

# INSURANCE – BILLINGSLEY 2017

## INSURANCE LAW INTRODUCTION

Insurance policies are **CONTRACTS**

- **Require consideration**
  - o How? Money paid by the insured (**premiums**) AND the insurer promises to compensate for the loss (**indemnify**)
  - o **Financial arrangements.** There is money on both sides → insurance Ks are only about money and protecting monetary value
- The contract is given to the insured = purchase of the insurance K NOT negotiated
  - o **Standard Form Contract = contracts of adhesion (MOST)**
    - Courts have a different attitude to these Ks → tend to interpret these Ks in favour of the insured
  - o UNLESS – worth the time of insurance company to devise terms that a specific to that client = **manuscript contracts**
- Because of society's interest in having insurance, society is responsible for ensuring that the contracts are fair to both the insurance company and the insured
  - o So, insurance contracts are subject to specialized **common law rules** and **statutory provisions**

Insurance is **PROVINCIALY REGULATED**, and govern:

- The status of insurance companies;
- The conduct of the parties to an insurance contract; and
- The content of insurance contracts

Provinces voluntarily coordinate via the Canadian Council of Insurance Regulators to create some uniformity in provincial laws

- Legislation may be influenced by insurance trade organizations
- Insurance companies can voluntarily enter into agreements (“inter-company agreements”) that impact on insurance issues

**PURPOSE:** to spread the risk of loss

- Thus, the more people in the ‘pool’, the lower the premiums
- Insurance is about contingencies i.e. the possibility of a loss occurring
  - o Insurance companies assess the **probability of a loss occurring = risk**
  - o The likelihood of a risk occurring is individually dependent
- Does not cover ‘burning down own loss’ – the risk becomes a certainty
  - o No longer contingent
  - o Insurance covers the uncertain/unexpected = **fortuitous loss** i.e. not within the control of the insured
    - Timing and cause is the fortuitous component of life insurance, but is different than other policies
- Reliance on the insured to provide information for the contract so they can determine what the likelihood of the loss is
  - o This reliance makes insurance contracts different than other contracts (one of the features)
  - o Insured also relies on insurance company to pay out in time of loss
  - o Common law principle = **uberimmae fides** = “utmost good faith”
    - Does not occur in other types of contracts

### **GENERAL APPROACH TO A FACT PATTERN**

- 1. Is there a K? Is there a contractual relationship?**
- 2. Was their coverage under the K for this loss?**
  - Interpret the terms of the policy
- 3. If yes on both the above, was the contract breached?**
  - If no = insurance policy will pay
- 4. Valuation = how much needs to be paid?**

#### **Current classification in *Alberta's Insurance Act, Part V:***

Subpart 1: Insurance Contracts (general): applies to all insurance contracts including more specific sections below. However, some are excluded.

Subpart 2: Automobile Insurance

Subpart 3: Fraternal Societies

Subpart 4: Hail Insurance

Subpart 5: Life Insurance

Subpart 6: Accident & Sickness Insurance

Subpart 7: Transitional Provisions

## DEFINITIONS AND CLASSIFICATION

### I. Common Law Definition

- **Re Bendix Automotive:** (1) An undertaking by one person, (2) to indemnify another person (3) for an agreed consideration (4) for loss/ liability resulting from an event, (5) where the happening of the event is uncertain.

### II. Statutory Definition

- **Alberta Insurance Act, s. 1(aa):** the undertaking by one person to indemnify another person against loss or liability for loss in respect of certain risk or peril to which the object of the insurance might be exposed or to pay a sum of money or other thing of value on the happening of a certain event and, without limiting the generality of the foregoing, includes life insurance
  - o *Certain* = 'particular event'
  - o **Codification of common law definition**

**III. Definition is important to determine what legal principles apply:** Need to know whether a contract is an insurance contract so we know whether it is governed by insurance law principles:

→ **Co-operators v. Alberta Human Rights Commission (ABCA)**

**SUM: insurance companies are allowed to rely on statistical probabilities**

**FACTS:** insurance premium calculations based on gender and age (25yo male)

**DECISION:** this is not unfair because the nature of insurance, insurance is all about risk assessment – evaluate the premiums based on the likelihood they will have to pay for a loss.

- Rely on statistical probabilities – insurance companies are allowed to distinguish on these probabilities

→ **Ferme Vi-Ber Inc. v. La Financiere agricole du Quebec (2016 SCC)**

**SUM: Substantive analysis to determine is contract is one of insurance**

**FACTS:** Gov't insurance program in Quebec to assist farm producers. Producers all contributed to fund that would support them in income fluctuations. Amount payable calculated by comparing their income to the fund's benchmark average income. Disagreement in amount.

**ISSUE:** Came down to one term – should it be interpreted as an insurance scheme?

**DECISION:** Reasonable expectation of the insured doctrine – does not apply to every K

- To apply, the court had to decide if it was a contract of insurance.
- NOT a K of insurance

**REASONING:**

- (1) Insurance K is an obligation on the insured to pay a premium. Here, there was no premium
- (2) No risk being covered here – not a happening of an unanticipated event. Payout is determined by fund organizers whether there is a payment needed.
- (3) Insurance K imposes an obligation to pay on the insured if the risk occurs. Here, there is no obligation. Fund determines if they pay

**REMEMBER:** K under consideration does contain similar language to the terminology of an insurance K. SCC determines does not depend on language used. **Not dependant on form but SUBSTANCE**

### IV. People Impacted by the Insurance Contract

- **Insurer:** the insurance company i.e. the party agreeing to indemnify the other if there is a loss
- **Insured:** the party buying the insurance i.e. paying the consideration (premium) in exchange if they suffer a loss covered by the K they will get paid
- **Assured:** life insurance/accident and sickness insurance. Buying a policy on someone else's life. Party whose life is the subject of the insurance is insured. Person buying the policy is assured.
  - o E.g. buying life insurance for yourself = both assured/insured
- **Beneficiary:** whom the insurance benefits or who the insurance payout goes to
  - o \*\*For most insurance, the person is the insured/assured/beneficiary

- **Name insured:** person who is written in on the insurance K specifically identified
- **Unnamed insured:** person who is covered by the policy but not specifically identified by name
  - o E.g. automobile insurance = person given permission to drive your car will be covered by your car i.e. covered by relationship

## V. Parts of the Contract

- **Policy:** used interchangeably with insurance K BUT there is a technical difference. Insurance policy by itself are no a K, have to have an agreement between the parties to be a K
  - o Policy is made into a K
  - o Policy is evidence of a K, but still have to show agreement.
- **Policy Limits:** maximum amount of coverage that the insurance company agreed to pay
- **Premium:** consideration the insured pays for coverage. Amount is a matter of negotiation. An essential term of an insurance K
- **Deductible:** the amount that the insured has to pay before the insurance company's obligation to pay is triggered (amount of loss)
- **Term of Insurance:** duration of the contract
- **Statutory condition:** Ks are highly regulated by statute and this may include imposed conditions by the statute
  - o E.g. statutory conditions in the general provisions of the IA that are included in most insurance Ks
  - o E.g. statutory conditions that must be included into auto insurance Ks
  - o **"Deemed" by statute → general = s.540; auto = s.556**
- **Coverage:** to who for what; involves interpreting the insurance K
- **Subject matter of insurance:** the 'thing' that is insured – e.g. life, property, illness, etc.
- **Subject matter of the K of insurance:** money from insured to insurance company and vice versa

## VI. Personnel/Policies

- **Agent:** selling insurance on behalf of a particular insurance company; employed by the insurance company
- **Broker:** sells for many insurance companies – sell a variety of insurance products (more independent but both are selling insurance)
- **Underwriter:** person who assesses the risk of loss and decides whether the insurance company should enter the K and what they should charge for it; employee of insurance company
- **Adjuster:** person hired by insurance company to assess the value of a loss after it happens; investigate the loss and determine if it is covered and how much the company has to pay
- **Policy of adhesion:** sold as a pre-formed product to insured; not negotiated clause by clause.
- **Manuscript policy:** policy written clause by clause
- **Standard auto policy:** policy of auto insurance mandated or approved by government to be sold to people who own automobiles; basic auto policy
- **Endorsement:** addition to insurance K/'mini K' that gets added to provide extra terms and conditions that either limit or expand the coverage

## VII: Common Elements of an Insurance Policy

\*\*Insurance Ks look deceptively complicated

- **Insurance Agreement:** the part of the agreement that tells you what the subject matter of the insurance is and what risks are covered
- **Exclusions:** restrict the insuring agreement; 'what is carved out of the coverage?'
- **Definitions:** important to read because they can drastically change the meaning of the K, even sometimes changing words where the meaning seems obvious
- **Declarations page:** sets out the basis which the parties have agreed to be bound by that policy; personally agreed upon terms
  - E.g. named insured, what policy has been purchased, time it is in place, premium, policy, etc.
- **Endorsements:** either add or detract from the coverage

## **VIII. PARTICULAR STATUTORY PROVISIONS CAN OVERRIDE CLASSIFICATIONS**

- Example: **Part V, Subpart 1, s. 513**: *Subject to ss. 638 and 696 and except as otherwise provided, the provisions of this Subpart, where not inconsistent with other provisions of this Act, apply to every contract made in Alberta other than a contract of*
  - (a) life insurance
  - (b) accident and sickness insurance or
  - (c) reinsurance
- Have to read both provisions concurrently to determine what may or may not apply

## **IX. Classification can Impact Substantive Rights:** illustrate the importance of classifying insurance contracts

- SCC decisions – significantly affected insurance reform in AB therefore the issues in these cases are no longer an issue in our province but are in others
- Substantive rights to parties to a K can be affected by how insurance is classified

### → ***KP Pacific Holdings Ltd. v. Guardian Insurance Co. of Canada (2003) SCC***

**SUM: even though *Insurance Act* did not reflect modern reality, general limitation period applies.**

**FACTS:** KP owned hotel that was damaged in fire. KP went to insurance company and claimed loss. Had all risks insurance policy for the property. Dispute about coverage – KP ended up suing.

**ISSUE:** Insurance company argued that suing was too late because provision in statute that said under fire insurance had to bring claim within a year. Insured relied on general section of statute which said that a two-year limitation period applied.

- *What is the classification of the insurance contract?*

**DECISION:** not fire insurance despite fact claiming loss from a fire. K was designed to cover a lot of different things = general 2-year limitation period applies

### → ***Churchland v. Gore Mutual Insurance Co. (2003) SCC***

**SUM: AB modernized insurance classifications in accordance with this SCC decision**

**FACTS:** Homeowners insurance covers multiple risks. Residence broken into and they bring claim but company said claim was statute barred because it was not brought within limitation period of one year prescribed under Part 5 Fire Insurance.

**DECISION:** SCC reprimanded legislation for having such ancient wording – no one sells strictly fire insurance anymore. Legislation should reflect the reality. Recommended the legislators modernize their classifications – AB did this but not all provinces have

- Therefore classification is important because the provisions contain different protections
  - Multi-risk policies are common and the interpretive issues involved with analyzing a multi-peril policy within Part 5 lead to impractical consequences and thus must fall under general provisions of Part 2.
- Now – 2 year limitation period for suing insurance company

## AUTOMOBILE INSURANCE IN ALBERTA

### I. Nature of the Automobile Insurance System in Alberta

- **Fault based/private insurance:** recovery for losses caused in automobile accidents is primarily tort-based (i.e. "fault" based) with insurers providing limited "no fault" benefits
- Liability insurance is mandatory for a vehicle which is being operated on public roads (*Traffic Safety Act*) and is provided by private insurers

### II. SPF #1 Standard Auto Policy (Owner's Policy) – content pre-determined by government

**Section A (Liability Insurance [Third Party Benefits]):** MANDATORY, with required minimum policy limit of \$200,000)

- Section A provides coverage for intentional acts AND impaired driving
- Loss caused to third party from use and operation of your vehicle

**Section B (First Party Benefits):** medical, funeral & death, disability – MANDATORY

- No fault benefits regardless of who causes the accident
- Minimum benefits
- Excludes coverage for loss caused by the insured's own impaired driving

**Section C (First Party Collision Coverage):** for damage to the insured vehicle – OPTIONAL

- Provides coverage only for *accidentally* caused loss [no coverage for loss intentionally caused by the insured] and expressly excludes coverage for loss caused while the insured was impaired
- Technically property insurance

**Motor Vehicle Accident Claims Act:** \$200,000 statutory minimum s. A limits (see *Insurance Act*, s. 571)

- Guaranteed minimum coverage for loss caused by another driver
- BUT protection against uninsured driver is available:

**SEF 44 Family Protection Endorsement:** coverage for loss caused by an underinsured driver

- Very common for insurance companies to sell now
- It also has a policy limit, so technically both the limit of the at fault party and the endorsement could BOTH be exceeded
- LAYERS ON TOP – never pays from the base amount
  - o Always added when a limit is reached and only gives you the guaranteed amount the endorsement → therefore the entire judgment could still not be covered

**SEE EXAMPLE IN SLIDES**

## INSURABLE INTEREST

A *distinct* and a *necessary* element of an insurance contract

- Distinct because only insurance contracts require insurable interest
- Necessary because it promotes societal interest in promoting personal property and wealth acquisition and minimizes the risk of moral hazard
  - o Makes an insurance contract different from a wager
  - o Insurance increases the 'moral hazard' in relation to property because people are going to take less care in knowing that insurance exists

### I. What is Insurable Interest?

→ **Constitution Insurance v. Kosmopolous (SCC 1987)**

**SUM:** the factual expectancy test/definition prevents wagering in favor of a loss **BETTER** than the bare legal title test

- **APPLY THIS TEST TO DETERMINE IF AN INSURABLE INTEREST EXISTS**

**Factual Expectancy Test: insurable interest exists if the insured stands in relation to the subject-matter insured so as to suffer a loss or detriment if the event insured against**

**FACTS:** Kosmopolous carrying out business selling leather goods in rented store as a sole proprietor. Buys a policy for this store – “Spring leather goods”. K gets advice to incorporate, which he does and names himself as sole shareholder and sole director of the company – “K leather goods”. Does not make any change to the insurance contract. There is a fire that destroys much of his assets and brings claim on insurance company. Company says he has no insurable interest because insurance policy is for Mr. K not the incorporated company, so the incorporated company who ‘owns’ the property does not have a policy.

