CITATION: Allstate Insurance Company Of Canada v. Klimitz, 2014 ONSC 7108
DIVISIONAL COURT FILE NO.: 212/13
DATE: 20141212

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

MARROCCO A.C.J., SPENCE and C. HORKINS JJ.

BETWEEN:	)	
	)	
ALLSTATE INSURANCE COMPANY OF CANADA	)	*Todd J. McCarthy*, for the Applicant
	)	
Applicant	)	
	)	
– and –	)	
	)	
EDNA KLIMITZ and THE FINANCIAL SERVICES COMMISSION OF ONTARIO	)	*Jillian Van Allen,* for the Respondent Klimitz
	)	
Respondents	)	*Robert Conway*, for the Respondent The Financial Services Commission of Ontario
	)	
	)	**HEARD at Toronto:** December 4 2014

C. HORKINS J.

INTRODUCTION

[1] The applicant Allstate Insurance Company of Canada ("Allstate") seeks judicial review of the decision of the Director's Delegate Lawrence Blackman dated March 21, 2013 ("the Decision").

[2] The Decision rescinded an Arbitrator's order that the respondent Edna Klimitz was precluded from proceeding to arbitration because she filed her Application for Mediation more than two years after Allstate denied her non-earner benefit.

[3] Section 281.1 of the *Insurance Act,* R.S.O. 1990, c. I.8 and s. 51(1) of the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996,* Ontario Regulation 403/96 as amended ("the *Schedule*") state that the mediation "shall be commenced within two years after the insurer's refusal to pay" the claim.

[4] Allstate argues that the Decision is unreasonable because it set aside the legally correct decision of the Arbitrator.

THE FACTS

[5] The relevant facts are as follows. On November 7, 2003, Edna Klimitz was injured when she was struck by a vehicle while crossing an intersection on a green light. At the time of the accident, Ms. Klimitz was 68 years old.

[6] Ms. Klimitz took the necessary steps to apply for statutory accident benefits. Her doctor submitted a Disability Certificate (OCF-3) on her behalf and on January 7, 2004, Ms. Klimitz submitted her Application for Accident Benefits to Allstate.

[7] On January 14 and 22, 2004, Allstate sent Explanation of Benefits Payable forms acknowledging Ms. Klimitz's potential eligibility for the non-earner benefit and advising her of the 26 week waiting period.

[8] At the request of Allstate, Ms. Klimitz was examined by Dr. Edward English, an orthopaedic surgeon and Dr. Garry Moddel, a neurologist.

[9] Allstate was required to provide Ms. Klimitz with copies of these reports within five business days after receiving them from the doctors. This is mandated by s. 37(5) of the *Schedule* that states as follows:

> (5) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination with respect to the specified benefit to the insured person and to the health practitioner who completed the disability certificate.

[10] On May 31, 2004, Allstate sent Ms. Klimitz an Explanation of Benefits Payable by Insurance Company ("the Denial Notice"). By this point Allstate had provided Ms. Klimitz with a copy of Dr. English's report dated March 19, 2004. She received it on April 15, 2004, after the five day disclosure requirement.

[11] The Denial Notice stated:

> A recent insurer's neurological evaluation and a previous insurer's orthopaedic evaluation have determined that you do not suffer a complete inability to carry on a normal life due to any impairment sustined [sic] in the accident of November 7, 2003. Therefore you do not qualify for a Non-Earner Benefit.

[12] The Denial Notice was sent with a covering letter. While this letter stated that Dr. Moddel's report was enclosed, it is agreed that it was not.

[13] After the Denial Notice was delivered to Ms. Klimitz, Allstate received an addendum report from Dr. Moddel on June 4, 2004. Allstate did not provide Ms. Klimitz with a copy of Dr. Moddel's two reports until July 18, 2006.

[14] The Denial Notice provided details of Ms. Klimitz's right to dispute Allstate's refusal to pay benefits including the right to seek mediation, arbitrate or litigate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limit that governs the entire process pursuant to ss. 281 and 281.1 of the *Insurance Act*. Specifically, Ms. Klimitz had two years from receipt of the Denial Notice to dispute Allstate's denial of benefits.

[15] Ms. Klimitz submitted an Application for Mediation to the Financial Services Commission of Ontario on July 20, 2006. This was two days after she received copies of Dr. Moddel's reports and more than two years after her receipt of the Denial Notice.

[16] A preliminary issue arbitration was held before Arbitrator Sapin on December 9, 2011 to determine the issue of whether Ms. Klimitz was precluded from proceeding to arbitration because she filed her Application for Mediation more than two years after Allstate's denial of her non-earner benefit.

