436.

person insured's memory of what factors may be considered material will have faded - even if they are specifically set out in the policy.

The second difficulty with existing legal controls is that the crude protection of the two year incontestability clause seems unsuitable for the post-contractual period. The protection given to the person insured would be severely limited if the contestability period began to run anew for each subsequent non-compliance.

We have already discussed some alternative ways of controlling the scope of the disclosure obligation and the remedies for non-compliance. None of these suggestions may be adequate to protect the insured (or person insured) from disclosure obligations after the contract is made. Apart from the complete prohibition of such requirements, several other limitations are possible, including: (1) creating a mechanism to remind the person insured of the scope and importance of this continuing obligation, (2) restricting the obligation to a short list of notorious matters, and (3) allowing a remedy only when the person insured has fraudulently or knowingly failed to disclose a material change. I recommend the adoption of the third alternative for several reasons. First, while such continuing warranties are not common, and they should be subject to the same administrative control as all policy terms, there is no need for their complete prohibition. Second, adopting this standard will put the onus on the industry to keep consumer's informed of the need for continuing disclosure. Third, no other mechanism for reminding persons insured of their continuing obligation is likely to be effective in practice.

In any event, the remedy for breach should be the same as for the breach of the disclosure obligation before the contract is made and for the breach of any warranty obligation. This remedy should be the adjustment of the benefits recoverable under the contract according to the proportionality principle. As we have seen this remedy has the advantage of encouraging compliance, avoiding the freeloader problem and more closely matching the remedy to the consequences of non-compliance.[58] Moreover, the existing Accident and Sickness Part of the Act already adopts an adjustment of benefits approach to one type of material change after the contract is formed.[59] Statutory Condition 3 covers a change in occupation and provides that if the person insured engages in a more hazardous occupation, the insurance benefits will be adjusted to the amount that the premium paid would have purchased for the more hazardous occupation.

RECOMMENDATIONS

That an insurer may periodically require the insured or person insured to disclose any material change in the risk after the contract is made.

That an insured or person insured breaches this duty only if they knowingly and fraudulently fail to disclose a material change.

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58 *Supra*, note 32.

59 Section 300, Stat. Cond. 3.

That the insurer's remedy for the insured or person insured's breach of this duty should be an adjustment of the benefits such that the person insured receives a proportionate amount based on the ratio of the premium received and the premium that would have been charged if the duty had been complied with.

5. RETROSPECTIVE UNDERWRITING: THE PROBLEM OF PHANTOM INSURANCE

There are several reported cases in which the courts have considered the attempts by insurers to make underwriting decisions after the insured or person insured has reasonably assumed coverage is in place.[60] In some cases the underwriting decision has been postponed in order to allow home office underwriters or other central decision makers to gather further evidence and make a deliberate decision. Often the insurer's preferred position would be to provide coverage retrospectively, if the applicant is insurable at standard rates. The difficulty is that by the time the decision is made, it is already known whether the risk has occurred in the meantime. In spite of the assurance by insurers that they would not allow their judgment to be effected by what has occurred while the application is pending, the courts have usually decided that the insured has reasonably expected to receive something more than favourable consideration by the insurer. As a consequence, the courts have interpreted a variety of conditional interim receipts as providing immediate coverage subject to a condition subsequent that would allow the insurers to terminate coverage if the person insured was not insurable. However, since the courts have purported to be interpreting the interim receipts, these judgments have not prevented the industry from using differently worded receipts in an attempt to provide coverage retroactively.[61]

The problem of phantom insurance is made more complex in the context of group disability insurance in two ways. The first complexity is caused by the fact that there is often no direct communication between the person insured and the insurer. Instead communication is conducted through the insured, often an employer who may be unfamiliar with all of the underwriting rules of the insurer. Moreover, the insurer may be unwilling to delegate underwriting decisions to the insured employer. As a result there can easily be some misunderstanding caused by the insured. The courts have had to decide which party should bear the consequences of this misunderstanding, the person insured (and the beneficiaries) or the insurer. They have decided this question by attempting to identify whether in relation to this function the insured employer has acted as agent for the person insured or the insurer. As we discussed in an earlier section,[62] the courts regard this as a question of fact, but the courts have often been unduly influenced by the express authority that the insurer has given the

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60 *See* e.g. *Zurich Life Insurance Co. of Canada v. Davies*, [1981] 2 S.C.R. 670, 130 D.L.R. (3d) 748, [1982] I.L.R. 1-1471, 39 N.R. 457; *Blanchette v. C.I.S. Limited*, 36 D.L.R. (3d) 561, [1973] S.C.R. 833, [1973] I.L.R. 1-532, [1973] 5 W.W.R. 547, *Matchett v. London Life Ins. Co.*, 14 C.C.L.I. 89, [1986] I.L.R. 1-1994, 42 Sask R. 200 (C.A.) leave to appeal to S.C.C. refused 44 Sask. R. 240n, 64 N.R. 394n (S.C.C.); *Wagner Bothers Holding Inc. v. Laurier* (1992), 10 C.C.L.I. (2nd) 9 (Ont. C.A.).

61 See Norwood, and Weir, Norwood on Life Insurance Law in Canada (2nd ed, 1993), at 80-83, 88-90.

62 *Supra*, at p. 24.

insured. Treating the insured as an agent of the person insured is unrealistic. The insurer, rather than the person insured is in the only position to provide forms, training, supervision and operating instructions in relation to applications for disability insurance.

In some circumstances the person insured, as an employee, may have an effective remedy against an employer who gives improper assurances of disability insurance coverage. Nevertheless, this may not always be the case, and it would be preferable to allow the person insured immediate recovery of disability benefits while leaving the employer and insurer to sort out their respective rights.

The second complexity with group disability insurance is caused by the practice of some insurers of not determining the eligibility of the person insured to coverage until after a claim is made.[63] At first blush this practice may seem to be efficient and to cause no particular hardship to the person insured. The insurer does not have the expense of making an individual underwriting decision until after a claim is made. At that time, if it is determined that the person insured did not qualify for coverage, the premiums can be returned and the person insured will be no worse off than they would have been if a more timely underwriting decision had been made. However, this line of reasoning overlooks the fact that there may be some detrimental reliance by the persons insured based on their reasonable belief that they had disability coverage. It also overlooks the fact that the insurer will collect premiums from many uninsured whose status will not be discovered because no claim is made. This premium income is at best an unfair cross subsidy by the uninsured and at worst an unearned windfall for the insurer.

Given the nature of this underwriting practice it is not easy to determine whether it is widespread or whether it is confined to certain types of creditors life and disability group insurance. Nevertheless the practice is basically misleading and unfair and should be prohibited.

RECOMMENDATIONS

That the Act should be amended to provide that an insured administering a group insurance plan should be deemed to be the agent of the insurer for the purpose of determining when coverage becomes effective.

That the Act should be amended to provide that an insurer must make a final underwriting decision within a reasonable length of time.

That the Act should be amended to provide that (interim) certificates of insurance must clearly state when coverage becomes effective and that no coverage be denied retrospectively.

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63 See *Cameron v. Coopérants Mutual Life Insurance Society* (1992), 16 C.C.L.I. (2d) 228 (N.S.C.A.).

6. UNDERWRITING CRITERIA

The existing Act contains no specific control on the underwriting criteria that can be used in disability insurance. However, Part XVIII of the Act contains a general prohibition against "unfair or deceptive acts or practices".[64] The definition of an unfair or deceptive act or practice includes "any unfair discrimination in any rate or schedule of rates between risks in Ontario of essentially the same physical hazards in the same territorial classification". The Superintendent may investigate and determine whether any person has engaged in an unfair or deceptive act or practice and issue cease and desist orders. So far, the Superintendent has exercised his authority with restraint. This restraint is consistent with a long tradition in Canada of treating rate setting as largely a private matter, not subject to public control. This tradition is in sharp contrast to that in most American jurisdictions where the determination of rates is seen to involve significant public issues of distributive justice and equity amongst insureds.[65]

This lack of public control has extended to the human rights legislation in most provinces, although there are some exceptions which the courts have interpreted with some surprising results.[66] At the same time, permissible discrimination under the Charter remains unclear.[67] Nor, as we've seen in a previous section, have the courts used the concept of materiality to control unreasonable discrimination (although they might not accept xenophobic or anti-semitic underwriting with quite the same equanimity as they appeared to do sixty years ago).[68]

Since there has been so little public regulation of underwriting in Canada, it is not surprising that there is little public information about the criteria used by the industry. When a Select Committee of the Ontario legislature considered the matter in the 1970's they discovered a wide variety of matters influenced the underwriting decisions of individual insurers in the life and health field.[69] These factors went beyond obvious matters relating to the health, occupation or pastimes of the persons insured. As we discussed in a previous section, some of these factors are based on actuarial evidence, while others are based on experiential judgment. Some may be based on stereotyping, while others are based on matters

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64 Section 439.

65 See Banks McDowell, Deregulation and Competition in the Insurance Industry (1989), Chapt. 3, and S. Kimball and R. Boyce "The Adequacy of State Insurance Rate Regulation. The McCarron-Ferguson Act in Historical Perspective", 56 Mich L. Rev. at 546-52 (1958).

66 See I.C.B.C. v. Heerspink, [1982] 2 S.C.R. 145, 39 B.C.L.R. 145, [1983] 1 W.W.R. 137, 137 D.L.R. (3d) 219, [1982] I.L.R. 1-1555, 43 N.R. 168, 82 C.L.L.C. 17, 014. See also Battlefords and District Co-operative Ltd. v. Gibbs. May 1, 1996 (orally) S.C.C.

67 Compare *Bates v. Zurich Ins. Co.*, [1992] 2 S.C.R. 321, 16 C.H.R.R. D/255, 12 C.C.L.I. (2d) 206, [1992] I.L.R. 1-2848, 39 M.V.R. (2d) 1, 93 D.L.R. (4th) 346, 138 N.R.I. 550 A.C. 81 and *Miron v. Trudel* (1995), 1 24 D.L.R. (4th) 693 (S.C.C.).

68 *London Guarantee & Accident Co. v. Green*, 38 O.W.N. 398, affirmed by 39 O.W.N. 164 (Div. Ct.); *Horne v. Poland*, [1992] K.B. 364.

69 *Supra*, note 3.

other than the likelihood of loss (such as factors that might make servicing a policy particularly expensive).

Much disability insurance (particularly group insurance) is now sold with little if any rating. That is, all members of an organization may be accepted into a group plan with membership in the group (such as employment) used as a rough proxy for good health, and a limited enrollment period for participation in the plan used to guard against adverse risk selection. The risk may be further controlled by various policy exclusions (particularly an exclusion relating to a prior medical condition).

Assuming the movement towards more widespread availability of disability insurance is a good thing, are any changes in the law needed to encourage this development? In particular, should there be more public control of underwriting criteria? If so, should rating criteria be controlled by prescribed list, by the courts or by an administrative agency?

Since individual rating is no longer a universal practice with disability insurance, one could ask whether it is necessary at all and whether disability insurance would be more widely available if it were abolished. Our experience with workers' compensation shows that at least with accident insurance, many individual factors that may have once been considered material can be ignored. The same thing may be true for sickness insurance offered to a group of employed individuals, assuming coverage is compulsory for all members of the group. More universal coverage may however increase the moral hazard and put additional pressure on the claims process to identify legitimate claims and to control costs, since some individual rating may be aimed at prior screening. Nevertheless, this is probably a good thing since it allows the legitimacy of individual claims to be judged directly and does not hide them behind some crude exclusionary rules.

Membership in many groups, however, is not a sufficient protection against adverse risk selection and this explains why accident insurance is more widely available on a group basis with no individual rating than sickness insurance. One cannot easily become employed in order to obtain disability coverage. Nor do many individuals arrange to acquire assets on credit in order to obtain creditors group insurance. But individuals could easily obtain credit cards or join a social organization for the primary purpose of obtaining group disability insurance.

It might be possible to prohibit individual underwriting whenever there was a reasonable alternative to guard against adverse risk selection. But the determination of what was reasonable would involve questions of efficacy and costs which are probably best determined by the participants in a competitive industry. If cheaper and efficacious alternatives can be found there is no reason to assume they won't be used.

It is assumed in this discussion that experience rating for the group should still be allowed and that for some smaller groups with unusual claims experience, coverage may be unavailable or prohibitively expensive. But this problem would exist whether or not individual rating is used. The difficulty for insurers is to determine what is statistically significant and to identify causally relevant factors. They may not have the scientific knowledge or actuarial evidence to do this with confidence and may chose to withdraw

coverage instead. But it is not likely that this problem of availability will be solved by the use of individual rating. It could only be solved by a system that guaranteed availability at some controlled reasonable cost, perhaps similar in structure to the assigned risk plans that has operated in the automobile insurance field.[70]

RECOMMENDATIONS

That there be no general prohibition against individual rating of person insured in group disability policies, but that the Commissioner continue to explore with the industry alternative ways to protect against adverse risk selection.

Even if individual underwriting is allowed, the more difficult question is whether there should be any public control on the criteria used. There may be several issues involved in this question which should be distinguished and addressed separately. These include whether the criteria used requires insurers to become too intrusive, whether the criteria is supported by scientific or actuarial evidence, whether the criteria reinforces systemic disadvantage in society, and whether it is appropriate to use criteria which is beyond the control of individuals. There is a further question in the case of group plans arranged by employers of whether underwriting criteria frustrates the goals of employment equity.

These are complex issues and once again it may be felt that they are best left to be worked out by competition in an open market. However, there are several factors which suggest the need for public intervention. One factor is that the cooperation necessary for effective rate setting may discourage the use of innovative criteria. There is a long history of exempting the insurance industry from anti-combines legislation and encouraging the formation of rating bureaus. A second factor is that the state of scientific knowledge may be such that insurers are left to grope and they may use markers or attempt to acquire character evidence which arouses serious public concerns about reliability and the invasion of privacy. The on-going debate concerning the industry's attempt to identify groups that are at higher risk of acquiring A.I.D.S. is a good illustration. A third factor is that competitive pressure may in fact re-enforce systemic disadvantage. The use of sex in life insurance and pension plans is an older example of this, as is sex, age, and marital status in automobile insurance. In fact so great is the competitive pressure to use these criteria that it has been argued that any attempt to prevent their use in automobile insurance would result in significant flouting of the law.71 Of course similar fears of significant civil disobedience in the life insurance and pension fields have turned out to be groundless.

The difficulty is not so much to identify the public interest in the criteria used in individual rating, but to determine how it can best be brought to bear on industry practice. The two existing mechanisms, individual challenges under provincial human rights

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70 This in fact was the recommendation made in 1981 to the Select Committee by C.A.A.S.I. See *supra*, note 6.

71 See Samuel A. Rae and Michael J. Trebilcock, Rate Determination in the Automobile Industry in Ontario: The Use of Age, Sex and Marital Status as Rating Variables, a study submitted to the Insurance Bureau of Canada, Nov. 1982.

legislation and the federal Charter[72] and the Superintendent's authority to disallow discriminatory rates,[73] have, so far, not been used significantly. Should either mechanism be made more effective, and if so, how? They involve forums with radically different institutional philosophies and practices. Providing they don't adopt inconsistent positions there may be no compelling reason why one of them should have exclusive authority over insurance rating. However, it may seem logical to give primary responsibility to this matter to the Commissioner (or Superintendent), because of his or her greater expertise.

There may be several ways to make the Commissioner's role more effective in controlling the criteria used in rating. These include clarifying the factors which ought to be taken into account in determining whether rates are impermissibly or discriminatory, creating a formal mechanism for individuals and representatives to complain, providing for an open public hearing, and adding additional public representation to the decision making body.

RECOMMENDATIONS

That the authority of the Superintendent or Commissioner to disallow discriminatory rates be strengthened by clarifying the factors which should and should not be taken into account, and by providing for a more formal public hearing.

That additional public representatives be appointed to assist the Commissioner in making his or her decision.

Apart from determining what underwriting criteria should be allowed, there is a further question of whether there is any need for a mechanism to ensure that any rating has been done accurately. Once again, will competitive pressures ensure that individuals are appropriately categorized? This may happen in the case of individual policies where the insured gets competitive quotes and no insurer places undue importance on the prior rejection of the application by another insurer.[74] However, in the case of group plans, the person insured may have few if any alternatives. In fact if the group is based on employment, the insurers' underwriting decision could have an adverse effect on the person insured's employment. One way to protect the person insured from an adverse underwriting decision by the insurer would be to require the insurer to notify the person insured of any adverse decision together with the reason for it. This would give the person insured an opportunity to correct any inaccurate information. The system could be modeled after the system used to promote accuracy in the credit reporting field. For these purposes an adverse underwriting decision could be defined as any decision to decline the risk or to charge more than the standard premium.

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72 *Supra*, notes 66 and 67.

73 *Insurance Act*, s.438. Amongst other things the Act should be amended to clarify its application to Accident and Sickness Insurance.

74 But even in the case of individual policies, insurers may in fact place considerable importance on a prior rejection of the application by another insurer.

RECOMMENDATIONS

That an insurer be required to notify the person insured (or potential person insured) of any adverse underwriting decision and the reasons for it.

That a mechanism be adopted to enable an applicant or person insured to correct any information acquired by the insurer.

Some concern has been expressed about the possibility that health screening done for the purpose of disability insurance rating may also be used for other purposes. In particular in some contexts health screening may have an adverse effect on employment and this may frustrate attempts to promote employment equity. The confidentiality of health records has been considered in other contexts and suggestions made to guard against their use for purposes other than those for which they were intended.[75] However, the concern may be whether health information can be requested for both insurance and employment purposes. These questions have to be answered individually. If health screening is a legitimate practice for both insurance and employment purposes there would seem to be little justification for not allowing the screening to be linked. However, if health screening is to be limited or controlled for the purpose of employment, screening for insurance purposes should not be allowed to evade these controls. The need for health screening for group disability insurance is probably not so great as to justify such evasion and an extension of such controls would be simpler to administer than an attempt to create barriers to the exchange of information between insurers and their insureds (the employers).[76]

RECOMMENDATION

Health screening for the purpose of group disability insurance underwriting should not be allowed to evade any controls on health screening for the purpose of employment.

7. MARKETING PRACTICES

(a) INTEGRITY IN MARKETING

Most litigation relating to the formation of insurance contracts involves the applicant's obligation to observe the utmost good faith. Yet in theory the obligation is reciprocal, requiring insurance companies to observe the same high standard of honesty and fair dealing

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[75] Report of the Commission of Inquiry into the Confidentiality of Health Information (1980). (Hereafter, the Krever Report).

[76] The Krever Report anticipated that health information required by insurers at the time of application or claim might be greater than the health information that could be used for employment purposes. Several recommendations in the Krever Report are designed to prevent this health information from being made available for use in making employment decisions. The recommendations of the Krever Report concerning health information required to satisfy a claim would still be apt. Moreover, to guard against adverse risk selection the insurer may require additional health information for applications that are made after employment commences. Here too the recommendations of the Krever Report should apply.

as insureds. In addition Part XVIII of the *Insurance Act* has specific prohibitions against unfair and deceptive acts and practices by insurers.[77] The prohibited acts and practices cover integrity in marketing, unfair discrimination in rates, unreasonable delay or resistance to the fair adjustment and settlement of claims, the linking of certain insurance products, and the offering of gifts or allowances as an inducement to purchase insurance.

The provisions relating to integrity in marketing are the usual type of prohibitions against false and misleading representations and advertisements. They also prohibit any incomplete comparison of any policy or contract of insurance, but stop short of imposing a positive disclosure obligation on insurers. To this extent, the Act's provisions may not go as far as the common law requirement of the utmost good faith.

The Superintendent is charged with the responsibility of enforcing these provisions of the Act and he has the power to order any person to cease or refrain from doing any act or pursuing any course of conduct, to cease engaging in the business of insurance or any aspect of the business of insurance, and to perform such acts as are necessary to remedy the situation.[78]

Insurance is generally thought to be a complex product. Indeed the whole system of independent intermediaries is based on the notion that the public needs expert help to make wise choices. From time to time, the difficulty of comparing the products offered by some parts of the Industry, such as life insurance, has attracted public attention. However, the common law obligation of the utmost good faith did not develop primarily in response to this concern and the incidental application of this doctrine to insurers has only limited value for insureds. Misrepresentation or concealment by insurers allows insureds to rescind the contract and recover any premiums paid, but does not give them insurance to match their expectations or compensate them for any consequential damages they incur. These shortcomings are not corrected by Part XVIII of the Act. Nor does the Act, in theory, change the standard of conduct expected of insurers. However, the Act's provisions are useful in other ways since they allow for administrative action to enforce the law.

The central question in relation to the law applicable to marketing practices is whether this combination of common law doctrine and statutory prohibition is adequate. Should changes in the law be made in order to allow consumers to help themselves or to make public or administrative enforcement more effective? These questions were examined by the Insurance Legislative Review Project in 1991, but given its mandate, it largely concentrated on the provisions of the *Insurance Act*.[79]

As to administrative enforcement, the Review Committee made a number of recommendations designed to clarify the meaning of unfair or deceptive acts or practices, to

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77 Section 438.

78 Section 441.

79 "Insuring for the Future: Modern Insurance Legislation for Ontario", Report of the Insurance Legislation Review Project to the Ontario Insurance Commission, 1991.

limit the Superintendent's authority to identify unfair and deceptive conduct, to place more responsibility on insurers for the acts done by others on their behalf and to separate other prohibited conduct from the definition of unfair or deceptive acts or practices. These recommendations are not all consistent and I doubt that some of them will do much to clarify what is prohibited conduct and enhance public enforcement. Essentially the Committee adopts the position that prohibited conduct should be defined by an exhaustive list, established by regulation.[80] Yet at the same time they urge the assimilation of insurance law with general trade practice legislation which is based on general standards, illustrated by a non-exhaustive list of prohibited acts.[81] The Committee's concern seems to be to prevent arbitrary and punitive action by the Superintendent. This concern seems misconceived for a number of reasons. There is no evidence that the Superintendent has exercised his authority under the existing Act in an aggressive or arbitrary way. Nor does the discretion given to the Superintendent under the Act allow him to act arbitrarily or without restraint. His decisions can be appealed to the Commissioner whose decision is subject to judicial review.[82] But even more significantly, the Review Committee places too little emphasis on the consultative and co-operative practices that actually exist between the Superintendent and the industry and ignores the fact that what is often missing in this process is an active dialogue with consumer groups outside the industry.

Thus, while I agree that the provisions of Part XVIII of the *Insurance Act* ought to be compared and, if possible, made compatible with the provincial trade practices legislation,[83] I do not think that the Committee's actual recommendations accomplish this goal. I also agree with the Review Committee that there is a need to translate the general standard of "unfair or deceptive" into more specific rules. This task is now the responsibility of the Superintendent who has acted with restraint. The difficulty is not that the Superintendent has acted arbitrarily, but that there has been no formal mechanism for public participation in this rule making.

RECOMMENDATIONS

That unfair or deceptive acts or practices continue to be defined by way of a non-exhaustive list.