**ISSUE:** Can Mr. K say he has an insurable interest in assets owned by the company?

**ARGUMENTS:** (1) he is the sole director and shareholder – lift the corporate veil, (2) even if his company owns the assets, Mr. K is the bailee of the company and is therefore related to the assets, (3) English law says sole shareholder does not have insurable interest in the company, so let’s forget this law and say yes you can

**DECISION:** Mr. K **DOES** have an insurable interest. Rejected argument 1 and 2 (because facts didn’t make out a bailment), but accepted 3 to overturn English law.

- This old law was based on **Macaura** – said what you look for insurable interest is legal title. SHs do not have legal title, the corporation does
- **Dissent in Lucena:** SCC adopted this dissent i.e. more flexible definition that is based on **factual expectancy** i.e. what would you expect to be the case based on the facts of the relationship
- Applied on a case-by-case basis

### **Features of Insurable Interest:**

- It is a pecuniary interest – *financial loss or detriment*
- It is **NOT** created by the payment of insurance premiums – *insurable interest has to exist independent from the insurance contract*
- It is a legally enforceable interest, even if that is a presently vested future interest
- Bare legal title is NOT enough
  - o Not to say legal title doesn’t matter, this is important evidence for insurable interest **BUT** is not enough to establish
- Can be defeated by public policy considerations (e.g. knowingly buying a stolen item)
- Onus of establishing is on the insured (but courts often favour finding II if doubt exists) – *have to prove on a balance of probabilities*
  - o If doubt exists, Courts “tend” to want to benefit the insured over the insurance company in terms of insurable interest

**Re Life Insurance:** NOT required for life insurance; seems in bad taste to make someone stand in court and prove insurable interest in someone’s life

- **s. 646(2):** A contract is not void for lack of insurable interest . . . (b) if the person whose life is insured has consented in writing to the insurance being placed on his or her life.

- **s. 647:** A person has an insurable interest in:
  - o his/her own life;
  - o the life of his/her child or grandchild;
  - o the life of his/her spouse or partner;
  - o the life of anyone on whom that person is dependent for support or education;
  - o his/her employee; and
  - o anyone in the duration of whose life the person has a pecuniary interest.
- Statute is not written as though these are the only options, but in reality it is because unlikely to satisfy K test in any other scenario = statute is designed to capture the same relationships as the K test
  - o SO – life insurance start with statute then move to K test
  - o Because insurable interest mostly covered in statute, unlikely to find insurable interest outside

## **II. Can you insure the interests of Others?**

**QUESTION:** when can you insure the whole value of something when you do not have an insurable interest in the whole value?

- *This question presumes you have some degree of insurable interest in the property*
- For example:
  - o Shared ownership of property
  - o Items owned by another party are on the insured's property (e.g. *someone else's furniture is stored on your property*)

### **You CAN insure the interests of others if:**

- Insurance contract provides for/allows it i.e. *contract must be broad enough* (BIGGEST FACTOR)
- You intended to do so

**AND**

- The insured's relationship to the other party requires or authorizes the insured to obtain insurance for the other party's interest - *must be authorized or ratified after the fact*

### **→ *Keefer and Quebec Bank v. Phoenix Insurance (1901) SCC***

**SUM:** if terms of policy suggest full interest was insured, the insured may hold an equitable trust arrangement for their diminishing interest in the insured item

**FACTS:** K agreed to sell land for 2000 to purchaser who will pay by installments. Sale agreement said will be in K's name until whole payment is received AND that K would maintain insurance for full value of purchase price. K receives 800 when there is a fire and property is damaged for 1740. K makes claim

- Insurance company refuses to pay full amount. His insurable interest has been diminished by 800 because only retains 1200 of insurable interest

**ISSUE:** is insurance co responsible to pay portion of loss that is over and above the insurable interest

**DECISION:** company has to pay full amount – both K and purchaser's interest

**REASONING:** Issue is whether K was entitled to insure the full value of the property, and SCC said a person can take out full value insurance K as long as the policy allows him to recover the full value and he intends to insure the full value

- BUT when insurance company pays Keefer, he holds **in trust** the value of the insurable interest damaged that belongs to the purchaser
- **REMEMBER:** this is a 'diminishing interest', when purchased policy, K was full owner

### **→ *Spencer v. Continental Insurance Co. (1945) BCSC***

**SUM:** Four components necessary for an insured to be able to cover someone else:

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

**FACTS:** father buying insurance on contents of his house, including son's stereo unit

**DECISION:** When loss occurred, and father included stereo on list, company said he had no insurable interest in it → didn't have legal title and didn't meet test YET court found he did have insurable test because "any father will feel compelled to buy a new stereo for his son"

- I.e. here compassion = satisfying test for insurable interest, this is a case of the court stretching the idea of suffering a loss when they want to find coverage
- Read excerpt for insuring for someone else i.e. policy has clause or can be reasonably read to cover someone else's insurable interest, intent, and person insuring for has to be in existence and ascertainable at time of purchasing policy

#### STATUTE:

**Alberta Insurance Act, s. 540, S.C.#2:** The insurer is not liable for loss or damage to property owned by a person other than the insured unless

- (a) otherwise specifically stated in the contract, or
- (b) the interest of the insured in that property is stated in the contract.

\*\*Found under the general section of part V so applies to **ALL insurance Ks** other than specified under act

- Statutory condition = deemed to be a part of every insurance K that falls under the general provision
- (a) specific K or (b) recognizes a non-owner interest
- Really a disclosure provision = the insurance company needs to know that you are not the owner

→ **Dudelzak & Landry v. Non-Marine Underwriters (1985) ABQB**

**SUM:** this remains the law in Alberta – therefore all you need to prove is an insurable interest in property owned by someone else

- **Therefore S.C. #2 does not narrow the insurable interest test for property owned by someone else**

**FACTS:** law firm purchased insurance coverage on the contents of the office, among those being a number of original wills written for clients. Clients paid for the service therefore wills actually belonged to the client. Wills were stolen from the firm and firm makes insurance claim for cost of having wills redone. Insurance co says firm has no insurable interest and EVEN if they did, not obligated to pay the firm because this condition was not complied with because nothing in K for coverage to items not owned by the insured.

**DECISION:** court held the firm did have an insurable interest, wills are being held on behalf of the clients and they suffer a loss on the wills being destroyed i.e. responsible to the will owners.

- Court says the firm has insurable interest because they have to replace the property (bailor-bailee situation) and attend to its execution by the testator.
- Argument of insurance company = SC #2 provision is a disclosure provision. Insured has to tell the company the extent of their ownership. *Why?* Owner may care more i.e. non-owners are not as invested therefore is a different risk for insurance cos
- Nova Scotia Case says this is not what the provision means at all – 'owner by a person' just references insurable interest. Therefore, if firm has insurable interest they have satisfied this condition. **BUT this interpretation makes this provision completely unnecessary – just repeats common law rule**

The court mentions that it is well settled law that all that is necessary to satisfy SC#2 is that the insured have an insurable interest in the property and the fact that the limited interest of the insured in the property is not stated in the contract does not constitute a breach of this statutory condition

**Privity:** SCC has relaxed the rule of privity for insurance Ks, third parties can claim a benefit under the K if the K is clear to extend benefits to that person and the loss falls under the coverage of that K

- E.g. **Section A of auto insurance K** = named insured and anyone driving with your provision.

#### III. Does Insurable Interest run with the Property?

- No because insurance is a personal contract
- Receipt of property insurance = company is going to ask questions about YOU and calculate the risk of loss of your house. A new owner has different risk factors (more/less)

→ **Rayner v. Preston (1881) Eng. C.A.**

**SUM: Insurance contract does not run with the subject matter of the insurance. Insurance contracts are a mere personal contract for the payment of money, not a contract that runs with the land. Unless the insurance contract is assigned, no suit or action can be maintained upon it except between the original parties to it.**

**FACTS:** sale of house that K said nothing about insurance. Fire occurred and purchaser claimed against vendor's insurance company for their equitable interest on the property.

- NO ASSIGNMENT OF INSURANCE POLICY.

**ISSUE:** Can the purchaser benefit under the K?

**DECISION:** NO - it is a personal K between the co and the vendor and has not been assigned to purchaser. Court did not in some cases the vendor may recover the total amount of loss and may hold some in trust for the purchaser, but not in this case.

**How is this case different than Keefe?** In both cases, the purchaser has not paid the full purchase price. In that case, vendor was able to recover the total amount of loss. This case is different because it is the purchaser making the claim and there is nothing in the insurance policy that suggests recovering insurance for anyone else.

- In *Keefe*, it was the vendor i.e. the named insured who collected on behalf of someone else
  - I.E. YOU can insure interests of others, another cannot claim an interest unless the K recognizes the other party
  - Furthermore, in *Keefe*, the sale agreement was written with the intention to protect both the vendor and the purchaser

**NOTE:** for real estate contract, there will be provision to maintain policy of insurance until sale goes through on understanding there will be money for both vendor and purchaser.

**Problem with Privity:** if you are the party who is reliant on someone contract, if the K is breached, the insured nor anyone else is protected by the K. Therefore, the party should get their own insurance

- E.g. if it is a K of sale, they have an insurable interest in the amount paid.
- **Can sort out overlapping coverage BUT cannot fill missing insurance**
  - The easiest thing is to by a policy of insurance yourself. Obviously if insurance is included in K, can sue the insured, but this is the long way of getting paid.

#### **IV. When is Insurable Interest Required?**

**General Rule:** on the date of loss

- Authorities agree that an insurable interest must definitely exist at the time of the loss; otherwise the insured has not lost anything at all and there is no need for indemnity

**The Exception is life insurance: ONLY at the time the contract takes effect (IA s. 646)**

- E.g. if you get life insurance for spouse but then get divorced and keep paying premiums, you can collect because you only need insurable interest at the time the contract was formed.
- **S. 648** allows the insured of life insurance to apply to court to have policy removed when they feel the purchaser of the insurance may kill them.

It is possible under a K that you may lose the insurable interest in the interim.

- Because in this type of K they only care about date of loss or date of creation for life insurance, irrelevant that you lost and then gained back the insurable interest
- Life insurance K doesn't even matter if you gain it back

Some Ks make it impossible to have an insurable interest at the outset of the K creation

- E.g. insurance that covers inventory that gets brought in on rolling bases, crop insurance (get before crop is grown – anticipatory), liability insurance (possibility of liability in the future)

## INDEMNITY

### I. Insurer's Obligation to Indemnify

- Once you have a valid insurance K, the principle of indemnity is essential to understand the obligations owed to the insurance company

#### **A. GENERAL**

Indemnity is a fundamental principle of insurance contracts; **2 definitions:**

1. Can be used in a general sense (applicable to all insurance contracts) to refer to the **insurer's obligation to respond to** (i.e. to pay for) a loss.
2. Can be used in a more specific sense to refer to the **amount** (dollar value) that the insurer must pay.