[17] Arbitrator Sapin found that Ms. Klimitz was precluded from proceeding to arbitration and that Allstate's denial of the non-earner benefit conformed to the requirements for a valid termination because:

- Allstate's failure to provide Ms. Klimitz with Dr. Moddel's report did not detract from the clarity and certainty of its refusal to pay the benefit.
- The Denial Notice was clear and unequivocal.
- If Allstate was required to provide Dr. Moddel's report as part of its reasons for denial this would amount to holding the insurer to a standard of perfection.
- Allstate's failure to comply with s. 37(1) of the *Schedule* did not prevent it from relying on the two year limitation period.

[18] Ms. Klimitz appealed the arbitrator's decision to the Director's Delegate. Section 281(1) of the *Insurance Act* restricts appeals from the order of an arbitrator to errors of law.

THE DECISION

[19] The Director's Delegate allowed the appeal, rescinded Arbitrator Sapin's order of April 13, 2012 and substituted it with a new order that Ms. Klimitz was not precluded from proceeding to arbitration.

[20] The Decision states at p.5 as follows:

The parties agree that an insurer's notice of refusal to pay benefits must provide:

1. A clear and unequivocal refusal;

2. Reasons for the insurer's determination; and,

3. An adequate explanation of the right of the insured person to dispute the refusal and the process for doing so.

[21] The Director's Delegate found that the Denial Notice was a "clear and unequivocal refusal" of Ms. Klimitz's claim. It provided Ms. Klimitz with "a straightforward explanation of the mediation and arbitration, lawsuit or neutral evaluation processes" to dispute the denial of her claim.

[22] The Director's Delegate found that Arbitrator Sapin erred in law when she rejected the position that Allstate was required to provide Ms. Klimitz with Dr. Moddel's report as part of its reasons for denial. This error of law is described in the Decision as follows:

> 70 The Arbitrator found that the absence of Dr. Moddel's report did not detract from the clarity and certainty of the refusal. I agree that it was clear and certain that the Respondent was denying the Appellant's NEB claim. However, there was, as agreed by the parties, a further requirement under subsection 37(1) of the *Schedule*, as stated by the Court of Appeal in *Turner*, that the Respondent give reasons that permitted the Appellant to decide whether to challenge its denial. Respectfully, I am persuaded that the Arbitrator erred in law regarding the legal test in stating:
>
> > Although I suppose one could argue that the refusal, without Dr. Moddel's report, did not fully comply with the requirement for Allstate to provide 'reasons' under s. 37(1)(a), I find such an argument, in this case, amounts to holding the insurer to a standard of perfection which is contrary to the jurisprudence.

[23] The Director's Delegate found that requiring Allstate to provide an actual copy of the medical report, upon which Allstate was basing its refusal, was not an onerous task nor did it hold the insurer to a standard of perfection.

[24] As a result the Director's Delegate found that Ms. Klimitz was not precluded from proceeding to arbitration because the two year limitation period under s. 281.1(1) of the *Insurance Act* did not commence to run until the report of Dr. Moddel dated May 5, 2004 was finally provided to Ms. Klimitz on July 18, 2006. Ms. Klimitz submitted an Application for Mediation to the Financial Services Commission on July 20, 2006. Therefore she commenced her mediation proceeding within the two year limitation period.

POSITION OF THE PARTIES

[25] Allstate argues that the Decision was unreasonable because it overturned a decision that was correct in law. In essence, it is Allstate's position that the obligation to provide the insured with a clear and unequivocal denial does not include a requirement that it comply with the statutory obligation to provide the insured with copies of the medical reports within five days of receipt.

[26] The respondent Financial Services Commission of Ontario takes no position on the merits of this application for judicial review.

[27] Ms. Klimitz argues that it was reasonable for the Director's Delegate to conclude that Allstate was required to provide her with Dr. Moddel's report as part of its reasons for denial because without the report, she could not make an informed decision on whether to challenge the denial of benefits.

THE STANDARD OF REVIEW

[28] It is agreed that the applicable standard of review for Director's Delegate decisions is reasonableness. Since *Dunsmuir v. New Brunswick*, 2008 SCC 9, [2008] 1 S.C.R. 190, numerous Divisional Court and Court of Appeal decisions have confirmed that Director's Delegates' statutory interpretation of statutory accident benefits and entitlement to the benefits are subject to a reasonableness standard: see *TTC Insurance Company Limited v. Watson*, [2008] O.J. No. 3820 (Ont. Div. Ct.), at paras. 14-16; *Aviva Canada Inc. v. Murugappa*, [2009] O.J. No. 2770 (Ont. Div. Ct.), at paras. 5-6; *Wawanesa Mutual Insurance* Co. *v. Motor Vehicle Accident Claims Fund*, 2010 ONSC 1949 (Div. Ct.), at paras. 3-4; *Wawanesa Mutual Insurance Co. v. Uribe,* 2010 ONSC 5904 (Div. Ct.), at paras. 9-10; and *Aviva Canada Inc. v. Pastore*, 2012 ONCA 642, 112 O.R. (3d) 523, at paras. 18-22.