That some of the illustrations of an unfair practice found in the Business Practices Act might be incorporated as part of the list of unfair practices in the Insurance Act as well.

That the Superintendent or Commissioner continue to have the initial authority to determine whether conduct is unfair or deceptive.

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80 *Ibid.*, recommendation 169.

81 *Ibid*, recommendation 170. The Review Committee anticipated the adoption of a new Consumer and Business Practices Code based on a Consultation Draft published in June 1990.

82 *Insurance Act*, ss.18, 20. Moreover, the L.G. in Council may make regulations "prescribing any activity and failure to act that constitutes an unfair or deceptive act or practice ..." s.121, para 23.

83 Particularly the Business Practices Act, R.S.O. 1990, c.B.18.

That the Superintendent or Commissioner consult with other consumer groups as well as the industry in developing guidelines or prior rulings about what conduct is unfair or deceptive.

The Review Committee did not consider whether administrative enforcement of the Act could be improved by including some of the measures that are found in other provincial trade practices legislation (such as the British Columbia *Trade Practice Act.*)[84]

These measures include the granting of standing to individuals and consumer groups to seek an order for compliance and a concomitant right of the Superintendent to initiate substitute actions, a right to provide for ancillary orders of restitution, the right to require assurances of voluntary compliance and the right for prior public notice and public participation in the drafting of guidelines or assurances of voluntary compliance.

Some of these powers may be implicit in the general power given to the Superintendent in section 441(1)(b) to order any person "to perform such acts as, in the opinion of the Superintendent, are necessary to remedy the situation". However, without more explicit authority it is doubtful that the Superintendent would order restitution to individual policyholders or adopt a scheme for more public participation in the enforcement process.

RECOMMENDATIONS

That the Act be amended to give the Superintendent or Commissioner additional enforcement powers including the right to seek assurances of voluntary compliance, the right initiate substitute actions on behalf of consumers and the right to order restitution.

That the Act be amended to allow consumers and consumer groups standing to seek an order for compliance.

The Review Committee also considered whether the civil remedies available to insureds in the case of unfair or deceptive practices were adequate. They concluded that they were not, although they did not consider the existing contract and tort remedies in any detail. To correct this deficiency they recommended the adoption of the civil remedies found in *the Business Practices Act.*[85]

In relation to marketing practices, the inadequacies in the existing insurance law are similar to those found in other branches of contract law. They include a restrictive notion of what are the contractual terms, the failure of the common law to give damages for mere misrepresentations, and the slow development of concurrent tort liability for pure economic loss caused by negligent acts or misstatements. In relation to other types of unfair acts or practices (i.e. unfair discrimination in rates and unreasonable delay or resistance to the fair

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84 R.S.B.C. 1979, c.406, ss.17, 18 and 24.

85 *Supra*, note 83.

adjustment and settlement of claims), the inadequacies in insurance law are more unique and are considered elsewhere.

The shortcomings in the existing law are partially overcome in the *Business Practices Act* by abolishing the parole evidence rule and providing for damages for any misrepresentation or unconscionable practice whether a transaction has been concluded or not. A similar expansion of the insured's civil remedies for unfair and deceptive representations at the time of contracting would also be desirable. However, this expansion may not be enough to protect the insured in all circumstances. The insured may in fact rely on representations or conduct which has not been prohibited by administrative action. The representations may be such that a court would be reluctant to stigmatize them as unfair or deceptive (although, strictly speaking, any representation that would lead a reasonable insured to believe that coverage was broader than that provided in the policy could be characterized as deceptive). I believe that the matter should not be left in doubt and that there should be a more fundamental reform of what constitutes the contract between the parties and how it should be interpreted.

There is no doubt that the common law courts, without expressly relying on the parole evidence rule, have often tried to construe insurance policies in isolation, without regard for context or purpose.[86] So advertisements and other communications by insurers have not often been used as an aid in interpretation, let alone recognized as terms of the insurance contract. This privileging of the written policy has continued even in circumstances where the parties themselves have treated the document rather informally. At the same time, the courts have not relied exclusively on the policy, since many basic insurance doctrines are implied. However, many of these implied doctrines are based on the needs of insurers and the insuring public more generally.

This traditional policy centered approach has been replaced in many American jurisdictions with a broader approach which emphasizes the reasonable expectations of the insured.[87] The American doctrine comes in several forms, and its less ambitious forms have already been accepted by many Canadian courts.[88] The less ambitious forms see the doctrine as an aid in the interpretation of ambiguous contracts. However, more ambitious forms of the doctrine allow courts to mandate coverage, apart from or in spite of the policy's wording. The courts' intervention is justified on two distinct grounds. The first emphasizes some shortcoming in the negotiation process. Either the insurer has misled the insured or has failed to make adequate and frank disclosure. The second ground bases the courts' intervention on the substance of the policy term or exclusion. The court, in effect, finds the term or exclusion ineffective because it is unfair or arbitrary (that is, the exclusion seems haphazard, too broadly drawn or with no apparent or reasonable justification).

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86 See Baer, "Recent Developments in Canadian Law: Insurance" (1990), 22 Ottawa L.R. 387 at 409; Baer, Rethinking Basic Concepts of Insurance Law, L.S.U.C. Special Lectures 1987, at 223.

87 Keeton, "Insurance Rights at Variance with Policy Provisions". (1970, 83 Harv. L.R. 961.

88 Some of the cases are noted in Baer, *supra* note 86, Ottawa L.R., at 410.

Some forms of the reasonable expectations doctrine are similar to the emerging tort liability for brokers and direct underwriters. That is, brokers and direct underwriters are expected to know the insuring needs of their clients and are liable for failure to meet those needs or warn that coverage is unavailable.[89]

I believe that a form of the reasonable expectation doctrine should be adopted in Canada and applied to LTD insurance contracts. The application of the doctrine should not be restricted to situations where the policy wording is, on its face, ambiguous. Instead the doctrine should be used to require the court to determine the content and meaning of the insurance contract by considering all of the communications between the parties. Essentially this approach would eliminate the existing distinction between representations and terms of the contract. In other contexts, this distinction may be useful to limit damages for some types of breach to reliance damages. However, the distinction serves no useful function in the insurance context. An alternative approach would be to continue to define the terms of the contract more narrowly as those terms set out in the written policy but to provide a remedy in damages for any misrepresentation that has reasonably been relied upon by the insured.

RECOMMENDATIONS

That the insured should be allowed to claim damages for any loss resulting from an unfair act or practice by the insurer.

That the terms of the insurance contract should include all representations by the insurer which were reasonably relied upon by the insured.

That the insured should be allowed to claim damages for any loss resulting from reliance on any misrepresentation of the insurer.

(b) MASS MARKETING

In the past, most insurance was sold through agents or brokers and a significant amount of regulation was directed at improving the honesty, competence and financial integrity of such intermediaries. At the same time, the insuring public's civil remedies against intermediaries who provide inadequate or negligent advice also expanded. However, a growing amount of insurance (both group and individual policies) is now sold without the services of such intermediaries as insurers have adopted a variety of mass marketing techniques to solicit business directly from the public. This phenomenon has led to some concern about whether the general provisions against unfair and deceptive acts or practices are adequate to protect the public.[90] The concern is in part linked with other concerns related

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89 The leading decision is *Fine's Flowers Ltd. v. Gen. Accident Assur. Co.*, 81 D.L.R. (3d) 139, [1978] I.L.R. 1-937, 2 B.L.R. 257, 17 O.R. (2d) 529 (C.A.). In England, see Clarke, "The Reasonable expectations of the insured in England?", [1989] J.B.L. 389.

90 The matter was considered by the Insurance Legislation Review Committee in Chapt. 18 of its Report. They referred to the Guidelines Respecting Mass Marketing of Life, Accident and Sickness Insurance originally adopted by the Canadian Council of Insurance Regulators. They reported, however, that the guidelines are not

to group insurance plans, but there are issues of marketing integrity that apply to both individual and group policies. Essentially these issues relate to whether there is a greater need for accuracy and disclosure on the part of insurers when marketing does not involve the services of an agent or broker. The Review Committee concluded that there was, and recommended that separate regulations be adopted to cover Mass marketing. The Committee also provided a list of matters that should be included in its proposed mass marketing regulation.[91]

It is not entirely clear what differences the Committee contemplated between the separate mass marketing regulation and the more general regulation against unfair or deceptive acts and practices. In neither case do they contemplate prior filing or approval of advertisements or other promotional material. In both cases they contemplate that insurers will be made responsible for any advertisements promoting their insurance regardless of who wrote, created, designed or presented it and that the Superintendent will have full enforcement powers. Some of the apparent differences may be caused by the fact that the Committee has provided more detail concerning their proposed mass marketing regulation. Nevertheless, they do seem to contemplate a more active role for the Superintendent in establishing criteria (including standards and principles) that are to be used in the development of advertisements for insurance in a mass marketing context.[92] While in the context of the general regulation against unfair and deceptive acts and practices they seemed more concerned about limiting the Superintendent's arbitrary power.

I believe that it may be useful to have some regulations that cover particular problems associated with mass marketing of insurance, including LTD. However there are some general issues that ought to be treated in a uniform way in the regulations, including the Superintendent's rule making and enforcement powers, the right to a formal hearing by persons whose advertisements or conduct is being objected to, a mechanism for public participation in the rule making process and the right of individual or representative actions to enforce the Act. Apart from some matters of detail, what is required is not the separate regulation of mass marketing, but more vigilant public enforcement of the general regulations against deceptive acts and practices.

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well drafted and have not been actively enforced. (The Committee's Report, at 149). The Committee also observed that at the September 1988 Conference of Canadian Insurance Regulators, the Superintendents withdrew their sponsorship of all the Superintendents' guidelines because of lack of enforcement authority. The Committee's Report, at 156 urged the CLHIA to adopt and sponsor the guidelines.

91 *Ibid*, at 150.

92 Although their recommendation was that the cabinet should adopt Mass marketing Regulations. (Recommendation #182 of the Committee's Report, at 150).

The matters of particular concern in relation to mass marketing that may need to be regulated are those that involve the need to provide insureds with the type of service that would normally be provided by an agent or broker. The Review committee listed the following matters:

- A requirement that an insurer make available (including access by telephone) a knowledgeable representative to answer questions and render service to an applicant for insurance, a policyholder or a group person insured in respect of the advertised insurance.

- A requirement that any insurance program sponsor (such as a credit card issuer) and an insurer, agent or broker enter into an agreement with respect to the servicing of contracts under the insurance program that is the subject of an advertisement; and

- A provision for an alternative payment method to avoid the cancellation of insurance coverage, purchased pursuant to an advertised solicitation, for non-payment of premiums collected by way of a credit card when credit card privileges are cancelled or revoked.

Whether it is necessary to adopt detailed rules to cover such matters should be left to the Superintendent or Commissioner.

RECOMMENDATIONS

That the Superintendent or Commissioner be given express authority to regulate the mass marketing of insurance.

That the Superintendent's or Commissioner's rule making and enforcement power be subject to the general recommendations found in the prior section.

(c) GROUP OR TARGETED MARKETING

A substantial amount of LTD insurance is provided through group insurance plans. When such plans first became common, there was some concern that they presented unique issues that required separate regulation. At one time the superintendents issued guidelines to cover such matters as advertisements, affinity rules and rate discrimination.[93] The affinity rules, which set out what could be the basis of a group, were designed to meet the concern that such groups be stable and the organizers competent to service such policies. There was also a concern that synthetic groups might be formed solely for the purpose of buying insurance, and that this might lead to unfair rates. No doubt, some of the concern came from insurance intermediaries who saw group plans as undermining their role in the selling and servicing of insurance contracts. The guidelines covering rate discrimination were the result

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[93] See the Rules Governing Group Accident Insurance and Group Sickness adopted by the Association of Provincial Superintendents of Insurance (1976).

of an unresolved debate about what type of cost savings could legitimately be passed on to members of the group.

The Insurance Legislative Review Committee reported in 1991 that these guidelines had not been actively enforced and were no longer in effect. They reported that the guidelines were "currently under review by the Canadian Life and Health Insurance Association (CLHIA), together with other Superintendents Guidelines, with the expectation that they will become 'industry guidelines'."[94]

The Review Committee did not comment further on the lack of effectiveness of these guidelines. Instead it distinguished between the sale of group policies and the selling of individual policies (particularly property and casualty insurance policies) to the members of a group and restricted its concern and recommendations to the latter category.

The distinction drawn by the Review Committee may mask a common concern about affinity rules and rate discrimination whenever a group is targeted. The legitimacy of these concerns does not depend on whether the insurance sold to the group takes the form of a group policy or individual policies. In any event the need for more specific regulations to cover these particular matters should be left to the Commissioner or Superintendent.

RECOMMENDATIONS

That the Superintendent or Commissioner be granted the authority to establish affinity rules for the group marketing of insurance.

That the Superintendent or Commissioner be granted authority to establish whether any rate discrimination offered to members of a group is justifiable and fair.

8. ISSUES RELATING TO COVERAGE

(a) WARRANTY LAW

In order to understand the law in relation to issues of coverage and how this has been controlled by the legislature it is necessary to consider insurance warranty doctrine and the distinction between warranties and the definition of the risk.

Insurance law is unique not only in the obligation it imposes on the parties (particularly the insured) to bargain in good faith, but also in the way it treats contract terms. This unique treatment includes the following:

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94 *Supra*, note 90, at 151. The C.L.H.I.A. has adopted Guidelines covering a number of matters including certificates and plan descriptions, conversion privileges, termination, change of insurer, and coordination of cost of living adjustments in government plans. These guidelines were approved by the CLHIA Board of Directors on June 5, 1994.

(1) all contract promises (called warranties) are considered major, that is their breach discharges the insurer from liability,

(2) the insurer is discharged regardless of whether the loss is related to the breach,

(3) the insurer does not have to prove that the warranty is material to the risk,

(4) a warranty must be strictly complied with, and

(5) the Court has no general power to relieve against forfeiture caused by breach of warranty.

The courts may in fact be moving away from the last two rules,[95] but the first three continue to be accepted doctrine. Few Canadian courts have explained the need for such unique rules and the oppressive nature of them lead to legislative intervention as early as 1876.[96] Unfortunately the subsequent statutory control has been piecemeal, has taken different forms in different parts of the Act, and has not affected general insurance warranty doctrine.

The rule that any breach of a policy term results in the forfeiture of the insured's claim seems particularly harsh. It has been explained on the basis that no other remedy would adequately protect the insurer from undisclosed breaches. That is, many breaches by the insured increase the risk, but would go undetected if no loss occurred. So an example has to be made of those who are detected, so that all insureds have an adequate incentive to observe their promises. The argument is similar to the problem of the undetected freeloader that is used to justify forfeiture of claims for failure to disclose material facts.[97]

Insurance law also distinguishes between warranties and the definition of the risk.[98] Warranties are terms of the contract which are promissory in nature. The breach of such terms results in the forfeiture of any clam under the contract. The definition of the risk (including exclusions) are non-promissory conditions which must be satisfied before loss is

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95 The courts now use a variety of rules for construing insurance contracts which favour the insured. These include (1) contra proferentem - in which the language of the policy is construed against the drafting party (2) the principle that policy provisions should be broadly construed in favour of coverage and the corollary that exclusions would be narrowly construed (3) the reasonable expectations doctrine - in which ambiguous language is interpreted so as to give effect to the insured's reasonable expectation, (4) the principle that exclusions should not be interpreted so that they are repugnant with the main purpose of the insurance coverage or so as to nullify coverage. See *Reid Crowther & Partners Ltd v. Simcoe & Erie General Ins. Co.* (1993), 13 C.C.L.I. (2d) 161 (S.C.C.) and *Consolidated Bathurst Export Ltd. v. Mutual Boiler & Machinery Ins. Co.* (1979), 112 D.L.R. (3d) 49 (S.C.C.). The courts' power to relieve against forfeiture is considered *infra*.

96 The first Statutory Conditions for fire insurance were adopted in 1876 following the report of a provincial Royal Commission in 1875.

97 See text *supra* at note 23.

98 See Baer, "The Distinction Between Breach of Condition and a Restrictive Definition of the Risk: A Reply to Professor Rendall", (1978), 2 Can. B.L.J. 485.

payable. Both are methods used by insurers to control the risk. They differ, however, in the way they operate to control the risk. A breach of warranty relieves the insurer of liability even though there is no causal relationship between the breach and the loss. On the other hand an insurer is only relieved of liability if there is a causal relationship between the loss and the definition of the risk. An example from one of the early authorities which considered this distinction illustrates the significance of this causal link.[99]

Suppose an insured warrants (i.e. promises) that a truck will only be used to carry coal. If this promise is broken at any time, the insured's claim for recovery for a loss, even while the truck is carrying coal, is forfeited. Alternatively, if the definition of the risk includes coverage only while the truck is carrying coal, recovery will be allowed as long as the truck is carrying coal at the time of the loss, even though the truck may have carried other material on a different occasion.

This distinction is similar to a distinction found in the general law of contracts between promissory conditions and suspensive or non-promissory conditions. However, in other contexts, the distinction is significant for different reasons - often for the question of whether one of the parties is liable if the condition is not met and whether the condition can be waived. However in the insurance context these types of questions are not relevant. There is no question of the insurer trying to collect damages for breach of condition, nor any context in which the parties might intend that the condition could not be waived.

From the point of view of the insurer, the distinction between a warranty and an exclusion may be largely a matter of form rather than substance. The insurer may be primarily concerned with excluding certain types of losses without being concerned about the broader protection that is implicit in warranty doctrine. Since the distinction may be largely a matter of form, the courts have been able to exploit the distinction to avoid some of the harshness of the warranty doctrine.[100]

Canadian statutory provisions designed to redress the balance between insurers and insureds, have modified the common law disclosure obligation, but have not attempted to modify the general law in relation to insurance warranties or to affect the distinction between warranties and the definition of the risk. That is, the Act has not attempted to change the legal consequences of a breach of warranty. Instead the Act has attempted to control the content of insurance warranties in a variety of ways - either by judicial, legislative or administrative control. The courts have assumed that some of these controls, particularly the legislative controls (statutory conditions) are based on the distinction between warranties and the definition of the risk (exclusions), although they have recognized that insurers cannot amend the statutory conditions by redrafting them as exclusions.[101]

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99 *Re Morgan* and *Provincial Ins. Co.*, [1932] 2 K.B. 70 (C.A.) affirmed [1933] A.C. 240 (H.L.).

100 See e.g. *Case Existological Laboratories v. Century Insurance Co. of Canada*, [1981] I.L.R. 1-1567, 133 D.L.R. (3d) 727 (B.C.C.A.) affirmed [1983] 2 S.C.R. 47, 150 D.L.R. (3d) 9 2 C.C.L.I. 172 (S.C.C.).

101 See *Curtis' and Harvey (Canada) Limited v. North Br. & Mercantile Ins. Co.* and *Continental Casualty Co. v. Casey*, *supra*, notes 54 and 55.

There are several issues that need to be addressed in relation to the existing warranty law, including: (1) should the existing law be modified by altering the remedies available to insurers and by eliminating the distinction between warranties and exclusions (or the definition of the risk), (2) what parts of the contract should be mandatory or subject to administrative or judicial control and what parts should be optional, (3) what should be the form of any judicial or administrative control?

(b) MODIFYING EXISTING WARRANTY LAW

Apart from controlling the content of insurance warranties or other contract terms, is there any need to reform the general law in relation to insurance warranties? That is, should there be some attempt to harmonize insurance warranty law with the general law of contract, or make other changes to ameliorate the harshness of existing law. These changes might include (1) limiting the circumstances in which the insurer can deny recovery altogether and substituting a more limited remedy (2) providing a remedy to the insurer only when the insured's conduct caused or contributed to the loss or when it materially increased the risk of loss (3) eliminating the distinction between warranties and exclusions and (4) expanding the court's authority to relieve against forfeiture.

Both the Law Commission[102] and the Australian Law Reform Commission[103] recommended changes in the remedies associated with insurance warranties. The Australian Law Reform Commission also recommended that breach of warranty and the occurrence of an excluded loss should be treated in the same way.

> "... the difference in effect between breach of warranty and the occurrence of an excluded loss is not justified. The rights of the parties should depend on matters of substance, not on subtle differences in form. The occurrence of an excluded loss should be treated as if the insured's conduct constituted a breach of warranty".[104]

After considering several possible reforms including restricting the right of insurers to terminate the contract and substituting a right to claim damages, the Australian Law Reform Commission adopted a recommendation that allows insurers to refuse to pay a claim in some circumstances while claiming damages in others.[105] The recommendations of the Commission are complex, but essentially they deal with three situations: (1) where some act (breach of warranty or occurrence of an excluded loss) causes or contributes to the loss (2) where some act does not cause or contribute to the loss, but prejudices the insurer by increasing the likelihood of a loss, and (3) where some act does not prejudice the insurer. The first and third category are fairly straight forward. The first continues the existing law in allowing the insurer to refuse to pay a claim where a prohibited act has caused or contributed to the loss.

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102 Non-disclosure and Breach of Warranty, Law Com. Report No. 104., 1980 Cmnd. 8064.

103 Report No. 20, Insurance Contracts (1982).

104 *Ibid.*, at 136.

105 *Ibid*, at 139-140.

The third category reforms the law by depriving the insurer of any remedy if the prohibited act has not prejudiced the insurer. This means the insurer can no longer rely on a technical defence (and to this extent would harmonize insurance law with general contract law doctrine). The second category however is more complex and attempts to recognize that insurers may be affected by a prohibited act even though it does not cause or contribute to the loss that has occurred. This happens when the prohibited act leads to an increase in the risk of loss. For this category, the Commission recommended a remedy of adjusting the insurer's liability based on the principle of proportionality.[106] For instance, if an insured changed to an occupation that was twice as hazardous (without notifying the insurer as required by the policy), the liability of the insurer would be reduced by one-half. This reduction would occur even though the loss was not causally related to the changed occupation.

The Commission recognized that the principle of proportionality might sometimes be difficult to apply, since existing actuarial or statistical data may not accurately measure the increase in risk. Nevertheless, the Commission thought that to provide no remedy would seriously inhibit acceptable underwriting practices, while the existing law (which allows insurers to deny the claim completely) treated insureds too harshly.

The Commission also considered two circumstances where the insured's commission of a prohibited act should be excusable. These circumstances were (1) where the act was necessary to protect the safety of a person or to preserve property, and (2) when it was not reasonably possible for the insured or other person to do the act.[107] The first circumstance is not likely to arise in the case of LTD insurance, but the second may arise in relation to some attendance, treatment and similar clauses.

Several factors should be noted in considering whether similar reforms should be adopted in Ontario. First, accident and sickness insurance contracts (including LTD policies) contain few promissory warranties. Many prohibited acts are contained as part of the definition of the risk or exclusions. Second, many of the promissory warranties relate to conduct after loss, where the court's ability to relieve against forfeiture may be broader in Canada than in Australia. Third, the notion of proportionality as an appropriate balancing of the rights of the parties, is not a new idea in Canadian law. The existing Statutory Condition 3 in the Accident and Sickness part adopts the principle in relation to changes in occupation. Fourth, the distinction between a promissory warranty and the definition of the risk may not always be a matter of form. There is often a real distinction between them which was ignored by the Australian Law Reform Commission. Fifth, while these reforms do not completely harmonize insurance law with general contract law, they do reduce the unique remedies of insurers.