Insurer only has to compensate NOT profit the insured – at most, the payment of insurance proceeds should restore the insured to its pre-loss financial position, subject to the policy limit.

- Policies which provide indemnity on this basis are **open policies**

- **To claim under an indemnity policy, the insured must first prove:**

- o That a valid contract exists
- o That a loss occurred
- o That the contract covers the loss
- o The amount of the loss suffered

Life insurance is an exception because the amount of insurance proceeds payable to the insured is set by the terms of the contract and does not depend upon proof of the pecuniary value of the loss actually suffered. Life insurance contracts are therefore sometimes called **non-indemnity contracts or valued policies**

- Never will be a value assessment = **pre-determined** at the outset of the contract

- **To claim under a non-indemnity policy, the insured must first prove:**

- o That a valid contract exists
- o That a loss occurred
- o That the contract covers the loss
- o The amount payable by the terms of the contract

#### **B. INDEMNITY AND PUBLIC POLICY**

- Even where an insurance contract provides coverage for a particular loss, courts may deny the insured indemnity on **public policy grounds**

- This benefits the insurer, BUT:

- o Because the insurer COULD have expressly excluded coverage, the courts reluctantly apply public policy to relieve an insurer from its obligation to indemnify
- o The insurer bears the burden of proving that public policy should be applied to deny indemnity to the insured (i.e. that public policy outweighs the obligation to pay)

- **SO:** Contract provisions govern coverage . . . BUT can be superseded by public policy considerations (imposed by courts) . . . WHICH can in turn be superseded by legislation

- o **STATUTE > PUBLIC POLICY > CONTRACT**

→ **Insurance for an Illegal Activity:** courts will not enforce such insurance contracts for public policy reasons: i.e. to allow coverage would encourage illegal activity.

- **Dominion Fire Insurance v. Nakata (1915) SCC:** insured and insurance company entered agreement to insure brothel ('sporting house') insured as a brothel operation

- o **DECISION:** SCC said no – because an illegal activity do not allow a contract of insurance

→ **Criminal Act:** loss can be (1) **INTENTIONALLY** caused by a CRIMINAL act by the insured (e.g. murder or arson) or (2) **UNINTENTIONALLY** caused by a CRIMINAL act by the insured (e.g. only arson was intended but death occurred in the fire).

- Canadian courts apply public policy to prohibit recovery by the insured in either situation because a criminal should not benefit from his/her crime.
  - o **Therefore does not matter whether or not you are intending to cause the loss, do not get to recover for the loss if occurred by criminal act**
- This public policy rule extends to the estate of the insured and all beneficiaries of the estate.
  - o Common law says it does not matter if you are not around, your estate still does not receive the recovery

BUT it does not apply to **an innocent beneficiary** under an insurance contract

→ **Oldfield v. Transamerica Life (2002) SCC**

<p><b>SUM:</b> public policy works independent from the terms of the K, court can step in and override the terms.  <b>Court narrows PP exception and says it does not apply in life insurance contract where beneficiary is innocent in the criminal act.</b></p>
<p><b>FACTS:</b> smuggling cocaine, under life insurance policy his wife was named as beneficiary. Cocaine balloons swallowed exploded inside him and died. Didn't intend to die but was committing criminal act.  <b>ISSUE:</b> is the insurance contract enforced?  <b>DECISION:</b> Because she was named as innocent beneficiary, she could recover separate from the estate</p> <ul style="list-style-type: none"> <li>- This is uneven in the common law because under estate wife is usually the beneficiary, so she would have to specifically be named separate from estate</li> </ul>

**Statutory Modification of the Common Law:**

- **S. 533(2) IA:** *Unless a contract of insurance provides otherwise, a contravention of any criminal or other law in force in Alberta or elsewhere does not render unenforceable a claim for indemnity under a contract of insurance except when the contravention is committed by the insured, or by another person with the consent of the insured, with intent to bring about loss or damage*
- So, pursuant to the statute, loss unintentionally caused by a criminal act committed by the insured or colluded in by the insured does not void coverage unless the insurance contract expressly excludes coverage in this circumstance
- **NOTE:** s. 533(2) appears in general section and s. 513 says general does not apply to life insurance
  - o BUT s. 533 says subject to 638 (in life insurance section and says 533 applies to life insurance)

<b>WRONGFUL ACT</b>	<b>COMMON LAW</b>	<b>STATUTE</b>
Unintended loss / criminal act	No coverage	Coverage UNLESS contract provides otherwise
Intended loss / criminal act	No coverage	No coverage (statute does not change common law)

- o Therefore statute changes common law with unintended criminal acts = creates coverage
  - Can no longer make public policy argument for unintended criminal act, dependent on what is within the contract
  - E.g. insurance contract providing otherwise = section C of standard auto policy which says coverage is excluded for unintended loss caused by impaired driving
- o *Oldfield* is still important because not all jurisdictions in Canada have s.533 in their statute
- o NOTE: this provision applies to life insurance, pursuant to s.638 of IA
- Insurer must prove criminal act on a balance of probabilities (**Hanes v. Wawanesa**)
- Criminal act exclusion (contract or public policy) does not apply where the insured is found not criminally responsible (**Dhingra v. Dhingra Estate**)
- **s. 541 of Alberta's Insurance Act** says that a contract exclusion for loss intentionally caused by the criminal act of an insured does not prevent recovery by an **innocent co-insured**
  - o This provision was enacted in response to **Scott v Wawanesa (SCC)**: Scotts owned home. Provision said if insured intentionally causes damage to the home, they cannot recover. Their son set the house on fire.

- Scott argument – our son committed arson, we owned the house and had nothing to do with it.
- But wording of the policy said ‘any insured’, which included the son.
- **DECISION:** SCC upheld the provision. Legislatures didn’t like this so they enacted s. 541 to protect innocent co-insureds

→ **Suicide:** at common law, no coverage under a life insurance contract even if the contract expressly or implicitly covers death from suicide i.e. a “suicide clause” is invalid

- Altered by statute - **S. 657(1) IA validates suicide clauses:**
  - *If a contract contains an undertaking, express or implied, that insurance money will be paid if a person whose life is insured commits suicide, the undertaking is lawful and enforceable*
- E.g. suicide clause: “We will not pay the death benefit if the life insured commits suicide, while sane or insane, within 2 (two) years of the policy date or reinstatement date.”

### C. VALUATION

**Issue:** How much money does the insurer pay to an insured following a loss?

Determined first by the **type of policy**

→ **Open Policy:** valuation under an Open Policy is determined by a combination of these factors:

1. Method described in the contract (e.g. “Actual Cash Value” v. “Replacement Cost”)
  2. Policy Limit
  3. Extent of loss suffered (e.g. whole or partial loss to the insured item; extent of insurable; deductible also plays a role here)
- Payment usually is the **actual cash value** of the loss, up to the policy limit
    - Actual Cash Value = intrinsic value to the insured on the date of loss
      - Commonly = replacement cost less depreciation
        - This is a default, the K can define this calculation as something totally different
  - May be varied by a **Replacement Cost Endorsement** = addition or variation the K where insurance company agrees to pay something different than the cash value.
    - Cost of replacing the item (like kind and quality)
    - Does not take into account depreciation
    - Generally has higher premium attached because payout amount will likely be higher
  - For actual cash value, how does a court determine the intrinsic value of the property to the insured on the date of loss?

→ **Leger v. Royal Insurance (1968) NBCA**

**SUM:** Cash value does not take into account future contingencies. What assessment value is best depends on the circumstances of the case – more options you give the court the better

**If you have open policy, the value of the loss is the least of either the actual cash value of the loss, interest of insured in the property, or policy limits**

**FACTS:** Leger paid 30,000 for lot with building on it. D insurer plus other insurer Home Insurance. RI had policy insurance of 20,000 and contained co-insurance clause. HI issued 5,000 policy on same terms. Building was in need of repair, so much so city scheduled it for demolition. Building destroyed by fire (3 fires occurred but could not prove arson)

- Companies argued building value is zero because it is scheduled for demolition

**ISSUE:** how do you assess value under an open policy?

**DECISION:** intrinsic value on date of loss, cannot take into account future contingencies such as demolition.

- **Value under open policy** = lowest of either the actual cash value, the interest of the insured in the property, and the policy limits.
- Under the circumstances, **4 possible calculation methods in this instance:** (1) market value, (2) tax assessment from municipality value, (3) rental value, (4) replacement cost
  - THIS IS NOT A CLOSED LIST
  - Point is = various ways to assign intrinsic value

- Court here looked at what building was being used for = it was rented out. Therefore they used rental value since it was what insured was doing
  - o Calculated yearly revenue multiplied by expected life of building (NOT taking into account demolition)
  - o Ask: Which one of those would most accurately reflect the actual intrinsic value of the property to “this insured” and they decided it was rental value?

→ **Valued Policies**: the amount paid by the insurer is determined by the amount agreed under the contract i.e. NOT determined after the loss

- The amount agreed to *may or may not* be related to the actual pre-loss value of the subject-matter of insurance
- Parties agree on the actual figure that the insurance company will pay if there is a loss
  - o \*\*\*Therefore insured does not need to prove amount of loss
- E.g. life insurance policies (cannot determine value), ‘pre-valued’ policies for property (uncommon; still need to know value but at the outset of the contract)

→ **Raymond v. U.S. Fire (1972) SCC**

**SUM: valued policy is based on that assessment of the insured item at the outset of the contract.**

Types of items insured by these policies = artwork, collections, specialty items. These items require an appraisal at the outset

**FACTS:** insured item (wood-carved model that he made) completely destroyed. Wants to insure it. Company sends appraiser to assess value. Determines it as art object worth 85,000. Contract formed that represents this value. The policy wording said insurance company has to pay “actual cash value”. Raymond seeks 85,000 in recovery. Post-loss adjustor determines cash value is 6,000, which company states is all they have to pay i.e. is an open policy

**ISSUE:** how much does the insurance company have to pay? Is this a valued or an open policy?

**DECISION:** SCC held that insurance company had to pay 85,000 because of company’s conduct: (1) They knew it was a specialty item without market value, (2) Entered into K based on appraisal report, (3) Premium paid was based on the 85,000 appraisal.

- State that type of policy here does not matter – have to pay 85,000 either way, however very clear from the circumstances that it is an **open policy**

**NOTE:** case illustrates the difference of what would be paid out depending on whether found to be an open or valued policy

For valued policies on property, the amount to be paid by the insurer is also be affected by the extent of the loss (e.g. total loss v. partial loss).

- E.g. damaged not destroyed

→ **Re Art Gallery of Toronto (1961) ONHC**

**SUM: Under a valued policy, the agreed amount governs regardless of a partial loss or total loss.**

This puts the burden on the insured with valued policies that is reflects the value of the property and keeps up with inflation

**If you have a valued policy and a partial loss, the amount insurance company has to pay is the proportion of loss times the value of loss under the contract.**

**FACTS:** gallery purchased insurance coverage – a number of paintings insured under valued portion. Paintings stolen. Undamaged value on DOL assessed at \$1,045,000. Paintings are recovered, but are damaged, therefore their value being \$631,900 (i.e. lost value: \$413,100). The valued portion of the policy, the set value was appraised at \$640,000

- Insured argued: \$413,100 because it is less than insured assessed value
- Insurer argued: what the paintings were worth on DOL is irrelevant because it is valued policy NOT open. Therefore, have to pay proportion of loss in value x insured value
  - o **[Lost Value / Undamaged Value] x Insured Value**
  - o  $[(1,045,000-631,900)/1,045,000] \times 640,000 = \$252,999.04$

**DECISION:** Court ruled in favour of insurer. Both parties agreed at the outset that the paintings were worth 640,000 therefore the policy is a valued policy. This same principle applies to damaged properties.