[29] As the court stated in *Personal Insurance Co. v. Hoang (Litigation guardian of)*, 2014 ONSC 81 at para. 17, "Director's Delegate decisions are protected by a full privative clause in s. 20(2) of the *Insurance Act*. Such decisions are made in the context of a specialized adjudicative regime established by the *Insurance Act* and are deserving of deference."

[30] The Supreme Court in *Dunsmuir* described what a reasonableness standard entails as follows at para. 47:

> 47 Reasonableness is a deferential standard animated by the principle that underlies the development of the two previous standards of reasonableness: certain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of appreciation within the range of acceptable and rational solutions. A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In

> judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

ANALYSIS

[31] In my view, the Decision was reasonable. While the refusal was found to be "clear and unequivocal", the Director's Delegate found that the reasons were insufficient.

[32] The evidence supported this finding because Allstate did not provide Dr. Moddel's report to Ms. Klimitz. This was a report that Allstate relied upon to deny benefits and it formed part of the reasons for the denial as set out in the Denial Notice.

[33] The Director's Delegate reviewed the various authorities that supported his decision. These authorities serve to demonstrate the reasonableness of the Decision. In particular, the Director's Delegate relied on *Turner v. State Farm Mutual Automobile Insurance Co.*, [2005] O.J. No. 351 (C.A.).

[34] In *Turner*, the denial notice provided reasons for cancellation of the insured's benefits that were legally incorrect. This is because the notice addressed a benefit that was never claimed. However, the notice did clearly terminate the benefit that the insured was receiving and fully disclosed the reasons for termination. As a result, the Court of Appeal concluded that the error did not render the denial notice "less than clear and unequivocal".

[35] In reaching this conclusion, the Court of Appeal explained the purpose of the insurer's obligation to give reasons for a refusal of benefits. At para. 8, it stated as follows:

> Section 24(8) of the Statutory Accident Benefits Scheme obliges the insurer to give the insured "the reasons for the refusal". It does not provide that the reasons must be legally correct. The purpose of the requirement to give reasons is to permit the insured to decide whether or not to challenge the cancellation. If the reasons given are legally wrong the insured will succeed in that challenge. Requiring that the reasons be legally correct goes beyond both the requirement in the relevant regulation, and the purpose of such a notice.
>
> [Emphasis added.]

[36] The Director's Delegate also reviewed a series of arbitration decisions that supported his finding that reasons must be sufficient to allow the insured to decide whether or not to challenge the denial of benefits.

[37] It was entirely reasonable for the Director's Delegate to conclude that Allstate was required to produce Dr. Moddel's report as part of its reasons for refusing benefits. Allstate obviously relied on this report because it said so in the Denial Notice and the covering letter. It was statutorily obliged to give the insured the report within five days of receipt. Allstate failed to

comply with this mandatory requirement and as a result, the insured received incomplete reasons explaining the denial of her claim. Her ability to decide "whether or not to challenge the cancellation" was seriously limited.

[38] Allstate says that the *Schedule* does not require the medical reports to be produced before the limitation period starts to run.

[39] I reject Allstate's argument that the Decision should be overturned because it creates a link between the obligation to produce medical reports to an insured and the notice requirement that starts the running of the two year limitation period

[40] While there is no clear link in the *Schedule* between production of the medical reports and the commencement of the limitation period, the *Schedule* does require reasons in the Denial Notice and as stated in *Turner* the reasons have a purpose. The reasons that Allstate provided did not fulfill this purpose because Allstate did not provide Ms. Klimitz with Dr. Moddel's report.

[41] In summary, it was not unreasonable for the Director's Delegate to conclude that the two year limitation period did not start to run until Ms. Klimitz received a copy of Dr. Moddel's report. Allstate's application for judicial review is dismissed.

[42] The parties have agreed on costs. Allstate shall pay the respondent Ms. Klimitz $3,500 all inclusive.

C. HORKINS J.

MARROCCO A.C.J.S.C.

SPENCE J.

Released:

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Applicant

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Respondents

REASONS FOR JUDGMENT

C. Horkins J.

Released: 20141212