Some of these factors may suggest that this type of reform is less important for LTD than for other types of insurance. At the same time they indicate that similar concepts have

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106 The adoption of this principle was also recommended as the appropriate remedy for breach of the insured's obligation to disclose all material facts.

107 *Supra*, note 103, at 140.

already been adopted on a piece-meal basis in the statutory conditions. Like several other matters discussed in this report having to do with basic insurance concepts, it would be preferable to have a general reform of insurance law. However, that has not been the pattern of reform in the past, so reforming the law of Accident and Sickness insurance as a first step would not lead to any significant new fracturing of insurance concepts.

(i) When should an Insurer be able to avoid liability?

As a general matter, an attempt to harmonize insurance warranty law with general contract doctrine would require insurers' remedies to be more closely related to the harm they suffer from the insured's improper conduct. Insurers would be entitled to refuse to pay only if the insured's improper conduct amounted to a substantial breach, would be compensated in damages for more minor breaches and would have no remedy at all, if they suffered no harm from a technical breach. There are two difficulties in applying these general concepts to insurance contracts. One is defining what amounts to substantial breach and the second is defining how damages should be assessed.

The Australian Law Reform Commission answered the first question by allowing the insurer to refuse to pay a claim whenever the insured's act "could reasonably be regarded as being capable of causing or contributing to a loss". They had in mind an act or omission that has the effect of altering the state or condition of the subject matter of the contract *before* loss (i.e. during the period of cover). Nevertheless some of the acts or omissions of the insured may occur after some loss has already happened. They may be intended to prevent further loss or to limit the damage caused by the occurrence of an insured peril. Several terms of the standard LTD policies are of this type. They serve the same purpose as a sue and labour (or salvage) clause in property insurance, and in general, are similar to an obligation to mitigate damages. I have considered this type of clause elsewhere, where I have concluded that while an insurer should not be liable to pay avoidable looses, there is no justification for the forfeiture of the insured's entire claim.[108] With this one qualification, I believe that the recommendation of the Australian Law Reform Commission which was adopted in the Australian *Insurance Contracts Act 1984* represents a fair and appropriate balance between the interests of the parties. The insurer should be able to refuse to pay only if the prohibited act has caused or contributed to the loss.

(ii) What remedy should an insurer have for conduct which increases the risk?

As we have seen, the insurer's remedy for any breach of warranty by the insured is the right to refuse to pay any claim. If this remedy is restricted, and insurers are given the alternative remedy of damages, how should they be assessed? If we were to adopt general contract principles, the answer might be the amount of additional premium necessary to cover the risk created by the insured's conduct (or breach). Alternatively the damages might be zero if in fact the insured's conduct did not cause or contribute to the loss.

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108 *Infra.*

Neither of these alternatives seems appropriate for the reasons given by the Australian Law Reform Commission.[109] The second, would seriously inhibit acceptable underwriting practices, while the first would provide little incentive for insureds to pay the appropriate premium. However there is a third alternative which has been adopted in several legal system, including our own in limited circumstances. This alternative has been called a principle of proportionality. It limits the insureds recover by the amount that the premium paid would have purchased for the risk that was actually covered. The Australian Law Commission explained how the principle works in the following way:

> "Its effect would be to place on the insured any additional risk arising from his conduct. The insurer would only be responsible for its proportion of the total risk. Where the additional risk was insurable, an objective assessment of the appropriate premium could be made and the principle of proportionality would be applied. When the additional risk was not insurable at all, the insured would be unable to recover any part of his claim from the insurer."[110]

The Australian Law Reform Commission asserted that the principle is consistent with the basis on which the assessment of damages proceeds in other areas of contract law. While this may be true in a general sense, the method of protecting the insurer from breach is sufficiently unique that it should be expressly stated in the Act. The Australian formula which states that "the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of [the insured's] act" may not convey the precise method of assessing loss contemplated by the principle of proportionality.

(iii) Should the distinction between breach of warranty and the definition of the risk be modified?

The Australian Law Reform Commission also recognized that the remedies available to the insurer should not depend on the formal distinction between a breach of warranty and the occurrence of an excluded loss. A similar sentiment has recently been expressed by the Supreme Court of Canada in considering whether the Court's jurisdiction to grant relief from forfeiture extends to situations where there is technically no breach of contract.[111] The Australian Act attempts to cut across this distinction by referring to "some act of the insured or of some other person, being an act that occurred after the contract was entered into ..."[112] However, this may not give sufficient recognition to the fact that the distinction between breach of warranty and the occurrence of an excluded loss is sometimes more than a matter of form. An example is the expiry of coverage through the passage of time. The Act (or in this case omission) of not renewing the contract does occur after the contract was entered into. It

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109 *Supra*, note 103, at 139.

110 *Ibid*, at 138.

111 *Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance Co.*, [1994] 2 S.C.R. 490, [1994] I.L.R. 1-3077, [1994] 7 W.W.R. 37, 23 C.C.L.I. (2d) 161, 20 Alta. L.R. (2d) 296, 155 A.R. 321, 115 D.L.R. (4th) 478, 168 N.R. 381.

112 Australian Insurance Contracts Act, (No.80), 1984, s.54(1).

may sometimes occur through the failure of the insured to pay the renewal premium on time. This looks like a failure similar to any breach of warranty, where the prejudice suffered by the insurer from late payment does not seem sufficient to justify forfeiture of the insured's claim. However, if neither party intends the contract to continue, the omission takes on a different character. A similar situation exists in relation to the description of insured persons and covered risks, especially in group policies. If the person insured is no longer employed or a qualifying card holder, is this changed status caused by an act or omission which no longer allows an insurer to refuse to pay a claim? The act or omission does not "cause or contribute to the loss" in any normal sense, so the insurer is not granted relief on that ground. The proportionality principle might protect the insurer in the case of expired policies (having received none of the premium it would have been entitled to, it is liable for none of the loss), but would not so obviously protect the insurer in the case of a person who no longer qualifies as a person insured. However, even in such cases the insurer may have an appropriate remedy as long as the person is still insurable at some appropriate premium. The prejudice suffered by the insurer because of the act or omission can then be calculated using an appropriate formula.

The underlying issue is under what circumstances should persons insured still be covered for some proportional amount even though their conduct has taken them outside the definition of the risk. The answer of the Australian Act is under all circumstances as long as the insureds' conduct has not caused or contributed to the loss, and as long as they remain insurable. Otherwise any protection for breach of warranty could be easily avoided, by rephrasing a warranty as an exclusion or as part of the definition of the risk. This may seem fair as long as the parties assume some insurance coverage still applies and premiums continue to be paid, i.e. where under the terms of the policy, the insureds' conduct had only temporarily taken them off coverage. If, however, the parties have assumed that all coverage is at an end and premiums are no longer paid, there seems little justification for providing the insureds with coverage for some proportional amount. An extreme example would be persons insured under a group policy who deliberately chose not to exercise the privilege to convert to individual coverage after leaving their employment.

There may be two ways of meeting the concern expressed in the previous paragraphs. One would be an attempt to limit the insureds' right to recover some proportional amount to those situations where their conduct temporarily takes them off coverage. While the discussion of the Australian Law Reform Commission's Report refers to "temporal exclusions" (i.e. "cover may simply be suspended during the existence of specified facts or circumstances which increase the risk"), their recommendations in fact cover acts which result in a permanent change. An example might be a change in occupation. As long as the insured is still insurable, the Commission anticipated that there would still be some recovery under the contract. The second way to meet the concerns considered in the previous paragraphs would be to rely on the courts to find that the prejudice suffered by the insurer in some circumstances, where the parties assume the contract has ended and no premiums are paid, should deprive the insureds of any recovery. On balance I think this is the better approach. The issue is not likely to arise often in practice and there are no indications that the Australian courts have had difficulty applying the proportionality remedy of the Australian Act.

RECOMMENDATIONS

That the insurer's right to refuse to pay a claim based on the breach of any warranty by the insured after the contract has been made should be limited to those situations where the breach caused or contributed to the loss.

Where the insured's breach of warranty has increased the risk, the insured's recovery should be limited to the amount that the premium paid would have purchased for the risk that actually existed.

Where the insured's breach of warranty relates to a requirement after loss, the appropriate remedy for the insurer should depend on whether the requirement is of an evidentiary or substantial nature. If the requirement is evidentiary, the insurer should remain liable to pay the claim, if it can be established by other means. If the requirement is designed to minimize the loss the insurer should not be liable for any loss that could reasonably have been avoided.

That the insurer's remedies should be the same whether the increased risk has occurred because of breach of warranty, occurrence of an excluded loss or the operation of the definition of the risk.

(iv) Relief from forfeiture

As we have seen, the application of insurance warranty doctrine often leads to the forfeiture of the insured's claim under the policy. This is often a penalty which is out of proportion to the harm suffered by the insurer as a result of the insured's breach. In some circumstances, such as a breach before loss, the penalty has been justified as a necessary means to discourage undetected freeloaders. Yet this justification can easily be used to support the opposite conclusion,[113] and in any event does not apply to breaches after loss.

For some time, the courts have attempted to ameliorate the harshness of this insurance doctrine, by invoking their equitable jurisdiction to relieve against forfeiture. For some time, they relied exclusively on the particular provisions of the *Insurance Act* which allowed them to grant such relief.[114] However, in recent years, the Supreme Court of Canada[115] has reversed long standing appellate decisions and found that the courts have more general jurisdiction to grant relief under the judicature acts (including the Ontario *Courts of Justice Act*) of the various provinces.

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[113] Under the existing law many people may be paying premiums for insurance that is in fact not collectable. They are subsidizing the effectively insured.

[114] The leading case in Ontario was *Johnston v. Dominion of Canada Guarantee & Accident Ins. Co.* (1909), 17 O.L.R. 462 (C.A.).

[115] *Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance Co.*, *supra*, note 111.

The relief from forfeiture section found in Part III of the Act is worded in a slightly different way from the comparable section in the Accident and Sickness Part of the Act.[116] Nevertheless some of the general issues are the same. These issues include:

- Is relief available for breach of other contract terms besides the statutory conditions?
- Is relief available for failure to meet other contract provisions besides promissory warranties?
- Is relief available for a breach of warranty before loss?
- Is relief available for non-compliance as well as imperfect compliance?
- Is relief available for breach of a limitation period?
- Is relief available if the insured has "dirty hands" or the insurer has suffered some prejudice?
- Should relief be granted even in the case of the insured's fraud?

The Supreme Court of Canada[117] has held that s.129 of the Act allows the courts to relieve against forfeiture for breach of a contractual term other than a statutory condition. The court reached this conclusion on the basis that the section was ambiguous and it had been applied to non-statutory conditions by appellate courts for more than a decade. Section 328 in the Accident and Sickness Part of the Act is probably not ambiguous, but its narrow reading leads to an anomalous result. There is no good reason why the court's jurisdiction should be more limited in accident and sickness insurance than in other types of insurance. Moreover it is anomalous to allow the courts only to relieve against forfeiture for the breach of the statutory conditions. These conditions have already been vetted by the legislature and presumably some thought has been given to balancing the interest of the parties. In contrast, the other contractual terms have not been vetted by the legislature and no control has been placed on overreaching by the insurer. Nor can a narrow application of the section be justified on the grounds that relief should be limited to cases of the breach of evidentiary requirements after loss, since some of the statutory conditions extend beyond that.

In a more recent decision the Supreme Court of Canada[118] has held that the court's jurisdiction to relieve against forfeiture does not depend exclusively on the provisions of the

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116 Compare s.129 (general) with s.328 (accident and sickness) of the Act. There is no specific section covering life insurance, but see *Loney v. Northern Life Assurance Co. of Can.* (1989) 37 C.C.L.I. 147 (Ont. Div. Ct.) where the court was prepared to grant relief from forfeiture to a person insured under a group life insurance contract.

117 *Elance Steel Fabricating Co. v. Falk Brothers Industries Ltd.*, [1989] 2 S.C.R. 778, [1989] I.L.R. 1-2506, [1990] 1 W.W.R. 29, 39 C.C.L.I. 161 80 Sask. R. 22, 62 D.L.R. (4th) 236, 35 C.L.R. 225.

118 *Supra*, note 111.

Insurance Act, and their more general power might extend to circumstances where the insured was not technically in breach of contract. Hence, the courts power to grant relief might extend to failure to satisfy the definition of the risk or to exercise a conversion privilege in time. The court probably recognized that the difference between a promissory warranty and an exclusion from cover may be a matter of form rather than substance. Yet the consequences for the insured in either case may be just as harsh.[119] Moreover, while there must be some causal connection between the insured's conduct and the loss in the application of an exclusion from the risk, there in fact may be little or no prejudice to the insurer.

In a prior section of this report I recommended the adoption of the Australian law which eliminates the distinction between insurance warranties and the definition of the risk or exclusions. Whether a provision of the insurance contract is promissory or suspensive of coverage, the remedies of the insurer should be the same. To be consistent, this treatment should extend to the courts' power to relieve against forfeiture. This appears to be the tentative view of the Supreme Court of Canada, but it should be set out explicitly in the Act.

The question of whether relief from forfeiture is available for non-compliance as well as imperfect compliance has a metaphysical quality, unless it is a substitute test for the good faith of the insured. That is, there may be some inclination to deny relief to people who have made no attempt at all to fulfill their obligations. Yet even complete non compliance may be innocent, and forfeiture out of all proportion to the harm suffered by the insurer. Here as well, the Act should be clarified to provide that relief is available for both non compliance and imperfect compliance.

More recently (and more obscurely) the distinction between imperfect and non compliance has been equated with the difference between failure to give timely notice and proof of loss and failure to commence an action within a limitation period.[120] The courts have also referred to the distinction between abolishing a right and a remedy. None of these analogies is very helpful in explaining why the court should have the power to relieve against forfeiture in one case and not the other.[121] Both types of time limits serve much the same purpose - that is, to allow for the early investigation and verification of a claim and preservation of evidence. The potential for prejudice exists, but is not inevitable, where delay occurs in either situation. The courts should be able to inquire whether the insurer has actually suffered prejudice and whether the insured should be granted relief in both situations.

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119 See the Australian Law Reform Commission Report on Insurance Contracts, *supra*, note 103, at 132-34.

120 *Supra*, note 117.

121 The distinction has been severely criticized by some courts. See e.g. the trial judgment in *Nat. Juice Co. v. Dom. Ins. Co.*, 13 O.R. (2d) 50, 70 D.L.R. (3d) 677 at 679-80 where the Court observed:

> "It would seem to me, with due respect, that to distinguish between a remedy and right in this context is unreasonable. If one is barred from his remedy, he is thereby totally deprived of his right to compensation. He has no alternative remedy. Consequently, the insurer avoids its contractual obligation to compensate the insured."

The two remaining questions from the above list may be more difficult to answer. The case law is divided about the effect of the insured's deliberateness or lack of innocence in breaching a contract term. That is, for some courts "clean hands" on the part of the insured and no significant harm to the insurer are seen as cumulative requirements for the exercise of the court's discretion. Yet other courts adopt a test which contemplates the balancing of the insured's conduct against the harm done to the insurer. The latter test does not automatically exclude anyone from relief - unless they have been guilty of fraud. Instead it adopts a proportionality test, even if the insured's conduct has been unreasonable. This test has the advantage of preventing forfeiture where the insurer has suffered no real harm, or where the amount forfeited is out of proportion to the harm suffered by the insurer.

The other remaining question is whether there are any circumstances where the court should be authorized to relieve against forfeiture when the insured's actions have been fraudulent. The Australian Law Reform Commission thought there were and its recommendation has been adopted in the Australian Act.[122] The relief is only available for fraudulent claims and allows the court to grant relief by ordering the payment of such amount as is just and equitable in the circumstances. In exercising this authority the court is "to have regard to the need to deter fraudulent conduct in relation to insurance" and "any other relevant matter".[123] No similar authority is given to the court to relieve against the forfeiture that results from other types of fraudulent conduct. In making its recommendation the Australian Law Reform Commission noted that the present law can operate most unevenly between an insured with a number of separate policies and one with a composite policy covering numerous risks. They also observed that "... it is doubtful whether many insurers would totally reject a substantial claim merely because the insured had acted fraudulently in relation to a minor part of it."[124]

RECOMMENDATIONS

That the Act be amended to clarify that the courts may relieve against forfeiture for any breach of contract (before or after loss) by the insured and against the consequences of conduct which takes the insured outside the definition of the risk.

That the Act be amended to clarify that the court may relieve against the effect of failure to meet a limitation period.

That the Act be amended to clarify that in deciding whether to grant relief the court should balance any failure by the insured against the damage caused to the insurer.

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122 *Supra*, note 103, at 147.

123 Australian Insurance Contracts Act, 1984, s.56.

124 *Supra*, note 122.

(c) THE NEED FOR MANDATED TERMS OR JUDICIAL OR LEGISLATIVE CONTROL

Part of the reason why the legislature has intervened to impose compulsory terms for various types of insurance or to impose judicial or administrative control on their contents has been the onerous nature of several common law doctrines (such as the disclosure obligation and warranty law) and their use as technical defences by insurers. The reform of these doctrines will help to redress the balance of rights between insureds and insurers. However, these reforms, which largely relate to the appropriate remedy for the insured's default will not entirely meet the public concern about the content of insurance contracts. Moreover, existing legislation extends to the content of insurance contracts, including accident and sickness insurance contracts.

In many ways the insurance industry, including that part of the industry offering LTD coverage, is competitive and innovative. Yet there are several factors which prevent market competition alone from eliminating all unexpected or unreasonable policy terms. These factors include not only those marketing practices and purchasing habits which limit the discrimination of consumers. They also include the industry's need for standardization in order to collect the actuarial evidence necessary for sound underwriting. Moreover, as we have seen, the concept of sound underwriting itself raises difficult issues of distributive justice which have a significant public dimension. So it is not surprising that some form of public control of policy terms is of long standing.

Another part of this study examines issues of coverage in some detail. These issues include matters which have been regulated in the past, some where new regulation seems necessary and some where the industry should be left to respond to consumer demand as it sees fit. This detailed examination supports the observation that there are various policy terms now in use which may create unnecessary hurdles for persons claiming benefits. Some relate to the criteria for benefits. These include the following:

- terms that require the person insured to have had an "accident" or a "sickness", as well as consequential disability,

- terms that provide that benefits may be terminated if the person insured is not currently under medical care, even though the nature of the disability is such that no kind of medical attention is of any use,

- terms that require a person insured to submit to medical treatment which may be risky or intrusive,

- terms that define disability benefits in such a way as to prevent or discourage the person insured from undertaking retraining or further education,

- terms that exclude mental disorders not related to a physical disability.

These various policy terms which define the criteria for benefits serve much the same function as promissory warranties or underwriting criteria. They control the risk in one of three ways: by excluding some hazards altogether, by requiring the person insured to do

things which the insurer believes will minimize the risk of loss both before and after loss, and by requiring the person insured to do things which will demonstrate the bona fides of the claim.

To the extent that any of these devices (terms which define coverage, promissory warranties or underwriting criteria) control costs by excluding some hazards or persons altogether, they raise basic questions of distributive justice, i.e. why should some persons with some disabilities be compensated while others are not. Moreover, the questions may seem more acute in the case of promissory warranties and terms which define the risk since these devices control claims from persons insured, i.e. those who have paid premiums into the insurance pool. Nevertheless, while the questions may seem more acute, they are similar to those discussed in the section on the appropriateness of underwriting criteria, namely:

- Is the exclusion based on actuarial evidence of high risk?
- Even if there is evidence of higher risk, is the trade-off between selective coverage and more comprehensive coverage appropriate?
- Is the exclusion used as a rough proxy to test the authenticity of claims? That is, does it exclude a type of disability which could easily be feigned?

There is an obvious public interest in the answers to these kinds of questions. Public input in the form of judicial, legislative or administrative control would not be entirely novel. The question is whether further regulation is needed and what form it should take.

(i) Existing Forms of Regulation

Three different methods of regulating the contents of insurance (including LTD) policies are possible and all are used in various parts of the existing *Insurance Act*. They include judicial review, administrative control and standardized contracts. In some parts of the Act, they are used in combinations. For instance, the oldest form of regulation is that found in the Fire Part which combines standardized contract terms with judicial review. The later Automobile part combines standardized contract terms with administrative control.

Judicial Review

The authority of courts to review insurance contracts is not new in Ontario. Significant protection is given to insureds by three related common law doctrines, that insurance policies be interpreted (1) *contra proferentem* (2) consistent with their main purpose and (3) so as to give effect to the insured's reasonable expectations.[125] So far each doctrine has been based on a preliminary finding that the policy is ambiguous. However, the use of "reasonable expectations" by American courts indicates that the doctrine can be used to limit unfair or

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[125] See *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Ins. Co.*, *supra*, note 95.

unreasonable policy obligations and exclusions. At the same time, courts have began to expand tort liability to overcome unexpected gaps in insurance coverage.[126]

The primary difficulties with the use of these traditional doctrines are that the finding of ambiguity is haphazard, the development of independent theories of liability based on reasonable expectation (either in contract or tort) has been sporadic (and not necessarily irreversibly established), and that they are not effective outside the context of litigation.

In addition to these common law doctrines the courts have the authority under s.151 of the Fire Part of the Act to disallow stipulations which are unfair or unreasonable. This authority survives from an earlier period when variations of the Fire Statutory Conditions were allowed subject to judicial scrutiny. At that time, the Statutory Conditions provided a standard against which variations could be measured. However, since variations of the Statutory Conditions in the Fire Part are no longer permitted, the authority must now apply to other matters. Since there are no statutory standards in relation to these other matters, the earlier case law defining what is "just and reasonable" has little relevance. Moreover, the courts have been remarkably reluctant to develop standards on their own and the section has fallen into disuse. This atrophy of the court's authority under s.157 is all the more remarkable when it is compared with the court's search for alternative contract and tort doctrines to give effect to the reasonable expectations of insureds and to protect them from unexpected or arbitrary gaps in coverage.

A similar authority once existed in the Accident and Sickness Part of the Act.[127] That is, variation of the Statutory Conditions were allowed subject to judicial scrutiny. The existing Act is now more ambiguous about whether variations of the Statutory Conditions are allowed, and the court's authority to review contractual terms has been removed from the Accident and Sickness Part.

Standardized Contracts

The Accident and Sickness Part of the existing Act sets out Statutory Conditions which are deemed to be part of every individual contract of insurance. In contrast, the Life Insurance Part of the Act has no such conditions. The Statutory Conditions do not apply to group insurance contracts for reasons which are not readily apparent. One possible explanation is that their omission is based on a confusion of policy and contract, but this does not seem convincing. Alternatively, the content of the Statutory Conditions may not be considered relevant or suitable for group contracts, but this seems true for only some of the conditions.[128]

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126 *Fletcher v. M.P.I.C.*, [1990] 3 S.C.R. 191, [1990] I.L.R. 1-2672, 1 C.C.L.I. (2d) 1, 5 C.C.L.T. (2d) 1, 71 Man. R. (2d) 81, 30 M.V.R. (2d) 261, 74 D.L.R. (4th) 636, 116 N.R. 1, 44 O.A.C. 81.