**NOTE: governing law in Canada with respect to valued policies.**

**THIS IS ALWAYS ON THE EXAM – know the formula i.e. how it works and how it makes for a different result for partial loss under an open policy**

- **Fundamental Valuation Terms:**

- Replacement Cost Endorsement: require the insurer to replace the item without accounting for depreciation
  - Various ways to put into contract
    - E.g. guaranteed replacement cost endorsement on buildings
    - E.g. scheduled loss endorsement on personal property
  - Come with conditions
- Deductible: amount the insured has to pay before the insurer has any obligation to pay
- Constructive Total Loss: cost of repairing the item is more than replacing the item; if repairing costs more, the insurer can declare it to be a constructive total loss and pay you the value of a new item
- Salvage (e.g. IA s. 556 SC#4(8)): keeping damaged car if get it placed, the insured has been over-indemnified. Therefore this is the right of the insurer has to keep the damaged item under a constructive total loss
  - Under common law, have this right because of indemnity
  - **S. 556**: this statutory provision in automobile Ks gives insurance companies the right to declare constructive total loss
- Abandonment (e.g. IA s. 540 SC#10 [General]; IA s. 556 SC#4(7) [Auto])
  - Want a new item, not repaired
  - The provisions state that you cannot do this without the insurance company agreeing i.e. cannot abandon your insured property to the company without their consent
- Optional Repair Clause (e.g. IA s. 540 SC#13 [General]; IA s. 556 SC#6 [Auto]): provision in K that gives company the option of repairing the damaged property rather than paying the cash value of the loss
  - The provisions provide this in effect of a statutory term for general and auto Ks
  - **North West Electric v. Switzerland General Insurance [1976] SKQB**: once make this election, they are stuck. Even if the repair ends up costing more, they cannot change their mind even if it exceeds the actual cash value. Have to complete repair
- Co-Insurance Clause & Optional Loss Settlement Clause: can take different forms dependent on what is insured, requires you to pay a minimum percentage of the insurance coverage relative to the actual value of the insured item
  - If you do not insure your property to this amount in the K, the loss gets divided between the insured and insurer – have to ensure up to a particular amount
  - Way of insurance company to ensure the insured purchases adequate amount of coverage
- Relationship between deductible & salvage:
  - **Pauli v. ACE Ina Insurance Co. [2004] ABCA**: under principles of salvage, the insurance company should be able to keep recovered stolen property. But you have paid the deductible. Who gets the right to salvage?
    - **ISSUE**: Could the company keep the salvage of a vehicle even though the insured had paid the deductible of the policy?
    - **DECISION**: because of the statutory provisions, the company gets salvage even though the insured paid the deductible
      - Premium is based on non-deductible portion of the policy
      - In public interest because of the indemnity policy and its relation to the insured not the insurer

- **Other Statutory Provisions:**
  - o **s. 519:** Dispute Resolution Mechanism provided for in IA relating to disputes in valuation
    - Either party can trigger this mechanism; similar to arbitration to try to keep things out of the courts (rarely used)
  - o **s. 543 [General] & s. 584 [Auto]:** the existence of deductible & co-insurance clauses must be noted on the front of the contract or else are not binding on the insured

#### **D. SUE AND LABOUR CLAUSES**

- Contract clauses (in property insurance contracts) which **impose particular obligations** on the insured and the insurer in regards to efforts to protect insured property from further loss: **“suing” or “labouring” to preserve the subject matter of insurance**
  - o NOTE: partial loss, want to prevent more
  - o **Purpose:** benefit the insurer by giving the insured incentive to protect damaged property because it impacts the insurer’s obligation to indemnify the insured.
- After a loss has occurred, the insured must take **ALL reasonable steps** to prevent further loss from the same risk
  - o The **insurer must pay for these steps** even if they fail to prevent further loss
    - So, may result in the insurer paying MORE than the policy limits
    - If the insured fails to fulfill this obligation, the insurer can rely on the policy breach to avoid paying for the further loss
      - **I.E. must pay for the entire loss AND reasonable steps**

#### **- Applies only to expenses:**

- o Protecting the property against a risk covered by the policy
- o Relating to a materialized risk
  - The risk must have happened and trying to prevent further loss
- o Which are reasonable
- Doesn’t matter if reasonable efforts are ultimately unsuccessful in preventing loss
- These clauses are now deemed to be part of insurance contracts by statute (see below)

**S. 540 SC#9:** Sue and Labour Clauses deemed to be a part of any property insurance contract in Alberta; cannot contract out of them

- (1) In the event of loss or damage to insured property, the insured must take all reasonable steps to prevent further loss or damage to that property and to prevent loss or damage to other property insured under the contract, including, if necessary, removing the property to prevent loss or damage or further loss or damage to the property.
- (2) The **insurer must contribute on a prorated basis** towards any reasonable and proper expenses in connection with steps taken by the insured under subparagraph (1) of this condition.
  - o (1) gives the insured the obligations; (2) determines that the insurer as to contribute and how much – prorated against how much insurance coverage relative to the amount of damage and property value

**S. 556 SC#4(1)(b) & SC#4(2):** ONLY apply to section C coverage!

(1) When loss of or damage to the automobile occurs, the insured must, if the loss or damage is covered by the contract . . . (b) at the expense of the insurer, and as far as reasonably possible, protect the automobile from further loss or damage . . .

- (2) Any further loss or damage accruing to the automobile directly or indirectly from a failure to protect it as required under subparagraph (1) of this condition is not recoverable under the contract.
  - o No prorating under (1) – insurer pays for all reasonable expenses

Case law shows that determining what is a reasonable step is in the eye of the beholder; not based on certainty

- **ISSUE: what is a reasonable step?**

→ **Office Garages v. Phoenix Insurance (1966) ONHC**

**SUM: when assessing reasonability, assess value spent on sue and labour efforts as compared to the loss that may actually occur i.e. what you are trying to prevent NOT what happened**

**FACTS:** insured garage used to store tanks of gasoline. Tank explodes and damages garage. The explosion caused by a leak in the tank. Total damage = \$8,000. Policy limit = \$813,000. Actual value of the building = \$900,000. To avoid the risk of another explosion, insured hires an expecting engineer who identifies leakage problems. Insured spends \$45,000 to prevent further leaks and damage – improved things beyond what was necessary; \$10,000 was unnecessary. Insurance company argued this was not a reasonable step because the prevention costs were way more than the value of the actual loss

**ISSUE:** were the steps taken reasonable and how much does the insurance company have to pay?

**DECISION:** insurance company does have to pay pro-rated share of \$35,000 because reasonability is not assessed on the cost of the loss, compare it to cost of the possible total loss, which here would be \$900,000

- In assessing what is reasonable you don't look at damage that has already occurred you look at potential future damage (damage that might have occurred) within range of reason

→ **Hartford Fire v. Benson & Hedges (1978) SCC**

**SUM: This case shows that it is unpredictable to determine what is reasonable and if the loss has materialized. SCC cannot agree on this analysis**

- Shows that court is divided (4:3) on what is a materialized risk

**FACTS:** insured owned a brewery. Tank ruptured and caused damage. Insured hired engineer to determine what occurred – engineer determines defect in exploding tank. Inspection showed same defect in all tanks. Insured corrected all tanks. Total cost for this = \$60,000.

**ISSUE:** do sue and labour clauses include the obligation to minimize a risk that has yet to materialize?

**DECISION:** majority held that work being done fell into 3 categories:

- (1) Work done on the actual ruptured tank – not sue and labour but in the actual repair of the property
- (2) Inspection of un-ruptured tanks and correction – not covered by clause
  - o This was to prevent damage from a loss that had not yet materialized
- (3) Re-inspection of re-welded tanks
- Incredible narrow definition of materialize – only materialized for that one tank
  - o No repairs are covered under SL because they were not the risk that already materialized.
- Obligation does not extend to correcting faulty workmanship in un-ruptured tanks so as to reduce the risk of explosion; such a risk was another hazard which existed independently from and was not a result of the loss. It was made known by the explosion NOT caused by it.

**DISSENT:** took much broader view of what concluded to be a materialized risk. These clauses are to prevent future loss from the same risk i.e. any of the tanks exploding

## **II. Subrogation**

Subrogation allows the insurer, upon paying the insured is entitled to **assume the insured's cause of action** against the party at fault and to sue them for the cost of repairing insured's car

- Do not sue the party at fault as the insurer, but act as the insured → therefore just need to establish this duty of care
- Therefore anything the insurer sues for from the party at fault, they get to keep
  - o **"Step into the shoes of the insured"** = could do no more or no less than the insured could have done in this cause of action

But remember the **"single cause of action" rule**: *a plaintiff can only obtain one judgment for all losses resulting from a particular cause*

- This is not an issue when all losses are insured losses (i.e. when the claim against the wrongdoer is entirely a subrogated claim). But . . .
- The problem arises when some of the losses are insured AND some losses are uninsured
  - o E.g. property damages (recoverable by insurer) and personal injury damages not covered by insurance
- The single cause of action rule means that a judgment in one of these lawsuits will nullify the other claim.
  - o **Way around**: any lawsuit in relation to damages arising from this COA must include BOTH the insurer's subrogated claim and the insured's uninsured claim i.e. **coordination is required**
  - o **Issues**: (1) Who controls the lawsuit against Jill? (2) If the \$ recovered is not enough to pay both the subrogated and uninsured claims, who gets the \$? (3) Inadvertent negligence claims

### **A. Basic Principles of Subrogation**

- **Equitable doctrine**: courts are asking about fairness and the relationship between the insured and insurance company
  - o Company must have 'clean hands' to exercise right of subrogation
- Goes **"hand in hand" with the principle of indemnity** [except to the extent it is altered by contract or by statute] to prevent someone from being over-indemnified
  - o As soon as you have an indemnity policy of insurance, the company has a right to subrogate
  - o Remember that life insurance policies are non-indemnity policies
- **Definition**: Upon indemnifying an insured, the insurer is entitled to "step into the shoes" of the insured to recover any amount that the insured would have been legally entitled to recover from a party responsible for causing the loss
  - o They can only do what the insured could have done = cause of action is limited
- Can be altered **only by express / clearly worded statutory provisions or contract terms**
  - o Courts are not going to read in some sort of change to these principles implicitly

### **Benefits of Subrogation**

- No over-indemnification of the insured
- No benefit to the party responsible for causing the loss: **wrong-doer remains responsible**
- Shortfall in recovery is borne by the insurer

### **Subrogation Relationship**

- Insured and insurer is contractual relationship (insurer has to pay insured when there is a loss). Wrongdoer and insured may be contractual but may be just duty of care
- Loss, insurer pays insured and "steps into shoes" of insured to sue wrongdoer. Insurer no longer has to pay out if the insured successfully wins in suit against wrongdoer (receives full indemnity from wrongdoer)
- If insured sues wrongdoer and gets money from insurer, the insurer can claim back its money because again the insured has been over-indemnified, because subrogation is an equitable principle
- Therefore the relationships are dependent on the order in which things happen

→ Common Law Principles of Subrogation can be EXPRESSLY changed by Statute

COMMON LAW	STATUTE
No subrogation until the insured is <b>fully indemnified</b> for the loss i.e. the insured has been made whole	s. 546(1) – The insurer’s subrogation right arises upon <b>“any payment”</b> being made to the insured
<p><i>E.g. Deductible = IC will pay what they are contractually obligated to do. Technically under common law rule, insured is not fully indemnified because they have had to pay their own deductible. Does not matter IC has paid all that they are contractually obligated to. This would give the insured the right to sue the wrongdoer. Statute changes this principle to ‘any money’ – statute therefore recognizes deductibles and protects insurer’s right to subrogate.</i></p> <p><i>E.g. Car was not insured to its full value but destroyed in an accident. IC is only contractually obligated to pay for the amount insured, but insured technically not fully indemnified</i></p> <p><i>E.g. Insured suffers personal injuries. IC waives deductible, therefore has right to subrogate even under common law. Because personal injuries are not covered by the contract.</i></p> <p><i>***Remember full indemnity means full recovery of amount of the loss to the insured of what is covered by the contract, even if the loss value is greater than what is covered by the contract. This does not mean OTHER or ADDITIONAL losses that occur to the insured because they are not covered by the contract (e.g. here personal injury)</i></p>	
The <b>insurer keeps \$</b> collected from the subrogated claim	s. 546(2) – If recovery on subrogation is not full indemnity, then <b>the insurer and the insured divide the amount recovered on a “pro rata” basis</b>
<p><i>E.g. 10,000 damage and 1,000 deductible. Insured and IC together sue the wrongdoer who only has 5,000 to pay judgment. This 5,000 is split on a 9/10 to IC and 1/10 to insured ratio</i></p> <p><i>At common law, fully indemnified means the full amount of insured loss. Therefore if there was a deductible, the IC cannot exercise subrogation. Statute changes this by saying that any payment made to insured, they assume right of subrogation.</i></p>	
The <b>insurer controls</b> the subrogated action	<p>s. 546(3): If the insured’s interest is limited to the deductible, then the insurer controls the action</p> <p>s. 546(4): <b>Otherwise insurer and insured must coordinate</b>; if cannot agree, court may decide</p> <p>s. 546(6): Neither insurer nor insured is bound by a settlement or release unless they have agreed to it</p>
<p><i>Commonly, the insurer has the higher portion of risk = insurer will usually be in control</i></p> <p>s. 546(6): settlement or release NOT judgment – one party cannot bind all 3 parties to a settlement without consideration of both the insured and IC. Does not effect single COA rule for a judgment</p> <p>- Confusion about this rule = most court decisions say this provision unravels any settlement</p>	
The <b>subrogated claim is derivative</b> : the insurer has only the same legal rights against the 3 <sup>rd</sup> Party as the insured would have had.	<b>No change</b>
The <b>insured has a duty to cooperate</b> with the insurer’s subrogated claim.	<b>No change</b>
<p><i>Duty on insured to cooperate with IC when IC is exercising subrogated claim (if insured got paid he still has obligation with IC to help them succeed in subrogated claim; has to do everything he would if it was his own claim; doesn’t have to pay for anything). If not, IC can sue insured for money back because he is preventing subrogated claim.</i></p>	
<p><i>What is not required by duty to cooperate is spending money on part of the insured</i></p>	