127 The courts' authority to disallow variations, omissions or additions of the statutory conditions which were unjust or unreasonable was introduced in 1922, S.O. 1922, c.61, s.12, and repealed in 1969, S.O. 1968-69, c.53, s.16(1).

128 The Act does, however, authorize the Lieutenant Governor in Council to regulate group insurance contracts, see s.121, para 29.

At the same time the Act is ambiguous about the extent to which insurers can add to the Statutory Conditions. The Act provides that some of them can be omitted if the policy contains no related requirement. It also provides that any variation of some of the Conditions will be permitted only if it is more favourable to the insured or person insured.[129]

As we have explained in a previous section, at one time the Accident and Sickness Part contained express provisions allowing variations, omissions, and additions to the statutory conditions subject to a special notice requirement and vetting by the courts to determine whether the changes were just and reasonable.[130] At the same time, the courts distinguished between promissory warranties and the definition of the risk and allowed exclusions or limitations to the risk even though they covered closely related matters to those covered by the statutory conditions.[131]

Apart from the Statutory Conditions the Act contains numerous other provisions in the Accident and Sickness part which effectively control the contents of both group and individual insurance contracts. The only discernible pattern governing those things which are covered by a statutory condition and those that are covered by a more traditional legislative approach seems to be that the division follows that used in other parts of the Act. Nor is there any significant difference in the type of language used in the statutory conditions. They do not attempt to express the rights of insureds or persons insured in plain language.

The overall pattern then of existing regulation is to standardize and control some parts of all disability insurance contracts and to allow other parts to be set by insurers (with perhaps some input from insureds or their brokers). More control is imposed over individual contracts than group contracts, although the division is not obviously based on the greater bargaining strength of insureds under group contracts.

Various other Parts of the *Insurance Act* also impose standard policy terms, but they are not exhaustive. In some Parts, they can be supplemented by other terms which are subject to judicial review (Fire) or administrative control (automobile).

Administrative Controls

Two types of administrative control are now practised in Ontario, although only one is clearly set out in the *Insurance Act*. The Automobile Part requires all automobile insurance policies and endorsements to be approved by the Commissioner. This authority supplements the legislative control over policy terms found in both the Act itself and the regulations. However for some other types of insurance, particularly group policies, the Commissioner, along with other provincial Superintendents, has issued informal guidelines. The Commissioner's authority to act in this way seems to be based on his ability to initiate, if necessary, the passage of regulations or legislative amendments. The effectiveness of these

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129 Section 301.

130 *Supra*, note 127.

131 *Continental Casualty Co. v. Casey*, *supra*, note 55.

guidelines depends upon voluntary compliance and some of them have largely been ignored.[132]

One of the common themes in the annual discussions between the insurance industry and the Canadian Council of Insurance Regulators is the need to have flexible regulation in order not to discourage innovation and to respond quickly to new problems in the industry.[133] This may be one reason why the Act does not apply the Statutory Conditions to group contracts. It may also explain why the regulators (Commissioner in Ontario, Superintendent in the other provinces) prefer informal guidelines to formal amendments to the Act or the Regulations. However this form of regulation has several disadvantages, including the fact that it often does not provide insureds or persons insured with clear legal rights, the guidelines may not be well known to the insuring public and often, there is no public input in their creation.

(ii) Possible Reform

The recent history of s.157 suggests that the re-introduction of similar authority in the Accident and Sickness Part of the Act would have a limited impact. However, courts might exercise such authority more vigorously if they were given more specific directions about the relevant criteria to determine whether contract terms were unfair or unreasonable. The best way to do this may be to adopt a statutory form of the reasonable expectations doctrine. The courts should be authorized to give effect to the insured's reasonable expectations not just when the policy wording is ambiguous but whenever there is an unexpected or arbitrary gap in coverage. The adoption of this form of protection would give the courts more concrete direction as to what matters make contractual terms unfair or unreasonable. The emphasis would not be restricted to the policy wording but would be on the broader questions of what attempts have been made to communicate to the insured the limits on coverage and whether such limits are supported by valid underwriting considerations (including sound actuarial evidence). While this would be a useful incremental change in the law, it probably would have a limited effect outside the context of litigation. It would not prevent insurers from using unexpected or arbitrary exclusion or imposing burdensome obligations.

There are several ways in which the use of standard accident and sickness insurance contracts could be expanded. These include the expansion of the statutory conditions alone or with various other supplementary measures such as those found in the Fire and Automobile Parts of the Act. An alternative model is suggested by the Australian reforms which set out standard cover in the regulations but allow insurers to offer more limited cover if the insured is clearly informed of the limitations. The Australian reforms are based on the Australian Law Reform Commission's finding that consumers faced numerous unexpected limitations and obligations and that this lack of information prevented effective competition.

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[132] The Canadian Council of Insurance Regulators has apparently withdrawn its endorsement of the guidelines with the intention that the industry adopt its own rules. *Supra*, notes 90 and 94.

[133] The proceedings of the annual meeting are published as the Proceedings of the Annual Meeting of the Canadian Council of Insurance Regulators.

I believe that a combination of mandated terms plus administrative control would provide the most flexible means to balance the need to protect consumers from unexpected and arbitrary policy terms while encouraging innovation and competition.

Regardless of whether the present pattern of standardized and optional terms is continued or replaced with one of a series of standard contracts, there needs to be some new mechanism to decide which terms should be standardized and in what form. This mechanism has to be more flexible than amendments to the statute, but more public than informal guidelines issued by the Commissioner. Regulations passed by Order in Council might provide both flexibility and publicity, but there would also have to be a formal mechanism for soliciting public views. However, if the body created to solicit public views were purely advisory, I doubt that it would be effective. What is needed is a quasi-judicial commission, chaired by the Commissioner of Insurance and with a majority of members from outside the industry. The decisions of the Commission should be binding, perhaps subject to an appeal on the substance of some decisions to the Provincial Cabinet, and of course, subject to judicial review.

9. SPECIFIC ISSUES RELATING TO COVER

There are several matters which are covered in most disability contracts in a similar way, i.e. with the use of similar types of contract clauses. However, while the clauses are similar in most contracts, there can be endless variation in their wording. In addition, there are often several different clauses in the policy that have similar purposes. Some of these clauses may work in a crude and arbitrary way to accomplish their goals. Most of the different types of clauses have been in use for a significant period of time, while some are of more recent origin.

The considerable variation in contract terms causes several problems. First, it makes it difficult for consumers or their advisers to make comparisons between the contracts of various insurers, thereby lessening competition. Second, it makes it difficult for the courts to become familiar with the underlying rationale for these terms and to develop consistent theories for their application. Third, the fact that some of these terms are arbitrary substitutes or duplicates for other concerns, creates the possibility that they will be invoked as technical defences.

Some of these problems could be met by the standardization of some or all contract terms. This could be done either by regulation or by some other administrative or quasi-judicial process. Variation might be permitted subject to administrative or judicial control. In addition, there could be a general requirement that contract terms be applied in good faith, i.e. that they be applied only when they serve their underlying purpose.

However, I do not think that the Commission should restrict its recommendations to technique and process. There are some common types of clauses which have generated a considerable body of case law and critical comment. These clauses are considered in more detail below. I believe that the Commission could make some useful recommendations covering some of the substantive issues associated with these types of clauses, although some of the Commission's recommendations might be tentative ones with a final determination

(especially in matters of detail) by administrative or quasi-judicial process after input from the public and the industry.

The following list of clauses is not intended to be exhaustive, nor is it organized in a systematic way. However, there are two significant distinctions which run through this list. The first distinction is between accident and sickness insurance and the second is between group and individual contracts. Both distinctions are important because they distinguish when it is possible to guard against adverse risk selection by some other means than individual underwriting. That is, in both accident and group contracts, various clauses concerned with coverage may act as a substitute for individual underwriting. These clauses may sometimes appear in other contracts as well, but if they do they are in addition to individual underwriting and the justification for their use may be less compelling.

(a) TIME IN WHICH DISABILITY MUST OCCUR

Many accident insurance policies contain clauses that require a disability to occur at the time of an accident or within a fixed period of time of an accident.[134] Similar clauses are found in life insurance contracts with extra payment for accidental death. The time periods vary, but they all have the common purpose of trying to avoid difficult questions of causation. The notion is that the longer the period between accident and the manifestation of disability the more likelihood that the causal link between the two will be tenuous or difficult to determine. Since the person insured invariably has the onus of establishing such a connection, the time period is in part designed to reduce the juridical risk of an improper judicial finding and, perhaps in a vain hope, to avoid the cost of litigation. Of course the clause only works in favour of the insurer, since factual connection is still required within the time period. So the clause does not help the person insured avoid the cost of litigation or the juridical risk of an improper judicial finding. However, the primary concern with these clauses has not been that they only favour the insurer. Rather the concern has been that they may discourage medical treatment and, hence, may be contrary to public policy.

American courts have adopted several different approaches to these clauses. Some courts have held the clauses void as contrary to public policy. Others have adopted a "process of nature" doctrine which has allowed recovery if disability would have occurred within the time period in the normal course of events if there had been no medical intervention. Still other courts have adopted a third approach which is not to apply the time period if the cause of disability is not at issue.[135] The application of the Australian requirement that policy terms be applied in good faith might lead to the same result as this third American approach.[136]

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134 Some loss of life and dismemberment policies have time periods as short as 100 days.

135 Appleman, vol. 1C, s.612, at 128.

136 *Insurance Contract Act 1984*, s.15(1) provides:

> "If reliance by a party to a contract of insurance or a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision".

Canadian courts have not often considered such clauses, but have sometimes avoided their arbitrary application by innovative interpretation.[137]

A similar problem occurs in relation to some policies which require the disability to occur "immediately". As Appleman states "several courts have reached the ingenious result of holding that by the expression 'immediate', the insurer refers to causation, rather than time".[138] Some American courts have interpreted the phrase to mean a reasonable time and some such time as is required by the processes of nature to produce the disability. The decisions are not unanimous, however, and some courts have applied such clauses fairly strictly.

POSSIBLE REFORMS

The limited number of reported cases in Canada do not indicate that insurers apply such clauses with restraint only when the link between accident and injury is disputed. On the contrary, in both *Shirk* and *MacCulloch* the cause of injury was not in doubt. While in both cases the courts were able to find sufficient ambiguity in the policy to come to the insured's aid, this will not always be the case.

It would be preferable if Canadian Courts addressed the arbitrary application of such clauses more directly. They could be authorized to do this by a provision which held that time periods did not apply if the cause of injury was not an issue, or alternatively, by a more generalized provision requiring policy terms to be applied in good faith. However, such reform may still be too dependent on the unilateral attitude of the insurer and too litigation centered. Nor does this reform address the concern that such time periods may discourage appropriate medical treatment. This concern could be met if the "process of nature" doctrine was also adopted.

(b) PRE-EXISTING CONDITION CLAUSE

There are a variety of clauses which exclude coverage for pre-existing conditions. They contain various time limits (before and after coverage commences), knowledge requirements, or medical treatment provisions. Exceptions for pre-existing condition with or without a time limit, are designed to take the place of medical examination and individual underwriting. They may be desirable with individual contracts and certain types of group contracts. But in the case of some contracts (such as those arranged by employers) the requirement may be an additional protection for the insurer since other requirements (such as employment) already guarantee that the group will include a cross section of risks.

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137 *Shirk v. Pitts Life Ins. Co.*, [1979] I.L.R. 1-1162 (Ont. Cty. Ct.) and *Time MacCulloch v. Non-Marine Underwriters* (1989), 37 C.C.L.I. 99 (N.S.S.C.). In the latter case the court avoided a 3 month time period by finding the loss of an eye was not dismemberment.

138 *Supra*, note 135, at 170.

Such clauses are now regulated by s.311 of the Accident and Sickness Part of the Act. The section places two restrictions on such clauses: (1) they do not apply if a loss occurs or a disability begins after the contract has been in force for more than two years and (2) they do not apply to any condition that was disclosed in the application. These restrictions, however, do not apply in the case of fraud or where the disease or physical condition is excluded by name or specific description.

The existing Act does not address all of the concerns associated with the use of such clauses. These include:

- Should such clauses be permitted if there are suitable alternatives to guard against adverse risk selection?

- Should the clauses be standardized?

- Should the clauses be restricted to known pre-conditions or ones which have been medically treated within a fixed period immediately before the policy is issued?

- Should the dormancy period be shorter than the two years set out in s.311 of the Act?

Since pre-existing condition clauses are intended to guard against adverse risk selection, there is no justification for applying them to a condition that is not known to the person insured at the time the contract is made. At the same time it may be difficult to establish what the person insured actually knew, so a more objective standard may seem desirable. One common approach which meets this concern is to restrict pre-existing condition clauses to an illness known by the persons insured or for which they have received medical advice or treatment within 6 months (or some other fixed period) of the commencement of the risk. This restriction together with a maximum period of time should be made compulsory. However even with this restriction, some insureds or persons insured might still be denied benefits unexpectedly when a disease's progress was different from the medical prognosis. Moreover, if the restriction were not carefully explained, it might amount to a type of retrospective underwriting.[139]

However, if this restriction were coupled with a shorter dormancy period (i.e. provisions which provide coverage if the loss or disability begins after a period in which the pre-existing condition has been stable or dormant), the likelihood of an innocent insured being denied coverage would be reduced.

(c) Waiting or Elimination Periods

Policies usually provide that no benefits shall be recoverable until the disability has lasted a certain length of time. The purpose of such a provision is much the same as a

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[139] *See e.g. Cooper Estate v. Transamerican Occidental Life Ins. Co.* (1989), 40 C.C.L.I. 58 (N.S.T.D.).

deductible (or excess) clause in property insurance. First, it keeps the cost of insurance down by excluding many minor claims. The administration costs involved with such minor claims are high and insureds may be willing to bear the risk of such losses rather than pay the necessary premium. Second, a deductible may also help to reduce the moral hazard, since the insured person will continue to have some financial incentive to avoid the loss. This may not be very significant in disability insurance, especially in group plans where the insured employer may provide benefits during the waiting period. Third, a deductible helps to discourage fraudulent and frivolous claims (this is just a cruder expression of the notion that a deductible helps to reduce the moral hazard).

The arguments for controlling or standardizing such waiting periods are fairly weak. These terms are not likely to be difficult to understand or the subject of much judicial interpretation. There may be some disadvantage in comparing rates if insurers quote them using different waiting periods, but the problem should be obvious to insureds and their advisers and it is difficult to see why insurers would not respond to a request for a quotation using a standard period. Insurers are likely to be more responsive to such a request than a request that some other policy term be amended or redrafted.

There is, however, one aspect of these waiting periods that may create problems. In some contracts the eligibility period may begin anew after a person insured tries unsuccessfully to return to work. If short term sick leave benefits fill the gap, the person insured will not be discouraged from attempting to return to work. However, if sick leave benefits are applied cumulatively, they may be insufficient to cover the extended eligibility period. There are two possible ways to avoid such gaps in coverage. The first is to leave it to employers to expand sick leave benefits. The second is to provide that the eligibility period is only suspended when the person insured attempts unsuccessfully to return to work. The second approach has the advantage of not discouraging attempts at rehabilitation when there is no employer sick leave plan.

(d) PROOF OF LOSS AS CONDITION PRECEDENT TO PAYMENT

Some policies may limit the payment of benefits to the period after proof of loss has been received, or to a certain length of time after proof of loss is made. Such clauses have frequently been considered by American courts.[140] Some courts have found that the wording of the policy prevents the insured person from recovering any benefits for the period prior to the receipt of proof of loss, regardless of the date of the commencement of the disability. This interpretation overlooks the fact that proof of loss is intended to serve an evidentiary purpose and is particularly unfair when the delay causes the insurer no harm. Appleman characterizes this result as "absurd" and notes that, "The more serious is the condition of the insured, the more likely it is that proofs will be delayed - yet, under this approach, the insurer would have no liability until the technical act of furnishing proofs is fulfilled".[141] Many American courts

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[140] Appleman, *supra* note 135, s.615, at 149-54.

[141] *Ibid*, at 152.

avoid this result and find that benefits must be paid for the entire period of disability, although commencement of payment may be delayed until proofs are received.

In many circumstances the person insured might find relief under Canadian law through the doctrines of estoppel or waiver, or relief from forfeiture. However, this does not justify the use of such clauses to deny benefits for part of the period of disability in the first place. This possibility can and should be avoided by a more carefully drafted clause providing that benefits must be paid for the entire period of disability, although commencement of payment may be delayed until proofs are submitted.

(e) Age Limits For Commencement And Termination Of Benefits.

LTD policies may provide that coverage does not commence or terminates for a person insured who is over a specified age. The age may be a young one if it is part of the definition of dependent, and in other cases may be designed to integrate with private and public pension schemes. Assuming such age limits are permissible discrimination, the only questions may be whether the policy wording is clear and whether the integration with other pension schemes is successful.[142]

(f) Clauses Requiring The Person Insured To Seek Medical Attention Within A Specified Time After Accident Or Other Clause Requiring The Person Insured To Mitigate After Loss.

Such clauses are obviously desirable. But they should be expressly worded in such a way that they only reduce the insurer's liability by the amount that disability could have been avoided. Moreover the person insured should only have to submit to reasonable treatment. In deciding what is reasonable, regard should be had not only to the medical risks involved, but also to the religious scruples of the person insured.

(g) Termination and Replacement Policies.

Statutory Condition 6 of the Accident and Sickness Part allows an insurer to terminate the contract at any time. The Statutory Conditions do not apply to group contracts, but most group contracts contain similar provisions. At the same time, s.297 provides for the continuation of certain benefits when a group contract is terminated. The benefits are lost, however, in respect to the recurrence of disability after a period of 90 days, or such longer period as is provided in the contract, during which the group person insured was not disabled. This limit on benefits in the case of recurrence of disability is similar to the more general contract provisions requiring disability to be continuous. The justification for and need to control such clauses is considered in the next section.

Permitting insurers to terminate an individual contract of disability insurance during its term without excuse allows them to engage in propitious risk selection. This type of risk

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[142] The problems of integrating LTD insurance with other funds is considered in a later section.

selection is the opposite of adverse risk selection since it allows insurers to terminate the coverage of insureds who become a greater risk. While such conduct may reduce the costs of individual insurers, it may not be socially desirable since it may leave the person whose coverage has been terminated, uninsurable. A similar problem exists when an insurer fails to renew a term policy, and in both cases the insurer's conduct may not be anticipated by the person insured.

Concern about mid-term cancellations and the non renewal of automobile insurance has led to the passage of s.237 and s.238 in the Automobile Part of the Act. These sections authorize the Commissioner of Insurance to limit the circumstances when an insurer can decline to issue, terminate or refuse to renew any contract.[143] There are of course additional public concerns in the case of automobile insurance, particularly the desire to provide victims with recovery from compulsory motor vehicle liability insurance. Nevertheless the sections do reflect a broader public concern about underwriting criteria. The more general public interest in controlling underwriting criteria was considered in an earlier part of this report. Obviously it would make little sense to control the criteria used in the initial underwriting decision without similar controls over the decision to terminate or not to renew.

However, in the case of disability insurance the problem of termination and non-renewal may be more acute because the issue extends beyond the possibility that insurers will act on subjective, arbitrary or other grounds that bear little or no relationship to the risk. The problem is that insurers might act on highly material grounds, but at a time when in a sense the risk has begun to occur - that is when the person insured has a greater disposition to disease. Applying s.297 to individual disability insurance contracts would protect insureds when the disability arose from an accident or sickness that occurred before termination (or non-renewal). But it would not protect those insureds whose health had materially changed, but who had not yet, at the time of termination, developed the disease that causes their disability.

The termination or non-renewal of some group insurance contracts may raise similar problem to those raised by the termination or non-renewal of individual contracts. For example, the coverage of some groups (particularly smaller ones) may be affected by an adverse claims experience or the unrepresentative (skewered) composition of the group. In the case of many groups contracts, alternative coverage is readily available. But even if a replacement contract is readily available, the transition from one carrier to another may cause gaps in cover. This would be particularly true if all of the qualification clauses began to apply anew. Section 297(2) of the existing Act is designed to prevent such gaps by providing that the replacing contract shall provide continuation of coverage for those persons insured under the terminated contract. However, the section only applies to a replacing contract entered into

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[143] The sections are a good example of the confusing multi-level delegation that occurs in the Act. Section 237 contemplates regulations passed by the Lieutenant Governor in Council while s.238 allows the Commissioner to exercise much the same authority without the need for regulations.

within 31 days of termination and does not prevent the replacing policy from adopting different eligibility requirements.[144]

The appropriateness of any eligibility requirements is part of the question of appropriate underwriting criteria. Yet even if the eligibility requirements for the replacing policy are appropriate to define future members of the group (or class of the group), members of the former group (who are now excluded from coverage) may deserve special consideration. At the very least members of the former group who are now excluded should be entitled to notice and the advantage of any conversion rights. Moreover, assuming both the old and new contracts contain permissible criteria, that is, they both use underwriting criteria which is sound and fair, it would not be unreasonable to require coverage for all members who continue to meet criteria of the old group. However, the need for such a compulsory requirement may depend on the marketing or other factors which have led to the change and whether the former group persons insured have suitable alternatives. In the employment context, the change may be part of the collective bargaining process, while in other contexts, consumers may have several choices. In any event, private disability insurance is not mandatory in any context, and the coverage of the entire group could be terminated. So it may be difficult to justify a mandatory requirement that coverage be continued for any member of a group whose reliance may be no greater than members of other groups whose coverage may be ended.[145]

The requirement of continuity of coverage in the event of the replacement of a group contract now depends on the fact that the gap between the termination of one contract and its replacement with another is not too long. Section 297(2) applies only to a replacing contract entered into within thirty-one days of the termination of another contract. Beyond this period, the question of when coverage commenced under the replacing contract would be a matter of negotiation between the insured and insurer.

(h) THE DEFINITION OF DISABILITY

Disability insurance contracts commonly distinguish between two types of disability: disability to perform the person insured's usual occupation (often called occupational disability coverage) and disability to perform any occupation (often called general disability coverage). Typically benefits are paid for a limited duration when the first criteria is met, and over a longer period if the second is met. Policies typically contain a number of qualifiers to emphasize that in both circumstances the disability must be serious and long lasting. Such phrases as "permanently, continuously and wholly" or "totally and permanently" are common.

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144 The *Insurance Act*, s.297(2)(a)(ii).

145 One way to ensure universal access to LTD insurance would be to adopt a plan similar to that proposed by to the Select Committee in 1981. See *supra*, note 6.

(i) Totally And Wholly

Courts in Canada have consistently refused to interpret the words "total" or "wholly" in a literal fashion.[146] They have found that the words do not mean absolute helplessness or complete incapacity. Instead they have interpreted the words as inability to perform a substantial part of the functions associated with the person insured's usual occupation in the one case, and inability to perform any occupation for which the person insured is qualified given their education, training and experience in the other.

Many policies now define total disability by expressly adopting the flexible standard used by the courts. A typical definition of total disability for occupational disability coverage is "unable to perform the important duties of your [the person insured's] regular occupation", and for general disability coverage is "not engaged in any gainful occupation and completely unable to engage in any gainful occupation for which you [the person insured] are reasonably fitted by education, training or experience".

(ii) Permanently Disabled

Some standard policy terms such as "permanently" emphasize the duration of disability in addition to its severity. Such terms might literally require that the person insured remain disabled until death. Sometimes this is how the term "permanently" is expressly defined in the policy. The difficulty in applying such a term literally may be that such a long term prognosis may be difficult to establish. The requirement has not often been considered separately by Canadian courts, but they would likely follow American authority to find that the person insured may be permanently disabled even though they may or do recover after a period of time.[147]

It would be difficult to justify this limitation if it were interpreted literally. Qualifying or waiting periods already eliminate the claims for most temporary disabilities. In addition, the continuing requirement that the person insured be "totally" or "wholly" disabled means that the insurer's liability would end if the person insured recovered. Moreover, no Canadian Court has suggested that the use of this term means that the benefits received during a period of disability are recoverable by the insurer when later events show the disability was not permanent. However, even if Canadian courts continue to interpret "permanently" in a way that does not add any significant new dimension to the terms "totally" and "wholly", the term may still mislead insureds. Its use should only be allowed if it is defined in the policy to mean a disability of indefinite duration.

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146 The leading Canadian case is *Paul Revere Life Insurance Co. v. Sucharov*, [1983] 2 S.C.R. 541, 3 C.C.L.I. 114, [1984] I.L.R. 1-732, 5 D.L.R. (4th) 199, 26 Man. R. (2d) 161, 50 N.R. 144.

147 William F. Meyer, Life and Health Insurance Law, 1972, at 520.

(iii) Continuously Disabled

Some combinations of phrases also require the person insured to be "continuously" disabled. Some American courts have held that the word is not absolute in its meaning and means reasonable regularity of disability, or substantial and reasonable continuity.[148] However, even when the term is interpreted in this way, it may discourage rehabilitation. Temporary periods of employment or good health should not prevent the person insured from claiming to be totally disabled. Instead there should be some positive incentive to attempt rehabilitation. This can best be done by carefully drafted integration clauses which allow the person insured to keep both their disability benefits and some part of what they receive through an (approved) rehabilitation program.

In relation to all of these phrases, the absolute language found in some policies is bound to mislead some insureds, and cannot be justified as a mechanism for discouraging frivolous claims. The language ought to be brought in line with the more flexible standards that the courts actually use.

Making the policy language more consistent with the standard actually used by the courts will not, of course, make it any easier for the courts or others to determine if this standard has been met. This determination may involve a difficult factual inquiry involving complex medical evidence, speculation about potential job opportunities and difficult assessments of the claimant's qualifications.

Is it possible or desirable to try to cover some matters in advance? That is, are there some issues that keep re-occurring, such as:

- Does enrolment in education or training prevent the person insured from receiving disability benefits?
- Does the possibility of the person insured creating an occupation by employing his or her own capital prevent them from receiving benefits?
- Is the claimant expected to engage in employment that entails substantial risk to his life or remaining health?
- Is the claimant expected to engage in labour that subjects him or her to pain and suffering which persons of ordinary fortitude would be unwilling to endure?
- What if there is no work of the type that the person insured can perform? As some courts have put it, disability insurance is not intended to be unemployment insurance.

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[148] *Ibid.*

(i) CONFINEMENT CLAUSES

There are several clauses that have been used in disability insurance policies which are designed to guard against malingering. These include clauses which require the person insured to be confined to bed or to his or her residence before benefits are payable. Such confinement clauses may be reasonable if they describe when additional benefits are payable. A person insured who is bedridden will probably have additional medical and other expenses. However, clauses which deny any benefits unless the person insured is confined to bed or house are unreasonable and may be subject to arbitrary application by the insurer. They do not, of course, provide a reliable test to distinguish between genuine disability and malingering. Instead they provide such a severe limitation that the insurance coverage is largely an illusion.

Such clauses have been declared void in Ontario since 1973 by s.295 of the Accident and Sickness Part. There is no similar prohibition in the Life Part of the Act, and the Accident and Sickness Part does not apply to several types of disability insurance. Confinement clauses should be prohibited for all types of disability insurance.

(j) ATTENDANCE OF PHYSICIAN

Some disability policies require the attendance of a physician before benefits continue to be payable. Like confinement clauses, such clauses are designed to guard against malingering. They may do this in a more reliable and less intrusive way than confinement clauses, provided they are not applied arbitrarily or mechanically. According to Appleman, American courts have interpreted such clauses with three principles in mind: (1) that the law will not compel the performance of a useless act, (2) that in interpreting what amounts to reasonable attendance, the courts should take into consideration the fact that physicians are busy people and their charges are expensive, and (3) since such clause are designed to guard against malingering, if evidence of disability is clear, reinforcement by medical opinion may be unnecessary.[149] Whether Canadian courts would adopt a similar attitude is not clear. The tradition seems to be one of a more literal and mechanical application of policy terms. In particular, the more precise or specific the term is (and hence more unreasonable) the more likely the court will be to find it free of ambiguity and, hence, to apply it literally.[150] Moreover, the defences of waiver and relief from forfeiture will have limited application in this context.

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149 Appleman, *supra*, note 122, at p.270.

150 In *Froelich v. Continental Casualty Co.* (1956), 4 D.L.R. (2) 62 (Sask. C.A.), the policy provided that the insured must be "under the regular care and attendance of a legally qualified physician". The insured had been seriously disabled by a motor vehicle accident, but had discontinued medical treatment because he could get no benefit from it and could not afford it. The court decided that the condition, being clear and unambiguous, prevented the insured from recovering even though there would have been little, if any, point in the assured complying with it.

The approach of the American courts to "attendance" clauses should be adopted in Ontario. This should be done by requiring insurers to use a clause worded in terms of "reasonable" attendance by a physician or other medical personnel, with express reference to the evidentiary purpose of this requirement. Moreover the policy should provide that the clause will not apply if there is other convincing evidence of disability.

(k) SUBMISSION TO TREATMENT/"INCURABLE" DISABILITY

Apart from its evidentiary purpose, an "attendance" clause might also have a mild mitigating effect. That is, the attendance of a physician might help to eliminate the disability suffered by the person insured. However, insurers usually insert in their policies a more general term requiring the person insured to submit to medical treatment as a condition to receiving benefits. This can be done either in the definition of the risk, by requiring the person insured to be "incurably" disabled, or by an express condition requiring the person insured to submit to medical treatment in order to receive benefits.[151]

In any other contract setting, such provisions would be recognized as part of an obligation to avoid loss, similar to the obligation to mitigate damages following breach of a contract. Failure to observe such provisions would not result in the forfeiture of any claim under the contract, but would reduce recovery to those losses which could not be reasonably avoided. However, in the case of insurance contracts, the courts have occasionally treated such provisions like any other insurance condition or warranty and have refused to relieve against the resulting forfeiture. In relation to requirements after a loss has occurred, there is little, if any, justification for such an extreme penalty. Since all claims can be investigated, there is no problem of the undetected free-loader and no justification for making an example of the claimant. Yet the nature of disability insurance makes it difficult to allow for partial benefits. The person insured is either permanently disabled from performing the duties of his or her usual occupation (or alternatively, any occupation) or not.

At the same time, the difficulty of establishing the efficacy of medical treatment that has been declined, may lead some courts to accept the fact that such policy terms may lead to forfeiture. That is, this difficulty may lead some courts to deny coverage when the person insured declines reasonable treatment, without any burden on the insurer to prove that the treatment would be efficacious to prevent total disability.

Apart from the intention of insurers and the attitude of the courts, the effect of such clauses will depend on the attitude of the person insured. The person insured may be unwilling to submit to medical treatment out of ignorance, fear, an informed calculation of the risks and possible side effects, or religious belief. Which of these concerns should be considered sufficient to relieve the person insured of the requirement for medical treatment?

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[151] Whether the person insured would be under a similar obligation to avoid loss in the absence of such policy terms is unclear. If the rules applicable to other types of insurance coverage are applied by analogy, there would be very little obligation on the insured to avoid loss before the risk has occurred (before an accident has happened or before a disease has commenced). After the loss has begun to operate, there may well be an obligation to avoid loss, but in the absence of a policy term, the scope of such an obligation is uncertain.

No court is likely to require the person insured to submit to medical treatment which involves a serious risk to life. But should the insured be entitled to some autonomous judgment in other less extreme situations? There is little authority covering this question in Canada, but without further legislative guidance, the courts are likely to require the claimant to act "reasonably".[152]

(l) INTENTIONAL INJURIES, UNLAWFUL ACTIVITIES

Apart from any express term in the policy, courts would imply that insurance is intended to cover fortuitous events. Hence disability insurance would not cover injuries which are self inflicted. This implied exception is distinct from the public policy against allowing wrongdoers to profit from crime, but in many cases both doctrines may operate.[153] The precise reach of the public policy against allowing wrongdoers to profit from crime is not clear, although the thrust of modern Canadian judgments is to extend the doctrine no further than is necessary to accomplish its underlying purpose.[154]

There are various clauses in disability insurance which are intended to affirm and perhaps clarify the public policy rule and the implied exception. Often courts interpret such express terms in such a way that they simply affirm what would otherwise be the effect of the contract. That is, if there is any possibility to do so, they assume that there must be a causal link between the illegal or intentional activity and the loss,[155] that only certain crimes trigger the public policy prohibition,[156] and that intentional acts with undesired consequences (even if they would have been foreseen by a reasonable person) are not excluded.[157] However, other courts recognize that insurers are free to go beyond what the law would otherwise imply or require as a matter of public policy. Amongst other things, this has lead some courts to deny that there needs to be any casual link between the excluded activity and the loss, to distinguish between accidental means and consequences, and to deny recover even when the insured's violation of the law has been inadvertent.[158]

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152 In *McGrath v. Exelsior Life Insurance Co.* (1973), 6 Nfld & P.E.I. R. 203 (Nfld. S.C.), the claimant refused to undergo a spinal fusion to alleviate the pain from an injured back. The claimant's refusal was found to be reasonable where he, as an "unlettered man", was given conflicting medical opinion about the benefits of the operation. The court's reference to the claimant's literacy suggested the test may not be entirely objective.

153 In the case of suicide, the public policy has been modified by statute, but Canadian courts have held that this has not affected the separate implied exception as a matter of construction.

154 The scope of the public policy doctrine was considered by the Ontario Court of Appeal in *Stats. v. Mutual of Omaha Ins. Co.* (1976), 14 O.R. (2d) 233, 73 D.L.R. (3d) 324 (Ont. C.A.) affirmed [1978] 2 S.C.R. 1, 53, 87 D.L.R. (3d) 169, [1978] I.L.R. 1-1014, 72 N.R. 97.

155 See e.g. *Robinson v. L'Union St. Joseph*, [1950] 4 D.L.R. 541.

156 See e.g., *Shaw v. Gillan*, [1983] I.L.R. 1-1604, 143 D.L.R. (3d) 232 (Ont. H.C.).

157 *Supra*, note 154.

158 See MacGillivray & Parkington on Insurance Law (7th ed., 1981) at 763, Lee Stuesser, "Liability Insurance Covering Criminal Acts" (1989), I.C.I.L.R. 131.

(i) Accident

Whether a loss has been caused by an accident or intentional conduct has been a fertile source of litigation in Canada, as elsewhere. The issue arises in several different contexts, including both accident and liability insurance. The central issue is how to define intentional conduct with unforeseen consequences. At least three views have vied for acceptance by the Canadian courts.[159] The first view, which was supported by Welford, is that "... [a]n injury which is the natural and direct consequences of an act deliberately done by the assured is not caused by an accident".[160] In this view the issue is one of causation. While this view was supported by some earlier Canadian case law, it has largely fallen into disfavour.[161] The second view is expressed by Couch in the following terms: "Where the harm which befalls the insured is a reasonable and probable consequence of his volitional act, the harm, by definition, cannot be deemed accidental".[162] This view, which introduces the negligence test of reasonable foresight has been widely rejected by Canadian courts, especially in the context of liability insurance, on the grounds that it would deprive insurance of much of its efficacy.[163] The third view is that a loss is not caused by an accident where there has been a deliberate or reckless courting of the risk. The arresting image of Candler balancing on the coping of a thirteenth floor balcony is the most often cited example of this.[164] This test is the one which is adopted in most recent Canadian appellate decisions.

However, Canadian courts are divided about whether a distinction should be drawn between policies which refer to "accidental injuries" and those that refer to "injury caused by accident" (i.e. between accidental results and accidental means.) Canadian Courts have often quoted Cardozo J.'s observation that adopting the distinction "will plunge this branch of the law into a Serbonian Bog".[165] Moreover, the more recent decisions of the Supreme Court of Canada seem to have rejected the distinction.[166] Nevertheless, a recent decision by the Alberta Court of Appeal has resurrected the debate.[167]

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159 See Baer, Recent Developments in Canadian Law: Insurance Law, 17 Ottawa Law Rev. 631 at 665 (1985).

160 A. Welford, The Law Relating to accident Insurance Including Insurance Against personal Accident, Accident to Property and Liability for Accident (2nd ed, 1932).

161 Although the doctrine may not be completely dead. It appears to have been resurrected in *Sirois v. Saindon*, [1976] 1 S.C.R. 735, 56 D.L.R. (3d) 555.

162 Couch, Cyclopedia of Insurance Law, vol 10, at 35 (2nd ed. R. Anderson, 1982).

163 See the Supreme Court of Canada decision in *Mutual of Omaha Ins. Co. v. Stats supra*, note 154, where Spence J. observed "to exclude from the word 'accident' any act which involved negligence would be to exclude the very large proportions of the risks insured against" (87 D.L.R. (3d) 169 at 182).

164 *Candler v. London & Lancashire Guarantee & Accident Co. of Canada* [1963] 2 O.R. 547 [1961-65] I.L.R. 1-110.

165 *Landress v. Phoenix Mut. Life Ins. Co.*, 54 S. Ct. 461 (1934).

166 See in particular *Mutual of Omaha Insurance Co. v. Stats*, *supra*, note 154.

167 *Leontowicz v. Seaboard Life Ins. Co.* (1984), 58 A.R. 66, 6 C.C.L.I. 290 (C.A.).

Insurers may very well have concerns that go beyond or are different from those that are reflected in the public policy against profiting from crime. Insurers may also be concerned about the moral hazard. This separate concern should also be taken into consideration in determining what type of policy terms should be allowed. Nevertheless, there is a significant overlap in the type of conduct which attracts both public and insurers' concern. Part of what attracts both public condemnation and the insurers' alarm is conduct which is deliberately intended to bring about the loss. Neither public policy nor moral hazard, however, is much concerned about intentional acts with undesired consequences. This suggests that there is not much tension between these concerns in deciding how a policy term excluding intentional conduct should be interpreted. The line should be drawn in the same way as the majority of the courts have drawn it in defining accident. That is, coverage should only be excluded where the consequences of deliberate conduct are intended or recklessly courted.

The courts will on occasion have difficulty drawing the line between gross negligence and reckless behaviour. They may continue to draw it in a way that distinguishes isolated and bizarre behaviour and ignores more common situations where the element of moral hazard may be more significant. The important distinction for the courts may not be based on the concern of insurers, but on society's greater acceptance of everyday deliberate conduct involving calculated risk, but which has some social utility. Thus the moral hazard may be greater that a commercial trucker may take a calculated risk in driving an overweight vehicle over an insecure bridge[168] than that any angry combatant will threaten his neighbour with an upturned power mower.[169] Yet recovery may be allowed in the former case and not the latter. In fact there is probably little temptation to emulate the conduct of the various unsuccessful claimants in the Canadian cases. So the courts seem more concerned with punishment than deterrence. At the same time, the more common forms of temptation go unpunished even though they are more likely to be actuarially significant for insurers. This is not to suggest that society and insurers necessarily have different concerns, only that perhaps the courts are more struck by the moral repugnance of individual and unusual acts.

Given this continuing judicial uncertainty about various aspects of the meaning of accident, I recommend that the Act be amended to clarify several matters. First the distinction between accidental means and accidental consequences should be abolished. Second, the common definition that an accident includes deliberate conduct with unforeseen consequences should be adopted. Third, an exception should be made for deliberate conduct which recklessly courts the risk of obvious consequences should be included. However, in defining the type of reckless conduct which is excluded, courts should be instructed to pay more attention to the moral hazard involved, rather than the moral repugnance of isolated and unusual acts. That is, the emphasis should be on reducing the likelihood of others imitating the behaviour rather than punishing the isolated and unusual acts of individual insureds.

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168 *Trynor Construction Co. v. Can. Surely Co.*, 10 D.L.R. (3d) 482, 1 N.S.R. (2d) 599, [1970] I.L.R. 1-356. See also *Canadian Indemnity Co. v. Walkem Machinery Ltd.*, [1976] 1 S.C.R. 309, [1975] 5 W.W.R. 510, 53 D.L.R. (3d) 1, [1975] I.L.R. 1-654, 3 N.R. 523.

169 *Sirois v. Saindon*, *supra*, note 161. See also the comment by R.A. Hasson, "The Supreme Court of Canada and the Law of Insurance" (1976), 14 Osgoode Hall L.J. 769.

(ii) Illegal Acts

Those policy terms which exclude coverage while the insured person is engaged in criminal activity may reflect different concerns on the part of the public and insurers. The insurer may, in a public spirited way, be concerned to further the public policy against profiting from crime. However, the insurer may also be concerned about appropriate underwriting. There may be actuarial evidence that certain types of illegal activity create greater risks for the disability insurer. There is no reliable way to distinguish such risks in advance, so the only effective technique to recognize such risks is by an appropriately drawn definition of the risk or exclusion. Yet existing legal doctrine provides no method for the courts to ensure that the definition of the risk has been appropriately drawn. If insurers control the risk by appropriate underwriting, courts can sometimes consider whether the categories are reasonable, by determining what is material. For instance, if applicants were asked about criminal activity, their failure to disclose would only be relevant if the information was material. In determining what was material courts could inquire about whether there was any actuarial evidence to justify the insurer's position. However, there is no similar authority for the courts to limit exclusions which are too broadly drawn or not justified on the basis of the available actuarial evidence.

The present Act provides in section 118 that unless the contract otherwise provides, the contravention of any law does not, by that fact alone, render unenforceable a claim for indemnity except where the loss is intended. The section seems obviously directed at the appropriate scope of the public policy against profiting from crime rather than any underwriting concern of insurers. The section allows such underwriting concerns to be expressly covered in the policy.

Insurers should be entitled to continue to control the risk in this way subject to two general requirements discussed elsewhere in this report. First, the remedies associated with any breach of warranty or excluded activity should apply, and second, the policy term should be subject to some administrative control to ensure that it is based on sound actuarial evidence and does not operate in an arbitrary or unreasonable way. The first requirement would ensure that only losses that were caused by illegal activity would prevent all recovery while activity that increased the risk would result in an apportionment of benefits. The second requirement would control the type of criminal activity that could be covered by a policy exclusion, in particular by exempting minor or inadvertent offences.

(m) Exclusions of High Risks

There are several types of clauses in common use in disability policies which attempt to exclude high risks. Apart from the exclusion of criminal activity (which can also be supported on the grounds of public policy), they include exclusions of specific and occupational hazards and exclusions covering exposure to unnecessary danger. As we have seen, there is no existing legal doctrine which allows courts to determine whether such exclusions are appropriately drawn, i.e. whether the actuarial evidence supports such exclusions. Apart from creating some judicial or administrative mechanism to vet such clauses for their reasonableness (or actuarial soundness), there may be some general limitations which could be prescribed by legislation.

(i) Exposure to Unnecessary Danger

At one time it was common for disability insurance contracts to have a general exclusion covering exposure to unnecessary danger. The application of such a clause was obviously uncertain. The courts interpreted the clause in a narrow way to exclude ordinary negligence. The test seems to have been that the exclusion applied only when there was gross or wanton negligence with regard to a known risk. Such general exposure clauses seem no longer to be in common use. They are unreasonably vague and should be prohibited. An insurer will receive sufficient protection from the doctrines (based on both public policy and an implied term) that prevent recovery for self-inflicted injury.

(ii) Exceptions for specific hazards or for hazardous occupations

These types of clauses are more common in relation to accidental death and dismemberment contracts than general income protection plans. They come in a variety of forms, but two common categories are injuries sustained while serving as an operator or crew member of a conveyance (or aircraft), and injuries associated with (driving, riding as a passenger in, boarding or alighting from) a rental vehicle. The courts often have difficulty interpreting such clauses in any coherent way since they have no evidence of their actuarial basis and no way to judge whether they are justified and reasonable.

Some of these clauses are designed to integrate the coverage provided with other types of insurance (e.g. the common automobile or rental vehicle exclusions). However the integration may be unsuccessful without standard wording and consistent interpretation of the complementary policies. This in turn aggravates the difficulties consumers have in arranging comprehensive or adequate insurance coverage. These factors emphasize the need for standardized policy terms subject to administrative control.

10. CLAIMS

(a) SUBSTANCE

Insurers have a strategic advantage after loss in settling any claim. This advantage comes from a number of circumstances including the insurer's familiarity with the claims process, economies of scale and the financial plight or physical distress of the insured. Moreover, the vagueness of some contractual obligations, such as total disability under a general disability clause, give insurers a wide discretion in deciding what claims to meet, placing the burden and risk of litigation on the insured. Delay tends to favour insurers since they suffer few, if any adverse consequences, unless their conduct is "harsh, vindictive, reprehensible or malicious".[170]

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[170] The standard for determining when an award for punitive damages is appropriate. See *Vorvis v. I.C.B.C.*, [1989] 1 S.C.R. 1085, [1989] 4 W.W.R. 218, 36 B.C.L.R. (2d) 273, 58 D.L.R. (4th) 193, 25 C.C.E.L. 81, 42 B.L.R. 111 90 C.L.L.C. 14, 035, 94 N.R. 321.

The usual incentives for parties to settle a disputed claim, concern about the loss of good will and the potential liability for consequential damages in the event of an adverse decision, do not apply with much force to LTD insurers. Some of these strategic advantages are not unique to insurers, but others are. Of the unique advantages enjoyed by insurers, some are based on the parties' general circumstances, but some are created by the law.

The common law had two unique insurance rules which reinforced the insurer's strategic advantage. The first was the rule that insurers were not liable for consequential damage claims, so that even if they repudiated the insurance contract their liability was still limited by the face value or benefits provided by the policy.[171] The second rule was the ability of insurers to create warranties, whose breach by the insured resulted in the forfeiture of any claim under the policy. This rule allowed insurers to control the claims process by requiring insureds to perform certain tasks as a condition precedent to the insurers' liability.