<p><b>An insurer cannot subrogate against its own insured</b></p>	<p><b>No change</b> (BUT: there are situations where an insurer can claim back from the insured for \$ paid to a 3<sup>rd</sup> Party – see Chapter IV)</p>
<p><i>E.g. Section C of SFP#1 - cannot sue the insured in a single vehicle accident. Also doubles with being derivative, as you cannot have a COA against yourself</i></p> <p><i>Where does this get complicated? Multiple people under one insurance contract. IC must ask, are you an insured? This becomes a question of contractual interpretation of who is and who is not an insured</i></p> <p><i>Can claim money back against own insured under Section A (see CH 4, not technically subrogation)</i></p>	

**NOTE:** Regarding Automobile Insurance → no subrogation for s. B benefits (see IA ss. 587 & 588).

- Insurance company cannot pay your medical expenses and then sue a wrongdoer for these expenses; public policy provision

S. C says insurer will not subrogate against anyone driving the vehicle with the insured's permission

- Distinct from someone driving a stolen car/someone driving car without permission

**What is full indemnity for subrogation?**

→ **Confederation Life v Causton (1989) BCCA**

**SUM: at common law, if the insured is never fully indemnified for the loss which was the subject matter of the insurance, the insurers right to subrogation never arose. Costs to recover are included in the consideration of full indemnity**

**FACTS:** Causton (C) was insured under IC under group benefits that provide for short and long term disability to get % of income back. C involved in MVA and is permanently disabled. Makes claim under IC policy, where IC is only obligated to reimburse for % of lost wages, not full. C sues negligent driver and gets judgment against wrongdoer, including money for loss of wages (i.e. same loss under insurance policy). IC sues C to get money back because state she got was over-indemnified. Contract was completely silent on subrogation. Causton's lawyer acting on contingency bases (25%) – therefore her argument was that she was not over-indemnified

**ISSUES: (1)** Can IC raise subrogation if it wasn't part of the contract and **(2)** are legal fees expended in recovery from the wrongdoer included in consideration of full indemnity?

**DECISION:** Since the insured was never fully indemnified for the wage loss which was the subject matter of the insurance, the insurers right to subrogation never arose

- (1) At common law, subrogation goes hand in hand with an indemnity policy – therefore right of subrogation. Can be altered by clear provision in contract, which was not present. Contract of indemnity because being paid a portion of ACTUAL LOSS
- (2) Under the common law, subrogation only occurs after full indemnity, which includes money expended in loss recovery. Therefore, IC could not recover because she was not

**NOTE:** IC paid everything they were supposed to under the contract, so not issue of not fulfilling obligations. BUT she still was not fully indemnified – right to subrogation not triggered

- Statutory provision that alters the common law did not apply to the disability policy at issue here – important to know what statutory provisions apply to the contract at issue
- Note the statutory change in this recovery on part of the insurance companies, even if the insured has technically not been fully indemnified

→ **Somersall v. Friedman (2002) SCC**

**SUM: fundamental decision by SCC about the value of subrogation to an IC and the principles that are derived from it**

**There is a LIMITED duty on part of the insured for the duty to cooperate and need more than a settlement agreement to find bad faith and this duty breached**

**FACTS:** Somersalls (S) are injured in MVA by Friedman (F). F has a SFP with statutory minimum limit under s. A coverage. S suffers injuries far in excess of this amount. After suing F, enter into agreement that the most S will ever try to recover regardless of the judgment is the statutory minimum coverage = **limits**

**agreement.** S have SEF 44 under insurance K, and the IC is added as a defendant to the judgment. IC wants to subrogate against F and issue a third party claim against F in the same lawsuit. F says IC cannot do this because S cannot exercise this right due to limits agreement, and IC “steps into the shoes” of the insured. SEF 44 has clause that references subrogation and the duty to cooperate in any subrogation claim. **ISSUE:** did S breach their duty to cooperate with the IC by signing an agreement that prevented the IC’s right to subrogate?

- Note that there was an issue if the SEF 44 was triggered = court determined that yes, it was

**DECISION:** Majority (5-2) said S did NOT breach duty to cooperate by entering into the limits agreement.

- Common law principle/purpose of subrogation = to prevent over indemnification of the insured and ensure wrongdoer does not escape responsibility
- At common law, insurer’s right to subrogation only arises upon full indemnification of the insured. With respect to duty to cooperate, this clause in the K doesn’t alter the common law duty. No evidence that entering into agreement, S gave up anything that could have been recovered from F. They would only enter in this agreement if they knew F was impecunious. NO evidence to suggest that insured were in bad faith when entering into limits agreement
- Policy reasons for decision → the right of subrogation is of ‘negligible value to the insured’ because they are chasing someone who usually has no assets

**2 reasons → (1) no evidence of bad faith and (2) if you are weighing whether insured or insurer should suffer, it should be the insurer. This was a technical breach of the right to subrogation**

**DISSENT:** Binnie J – agrees with the interpretation of clause and common law duty but comes to different decision on common law

- States no evidence in court on that ACTUAL amount of money that F has, while majority’s decision is based on the fact the S entered into this agreement based on this assumption
- Disagrees with subrogation being a ‘theoretical right’ and that there is never any money. ICs spend lots of money pursuing subrogation claims – COA is never based on whether you not you can actually collected i.e. right to subrogate not whether you can actually collect

**NOTE:** majority’s characterization of subrogation created concerns about intrinsic value of the insured’s right to subrogation

- Prof believes that Binnie J has it right, majority acted more sympathetic to the insured and ignored basic insurance principles
- Decision doesn’t come to clear principle, but gives you flavor of what courts may do to find for the insured

### → *Zurich Insurance Co. v. Ison (2011) ONSC*

**SUM: IF an IC wants to change the principles of subrogation by terms of K, they MUST be completely clear and unambiguous in doing so**

**FACTS:** IC paid amount owed under the K. Insured paid the deductible and losses not covered under the K. IC sued the wrongdoer. K contained subrogation clause – upon making any payment, IC would be subrogated and could make action for the insured.

**ISSUES:** Does the insured or IC get to

**DECISION:** Court said clause just recognizes IC has right to subrogate on paying anything, but it does not address the issue of control. Because of this, cannot presume it changes the common law on this point

- In AB we now have statutory provision for who has control. In ONT, this provision does not apply thus have to look to terms of K.
- Courts will not assume that you meant to change common law principles of subrogation if the provision in the K is not specific

**NOTE:** still applies to contractual interpretation in AB, just not about control because our statute covers this

### → *Rochon v. Rochon (2014) ONSC*

**SUM: In order to alter common law principles of subrogation, legislation must exhibit a clear intention to do so**

**FACTS:** residential policy of insurance – house/garage/contents. 21 YO son of homeowners who lived in house was working on car in garage. Fire started and damaged the car and house. IC paid for the damages to the residence and then wanted to pursue a subrogated claim against the son and access to his section A

automobile policy. The automobile insurer steps in and says he cannot be sued because he was insured under the residential policy, cannot subrogate your

**ISSUES:** is the son an insured for purpose of rule that you cannot subrogate against your own insured?

**DECISION:** IC could not subrogate against the son because he was an **unnamed insured** under the residential policy. If you want to alter the common law principles by terms of a K, have to be specific in doing so. If want to subrogate against people living in home but not homeowners – need explicit provision in insurance K.

**NOTE:** from both these cases, know that the court will not read into the K and implicitly change the common law rules

### III. CONTRIBUTION

→ How does the existence of more than one policy of insurance for a loss affect the rights and obligations of the insured / insurers?

#### A. Basic Principles under Common Law

- **Equitable doctrine**
- Goes “hand in hand” with the principle of indemnity = thus will not apply to life insurance Ks. Can have multiple life insurance policies on the same individual and each one of them will payout
- **Definition:** where 2 or more policies of insurance cover the same risk, the policies must share in the indemnification of the insured
- **Benefits:** (1) No over-indemnification of the insured; (2) Insurer is not released from its payment obligation just because of the existence of another insurance policy

#### B. To Apply Contribution

**THRESHOLD QUESTION:** Is there more than 1 policy covering the loss?

- IF **NO**, contribution does not apply.
- IF **YES**, must ask...
  1. On what basis is the loss apportioned between the policies?
  2. How is payment made for the purposes of apportionment?

**For the answer to be YES (more than 1 policy), the policies must address:** (i) Same subject matter, (ii) same insured, (iii) same interest in the subject matter, (iv) same risk: *first loss / primary coverage v. excess coverage, “other” insurance clauses, statutory provisions*

- **Primary coverage** = SAP covers first loss for liability against the driver (e.g. 200,000 minimum) where SEF 44 provides **excess coverage** and layers on top of underlying coverage .
  - o SEF 44 will never be triggered as a first loss – therefore contribution will never apply between SAP and SEF 44 because they associate with different risks
- **Other insurance clauses** = ‘if you have any other coverage, this policy becomes excess’ i.e. trying to escape contribution’ OR try to negate liability completely
  - o Must read the terms of the K to know whether the policy becomes excess or disappears entirely due to presence of another K
- **Statutory provision** = e.g. owner’s policy is primary over any other insurance policy

#### C. If Contribution Applies...

1. How is the loss apportioned between the insurers?

- **Common law:**
  - o By whatever method is most fair
  - o Default is **pro rata** unless policies are not concurrent and subject to policy limits
- **Statute:** may codify or alter common law
- **Contract:** the contract between insurer and insured CANNOT alter common law contribution apportionment
  - Because the K is between the insured and insurance company, cannot bind apportionment rules to someone who is not a party to that K

## GENERAL: S. 544

- (1) If, on the happening of loss or damage, there is in force more than one contract covering the loss or damage, the insurers under the respective contract are each liable to the insured for their **rateable proportion of the loss, unless it is otherwise expressly agreed in writing between the insurers.** (*pro-rata apportionment*)
- (2) For the purposes of subsection (1), a contract is deemed to be in force despite any term or condition of it that the contract does not cover, attach, come into force or become insurance until after full or partial payment of any loss under any other contract. (*i.e. IC cannot declare themselves an excess insurance policy, UNLESS agreed between ICs as per 544(1)*)
- (3) Nothing in subsection (1) affects the validity of . . . Any contract condition limiting or prohibiting having or placing other insurance.
- (4) Despite subsection (1), **insurance on identified articles is a first loss insurance** as against all other insurance.

## AUTO s. 596(1):

- (1) . . . Insurance under a contract evidenced by a **valid owner's policy is, in respect of liability** arising from or occurring in connection with the ownership, use or operation of an automobile owned by the insured named in the contract and within the description or definition of an automobile in the policy, **a first loss insurance**, and insurance attaching under any other valid motor vehicle liability policy is excess insurance only.
- (2) . . . if the insured named in a contract has or places any other valid insurance, whether against liability for the ownership, use or operation of or against loss or damage to an automobile or otherwise . . . The insurer is liable only for its rateable proportion of any liability, expense, loss or damage.
- (3) In subsection (2), "rateable proportion" means
  - (a) If there are 2 insurers liable and each has the same policy limits, each of the insurers is liable to share equally in any liability, expense, loss or damage, or
  - (b) If there are 2 insurers liable with different policy limits, the insurers are liable to share equally up to the limit of the smaller policy limit . . . (*smaller policy will payout first before larger policy is expended because paying dollar for dollar – thus rateable portion is changed by statute to consider the limits of the policy*)

**NOTE: s. 587 and 588** = if you are a passenger it is first loss insurance in respect to section B coverage

## 2. How is the payment made?

- **Common law:** Insured collects in full from the insurer of his/her choice and that insurer [in its own name] seeks "contribution" from the other insurer
- **Statute:** s. 544 and s. 596 make **insurer liable to the insured only for the insurer's rateable portion** of the loss
  - o Statute changes common law to put the recovery obligation onto the insured

## → **Clarke v. Fidelity-Phoenix Insurance Co. (1926) ONCA**

**SUM: illustrates what courts are looking at in considering whether or not there is duplicate coverage**

**FACTS:** Clarke (C) owned a house and obtained a mortgage. C then took out fire insurance policy (not current classifications) Mortgage co takes out separate policy on the same house (2500 limit, C is 4000). C argued that mortgage co's policy should

**ISSUES:** is there duplicate coverage here?

**DECISION:** No duplicate coverage. Although there was the same subject matter – different insureds and different property interests (owner vs. security in property)

- No right of contribution because there is no duplicated coverage (not the same interest); **same subject matter is not enough**

→ **Continental Insurance Co. v. Prudential Insurance Co. (1965) MNQB**

**SUM: difference between statutory contribution and common law contribution**

**FACTS:** LeClaire (L) had policy insurance on property with D IC. L is approached by agent of P IC and says their policy is better, so buy policy and cancel the policy with D. L agrees, buys policy with P and cancels policy with D by letter. D never receives letter. Fire occurs and damages property. L collects from P and 2 other ICs – these 3 ICs notice the D policy has never properly been canceled and so they make a claim for contribution. Statutory provision in MN looks like s.544

**ISSUES:** is there a contribution obligation for D to contribute under the statute? If not, is there this right found under common law?