There is no satisfactory explanation for the unique insurance rule that an insurer is not liable to pay consequential damages for breach of contract. The suggestion of some modern courts that to do so, would amount to re-writing the policy, is obviously misconceived.[172]

Two possible sources for the court's reluctance to recognize consequential damage claims have been suggested.[173] The more likely source is a confusion with the prime facie rule of interpretation that indirect losses are not covered in an ordinary property insurance contract. In effect the courts have confused consequential losses from breach by the insurer with consequential losses that result from an insured hazard.

In any event the rule has prevented the courts from considering whether an insured should recover for mental distress in appropriate circumstances. If this type of recovery were considered a question of remoteness,[174] it might be appropriate in some types of insurance, including LTD.

The absence of consequential damage claims has led some courts to search for other ways of controlling the insurer's conduct after loss including extra-contractual liability based on tort or fiduciary obligation, punitive damages, or special awards of costs. These and other public law controls over the insurers conduct will be considered below.

Insurance policies, including LTD policies, have traditionally contained several requirements after loss that are designed for two main purposes, one evidentiary and the other

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171 The rule has been more often treated as axiomatic than explained by modern authority.

172 See *Gannon & Associates Ltd. v. Advocate General Insurance Co. of Can.* (1984), 12 C.C.L.I. 61, 32 Man. R. (2d) 1 (Q.B.).

173 M. Baer, Annotation: *Labelle v. Guardian Ins. Co. of Canada* (1989), 38 C.C.L.I. 274. Apart from the source discussed in the text, the courts might also be reluctant to award consequential damages because they view an insurance claim as analogous to a debt claim, such as an action for the price of goods, or for wages, rent or freight.

174 After *Vorvis v. I.C.B.C.*, *supra*, note 170, it remains unclear whether the recovery of aggravated damages is a matter of remoteness.

more substantive. The evidentiary requirements are those designed to establish the insured's right to recover by requiring the early disclosure and preservation of evidence. They do not in themselves affect the amount of loss that the insured has suffered. Other requirements, however, are designed to limit further loss. They are similar in effect to the general contract obligation to minimize damage from breach of contract, although they are based on a separate fundamental notion that insurance covers fortuitous rather than deliberate losses.

Canadian courts have not often distinguished between evidentiary and substantive requirements after loss. Nor, at common law did they always appreciate that requirements after loss should be treated differently from those before loss. Instead all policy requirements were treated as warranties, requiring strict compliance as a pre-condition to the insurer's liability.

The effect of treating all requirements after loss as insurance warranties was to apply such requirements strictly and to attach consequences for breach out of proportion to the harm suffered by the insurer. This approach led to several anomalies. For instance, the formal requirements of the notice and proof of loss (time, place, etc.) are often specified more precisely than the substantive requirements. So the courts have often required strict compliance with such formalities while accepting substantial compliance with more vaguely expressed substantive requirements. Moreover, the penalty for breach was thought to be the same as for the breach of any insurance warranty - i.e. forfeiture of any claim. This type of extreme penalty has been justified for breach of warranty before loss on the grounds that it is necessary to deter the undiscovered freeloader. However, for breach after loss, where the insurer would be liable for some loss and where all claims can be investigated, forfeiture is an obvious penalty.

The harshness of the common law has been modified in three ways: first, by the imposition of mandatory statutory conditions to cover some of the requirements after loss; second, by the use of the equitable jurisdiction to relieve against forfeiture; and third, by the use of the doctrines of waiver and estoppel.

The Accident and Sickness Part of the *Insurance Act* has several statutory conditions covering the evidentiary requirements after loss. These include statutory conditions 7 and 8 covering notice and proof of loss and statutory conditions 9 and 11 covering the insurer's right to examine the person insured and the insurer's right to require proof of continuing disability. The conditions are mandatory for every contract other than a contract of group insurance, although some variation is permitted as long as it is not less favourable to the insured.

Statutory Conditions 7 and 8 covering notice and proof of loss are similar to Statutory Conditions in the Fire and Automobile Insurance Parts of the Act. As in other parts of the Act, the Accident and Sickness Part does not expressly state what are the consequences of a breach of the Statutory Conditions by either party. However, Statutory Condition 7(2) provides that failure to give notice or furnish proof of claim within the time prescribed does not invalidate the claim in limited circumstances. The inference may be that failure to observe the Statutory Conditions in other circumstances does invalidate the claim. In contrast,

Statutory Condition 7 of the Fire Part may, by inference, limit forfeiture to cases of fraud or wilfully false statements.

There are no similar statutory conditions covering notice and proof of loss in the Life Insurance Part of the Act. However s.203 requires an insurer to pay a claim within 60 days of receiving "sufficient evidence" of the listed details of a claim. The Ontario Divisional Court has held that this prevents an insurer from specifying additional or inconsistent requirements in the policy.[175]

An accurate description of the effect of the Statutory Conditions requires consideration of the courts' jurisdiction to relieve against forfeiture and the doctrines of waiver and estoppel, since these latter theories do ameliorate much of the harshness of warranty doctrine. Nevertheless, neither theory is a complete antidote and even if they were expanded, there would remain a question of whether the scope and effect of requirements after loss were appropriately drafted.

There is an obvious advantage to both parties to have early disclosure of the matters that each is intending to rely upon to support a claim. Not only does this encourage the early settlement and payment of claims, but it also allows each side to investigate, gather and preserve evidence to be used in any subsequent litigation. It probably allows such litigation to be conducted more fairly and efficiently. Without denying these considerable advantages, the question is whether the evidentiary requirements contained in the Statutory Conditions apply equally to both parties and whether the penalties for failure to comply are appropriate. In short the disclosure requirements are not reciprocal and the penalties are disproportionate. Insurers enjoy an advantage that is not shared by any other provider of goods and services or any other civil litigant.

Insurers may seek this extra protection because of a fear that they are vulnerable targets for the dishonest and unscrupulous. Yet there is no statistical evidence to indicate that they are more likely victims of fraud than other potential litigants. Moreover, in the case of LTD insurance, the disclosure obligations may be broader than is necessary to meet the legitimate needs of insurers. The notice and proof of loss are designed to establish whether the person insured meets the criteria for coverage under the policy. Not all of these facts are transitory which will become more difficult to establish or refute, the longer the delay. For instance, the cause of disability may be important for some types of accident insurance and the early investigation and preservation of evidence relating to this issue may be important to the insurer. Yet the fact of continuing or permanent disability may be established by later evidence.

I recommend that the law be amended to more closely meet the legitimate needs of insurers, while at the same time removing any disproportionate penalties for insureds. Insurers should not have to pay claims until they have received satisfactory evidence of loss. This in fact will be the case in any event, regardless of whether the law expressly says so. For

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[175] *Loney v. Northern Life Assurance Co. of Can.* (1989), 36 C.C.L.I. 147 (Ont. Div. Ct.)

instance, few sellers would satisfy a warranty claim, unless they had some evidence of the buyer's entitlement. However, once entitlement is established by later satisfactory evidence or litigation, it is inappropriate for sellers or insurers to avoid liability altogether. The appropriate and sufficient protection for either sellers or insurers is to allow them an excuse for any delay in meeting their contractual commitments. This may involve some adjustment to either the award of pre-judgment interests or costs.

Apart from the evidentiary requirements found in the Statutory Conditions, LTD policies contain several provisions which are designed to serve both evidentiary and substantive purposes. One such provision which is regarded, at least by most authorities, as largely evidentiary is the "regular care and attendance" clause. However, many of the cases involving such clauses have not been concerned with whether such care and attendance would minimize the loss. Perhaps if there had been such evidence, the courts may have treated the clauses differently. Instead the issue has been whether such care is a condition precedent to liability.

It is not necessary to characterize care and attendance clauses as exclusively evidentiary, in order to protect the insured from the consequences of breach. Once again the courts' jurisdiction to relieve against forfeiture and the doctrines of waiver and estoppel may come to the insured's aid. To ensure that this happens, section 328 should be amended to make it clear that relief from forfeiture is available for breach of other contractual requirements after loss besides those provided by the statutory conditions.

However, the insured should not have to rely on such discretionary relief. The Act should recognize that while some policy terms may look like warranties, they are in fact designed to encourage the insured to minimize loss. The Act should provide that an insurer is not liable for avoidable losses, but there should be no forfeiture of the insured's entire claim. In the case of LTD insurance, this will require the insurer to prove not just that medical attention might have been beneficial, but that it would have shortened the period of disability.

What is said here applies not only to the care and attendance clause, but also all clauses which are designed to rehabilitate the insured. Apart from the question of how such clauses, should be drafted and construed, the Act should provide that failure to observe them should result in the insured being unable to collect for any loss that might have been avoided. Of course the success of a rehabilitation program may be difficult to predict and the insurer will have the significant burden of proving what might have happened in a hypothetical situation. Moreover, this recommendation will require them to prove not only the likelihood of success but also the extent of any likely rehabilitation. This rule may be more difficult to apply than the existing law (although not as much as first appears, once the expanding jurisdiction to relieve against forfeiture is applied) but it would be a more appropriate balance of the parties' rights.

RECOMMENDATIONS

There should be no separate contractual requirement that the insured or person insured give notice and proof of loss. Instead the obligation of the insurer should be to make payment 60 days after receiving reasonably satisfactory proof of loss.

The court should have authority to vary an award of costs or interest to compensate the insurer for any delay or additional expense caused by the insured's failure to respond to the insurer's reasonable requests for information concerning the loss.

The care and attendance clause should be restricted to those cases where such attendance would mitigate the loss.

Breach of the care and attendance clause and other clauses designed to rehabilitate the insured should only deprive the insured of benefits for losses that could have been avoided.

While the law has been assiduous in recognizing and developing doctrines to control abuse by the insured during the claims process, it has been slower and less effective in controlling abuse by the insurer. In fact insurers are insulated from the normal liability for breach of contract including consequential damages for both economic loss and emotional distress. However several devices have been developed by the legislature and the courts to try to redress the balance. In Canada the courts have used the award of costs and the threat of punitive damages to control abuse by insurers. However, so far they have not developed an extra-contractual remedy based on tort or fiduciary obligation. There has been some consideration of such American theories in the context of the insurer's obligation to defend in liability insurance, but not in other contexts.

The legislature has also adopted several measures in an attempt to control abuse by insurers. These include the long standing provision requiring payments to be made within 60 days[176] and the more recent provisions for pre-judgment interest and administrative control over unfair practices, particularly "unreasonable delay or resistance to the fair adjustment and settlement of claims".[177]

It is difficult to judge how effective any of these judicial or legislative measures have been in controlling unreasonable delay or resistance to the fair adjustment and settlement of claims. In part the extent of the problem is hidden by the absence of an accessible forum for insureds to resolve disputes and a lack of public accountability for administrative action.

The insurer's obligation to pay a claim within 60 days of receiving proof of loss together with liability for pre-judgment interest does provide some incentive for insurers to handle claims promptly. However, there is no penalty for the insurer's failure to pay within 60 days and pre-judgment interest seldom covers the real cost of insureds. Nor is the court's discretion to adjust the award of costs always an adequate remedy for insureds. At best an award will compensate insureds for the real cost of litigation, but will not otherwise compensate them for delay. Moreover, while the award of punitive damages is now a theoretical possibility in a contract action, almost all trial decisions awarding such damages have been reversed on appeal.

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176 The *Insurance Act*, s.300, Stat. Cond. 10, (accident and sickness insurance) and s.203 (life insurance).

177 The *Insurance Act*, s.438.

In short, none of these techniques is an adequate alternative to the general compensatory damages rule for breach of contract. There is no justification for a unique insurance rule limiting damages to the amount payable under the policy and it ought to be abolished. This implies that failure to pay LTD benefits in a timely way should be treated as a breach of contract and not just a debt claim and the insurer should be liable for the person insured's actual damages that result from the breach.

In addition, as the Insurance Legislation Review Committee recommended,[178] there should be a civil remedy attached to the unfair and unconscionable acts and practices prohibited by the Act. While the Review Committee primarily considered this possibility in the context of misrepresentations at the time of sale, such a civil remedy may be even more effective in the case of unfair practices that amount to unreasonable delay or resistance to the fair adjustment and settlement of claims.

Whether a person insured should be able to recover for mental distress as a result of either applying general contract law to insurance or the new civil remedy for unfair practices, ought to be made clear in the Act. The general contract law relating to damages for mental distress has been left too unclear by *Vorvis v. ICBC*, although some courts continue to view the matter as a question of remoteness.[179] I recommend that this approach be expressly adopted in the Act.

RECOMMENDATIONS

That an insured or person insured should be entitled to recover all reasonably foreseeable damages for the insurer's breach of contract.

That an insured or person insured should be able to recover damages for unfair and unconscionable acts and practices, including unfair practices that amount to unreasonable delay or resistance to the fair adjustment and settlement of claims.

That an insured or person insured should be allowed to recover aggravated damages for mental distress if such damages are a reasonably foreseeable consequence of the insurer's breach.

(b) ADMINISTRATIVE CONTROLS

The Act's administrative controls over unfair acts and practices have had little public impact. The Superintendent has not attempted to issue detailed rules of unfair claims practices, and has issued few if any cease and desist orders. The Superintendent's Office does receive public complaints about claims practices, but has generally adopted the attitude that it has no authority to settle private civil disputes. Hence the Office acts largely as a mail drop or answering service for the insurers who are the subjects of complaint. In recent years the

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178 *Supra*, note 79, at 143-144.

179 *Supra*, note 169.

Canadian Council of Insurance Regulators have indicated an interest in turning these matters over to the industry, to use the CLHIA and IBC to create a self-regulating industry.[180] Such self-regulation will probably not be effective without statutory authority, appropriate industry structures and enforcement mechanisms, and public accountability. The dilatory pace of the move to industry self-regulation may suggest that the industry and superintendents have something far more informal in mind.

There are two aspects involved in the establishment of fair claims procedures: the setting of rules and standards and the adoption of appropriate enforcement measures. In relation to both aspects, it may be possible to have a significant amount of industry self-regulation. This may well relieve the government of some of the costs and public responsibility that it would otherwise incur if it were to assume the regulatory role. However, as the Legislative Review Committee observed, "In fact, self-regulation usually works best when it is accompanied by some measure of residual government authority".[181]

In relation to the first aspect, the setting of rules and standards, the problem is primarily one of providing for public participation. The industry voice will always be heard, even if the rules are formally within the exclusive responsibility of administrators. Yet public participation will be difficult in a system where the rules are established by the industry. At the same time, shared attitudes in the industry may make it difficult for their organizations to strike an appropriate balance between industry concerns and those of the insuring public.

In relation to the second aspect, that of enforcement, there may not be the same incentive for industry self-regulation as in other situations. In the case of marketing practices, for instance, all firms have an interest in promoting fair competition and trying to prevent any firm from gaining an unfair advantage from misinformation. However, the unfair claims procedures of a rival firm may not seem to give it a competitive advantage. Moreover a firm's concern about its rival's conduct may be more muted because they share the perception of the need for vigilance against fraudulent or unmeritorious claims.

For these reasons, I believe that the Superintendent's Office should continue to have primary responsibility to enforce the prohibition against unfair claims practices. This should include both the responsibility to issue more detailed rules after appropriate consultation with the industry and the public, and also responsibility to ensure compliance.

Of course the vigour of administrative enforcement depends upon both the administrators' resources and attitude. These in turn depend upon public support and government action. But public indifference and governmental neglect is not likely to be overcome by industry self-regulation alone. There should also be other more effective mechanisms to relieve the government of some of the costs and responsibilities for regulatory enforcement. These should include the creation of private civil remedies which could be pursued in an accessible forum. Such private civil actions should include not only individual

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180 *Supra*, note 132.

181 *Supra*, note 79, at 3.

claims for damages (as suggested by the Legislative Review Committee in relation to other unfair marketing practices) but also representative actions for compliance orders.

RECOMMENDATIONS

That the Superintendent's Office continue to have primary responsibility to enforce the prohibition against unfair claims practices.

That the Superintendent's Office have responsibility to issue more detailed rules following public consultation.

That the Act be amended to supplement public enforcement with private remedies in an accessible forum.

There are two further changes that could be made to the remedies available to the parties after loss that would redress the balance between them. One is based on American judicial developments and the other on the Australian statutory change to the concept of good faith. For the most part they both attempt to do the same thing, i.e. control the unfair handling of claims by insurers. The American judiciary has done this by developing extra-contractual liability based on tort or fiduciary obligation.[182] While the remedy is said to be extra-contractual to overcome the unusual contractual limit on damages, in fact the nature of the insurer's obligation or duty is largely defined in terms of the express or implied terms of the contract. The Australian statutory provision tries to do more, by not allowing the insurer to rely on the strict terms of the contract, if to do so would mean it was not acting in good faith.[183] In effect the statute prevents the insurer from invoking "technical defences" or relying on remedies which are disproportionate to the damage it has suffered.

The American and Australian developments are in a sense complementary. The Australian provision prevents the insurer from enforcing the strict terms of the policy, while the American doctrine gives the insured a remedy for the insurer's breach of the policy. If the insured's contractual remedies are expanded to allow consequential damage claims and a complementary civil remedy for the insurer's unfair claims practices, there would be no need to adopt the American doctrines. The Australian statutory provision covers much of the same ground as the Canadian courts' jurisdiction to relieve against forfeiture. However, the Australian law has several possible advantages. First it would apply to any type of provision

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182 Many of the American cases occur in the context of a liability insurer's refusal to settle within the policy limits. See the authorities referred to by Esson C.J.S.C. in *Fredrickson v. I.C.B.C.* (1990), 42 C.C.L.I. 251 including 44 Am. Jur. 2d 28 (1985) ss 1393-1403, Appleman, Insurance Law and Practice rev. ed. (1979) at 181-83 and Couch on Insurance, 2nd rev. ed. 1982, paras. 57:15. For a discussion of some of the Canadian cases considering bad faith see Mark D. Lerner "Bad Faith - The Insurer's and the Lawyer's Obligations in Insurance Law", Special Lectures of the Law Society of Upper Canada, 1987, at 167. See also *Adams v. Confederation Life Insurance Co.* (1994), 25 C.C.L.I. (2d) 180 (Alta Q.B.).

183 The Australian *Insurance Contracts Act* 1984, s.15(1) provides:

> If reliance by a party to a contract of insurance or a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision.

in the policy (including exclusions, conversion privileges, etc.) not just promissory warranties. Second, it could apply even if the insured had slightly "dirty hands". Third, it shifts the emphasis from the supposed fault of the insured and whether it should be ignored or forgiven, to the good faith of the insurer in relying on a policy term.

RECOMMENDATION

That a provision similar to s.15 of the Australian Insurance Contract Act be adopted requiring the parties to act with the utmost good faith in relying on a term of the contract.

11. DISPUTE RESOLUTION MECHANISM

LTD claimants have few alternatives to civil litigation in order to settle disputes with insurers. Private arbitration or mediation is not readily available, there is no public official charged with settling disputes and the opportunity for informal political or public pressure is limited. At best the claimant can hope that a complaint to the Superintendent's office will lead to an enquiry addressed to the insurer which may lead to a more careful review or expeditious handling of the claim. In addition in some settings, such as group LTD insurance, the claimant may be able to turn to a union or employees' organization for advice and support.

In contrast an injured worker can appeal the denial of benefits to the Workers' Compensation Appeals Tribunal, can seek the intervention of the provincial Ombudsman, and often seek other forms of help.[184] In the same way automobile accident victims denied no-fault benefits can now seek mediation and arbitration by the Ontario Insurance Commission.

This lack of an alternative accessible forum, reinforces the strategic advantage of LTD insurers after loss. In the nature of things, it is impossible to know how many meritorious claimants are denied an effective remedy because of the costs and delay associated with civil litigation. However, the matters in dispute with an LTD claim are often similar to those involved with a workers' compensation claim. Hence the number and rate of success of appeals to the Workers' Compensation Appeals Tribunal may give some indication of the number of LTD claims that might be found meritorious by an accessible and independent review. Of course it may be that public authorities act more arbitrarily or are more prone to error than private insurers. However, the rate of success by claimants in arbitration by the Ontario Insurance Commission, may indicate that private insurers can also make mistakes and deny meritorious claims.[185]

I believe that there is a need for an alternative method for resolving disputes involving LTD insurance. Such a method should be cheaper, more efficient and more accessible than

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184 Special Legal Aid clinics and informal assistance from MPPs.

185 Of course arbitration of automobile no-fault claims involves a broader range of issues than workers' compensation or LTD. Nevertheless many disputes in fact centre on the question of disability.

civil litigation, should attempt to have all compensation issues determined in one forum, should be largely funded by the insuring public, and should have access to independent (medical and rehabilitation) experts in determining questions of disability.

There are several existing dispute resolution mechanisms which could be used as a model for LTD insurance. They include the Office of the Insurance Ombudsman in England, private arbitration similar to that used in property and casualty insurance, the Workers' Compensation Appeals Tribunal and the Dispute Resolution for No-Fault benefits in the Automobile Part of the *Insurance Act.*

The following material concentrates on the last two options for two reasons. First, it seems desirable to make use of an existing institution if possible, and second, a publicly run institution will relieve the parties, especially the claimant, of the need to negotiate the manner and form of private arbitration or to accept the form dictated by the insurer in the policy.

Both the W.C.A.T. and the Dispute Resolution mechanism under the Automobile Part of the Act deal in an accessible and expeditious way with questions of eligibility for disability payments. Both institutions hear disputes which involve mixed questions of law and medical evidence. Both have access to independent medical advisors. However, there are significant differences in the jurisdiction, composition, and procedures of the two institutions.

(a) JURISDICTION

The W.C.A.T. has exclusive jurisdiction to hear appeals by claimants denied benefits by the Workers' Compensation Board. Access to the courts is limited by a privative clause which gives the Board a virtually unreviewable discretion regarding both the procedure which it follows in arriving at its decisions and the substance of the decisions themselves.[186] Moreover the Board is not subject to the *Statutory Powers Procedure Act.* However, under the Automobile Part a claimant is only bound to pursue the first stage of the Alternative Dispute Resolution mechanism - i.e. mediation. If mediation fails, the claimant may bring a proceeding in a court of competent jurisdiction or may refer the matter to an arbitrator.[187] A party to an arbitration may appeal the order of an arbitrator to the Director[188] and the Director may state a case for the opinion of the Divisional Court upon any question of law.[189]

(b) COMPOSITION

The W.C.A.T. is made up of three member panels; a representative of the employers, a representative of the workers and a neutral chair. The panels are drawn from a list of full and part time members of the tribunal appointed by the Lieutenant Governor in Council. The

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[186] The *Workers' Compensation Act*, R.S.O. 1990, c.W.11, s.75.

[187] The *Insurance Act*, s.281.

[188] *Ibid*, s.283.

[189] *Ibid.*, s.285(1).

mediation and arbitration under the Automobile Part are performed by separate individuals. The Commissioner may appoint employees of the Commission or other persons to act as mediators[190] and the Commissioner is required to establish and maintain a roster of candidates to conduct arbitrations from persons recommended by the accident advisory committee which in turn is appointed by the Minister.[191]

(c) PROCEDURES

There are significant differences in the procedures adopted to handle disputes both prior and during a hearing. A workers' compensation claim is initially heard by a hearing officer. This decision is the subject of appeals, but before a hearing of the W.C.A.T. occurs, a Case Description is prepared by the Tribunal Counsel Office and the parties are required to disclose all documents, a list of witnesses and a summary of the testimony they will give three weeks prior to the hearing. In contrast disputes under the Automobile Part are first referred to mediation. If this fails, the claimant can chose between arbitration and legal action in an appropriate court. In either case there is no decision being appealed from so, initially, the dispute may be less focused than that before the W.C.A.T. However, if mediation fails under the Automobile Part, the mediator is required to prepare and give to the parties a description of the issues that remain in dispute. So while the preliminary procedures are quite different, they both attempt to clarify the matters in dispute.

There are also significant differences in the way hearings are conducted. The Board is not subject to the *Statutory Powers Procedures Act*, and it has adopted less formal procedures than a court and most private arbitrations. The parties are often represented by non lawyers, there is no cross-examination of witnesses and tribunal counsel may appear at a hearing in order to assist the panel. On the other hand, arbitration under the Automobile Part more closely resembles other forms of private-arbitration, with the arbitrator playing a more passive role, cross-examination of witnesses, and representation by legal counsel. However, under both systems the tribunal or arbitrator can seek advice on medical and rehabilitation questions from a roster of independent advisors.

(d) INSTITUTIONAL SUPPORT

As we have seen, both systems offer the parties more institutional support than would be the case with privately arranged arbitration. In addition, the W.C.B. has worker and employer advisors to help these groups in preparing and presenting their case before the W.C.A.T. There are also several other groups in the community who assist workers in presenting their claims. Similar institutional and private resources are not available to automobile accident victims, although they may be entitled to legal aid in appropriate circumstances.

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190 *Ibid.*, s.9.

191 *Ibid*, s.7 & 8. On an experimental basis, the Insurance Commission hired part time arbitrators in several cities outside Toronto in the summer of 1995.

There would be several advantages in assigning jurisdiction to hear disputes involving private LTD insurance to the W.C.A.T. The W.C.A.T. has greater institutional support, less formal procedure and would allow injured workers to pursue both workers' compensation and private LTD in one forum. However, the tripartite nature of the W.C.A.T. panels are not necessarily appropriate for LTD claims, and LTD claims may involve different and more varied legal issues than claims for workers' compensation. At the same time mediation may provide a more appropriate mechanism to resolve disputes or clarify the outstanding issues than a hearing before an officer whose primary responsibility is the administration of a particular statutory scheme. In any event there seems to be no particular reason why claimants should not have the option to sue in a court of competent jurisdiction.

On balance I believe that the Commission should recommend that LTD claimants be allowed to chose between litigation or arbitration arranged by the Ontario Insurance Commission. The arbitration should be conducted pursuant to the same rules and procedures as that for no-fault automobile benefits (statutory accident benefits). If this recommendation is adopted the Act should be amended to consolidate in Part I of the Act all of the provisions relating to arbitration.

For the most part, there seems to be an obvious advantage in adopting the existing rules of the Automobile Part to govern arbitration of LTD claims. However, there is one matter which requires further consideration because it is not part of many private arbitration schemes. The Automobile Part requires mediation as the first step in any dispute. If mediation fails a claimant can then sue or request arbitration. These provisions raise two question. Should mediation also be required of LTD claims and should mediation be required before both litigation and arbitration? There is, of course, no requirement for mediation before litigation in the existing law. In any event even if mediation is not required, it should be made available to the parties.

RECOMMENDATIONS

That LTD claimants should be allowed to chose between litigation and arbitration arranged by the Ontario Insurance Commission.

That the arbitration should be conducted pursuant to the same rules and procedures as that for no-fault automobile benefits.

That the mediation services available for disputes involving no fault automobile benefits should also be made available for disputes involving LTD benefits.

12. MISCELLANEOUS

(a) INTEGRATION OF BENEFITS

Disabled persons can often recover compensation from more than one source. These sources may include several public compensation schemes, private insurance and tort recovery. There is no single device to coordinate or integrate recovery from these various sources. Instead there are a variety of concepts which include subrogation, contribution and

collateral benefits. The resulting law is often complex and inconsistent and made more so by the difficulty courts have of viewing the problem in the round. For instance, insurance cases tend to concentrate on the relationship between insured and insurer, treating the tort recovery as fixed, while tort cases tend to concentrate on the relationship between tortfeasor and the victim, treating the insurance recovery as fixed.

Professor Fleming has described the relationship between tort recovery and other collateral(both private and public insurance) in the following way:

> Approaches. - More often than not a person tortiously injured may have his losses partially or wholly met from outside sources other than tort recovery. Time was when an accident victim had nothing else to fall back on besides his own resources or private charity. Today's prevalence of accident and life insurance, workmen's compensation and Social Security benefits associated with the modern Welfare State usually furnish one or more alternative funds on which he may draw to repair his losses. The coexistence of such collateral sources of compensation, side by side with conventional tort liability, raises pertinent questions as to their relation one to another. Are these various funds available to the injured person cumulatively, alternatively or in any particular order of priority? Should there be any loss sharing between the collateral fund and the tortfeasor?
>
> Four possible solutions are conceivable and have variously been adopted:
>
> (1) Election. Putting the injured person to his election between recourse against the tortfeasor or accepting compensation from the collateral source;
>
> (2) Cumulation. Permitting the injured person to take and retain both damages and the collateral benefit;
>
> (3) Reimbursement. Compelling the tortfeasor to pay the full amount of the damage but crediting any excess, after making the plaintiff whole, to the collateral source;
>
> (4) Relieving the tortfeasor. Reducing the tortfeasor's overall liability by the amount of the collateral benefit received by the injured person.[192]

Since there may be more than one collateral source with different approaches for each, the number of combinations may be very large.

The problem of integrating benefits from various sources has been a matter of public concern since the early 1980's. The Council of Insurance Regulators has referred to the matter at several meetings and the Select Committee considered the problem in its 1981 Report.[193] The Select Committee accepted the recommendation of the Superintendent that Stat. Condition 4 found in section 300 be eliminated from the Act with the aim of reducing over - insurance on the part of individuals. How the elimination of Stat. Condition 4 would lead to this result is not described in the Report. The Condition attempts to restrict the total benefits recoverable for loss of time to no more than the money value of the time of the

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[192] John Fleming, "Collateral Benefits", International Encyclopedia of Comparative Law, vol. XI Torts, at 11-1.

[193] *Supra*, note 3, at 11-13.

person insured, and to limit the insurer's liability to its pro rata share. Apparently the Committee accepted the Superintendent's view that Stat. Condition 4 prevented insurers from adopting policy terms which would more effectively integrate benefits.[194] Unfortunately the Report does not describe what alternatives the Superintendent may have had in mind. The problem is not likely to be solved by leaving insurers free to adopt a variety of potentially incompatible policy terms. Nor is it likely to be solved by changes to LTD policies alone, without also considering the issues of characterization, subrogation and collateral benefits.

The task of integrating all sources of recovery may be beyond the scope of this study. However, it seems desirable to have some presumptive or mandatory rules to integrate LTD insurance with other "collateral sources". In devising such rules the underlying issues that have to be addressed (as Professor Fleming suggests) are:

(1) should the insured's remedies be cumulative even if this results in double recovery?

(2) what should be the order of priority between the various funds?

(3) should the insured be free in the first instance to claim from any source, leaving the question of priorities to be decided amongst the various funds?

(i) Double recovery

One of the basic concerns of insurance underwriters is that the moral hazard increases as insureds recover a greater percentage of their loss. In the past, this has lead to such countervailing strategies as limiting coverage to a percentage of lost income, waiting or qualification periods and prohibitions against other insurance. This underwriting concern becomes even more acute if there is a possibility of double recovery. Not only does this significantly increase the moral hazard, but it also seems to be a misuse of scarce resources.

At one time this underwriting concern had sufficient public recognition that all insurance contracts were treated as indemnity contracts. However, the difficulties in quantifying the value of human life and dismemberment led to life and accident insurance being treated as non-indemnity insurance. In more recent years, Canadian courts have paid less regard to these underwriting concerns by refusing to categorize insurance contracts by broad type and by treating the question as largely an issue of contract interpretation.[195] This approach has even led some courts to reverse the onus in favour of indemnity by invoking a doctrine similar to *contra proferentem* (i.e. that silence should be interpreted against the party who had an opportunity to speak).[196]

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194 *Ibid*, at 295.

195 *Glynn v. Scottish Union & National Insur. Co. Ltd* (1963), 40 D.L.R. (2d) 929 (Ont. C.A.) See also later cases in Baer & Rendall, Cases on the Canadian Law of Insurance (5th ed., 1995), at 88-90.

196 *Mutual Life Assur. Co. v. Tucker*, [1993] I.L.R. 1-2948, 119 N.S.R. (2d) 417, 330 A.P.R. 417, 15 C.C.L.I. (2d) 77 (N.S.C.A.)

This more flexible approach in deciding which insurance contracts are indemnity contracts has developed at the same time as the courts have tried to develop a consistent collateral benefits doctrine.[197] The result has been significant uncertainty about the integration of benefits from individual accident and sickness insurance contracts and tort recovery.

There is more certainty in the integration of accident and sickness insurance benefits and social or public benefits such as workers' compensation and Canada Pension Plan benefits, since such public benefits are usually anticipated by private insurers. The usual approach is to make the private insurance benefits excess to any available public benefits.

Insurers often also anticipate other private insurance benefits, but here the integration is often less successful because of the variety of integration clauses in use, and the likelihood that they are not completely compatible. Finally, while there is the theoretical possibility that an insured might have a contractual right to recover for disability from someone other than another private insurer, in practice such claims have usually been assimilated with tort claims.

There is no compelling reason why the insured's ability to recover more than his or her loss should depend on the nature of the collateral source, whether it is a public fund, private insurance, or other contractual or tort remedy. There ought to be a universally applied presumption against double recovery which should not be displaced simply because the policy expressly provides for one type of collateral source and not others.[198] There is probably no need to have a mandatory rule against double recovery, since insurers are in the best position to judge the significance of any increased moral hazard and whether there are alternative ways to control it. Moreover, since most public schemes are first loss insurance, allowing double recovery would not result directly in the misuse of scarce public resources. However, the existing law governing when double recovery is permitted is too complex and uncertain, encourages litigation and creates subtle distinctions between similar types of policies.

Having accepted in principle the presumption that there should be no double recovery, the question remains how to implement this presumption. This involves the questions of what should be the priority of payment between the various sources and how to facilitate prompt payment to the insured while eliminating the need for multiple law suits.

(ii) Priority

a. Public Compensation Schemes

Most private LTD policies expressly provide that the benefits are reduced by disability income payable under provincial workers' compensation and the *Canada Pension Act.*

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197 *Compare Cunningham v. Wheeler*, [1994] 1 S.C.R. 359, 20 C.C.L.T. (2d) 1, 88 B.C.L.R. (2d) 273, 23 C.C.L.I. (2d) 205 113 D.L.R. (4th) 1, 164 N.R. 81 41 B.C.A.C. 1, 66 W.A.C. 1 with Ratych v. Bloomer [1990] 1 S.C.R. 940, 3 C.C.L.T. (2d) 1, 30 C.C.E.L. 161, 69 D.L.R. (4th) 25, 107 N.R. 335 39 O.A.C. 103. See also James M. Flaherty, "A Purposeful Uniform Collateral Benefits Rule", 3 C.I.L.R. 1 (1991-92).

198 This approach would be contrary to the approach adopted in *Mutual Life Assur Co. v. Tucker*, *supra*, note 196.

Alternatively some policies expressly provide that the benefits are reduced by disability income payable under any government plan.

The integration with the most common types of government disability payments (workers' compensation and Canada pension) is well established and accepted by both private insurers and the government. There is no compelling reason to change this system of priority. However, the integration with other forms of government disability payments may be less successful, particularly if the government scheme provides for discretionary payments. In the application of other government schemes, there may be no consistent or settled policy about whether private LTD benefits should be considered a "collateral source" and if they are taken into account, there may be an obvious inconsistency in the priorities contemplated in the two schemes. Where such inconsistency occurs in the provisions adopted by private insurers, it may be reasonable to ignore both provisions, or by more subtle methods of interpretation, allow one insurer's provision to prevail over the other's. However, where a government scheme is involved, the only reasonable solution is to read down the clause in the private LTD policy so that its benefits are not reduced by disability income payable under a government plan which is treated as excess insurance.

This approach assumes that not all government schemes will be first loss insurance. Whether they should be involves issues of public policy that are beyond the scope of this study. These issues are more significant than the need for a simple uniform method of integration with private LTD insurance.

b. Tort Recovery

The integration of private LTD benefits and tort recovery has been made more difficult by the uncertainty in the law about the classification of indemnity insurance contracts and the application of the collateral benefits doctrine.[199] Moreover, where integration does occur, there is no consistent approach to the question of priority.

Assuming, as we have, that integration is desirable, the choice is between restricting the notion of collateral benefits in tort law and thereby relieving the tortfeasor of liability for insured losses, or expanding the notion of collateral benefits in tort law, while reinforcing the subrogation rights of LTD insurers.

There are a variety of reasons which support the first approach. These include:

- the greater availability of first party LTD insurance.
- the greater likelihood that integration will actually occur (since the exercise of subrogation rights by insurers is haphazard).

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[199] *Supra*, notes 195 and 197.

- the reduction of tort litigation and the removal of complex conflict of interest issues in the cases that remain.

- consistency with the treatment in the Automobile Insurance Part of the Act.[200]

- clarification of how any shortfall in tort recovery should be borne.

c. Other LTD Insurance

As between private LTD insurers, there is no compelling reasons why the insurers should not be allowed to establish whatever priority they see fit, as long as their arrangements do not prejudice insureds. However, the difficulty is in trying to determine a common intention of the insurers by looking at the separate agreements they have made with their insureds. Often no such intention can be found or can only be found by the use of artificial interpretive techniques. Some courts may in fact go to extraordinary lengths to reconcile the wording of conflicting policies, in the belief that there is no other method or legal principles to govern the rights between the insurers.[201] However, it is not necessary to go to such extraordinary lengths. The common law does provide for pro rata contribution between insurers in the case of overlapping coverage.[202] This should continue to be the presumptive rule unless it is replaced by a clear agreement between the insurers. Such an agreement might be found in identical or similar terms in separate policies with the insured, but there is no need for courts to adopt artificial rules to find an agreement in a situation where there is really only a battle of inconsistent forms.

(iii) The Rights of the Insured

Having adopted presumptive rules for the integration of various benefits, the question remains whether these rules should affect the insured's rights against the various sources. That is, should the insured be free, in the first insurance, to claim from any source, or be obliged to claim according to the priority established by the rules. The first approach was the basic common law in relation to overlapping private insurance contracts, while the latter tends to be the approach adopted in various legislative provisions covering contribution amongst insurers.

The first approach favours insureds in a number of ways. First, it allows them to avoid any dispute concerning priority that may develop among the sources. Second, it may allow them to recover through one claims procedure (including one forum for settling disputes). The alternative may involve the claimant in multiple administrative and judicial procedures (involving public and private insurers and tort litigation). Third, it reduces the chance of any

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200 See The *Insurance Act*, s.267.

201 See e.g. *St. Paul Fire & Marine Ins. Co. v. Guardian Ins. Co. of Canada*, 43 O.R. (2d) 326, 2 C.C.L.I. 275, [1983] I.L.R. 1-1711, 1 O.A.C. 109 (CA).

202 This has been the rule since Lord Mansfield's time. See *Commercial Union Assur. Co. v. Hayden*, [1977] Q.B. 804 (C.A.).

shortfall in recovery in those circumstances where the insureds may have prejudiced their claim against one of the sources.[203] At the same time the common law approach may result in the need for a claim over by the source which is required to pay in order to give effect to the priority rules.

The common law approach, however, can only work where one or more of the sources provides a complete indemnity. Given the presumptive priority rules that we have recommended this could only be a private LTD insurer. Government schemes such as workers' compensation and the Canada Pension Plan provide only limited benefits and we have recommended that the 'collateral benefits' doctrine, in tort law be abolished so that tort recovery is reduced by all insurance benefits. So a claimant could not look to a government plan or tortfeasor alone as a source of complete indemnity.

Private LTD insurers do not now avoid liability on the grounds of the availability to the insured of a tort remedy. Their position in this regard will not change with the abolition of the collateral benefits rule in tort law, although their right to claim against the tortfeasor by way of subrogation would disappear. However, LTD insurers can now successfully avoid or reduce their liability on the grounds of the availability of other private and public insurance benefits. This may require the claimant to engage in multiple claims procedures with conflicting decisions about the availability of the alternative benefits .

There are several ways to reduce the burden on claimants of having to pursue several funds. The most effective would be to impose the common law solution of allowing complete recovery from the one private LTD insurer, while giving that insurer the right to claim subrogation against the other sources. Even in a routine case, where both liability and appropriate priority were acknowledged by the relevant funds, this would impose an administrative burden on the targeted insurer. In a disputed case, the targeted insurer would have the added burden of defending the claim. Moreover, unless the targeted insurer were allowed to raise defences available to the other insurers, the claimant would receive undeserved benefits. At the same time it may be unfair to exclude the other insurers from the claims process - especially if they would be bound by the result.

A second approach would be to provide a single forum where at least all disputed claims could be pursued. It may not be feasible to integrate all claims in a single forum. However, even a more limited integration involving the most important types of common claims such as private LTD insurance and workers' compensation may be desirable.

A single forum for these types of claims could be created by allowing claims against public funds such as workers' compensation to be brought in the same forum as that which hears private insurance claims. This would not be desirable unless an alternative method for resolving disputes (other than civil litigation) were adopted. The alternative way to provide a

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[203] Whether the fact that the insured has prejudiced his or her claim against one of the sources should affect the priority rights among the sources is a separate question. This question was recently considered in *Legal & General Assur. Society Ltd v. Drake Ins. Co. Ltd.*, [1991] 2 Lloyd's Rep. 36. (C.A.).

single forum would be to allow claims against private insurers to be heard by the Workers' Compensation Appeals Tribunal.

A third more modest approach would be to try to reduce the burden of duplicate claims by an expanded use of the concepts of *res judicata* or issue estoppel. This would eliminate the need to re-litigate such complex medical - legal issues as "total disability".

Apart from eliminating or reducing the burden of duplicate claims, it would be desirable to restrict the impact of "other insurance" or integration clauses by restricting their application to other available and collectible insurance. Many insurers now expressly limit their integration clauses in this way. This does not eliminate the need for the insured to make duplicate claims, but it restricts any reduction to the amount of any actual over-compensation.

RECOMMENDATIONS

That the Act contain a presumptive rule against double recovery of disability insurance benefits for lost income regardless of source.

That no change be made in existing provisions that make such general governmental insurance schemes as workers' compensation and Canada Pension disability benefits first loss insurance.

That private LTD benefits should be reduced only if disability payments from other government insurance plans are actually received by the insured. [In effect this would not allow private insurers to claim that their coverage was excess unless such an interpretation had been actually adopted by the government plan.]

That the "collateral benefits" doctrine in tort law be abolished, so that tort recovery is reduced by the amount of all LTD insurance benefits.

That the common law rule of pro rata contribution between private LTD insurers be retained, subject to any contrary agreement between the insurers which is clearly established either by express agreement or by compatible terms in separate policies.

That in the case of overlapping insurance coverage, the common law right of an insured to recover from either insurer be retained, but that the insured's right to claim against either insurer should not affect the insurer's rights to contribution.

(b) REHABILITATION

Existing LTD insurance contracts probably discourage rehabilitation in three ways: by limiting benefits to total disability, by providing no coverage for rehabilitation (especially vocational) costs and by postponing the determination of non-occupational disability for two or three years after disability first occurs. In addition the insurance industry may not view

rehabilitation as a desirable goal in its own right, but merely as an aspect of loss containment.[204]

The first factor is partially met in some policies by provisions which allow a person insured to attempt to return to work without penalty or to keep part of the remuneration earned from rehabilitation or retaining programs. Nevertheless, fear of losing total disability benefits does discourage rehabilitation efforts.

The fact that the insurer may have no contractual obligation to pay rehabilitation costs, does not prevent it from offering to do so in an attempt to minimize loss. However, the fact that non-occupational disability is not determined until after two or three years may discourage insurers from making an immediate decision to pay rehabilitation costs. To the extent that intervention is more effective if it occurs early, this delay may not help in the rehabilitation process.

Rehabilitation may also be discouraged by the richness of some LTD plans. Of course, insurers are acutely aware of the problem of moral hazard in the economic sense. For that reason, benefits are usually limited to a percentage of prior earnings. This is usually reinforced by an integration of benefits clause. However, some plans pay benefits which are non-taxable and may be supplemented by the continuation of other fringe benefits (including pension contributions) at the employer's expense.

Given that there are factors which discourage rehabilitation, should any legal changes be recommended? There are no existing legal barriers to prevent insurers from offering coverage for partial disability and rehabilitation costs. In a competitive industry such innovations should be offered if there is a market for them. Moreover, the experience with the increased coverage for rehabilitation costs in automobile insurance may provide insurers with the relevant information to determine the advantage and costs of offering such coverage with LTD insurance.

The existence of such additional coverage would also mean that recovery for rehabilitation expenses would not be restricted to those that limit the insurer's costs. That is, payment of rehabilitation expenses would not be offered by insurers primarily as a means to limit their obligation for future disability payments. This would meet some of the Select Committee's concern that rehabilitation is primarily viewed by insurers as a cost containment aspect of claims settlement.[205]

It may be that the existing law distorts the market, by providing insurers with various technical defences which can be used against malingerers. If these are removed, there may be more incentive for insurers to look for more positive ways to get persons insured back to work. This may include changes in the coverage they provide. Nevertheless, the question remains whether coverage for rehabilitation costs should be made mandatory for LTD

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[204] See the Select Committee Report, *supra*, note 3, at 307.

[205] *Ibid.*

insurance. Such coverage is mandatory for automobile insurance but in that context, the coverage is part of a no fault scheme to replace tort liability. Alternatively, if coverage for rehabilitation costs remains optional, are there some issues that ought to be clarified by a form of standard coverage?

The existing case law tends to limit the coverage for rehabilitation costs by interpreting such coverage as extending only to medically related payments. The Regulations providing Statutory Accident benefits under the Automobile Part of the Act now include:

> (c) necessary rehabilitation, life-skills training and occupational counselling and training:
>
> (d) transportation for the person to and from necessary treatment, counselling and training sessions, including transportation for an assistant if an assistant is necessary;
>
> (g) other necessary goods and services, whether medical or non-medical in nature, for the care of the insured person.

The Regulations also remove the insurer's veto over such expenses which is often found in LTD insurance policies. Both of these aspects of the Statutory Accident Benefits Schedule (i.e. coverage for necessary non-medical expenses, and replacement of the insurer's veto with an objective standard) should be included in any LTD coverage for rehabilitation costs.