**DECISION:**

- **Under statute, no.** Statute only obligates the insurer to pay their portion and obliges the insured to collect from the IC. ICs cannot claim contribution from another ICs. Under statute, only able to limit how much you have to payout as first loss.
- Also **no obligation under common law** – contribution is an equitable doctrine. P convinced the insured to cancelled their policy and this is what everyone thinks happened. Just because there was an error in policy cancellation, P should not be able to take advantage of this error
- Technicality therefore not fair to have that company pay

→ **Musca v. Wawanesa Mutual Insurance (2004) ABQB**

**SUM: Until communication of cancellation reaches the IC, the policy is in existence. Also, court will always look at what is equitable.**

**FACTS:** 1996 van insured. By SAP from defendant IC. IC gives M temporary pink card to evidence insurance policy. Van is already insured with AXA IC. Day after receive pink card, D IC sends notice of cancellation to AXA IC. Both policies have 1 million in s. A coverage. M is involved in MVA on this date that notice is sent that is their fault and they get sued for >1 million. AXA refunded all premiums back to insured since notice of cancellation – AXA argues this is proof of no contribution even though had not yet received notice

**ISSUES:** Does contribution apply i.e. is their 2 policies? If so, how is it apportioned?

**DECISION:** There were duplicate IPs at time of accident. M intended to cancel AXA policy, but they did not know this at the time of the accident. The intent of the insured has no legal effect until such time as that intent is communicated (in this case it was after the accident). Therefore both policies were in place and contribution is in place.

- Contribution = only applies where danger of insured being over indemnified. Here, amount sued for is greater than both policies so both policies must pay, no need for pro rata
- Cannot say the policy was cancelled until the company receives KNOWLEDGE that the policy was cancelled

**NOTE: see difference between this case and continental. Both deal with failed cancellations. The difference is the action of the IC that is trying to claim contribution. In Continental, there was an inducement of the insured. Here, there is no inducement therefore no unfairness to either IC.**

- Different outcomes because of the application of contribution as an **equitable doctrine** = court can consider on a fairness principle what should be happening in the policy

→ **Family Insurance Co. v. Lombard (2002) SCC**

**SUM: “other insurance clauses” – policies rendered either in excess or non-existent if another policy is in place**

**FACTS:** Leslie Young, insured, owns stable. Sued by client who injured herself at stable, was settled at 500,000. Dispute over who pays this amount. 2 insurance companies – Family provided insurance to Young under homeowners insurance policy (1 mill); Lombard provided commercial general insurance to Young (5 mill). Each policy contained ‘other insurance clause’ that stated that policy would change to excess if other policies were in place.

**ISSUES:** How do you apply these “other insurance clauses” when they act to shield each insurer from primary liability?

**DECISION:** SCC felt that each policy should be held mutually repugnant, and principles of contribution apply. Clauses negate each other

- Relays fundamental principles of contribution

- Argument made that policies were distinct – SCC said no because the nature of the agreement. Does not matter if one policy was more specific than the other
- Court employs *equal apportionment method* until the limits of the lower one is expanded. Court causes it *independent liability method* → MISLABELED
  - o Did not make a difference here because the claim was within both policy limits

To endorse the intentions of one insurer over another, where parties have sought to limit their liability to contribute and where offending clauses are irreconcilable, it does violence to the intentions of the insurers and does not respect the obligation of both insurers to contribute. Equitable contribution applies

**NOTE:** does not consider amended AB statute (claim arose in BC)

#### **IV. SUBROGATION VS CONTRIBUTION**

- **Related:** (1) only apply to true indemnity contracts (hand-in-hand), (2) purpose is to prevent over-indemnification for the insured 3) offer insurer way of recouping some of the money paid to and insured loss (either from wrongdoer or other IC).
- **Not the same thing:** right of recovery is fundamentally different.
  - o In **subrogation**, they step into the shoes of insured.
  - o **Contribution** is limiting the legal liability of IC to pay for loss when there is another IC that also has to pay for loss.

→ **Cameco Corp v. Ins. Co. of State of Pennsylvania (2010) SKCA**

**SUM:** subrogation and contribution are NOT the same thing. Contribution allows an IC to claim even after the insured has been fully indemnified, cannot happen in subrogation. **Subrogation is a derivative right, contribution is a right of the IC.**

**FACTS:** Insured, Cameco had 3 policies of liability insurance: Global (aviation); ICSOP (CGL); and American Home (CGL). Injured 3Ps sue Cameco (*3Ps v. Cameco*). Global defends under Reservation of Rights (responds to loss); ICSOP and AH deny coverage. Cameco sues ISCOP and AH for coverage (*Cameco v. ISCOP & AH*) - separate lawsuit in contract to sue IC's who refuse to pay. Global settles and fully indemnifies Cameco for the 3P judgment. Global wants to sue for contribution but is concerned that a contribution action in its own name against ISCOP and AH is barred by the passage of time (Limitations Act) so they don't pursue a lawsuit; so Global tries to have Cameco's lawsuit against ISCOP & AH amended to include a subrogated claim by Global. Global is trying to step into shoes of Cameco to pursue their subrogated claim against the two IC's. Argument is that Cameco has no obligation to sue because they have been fully indemnified.

**ISSUE:** Can an insurer have a subrogate claim against a non-paying insurer?

**DECISION:** Court says that the two IC's are correct. Global cannot pursue subrogated claim because Cameco has been fully indemnified. Subrogation is a derivative action. Cameco has no outstanding loss here. Once indemnified the insured has no right of action against other insurance companies so therefore there is no subrogation rights because you can only step into what the insured can do.

- **No legally enforceable claim** because the other insurers no longer have a legal obligation to pay the insured

## THE INSURANCE CONTRACT

### I. Uberrima Fides – The Insured’s Duty of Disclosure

- Insurance contracts are contracts *Uberrima Fides*: **contracts of “utmost good faith”**
- An insured’s utmost good faith obligations include fully and honestly disclosing to the insurer information relevant to the insurer’s assessment of the risk.
  - o Utmost good faith based on the **reliance** that the parties must have on each other
  - o Duty arises right at the beginning of entering the K, because this is when risk assessing occurs, although non-disclosure not have an effect until a claim arises
- Although questions about whether the insured complied with his/her duty of disclosure usually becomes an issue **AFTER** the loss, it **relates to pre-loss conduct by the insured which calls into question the validity / enforceability of the contract**
  - o **“Pre-loss obligation”**
  - o Huge consequences of non-disclosure, because it allows the IC to negate the policy

**Common Law Principles:** the insured must **disclose facts** which are within the **knowledge of the insured** and which are **material to the risk** covered by the contract of insurance.

- *Not about what the insured thinks the fact is or is not important – the question is did you know a fact and not tell the IC. Do not have to tell them ‘common knowledge’*
- **Material** = a fact that if the IC had known about it, they would have increased the premium or denied coverage of the risk = **NOT subjective, based on reasonable insurer**

#### **Strict Duty:**

- o Non-disclosure can be unintentional
- o Insured does not need to know the information was material
- o Undisclosed information does not need to be causally connected to the loss

**If the insured fails to fulfill its disclosure obligation, the insurer can:**

- 1. Treat the policy as valid anyway
- 2. Treat the policy as valid but terminate the contract going forward
- 3. Treat the policy as void ab initio (i.e. repudiate the contract):
  - o Requires premiums to be returned
  - o Is subject to defences of estoppel/waiver
- Most ICs would choose 3 because they escape liability after a loss occurs

#### → **Carter v. Boehm (1766) Eng. K.B.**

**SUM:** duty of utmost good faith is a grounded principle and defines the common law rule of disclosure on part of the insured → **requires an insured to disclose information which the insured knows or which the insured reasonable ought to know, even if the insured does not realize that the information is material to the insurance contract**

**DECISION:** if insured fails to disclose material facts, the failure is deemed to be fraud. Intent does not matter

- In ordinary contract, if one party intentionally misleads the other party, it is fraud. Because of the speculative nature of IC’s the duty is more strict.
- The special facts relied upon for assessing the risk lie with the knowledge of the insured only. In context of IC, any misinformation provided by insured is deemed to be fraud and voids the contract
- It doesn’t matter if insured forgot or didn’t mean to, the misrepresentation or non-disclosure is deemed to be fraudulent
- Raises Q of what is material?

#### → **Mutual Life v. Ont. Metal Products (1925) JCPC**

**SUM:** defines **material fact test** = **it is objective and based on a reasonable IC, but the outcome of the test is based on subjective evidence provided to the court**

**FACTS:** life insurance K and D is beneficiary. In application, the deceased was asked to list every doctor who had prescribed/treated him in past 5 years. Did not disclose he has received tonic injections unintentionally. Both as a matter of common law and under the K, court has to determine if this was material?

**ISSUES:** was this information material to the IC, and how does the court determine if it is or is not material?

**DECISION:** Court rejected both parties' arguments (reasonable man vs. everything requested). Test depends on the facts of the case applied to the test **would a reasonable IC declined to issue a policy or charged higher premium if they had known of the non-discloses/misrepresented fact?**

- Policy would have been issued for the same amount even with this fact disclosed

**NOTE:** statute may slightly re-word this test i.e. 'prejudicial'; applies to all types of insurance. REMEMBER that this test applies to the disclosure/application stage and not the time of the loss – material to the decision not material to the loss

→ **Badenhurst v. Great West Life (2013) MNCA**

**SUM:** does not matter what the insured thinks is material - good faith on the part of the insured arising from their innocent failure to appreciate the materiality is NOT considered a defence against a misrepresentation because it is objective

**FACTS:** disability insurance policy and insured who attended marriage counselling. In application, asked if she had ever consulted psychiatrist/suffered from anxiety or depression. Responded no, when in fact insured had. Claimed insurance for taking time off work for depression, IC said no.

**ISSUES:** is the non-disclosure material?

**DECISION:** in considering the question of materiality, do not consider what the insured thinks to be material.

**Objective materiality as determined by the reasonable IC.**

- Not a case about the insured misunderstanding the question = here the insured redefined the important of the facts
- **Misrepresentation = no coverage!**

→ **Henwood v. Prudential (1967) SCC**

**SUM:** evidence issue – what does a court need to see in way of evidence to determine if a fact is material. Difference between test and what evidence can be brought to prove the test

Can meet objective test by raising subjective evidence but you are taking a risk. **Burden is on IC, has to prove nondisclosure and its materiality on BOP, might get away with using their own employee for evidence if it is not contradicted.**

**FACTS:** Life insurance policy, insurer argued she did not disclose material information regarding her emotional health issues. Insurer gets their own company doctor as evidence of reasonable insurance company. No evidence to the contrary provided

**ISSUES:** is IC's own doctor sufficient to be conclusive evidence? How do you prove the material fact test has been met?