RECOMMENDATION

That the Commissioner or Superintendent approve a standard form of optional rehabilitation benefits, including coverage for necessary non-medical expenses modelled on those found in the regulations covering Automobile Statutory Accident (or No-Fault) Benefits.

(c) CONFIDENTIALITY OF MEDICAL RECORDS

In its 1991 report, the Insurance Legislation Review Committee summarized the widespread use of private medical and personal information by the life and health insurance industry, the numerous recommendations for tighter control over the use of such information and international initiatives to regulate its use by private industry.[206] While the Committee noted the industry guidelines developed by the Canadian Life and Health Insurance Association (CLHIA), they also observed that neither the CLHIA nor government regulators were actively monitoring compliance with the CLHIA guidelines and that in any event, the CLHIA has no regulatory powers as an organization to ensure compliance.[207] The Committee went on to make a number of recommendations to meet the following needs:

- to protect the confidentiality of personal information;

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206 *Supra*, note 79, at 178-81.

207 *Ibid*, at 180.

- to establish fair information practices for the insurance industry;
- to ensure compliance with the regulations; and
- to settle disputes between individuals and insurance companies and organizations.[208]

The proposed fair information practices covered the following matters:

- the adoption of reasonable procedures to ensure the accuracy, completeness and timeliness of information;
- prior notification to applicants of the type, collection techniques and sources of information to be pursued, the use and disclosure of information to be made and the right of the applicant of access to, and correction of information;
- access by individuals to information held by insurance companies, intermediaries and organizations and the right to correct, amend and delete personal information;
- an obligation on insurance companies to provide reasons in writing for adverse underwriting decisions and supporting information;
- prohibition against the disclosure of information except with the consent of the individual concerned or by the authority of law; and
- prohibition against insurance companies providing personal information relating to accident and health claims made under a group insurance policy issued by the company, to the employer-policyholder, except in statistical form, without identifying employees.[209]

For the most part, the Committee recommended that these practices should be implemented by regulation and enforcement monitored by the Superintendent. These recommendations are similar to the voluntary CLHIA Guidelines, the N.A.I.C. *Model Act* (the NAIC *Insurance Information and Privacy Protection Model Act*) which has been adopted in 13 states, and follow the recommendations made by a number of other groups.

It is not necessary to consider all of the recommendations of the Legislative Review Committee in detail here. They cover matters which have been considered by a number of other bodies and a general consensus (of industry and regulators) has developed in favour of them. For the reasons given by the Review Committee, they ought to be adopted in Ontario by regulation.

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[208] *Ibid*, at 181-87.

[209] *Ibid*, at 186-89.

There are, however, two recommendations of the Committee which are more closely linked with issues considered in this report, and for that reason they are considered in more detail here. The first is the recommendation that insurers be required to disclose the reasons for adverse underwriting decisions, and the second is the recommendation that insurers be prohibited from sharing with employers personal information relating to accident and health claims.

The Review Committee considered two issues in relation to adverse underwriting decisions: (1) whether there should be an automatic obligation to provide reasons for an adverse underwriting decision and (2) whether insurers should be prohibited from basing an underwriting decision on a previous adverse underwriting decision alone. The discussion of both of these issues was based on the assumption that insurers would continue to be allowed to use whatever underwriting criteria they chose, and the limited goal of any regulation would be to promote the accuracy of the information used by insurers. On this basis, the Committee recommended automatic disclosure, rather than the involvement of a government official in determining when reasons, and information upon which adverse underwriting decisions are based, should be disclosed.[210] The Committee also thought that regulation to prevent insurers from relying on prior adverse underwriting decisions alone would not be particularly effective. Instead they believed that the most effective discipline in respect of the use of previous adverse underwriting decisions was to require insurers to provide reasons for current adverse underwriting decisions.

I have discussed elsewhere[211] whether the Commission should recommend some form of public control over the underwriting criteria use by LTD insurers similar to the control that the Insurance Commissioner has over the underwriting criteria used in automobile insurance.[212] If such controls were adopted, the type of personal information that would be relevant for any underwriting decision would be limited. In order to prevent the approved underwriting criteria from being subverted, insurers should be expressly prohibited from collecting and using any other personal information. However, the question of the relevancy or weight to be attached to any particular bit of information may not be an easy one. Crude stereotyping or arbitrary and subjective judgments should be discouraged, but reasonably reliable proxies for approved underwriting criteria probably should be allowed. So while I agree with the Review Committee that disclosure should be automatic and that there is no need for the involvement of a government official in deciding when reasons and information should be disclosed, there is a need for public involvement in deciding what type of information can be collected and used in the first place.

In the same way, the other specific question considered by the Review Committee may require a different answer in the context of a more general public control of underwriting criteria. This specific question was whether insurers should be prohibited from making current underwriting decisions on the basis of prior adverse underwriting decisions alone.

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210 *Ibid*, at 190.

211 See Part 6 of the text, *supra*, at 19.

212 See the *Insurance Act*, s.238.

The Review Committee thought that such prohibition would not likely be particularly effective in achieving the objective of fair consideration of insurance applications. But their reasoning was based on the difficulty of enforcement "particularly in situations where the insurance company has not had to file a list of grounds that it proposes to use for adverse underwriting decisions".[213] The Review Committee went on to observe, "When a list is filed, it will certainly impose some constraint on adverse underwriting decisions".[214]

Apart from the efficacy of such a prohibition, there is also the question of the cost of requiring verification by insurers of the information used in the prior underwriting decisions. The issue is only one of many issues concerning the development of suitable underwriting criteria that should be left to the proposed Insurance Commission.

The Review Committee's recommendation that insurers be prohibited from sharing with employers personal information relating to accident and health claims was adopted from the Krever Report (the Report of the Commission of Inquiry into the Confidentiality of Health Information in Ontario). The recommendation was adopted with the comment, "This would make it more difficult for the employer to make individual employment decisions on the basis of the utilization of accident and sickness benefits or particular personal health information".[215]

The recommendation refers to "personal information relating to accident and health claims", so it does not appear to prohibit the sharing of information at the time of the application for employment and group insurance coverage, although this may be covered under other recommendations.

The adoption of this recommendation may have little impact on the way long term disability claims are now handled. There may be some claims where the person insured deals directly with the insurer while attempting to keep details of his or her medical condition from the employer. Even in such situations, the employer may be legitimately entitled to some general prognosis of the employee's illness. However, in many situations an employee may naturally turn to a more experienced or informed official of the employer for help in presenting the claim. While such officials may have different interests from the person they are advising, their advice and help may be useful. In any event, their participation should only be discouraged (or prohibited) if there is some other advisor or advocate (such as a union representative) available.

The recommendation of the Review Committee, does of course, allow persons insured to act in what they see as their own best interest. They are free to provide whatever personal information they choose to their employer. The prohibition against sharing information is directed only against insurers. So in the case of LTD claims, this prohibition may have

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213 *Supra*, note 79, at 190.

214 *Ibid.*

215 *Ibid*, at 191.

limited impact in preventing employers from using personal health information to make employment decisions.

(d) Responsibility for Administration of Group Plans

In an earlier section [216] we considered the question of whether a group person insured should be held responsible for any failure by the insured (an employer or other organizer of the group) to communicate material facts to the insurer at the time of the group person insured's application for coverage. That question is just one particular aspect of a broader question of whether the insurer should be responsible for the acts of the insured in administering the plan.[217]

Even in the best run plan, an employer or other organizer of the group may make errors or omissions in processing applications and claims or in explaining available coverage. Such errors may subject the employer or other organizer of the group to liability in equity, contract, or tort. However, whether such non-professional intermediaries will be held to the same high standard of care as traditional insurance intermediaries is still a matter of doubt.[218] In any event, they may not always have sufficient resources to compensate the person insured.

The responsibility of the insurer for the acts and defaults of the insured has been considered in a number of recent Canadian judgments.[219] These decisions have considered two American doctrines. One is based on the *Boseman*[220] decision which held that an employer acts for itself or its employees in obtaining the policy, taking applications, processing payroll deductions and making other administrative decisions. The second is based on the *Elfstrom*[221] decision which distinguished between an employer and an insurer administered plan. The *Boseman* decision is based on who benefits from the activities of the intermediary while the *Elfstrom* decision is based on the notion of direction and control. The Canadian courts prefer the *Elfstrom* approach although they focus on specific functions performed by the employer rather than on broad categories. In effect they have held that the employer will be considered the insurer's agent only with respect to those functions which the employer performs with the insurer's consent. This suggests that the insurer may not be responsible for some mistakes of the employer.[222] The difficulty with this approach is that it

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216 See Part III. 2 of the text, *supra*, at 22.

217 See Richard B. Hayles, Group Insurance: Agency Status of the Master Policyholder (1991-92), 3 C.I.L.R. 305.

218 There is a growing body of case law concerning the potential liability of non-traditional insurance intermediaries including banks, car dealers, employers, etc. See Baer & Rendall, Cases on the Canadian Law of Insurance (5th ed., 1995), at 476-85.

219 The cases are considered in Hayles, *supra*, note 217.

220 *Boseman v. Connecticut General Life Insurance Co.*, 301 U.S. 196, 57 S. Ct. 686 (1937).

221 *Elfstrom v. New York Life Insurance Co.* 432 P. 2d 731 (Calf. C.A., 1967).

222 Although Hayles reports:

seems to ignore the expectations of the persons insured. There is no way that they can determine if the employer is performing delegated tasks and, even if they were warned, no practical way they could supervise the employer's performance.

From the point of view of the person insured, the existing law may be haphazard. The loss arising from an insured's mistake may or may not be borne by the individual person insured even though he or she is entirely innocent.

The law should be clarified so that the risk of such errors is borne by all members of the group. This distribution of the risk is more likely to occur if the insurer is responsible for the insured's (or employer's) errors. The costs of such errors will be reflected in the premiums charged to the entire group. At the same time, the insurer can minimize such costs through its influence on the administrative procedures adopted by the insured.

RECOMMENDATIONS

That the insurer be held liable for all errors or omissions made by the insured in administering a group plan.

That the insured be deemed to be the agent of the insurer for all purposes in the administration of a group plan.

(e) EMPLOYER PROVIDED LTD

The Insurance Legislation Review Committee reported[223] that may employers, particularly the larger ones, have chosen to provide many contingent employee benefits including LTD on a self-insured basis rather than through group insurance. In such self-insured plans, an insurer may play a role either as administrator of the plan, on a fee for service basis, or as the provider of stop loss coverage to the employer.

The Committee reported that even though such self-insured plans constituted the writing of insurance, in fact neither the Commissioner nor the Superintendent had attempted to apply the provisions of the act in these circumstances. The Committee recommended that such plans should be exempted from the definition of "insurance" in the *Insurance Act.*

"Although the decisions of the [Canadian] Courts ... seem to leave open the possibility of situations in which the insurer will not be held accountable for the error of a group insurance intermediary, one can safely predict that no court will exonerate an insurer in an actual case. This is because of the harsh effect such a decision would have on the employee - beneficiary".

Mr. Hayles also bases his observation on his assessment that in the Canadian cases the evidentiary basis for the conclusion that the relevant administrative task has been delegated to the insured by the insurer is sometimes tenuous. *Supra*, note 217 at 313.

223 *Supra*, note 79, at 10.

In making this recommendation, the Committee may have had the Superintendent's responsibility for prudential regulation in mind. However, the *Insurance Act* does more than prescribe the regulatory authority of the Superintendent and Commissioner. It also affects the civil rights of the parties to an insurance contract. The parties' rights do not depend on the recognition or active concern of either the Superintendent or the Commissioner.

The effect of exempting self-insured plans from the definition of "insurance" in the *Insurance Act*, would mean that such plans would be governed by the common law of insurance. There is no justification for applying such different and unsatisfactory rules to employer provided benefits, including LTD. However, this is probably not what the Review Committee had in mind. They recognized that employees might not always be well protected under self-administered benefit plans. However, they concluded " ... we believe that the concern for the position of employees is better addressed through employment standards legislation rather than insurance legislation."[224] No explanation is given for this position. There may be some justification for the separate regulatory supervision of self-insured plans. However, the legal rights of plan members should be the same whether the plan is provided by the employer or a third party insurer. These rights should continue to be governed by the *Insurance Act*.

RECOMMENDATION

That the rights of a person insured under an employer self-insured plan should continue to be governed by the Insurance Act

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[224] *Ibid*, at 11.

SUMMARY OF RECOMMENDATIONS

The authors makes the following recommendations:

THE NATURE OF EXISTING REGULATION

1. That the Commission undertake a study of the law of insurance with a view to the reform and restatement of basic concepts common to all types of insurance and greater harmonization of the existing parts of the Insurance Act. (at 3)

2. That all disability insurance whether undertaken as part of a life insurance contract or not be subject to a single set of statutory rules. (at 4)

3. That more careful consideration be given to which matters concerning the regulation of disability insurance should be included in the Insurance Act and which matters should be left to regulation by the Commissioner of Insurance. (at 4)

4. That the Commissioner's rule making authority be made subject to more formal and open procedures allowing input from groups representing the insuring public. (at 5)

ISSUES RELATING TO THE APPLICATION FOR COVERAGE

THE INSURED'S DUTY TO DISCLOSURE MATERIAL FACTS

5. That the Act expressly provide that the insured and person insured's duty to disclose be confined to answering all questions asked of them in the application process to the best of their knowledge and belief. (at 13)

6. That the Act expressly provide that the duty to disclose is met if it would have been reasonable for a person in the applicant's position to have understood a question to have the meaning that the applicant apparently understood it to have. (at 13)

7. That the Act expressly provide that the insurer is deemed to have waived compliance with the duty to disclose in relation to matters where the answers are obviously incomplete or irrelevant. (at 13)

8. That the Act provide that the insurer's remedy for the insured or person insured's failure to meet their duty to disclose should be an adjustment of benefits such that the person insured receives a proportionate amount based on the ratio of the premium received and the premium that would have been charged if the duty of disclosure had been complied with. (at 13)

9. That the Act should continue to provide that where a contract has been in effect for two years, a failure to disclose or a misrepresentation of fact does not, in the absence of fraud, render the contract voidable. (at 13)

MISREPRESENTATION OR CONCEALMENT BY THE INSURED (EMPLOYER, ETC.)

10. That the Act be amended to provide that a (group) person insured's claim will not be affected by the misrepresentation or concealment of the insured unless the group person insured has participated in misleading the insurer. (at 14)

CHANGE MATERIAL TO THE RISK

11. That an insurer may periodically require the insured or person insured to disclose any material change in the risk after the contract is made. (at 16)

12. That an insured or person insured breaches this duty only if they knowingly and fraudulently fail to disclose a material change. (at 16)

13. That the insurer's remedy for the insured or person insured's breach of this duty should be an adjustment of the benefits such that the person insured receives a proportionate amount based on the ratio of the premium received and the premium that would have been charged if the duty had been complied with. (at 17)

RETROSPECTIVE UNDERWRITING: THE PROBLEM OF PHANTOM INSURANCE

14. That the Act should be amended to provide that an insured administering a group insurance plan should be deemed to be the agent of the insurer for the purpose of determining when coverage becomes effective. (at 18)

15. That the Act should be amended to provide that an insurer must make a final underwriting decision within a reasonable length of time. (at 18)

16. That the Act should be amended to provide that (interim) certificates of insurance must clearly state when coverage becomes effective and that no coverage be denied retrospectively. (at 18)

UNDERWRITING CRITERIA

17. That there be no general prohibition against individual rating of person insured in group disability policies, but that the Commissioner continue to explore with the industry alternative ways to protect against adverse risk selection. (at 21)

18. That the authority of the Superintendent or Commissioner to disallow discriminatory rates be strengthened by clarifying the factors which should and should not be taken into account, and by providing for a more formal public hearing. (at 22)

19. That additional public representatives be appointed to assist the Commissioner in making his or her decision. (at 22)

20. That an insurer be required to notify the person insured (or potential person insured) of any adverse underwriting decision and the reasons for it. (at 23)

21. That a mechanism be adopted to enable an applicant or person insured to correct any information acquired by the insurer. (at 23)

22. Health screening for the purpose of group disability insurance underwriting should not be allowed to evade any controls on health screening for the purpose of employment. (at 23)

MARKETING PRACTICES

INTEGRITY IN MARKETING

23. That unfair or deceptive acts or practices continue to be defined by way of a non-exhaustive list. (at 25)

24. That some of the illustrations of an unfair practice found in the Business Practices Act might be incorporated as part of the list of unfair practices in the Insurance Act as well. (at 25)

25. That the Superintendent or Commissioner continue to have the initial authority to determine whether conduct is unfair or deceptive. (at 25)

26. That the Superintendent or Commissioner consult with other consumer groups as well as the industry in developing guidelines or prior rulings about what conduct is unfair or deceptive. (at 26)

27. That the Act be amended to give the Superintendent or Commissioner additional enforcement powers including the right to seek assurances of voluntary compliance, the right initiate substitute actions on behalf of consumers and the right to order restitution. (at 26)

28. That the Act be amended to allow consumers and consumer groups standing to seek an order for compliance. (at 26)

29. That the insured should be allowed to claim damages for any loss resulting from an unfair act or practice by the insurer. (at 28)

30. That the terms of the insurance contract should include all representations by the insurer which were reasonably relied upon by the insured. (at 28)

31. That the insured should be allowed to claim damages for any loss resulting from reliance on any misrepresentation of the insurer. (at 28)

MASS MARKETING

32. That the Superintendent or Commissioner be given express authority to regulate the mass marketing of insurance. (at 30)

33. That the Superintendent's or Commissioner's rule making and enforcement power be subject to the general recommendations found in the prior section. (at 30)

GROUP OR TARGETED MARKETING

34. That the Superintendent or Commissioner be granted the authority to establish affinity rules for the group marketing of insurance. (at 31)

35. That the Superintendent or Commissioner be granted authority to establish whether any rate discrimination offered to members of a group is justifiable and fair. (at 31)

ISSUES RELATING TO COVERAGE

MODIFYING EXISTING WARRANTY LAW

36. That the insurer's right to refuse to pay a claim based on the breach of any warranty by the insured after the contract has been made should be limited to those situations where the breach caused or contributed to the loss. (at 39)

37. Where the insured's breach of warranty has increased the risk, the insured's recovery should be limited to the amount that the premium paid would have purchased for the risk that actually existed. (at 39)

38. Where the insured's breach of warranty relates to a requirement after loss, the appropriate remedy for the insurer should depend on whether the requirement is of an evidentiary or substantial nature. If the requirement is evidentiary, the insurer should remain liable to pay the claim, if it can be established by other means. If the requirement is designed to minimize the loss the insurer should not be liable for any loss that could reasonably have been avoided. (at 39)

39. That the insurer's remedies should be the same whether the increased risk has occurred because of breach of warranty, occurrence of an excluded loss or the operation of the definition of the risk. (at 39)

40. That the Act be amended to clarify that the courts may relieve against forfeiture for any breach of contract (before or after loss) by the insured and against the consequences of conduct which takes the insured outside the definition of the risk. (at 42)

41. That the Act be amended to clarify that the court may relieve against the effect of failure to meet a limitation period. (at 42)

42. That the Act be amended to clarify that in deciding whether to grant relief the court should balance any failure by the insured against the damage caused to the insurer. (at 40)

CLAIMS

SUBSTANCE

43. There should be no separate contractual requirement that the insured or person insured give notice and proof of loss. Instead the obligation of the insurer should be to make payment 60 days after receiving reasonably satisfactory proof of loss. (at 68)

44. The court should have authority to vary an award of costs or interest to compensate the insurer for any delay or additional expense caused by the insured's failure to respond to the insurer's reasonable requests for information concerning the loss. (at 68)

45. The care and attendance clause should be restricted to those cases where such attendance would mitigate the loss. (at 68)

46. Breach of the care and attendance clause and other clauses designed to rehabilitate the insured should only deprive the insured of benefits for losses that could have been avoided. (at 68)

47. That an insured or person insured should be entitled to recover all reasonably foreseeable damages for the insurer's breach of contract. (at 70)

48. That an insured or person insured should be able to recover damages for unfair and unconscionable acts and practices, including unfair practices that amount to unreasonable delay or resistance to the fair adjustment and settlement of claims. (at 70)

49. That an insured or person insured should be allowed to recover aggravated damages for mental distress if such damages are a reasonably foreseeable consequence of the insurer's breach. (at 70)

ADMINISTRATIVE CONTROLS

50. That the Superintendent's Office continue to have primary responsibility to enforce the prohibition against unfair claims practices. (at 72)

51. That the Superintendent's Office have responsibility to issue more detailed rules following public consultation. (at 72)

52. That the Act be amended to supplement public enforcement with private remedies in an accessible forum. (at 72)

53. That a provision similar to s.15 of the Australian Insurance Contract Act be adopted requiring the parties to act with the utmost good faith in relying on a term of the contract. (at 73)

DISPUTE RESOLUTION MECHANISM

INSTITUTIONAL SUPPORT

54. That LTD claimants should be allowed to chose between litigation and arbitration arranged by the Ontario Insurance Commission. (at 76)

55. That the arbitration should be conducted pursuant to the same rules and procedures as that for no-fault automobile benefits. (at 76)

56. That the mediation services available for disputes involving no fault automobile benefits should also be made available for disputes involving LTD benefits. (at 76)

MISCELLANEOUS

INTEGRATION OF BENEFITS

57. That the Act contain a presumptive rule against double recovery of disability insurance benefits for lost income regardless of source. (at 83)

58. That no change be made in existing provisions that make such general governmental insurance schemes as workers' compensation and Canada Pension disability benefits first loss insurance. (at 83)

59. That private LTD benefits should be reduced only if disability payments from other government insurance plans are actually received by the insured. [In effect this would not allow private insurers to claim that their coverage was excess unless such an interpretation had been actually adopted by the government plan.] (at 83)

60. That the "collateral benefits" doctrine in tort law be abolished, so that tort recovery is reduced by the amount of all LTD insurance benefits. (at 83)

61. That the common law rule of pro rata contribution between private LTD insurers be retained, subject to any contrary agreement between the insurers which is clearly established either by express agreement or by compatible terms in separate policies. (at 83)

62. That in the case of overlapping insurance coverage, the common law right of an insured to recover from either insurer be retained, but that the insured's right to claim against either insurer should not affect the insurer's rights to contribution. (at 83)

REHABILITATION

63. That the Commissioner or Superintendent approve a standard form of optional rehabilitation benefits, including coverage for necessary non-medical expenses modeled on those found in the regulations covering Automobile Statutory Accident (or No-Fault) Benefits. (at 85)

RESPONSIBILITY FOR ADMINISTRATION OF GROUP PLANS

64. That the insurer be held liable for all errors or omissions made by the insured in administering a group plan. (at 90)

65. That the insured be deemed to be the agent of the insurer for all purposes in the administration of a group plan. (at 90)

EMPLOYER PROVIDED LTD

66. That the rights of a person insured under an employer self-insured plan should continue to be governed by the *Insurance Act*. (at 91)

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