**DECISION:** Majority said in the absence of conflicting evidence, a court is at liberty to accept evidence of insurer's as to what would be reasonable (treat as adequate if there is no conflicting evidence). Burden is on insurance company to prove there was been breach of obligation of disclosure and that it was material. Court says there is nothing else for us to rely on so we will allow it. In other words, there is no evidence to suggest that this was unreasonable or that other insurance companies would have followed a different course. Insurer should have provided evidence

**DISSENT:** thought it needs to be objective from an outside source and that the evidence given by the IC doctors cannot be accepted as a discharge of the onus upon the insured to prove that of the facts had been truly represented they would have caused a reasonable insurer to decline the risk or required a higher premium

**NOTE:** To successfully argue misrepresentation or non-disclosure to avoid payment, an **Insurer must prove on a balance of probabilities:**

- (1) **Misrepresentation/non-disclosure** of fact
- (2) Materiality of fact on the basis of the reasonable insurer standard = Material Fact Test [**OBJECTIVE test**]
  - o The more objective the evidence is, the more likely the K will be void
- This insurer relied on the misrepresentation/non-disclosure (i.e. that the information was material to THIS insurer's decision-making) [**SUBJECTIVE test**]

- IC has to prove their own reliance on the misrepresentation/non-disclosure = (1) material to objective insurer AND (2) material to them

## **II. STATUTORY MODIFICATION OF COMMON LAW**

\*\*Statutory conditions cannot be altered by contract

### **A. Property Insurance**

#### **(a) Misdescription, Non-disclosure, Misrepresentation at Contract Formation**

**IA s. 540, SC#1:** *If a person applying for insurance falsely describes the property to the prejudice of the insurer, or misrepresents or fraudulently omits to communicate any circumstance that is material to be made known to the insurer in order to enable it to judge the risk to be undertaken, the contract is void as to any property in relation to which the misrepresentation or omission is material.*

- Statutory disclosure provision (duty of insured to disclose info to IC at the outset of a property insurance contract)
- Only matters if it prejudices the insurance company
- Material is not defined therefore turn to common law (**material fact test**)

→ **Taylor v. London Assurance Corp. (1935) SCC**

**SUM: require intention for insurer to prove actual fraud in SC#1 of s.540**

**FACTS:** P owned lumber camp in Ontario. His wife becomes aware of forest fire in adjoining company. Wife calls IC – does not tell about fire in adjoining county. Lumber camp destroyed by forest fire. Statute contained similar provision to above.

**ISSUES:** What does fraudulently mean? Is it referencing the common law or does actual fraudulent activity have to be found?

**DECISION:** SCC held that inclusion of 'fraudulent' in provision was intended to *change* the common law and intended to convey a **purposeful intention to omission** (not constructive or deemed fraud)

- Only changes it in respect to **omission**, misrepresentation is deemed to be fraudulent

**NOTE:** what is difference btw omission and misrepresentation?

- IC tend to plead both ways to find out which one they can prove better

→ **Bowes v. Fire Insurance Co. of Canada (1935) ONSC**

**SUM: distinction between fraudulently omits and a misrepresentation - non-disclosure has to be intentionally fraudulent, but misrepresentation does not**

**FACTS:** P manufactures shields and trophies – purchased fire IP from D. When applying for policy, asked if they had had previous policies. P said yes, both expired. In fact, ICs had cancelled them because the premiums had not been paid. Insured 'metal patterns' – misunderstanding about what material the patterns were constructed of.

**ISSUES:** What is the distinction between fraudulently omits and a misrepresentation?

**DECISION:** IC was entitled to rely on those misrepresentations therefore did not have to pay the loss. IC does not have to prove fraudulent intention (therefore does not have to be intentional), but it does have to be material and affect the IC.

- Generally, cancellation for non-payment is material
- Misrepresentation can be innocent and still result in policy being treated as void

**NOTE:** Hard to distinguish between what is an omission and what is a misrepresentation. If there is any misinformation the IC pleads both. For fraudulent omission you need to show subjective intent AND still need to prove material fact test or the objective portion

#### **(b) Changes Material to the Risk**

**IA SC#4(1):** *The insured must promptly give notice in writing to the insurer or its agent of a change that is*

**(a) material to the risk, and**

**(b) within the control and knowledge of the insured.**

- Changes the timing of the insured's obligation to disclose
- Imposes a duty on the insured to disclose material changes to the risk as long as they are in the 'knowledge and control' of the insured

- No definition of promptly – dependent on circumstances

**IA SC#4(2):** *If an insurer or its agent is not promptly notified of a change under subparagraph (1) of this condition, the contract is void as to the part affected by the change.*

- Effect of this duty = K is void as to any part that is affected by the undisclosed change
  - o Can void back to the date of the material change in relation to any part of the K that is affected by that change
  - o Does not require causal connection between material change and actual loss = material change is assessed on date it came into existence
  - o IC's burden to prove failure to disclose

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

**SUM: if insured has both physical and legal control, the material change is within the insured's knowledge and control**

**FACTS:** N owned general store, with fire IP from Pearl Insurance. Contained vacancy clause – “if property is vacant for >30 days, there will be no insurance”. N sold store provided for installment payments, so N would remain as owner until all payments were made, but purchaser was able to occupy as tenant. Purchaser defaulted payments, and N kicks them out. N goes into property and boards up the window. There is a fire.

- **IC argument:** says do not have to pay (1) because the vacancy of the building was an unreported material change, and (2) vacancy clause had been triggered because vacant for >30 days

**ISSUES:** what does ‘knowledge and control’ being imputed into the statute entail? Was the vacancy within the knowledge and control of the insured?

**DECISION:** no insurance coverage on both of IC's arguments

- Court found the vacancy was material and was clearly within the knowledge of N...but is it within the **N's control?**
  - o **YES, BECAUSE:** Sale agreement gave N right to enter property if purchaser defaulted, N was legal owner of the property, and N went in to the property and boarded up the window (last is most important because it shows not only legal, but physical control of property)
- Also, vacancy clause was also triggered and was not an unreasonable exclusion because vacancy changes the risk (if this was only found, would take K back to the date of material change)

**NOTE:** do NOT need to ‘know’ its material, just need to know of its *existence*

→ **Watkins v. Portage La Prairie Mutual Insurance Co. (1984) BCSC/BCCA**

**SUM: Control within the meaning of SC#4(1) means there must not only be legal control, but actual physical control as well. Insured must not only have knowledge of the material change in risk but also have control of the risk.**

**FACTS:** P rented out home to boarder who is alcoholic. P entered romantic relationship with boarder, until he turned violent. Issues notice to vacate and day after she applies for insurance. Tells IC that there is a boarder but tells him that he is leaving on certain date. Policy issued but boarder does not leave. Instead leaves 6 weeks later and takes 30,000 of the property's fixtures. Files claims.

- **IC argument:** denies payment on the fact there is a material change → thought policy was issued on date after the tenant vacated, when in fact the tenant caused the loss

**ISSUES:** was the vacancy of the property within the control of the insured

**DECISION:**

→ **BCSC:** change in tenancy is material

→ **BCCA:** IC could not deny coverage under SC#4 because insured must have knowledge AND control

- P did not have sufficient control over situation because she was scared of tenant (violent, could not physically remove him, had demanded him to leave)
- Court stated seeking legal control is not sufficient, need some level of **physical control**
- P could have taken legal steps but court says legal control is not enough, you need some element of physical control. You need to have physical control over the change.

**(c) What happens if there is a material change, but then it is reversed?**

**IA s. 545(1):** *If a contract contains a stipulation, condition, term, proviso or warranty, other than a prescribed exclusion . . . that is or may be material to the risk . . . The stipulation, condition, term, proviso or warranty is not binding on the insured if it is held to be unjust or unreasonable by the Court before which a question relating to it is tried.*

- ICs are the ones that draft the contract, this section gives the Court the power to not apply unreasonable terms
- Statutory conditions are inserted into ICs by the government

→ **Marche v. Halifax Insurance Co. (2005) SCC**

**SUM: if you have a material change that is unreported but does not relate to the loss, insured can use s.545 to excuse their breach of SC#4**

**Insurance condition may on its face be reasonable and just but in its application be unreasonable and unjust, must look at consequences from facts of case.**

**FACTS:** insureds purchase house in Nova Scotia and initially leave it vacant. They converted it into apartments and rented to 2 tenants. One tenant stopped paying rent – removed electrical box and shut off water to remove tenant. Tenant left but belongings remained. Canadian courts have defined ‘vacant’ property separate from ‘unoccupied’ property – **nothing vs. no people**. After tenant leaves, fire occurs on insured property which included vacancy clause – if on date of loss the property had been vacant for >30 days.

- IC argument: D could not rely on clause because said vacant NOT unoccupied. Instead, argued vacancy prior to tenant moving in was a material change.
- P argument: SC#4 was unreasonable to apply in this instance, and that s.545 should apply to relieve them of the SC’s obligations

**ISSUES:** (1) Can you rely on s.545 in relation to what is a statutory condition? (2) If you can, was there a breach of the SC and if there was, is it unreasonable to rely on it?

**DECISION:** IC could not rely on SC#4. S.545 applies to relieve against the unreasonable or unjust application of statutory conditions

- This is saying that SC#4 is unjust or unreasonable...but majority says not saying SC#4 is not unreasonable, but the **application** of the SC to these circumstances is unreasonable
- Unreasonable in this situation because the loss was not at all related to the vacancy
- The change and reversion back is the substance of the issue → not unreported material change because at the time of loss the unreported change no longer exists
  - o All there is, is a short period of time where the premiums may have been different

**DISSENT:** tries to focus on consistent application of insurance principles to create stability in insurance law

- What’s the point of a SC if you cannot apply it? Cannot separate the unreasonableness of a condition from the unreasonableness of its application
- Duty to disclosure is NOT linked to causation, therefore relatedness does not matter

**NOTE:** problem arising from this decision – majority says can look at application of a SC and determine it unreasonable. Prof believes dissent is more consistent with traditional insurance law principles. BUT

**B. Automobile Insurance**

**Non-Disclosure and Misrepresentation at Contract Formation**

- **s. 554** (*duty at the outset*), **555** (*limits the circumstances where insurer’s can take adverse contractual action against an insured; can’t take ACR unless this section or regulations says you can*) & **556 SC #1** (*ongoing duty to report material changes*).
- **Unless s. 555 or regulation specifically allow it, an insurance company cannot take adverse contractual action against insured in respect of BASIC MV coverage**
  - o What is ACA? Defined in 555(1); cancelling or terminating or refusing to provide coverage under an insurance contract
  - o What is basic coverage? Defined in 549; s. A limits of 200,000 and s. B coverage
  - o When allowed to take ACA? Not paying premiums, misrepresentation on application, suspended license, etc.
    - NOT change material to the risk = therefore have to pay s. A limits and s. B

**IA s. 554(1)(a):** *If an applicant for a contract*

- (i) **gives false particulars** of the described automobile to be insured **to the prejudice** of the insurer, or
- (ii) **knowingly misrepresents or fails to disclose in the application any fact required to be stated in the application**

**a claim by the insured is invalid** and the right of the insured to recovery indemnity is forfeited

- Note that this is NOT a SC, but a **clause in the statute** (therefore doesn't get imputed into the K)
- The CLAIM by the insured is invalid, does NOT mean the entire policy is
- "**Knowingly**" = have to know the truth and state something else. Reasons for misrepresentation do not matter
- (ii) is a **change to the material fact test for automobile insurance** to deem *anything* asked for in the insurance application to be deemed material
  - o Because regulated industry, the government approves the insurance applications

→ **Sleigh v. Stevenson (1943) ONCA**

**SUM: knowingly DOES NOT mean intention to mislead/defraud. It only means knowledge of the correct information and failure to give it**

**Where an applicant for automobile insurance knowingly misrepresents or fails to disclose in the application any fact required to be stated, any claim by the insured should be rendered invalid.**

**FACTS:** Agent goes to home of insured. Son meets with agent and gives him information about vehicle for policy. Agent fills out application for him – on application writes that mother is the registered owner and purchaser of the car. After application is filled out, mother signs the application. Misrepresentation about ownership – vehicle was purchased by the son and had put it in his mother's name. Therefore, she has bare legal title i.e. is neither purchaser or owner in reality. Loss occurs and IC refuses to pay.

- Son claims Agent wrote it down wrong and that Agent let mother sign it without reading application
- IC argument: there was misrepresentation and that the contract was void

**ISSUES:** was the misrepresentation in the application made *knowingly* within meaning of the statute?

**DECISION:** Yes – made knowingly.

- It was clear that the mother was not the owner

Even though the mother did not read the form, she made the misrepresentation. She had knowledge of correct facts, and authenticated a document that had incorrect facts. Did not matter if she didn't intend to mislead

- Not necessary for IC to prove she was trying to deceive. Knowingly under statute is the same thing under the common law. If she would have read that she was the real owner she would have known this was a misrepresentation

→ **Moxness v. Co-operative Casualty Co. (1979) ABSC**

**SUM: no duty on an insured to disclose information that is known to the IC or the information that the IC assumes the burden of finding out**

**FACTS:** P contacts IC to get auto insurance. P says has lots of speeding tickets, but does not know details. Agent says the IC will find out details themselves. P attends office and signs application without reading it. Application did not reflect that P had been convicted of traffic offences or had lost his licence. Involved in MVA and injures third party. P sues IC for indemnification.

- IC Argument: claims there is a misrepresentation with respect to driving record

**ISSUES:** can P be taken to make misrepresentations by signing the applications?

**DECISION:** P gave IC all the information he had. In signing the application, P was only authenticating the extent of his knowledge.

- **While signatures can be taken to authenticate all the information, circumstances of the case can change that**
- He explicitly told the IC he did not know details of his traffic offences = insured obligation to disclose is limited to what the insured knows or whatever the IC waives

**NOTE:** difference from previous case – mother had knowledge different from what was on the application. Here, P did NOT have that knowledge

## (b) Changes Material to the Risk

**IA s. 556 SC#1(1):** The *insured* named in the contract **must promptly notify the insurer** or its agent in writing of any change in the risk material to the contract and within the insured's knowledge.

- Ongoing duty to report changes material to the risk – common law test of materiality applies here
  - o **BUT** → see SC#1(2) for things that have been deemed to be material (e.g. mortgage, other IPs); not an exhaustive list
- **NOTE:** different from property – knowledge vs. knowledge AND control

→ **Thompson v. Allianz Insurance Co. (1996) ABQB**

**SUM:** this statutory duty does NOT modify the common law duty that the insured need not know the change is material, just that a factual change occurred

**FACTS:** P's friend buys Chevrolet truck for 8,000 and finances 6,000. Friend moves to P's farm. One month later, P buys the truck from friend for 7 cows. Friend does not tell P that there is a lien on the truck. P goes and gets IP on the truck. Time later, friend wants to leave. P says friend can take the truck and use it for sometime. Accident occurs while friend is driving and injures a third party. Friend is driving truck with P's permission BUT is there a material change? I.e. friend is sole driver of the vehicle in different area of Alberta for several months?

**IC argument:** 1) Thompson did not have insurable interest because he never bought it for value; court said value does not have to be cash, therefore insurable interest exists. 3) Thompson failed to report change material to the risk because Buck would be principal driver in different location for over a month.

**ISSUES:** is giving permission to drive vehicle for several months constitute a material change to the risk?

**DECISION:** YES - no coverage because of unreported material change to the risk.

- Apply the **material fact test**
  - o P argued that he didn't know IC would care, but it does not matter what he thinks, it matters what a reasonable IC would care to know
  - o Don't need knowledge of materiality, just need knowledge of factual change
  - o It is the insurer that assesses the materiality of the facts

## IA s.555 & the Adverse Contractual Action Regulation.

- At common law, any non-disclosure would render a K void. Alternatively, IC could terminate/cancel the K = these are **adverse contractual actions**
  - o **Problem:** in Alberta, every driver should have 200,000 coverage to protect injured parties. If ICs can void/terminate a K, innocent parties could not recover
- Together, these provisions **LIMIT an insurer's ability to invalidate or terminate BASIC coverage** under an automobile insurance policy due to the insured's breach of a disclosure duty
  - o IC cannot take away 200,000 liability coverage BUT what they can do is reduce coverage to this minimum
  - o Basic coverage = Section A and B up to 200,000
    - Can void/terminate coverage over 200,000 and can terminate optional collision coverage (Section C)
- Only applies to auto insurance – limited circumstances to the extent the provisions allow
  - o **Adverse Contractual Action Available if Insured:**
    - **Regulation s.555(2)(b):** (i) fails to complete the approved application form, (ii) provides false information on the approved application form, (iii) makes any misrepresentation on the application form, (iv) fails to submit any required information required in the approved application form, (x) or fails to inform who the principle driver is
      - Common law applies to these because not material change in the risk. Material change to the risk = not void; dropped down to basic coverage
    - **s. 555 (3):** a) non payment of premium, b) failure of insured to inform insurer, where requested, as to who principal driver is.

## C. Life Insurance

IA: ss. 652, 653(1) & (2) and 655(2) & (3)

Related: s. 649

### (a) Misrepresentation at Contract Formation

**IA s. 652(1):** *An applicant for insurance and a person whose life is to be insured must each disclose to the insurer in the application, on a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within the applicant's or person's knowledge that is material to the insurance and is not so disclosed by the other.*

- This disclosure duty is not only imposed on the applicant, but also the insured = both have to disclose every fact in their knowledge
  - o Does not require 'double disclosure'
- Material not defined by statute = apply common law (*material fact test*)
  - o No intention to mislead required to establish material
- Failure to report this information renders the K voidable

#### → **Murphy v. Sun Life Assurance Co. (1964) ABSC**

**SUM:** illustrates strictness of disclosure obligation for life insurance and the guiding principles

**FACTS:** Husband purchasing policy on own life with wife as beneficiary. 1 month prior = H suffered fainting spell. ECGs came up negative for heart problems. H examined by insurer's medical examiner, afterwards signs examination form. H dies.

- Three mistakes recorded on form: (1) said no to suffering loss of consciousness, (2) ever done ECG, (3) did not disclose information of fainting and ECG doctors.
- IC decides on misinformation/non-disclosure to deny coverage. Insurer presented evidence of what was material to make the contract voidable

**ISSUES:** did the misinformation arise from a non-disclosure or a misinterpretation from the doctor?

**DECISION:** Court accepts insurer's medical information = this was representative of what a reasonable insurance company would do.

- Court concluded mistakes were made by the insured by the sheer number of the mistakes and how they all related to one fainting incident

#### **Principles of disclosure relating to life insurance:**

- I. Burden of proving a nondisclosure/misrepresentation remains on the IC on a BOP
- II. The intention of the insured is irrelevant and does not matter if the insured thought the information was immaterial
- III. No requirement under statute for there to be a causal link between material fact and cause of loss
- IV. Material fact test applies
- V. The signature on the application form does not always mean the insurer has discharged its duty, especially when there are agents filling out the form
  - o Here, the signature was coupled with the sheer number of misrepresentations that were consistently found throughout the application

**NOTE:** life insurance is a tricky thing, because people's health changes all the time. Therefore, ICs' reliance on this has diminished over time (*see provisions below*)

### (b) Incontestability

**IA s. 653(2):** *... if a contract . . . has been in effect for 2 years during the lifetime of the person whose life is insured, a failure to disclose, or a misrepresentation of, a fact required by section 652 to be disclosed does not, in the absence of fraud, render the contract voidable.*

- Limits ICs' ability to rely on innocent misrepresentation
- Important statutory change to common law because it focuses on the **intention of the insured**
- Therefore, to get out of a life insurance policy that has been in effect for more than two years the IC must prove fraud

**IA s. 653(1):** *This section does not apply (a) to a misstatement to an insurer of the age of a person whose life is insured . . .*

- Exception is in regards to a mistaken of age; IC cannot rely on that misstatement to void contract, instead the insurance money payable is increased or decreased

**IA s. 655(2):** . . . if the age of a person whose life is insured is misstated to the insurer, **the insurance money provided by the contract must be increased or decreased to the amount that would have been provided for the same premium at the correct age.**

- All the IC can do is recalculate what the payout would be, even if fraudulent. Cannot void the policy
- **655(3):** Exception to exception: where IC limits the age right from the beginning. If in this circumstance there is misrepresentation to age, IC can void contract, have 5 years to do so, and within 60 days of learning the problem with age.

**IA s. 649(1):** Subject to a provision to the contrary in the application or the policy, **a contract does not take effect unless**

- The policy is delivered to an insured, the insured's assign or agent, or to a beneficiary**
  - Payment of the initial premium is made to the insurer or its authorized agent**
  - No change has taken place in the insurability of the life to be insured between the time the application was completed and the time the policy is delivered.**
- Unless the parties agree on some other effect date
  - Today – all of this can happen at the same time
  - Once the policy is issued, no ongoing duty to disclose changes in circumstances EXCEPT for this small window of time where changes must be disclosed because the policy is yet to take effect

**If policy has been in effect for 2 years, IC can only complain of misrepresentation or non-disclosure if there has been actual fraud. Difficult to prove actual fraud.**

→ **Bureau v. Manufacturers Life (1936) QCSC**

**SUM:** Not going to be fraud if evidence that court can conclude on that whatever was undisclosed, that it was just a 'passing' issue

**FACTS:** deceased applied for life insurance at 15yo. In application said in good health, but had a sore heel. After application, but before delivery of it, doctor states deceased must have all of his teeth pulled out (doesn't explain extent of disorder) 2 years later, he dies of rheumatism. Application contained no information of deceased having rheumatism. IC refuses to pay because there was no disclosure of this information

**ISSUES:** was the failure to disclose fraudulent?

- Because policy in place <2 years, the IC has to prove fraud

**DECISION:** prior to delivery of policy, deceased was not concerned about this health issue being anything proven. Based on this evidence court could conclude deceased was not acting fraudulently/trying to mislead the IC

- Looking at the facts today, something was changed before policy was delivered so it could have been won that way

→ **35445 Alberta Ltd. v. TransAmerica Life Insurance Co. of Canada (1998) ABCA**

**SUM:** fraud is a difficult thing to prove and will depend on the circumstances of the case. The more often the misrepresentation occurs, the more likely the court will accept the fraud argument.

**FACTS:** asked on policy if had flown in airplane *not as a passenger* in the past 2 years. Answers that he has never flown. In fact, insured had many times and been involved in plane crash. When he dies, the policy had been in effect for more than 2 years, so incontestability clause applies, therefore IC needs to fraud.

**ISSUES:** was the failure to disclose fraudulent?

**DECISION:** fraud proven on a BOP that the non-disclosure was a purposeful error. Several occasions in addition to the application where insured had repeated the false information, and was very aware of the fact he had flown planes before

### QUESTIONS ON DISCLOSURE

- 1) Think about what kind of insurance you are talking about
- 2) Look for issues raised for misinformation on application form at time it was filled out?
- 3) Itemize the law in that particular area? Does material fact test apply or is it deemed? No causal connection, determine whether intentional or innocent has application
- 4) Apply factors to facts
- 5) What are consequences? What can the insurance company do?

### III. Formation of the Contract

Insurance contracts are specialized contracts: have the “usual” legal requirements of formation, but also **notable unique features.**

- **For example:**

- o Most are “*contracts of adhesion*”
- o *Statutory requirements exist regarding the content of the contract:* statutory conditions, deemed coverages, government approval of forms, etc.
- o Formation of an insurance contract depends on the **intention of the parties**
- o In order for an insurance contract to be properly formed, the parties must be “**ad idem**” (have common intention) **as to essential terms**
- o This **common intention is established by offer & acceptance of the essential terms.**
- o There must also be **consideration** between the parties

### Essential Terms (Points of Negotiation):

- Subject matter and scope of the coverage (including endorsements)
- Duration of the coverage
- Policy limits
- Premium amounts

- o **Note:** Amount of Premium is a critical essential term, but premium payment is not always necessary for a contract to be formed: compare [ss. 522 \(general\)](#) and [s. 649 \(life insurance\)](#)
  - S. 649 is an exception the general provision, that states a premium must be paid before a life insurance policy takes effect

**THEREFORE** – details about the operation of the contract, even though they are contracts of adhesion, certain things are specific to the insured and insurer

When you fill out an application (*offer*) → IC issues the policy (*acceptance*)

- This order assumes there is a quote, or else there would be no *ad idem* between the parties
- Renewal of a contract is different – near to the expiry an IC will send a reminder
  - o In this instance, the offer of renewal is the offer, and the insured’s payment of the renewal amount is the acceptance
- Cases below deal with point of formation

→ **Davidson v. Global General Insurance (1965) ON High Ct.**

**SUM:** unless the parties are *ad idem* about the material terms (here, amount premium paid), there will be no insurance contract. Premiums are one of those essential terms.

**FACTS:** P operates a clothing store and is approached by agent that suggested he buy a fire IP through their company. Agent sent written proposal to P = no mention of premium amount or duration of K. P phones agent and they discuss premium amount, an amount that P thinks is too high. P then goes out and gets a policy from a different IC (Global). Global hears about these discussions and wants to claim contribution

**ISSUES:** was there a contract formed between the P and the other insurance contract? Is the proposal evidence of this?

**DECISION:** no contract – even though the letter implies the IC is binding themselves, there is not agreement of the essential terms. Especially the amount of the premium. The IC made an offer, which the P never accepted

- Other essential terms: definition of the risk; duration of the risk, amount of premium, policy limits/value of the coverage
  - o These do not need to be explicit, can be implied evidence that the parties intended to be bound to a contract of insurance

→ **McCunn Estate v. CIBC (2001) ONCA**

**SUM: not always easy to determine what intention is, but the courts are looking for what the parties intended to determine if a contract is present**

**FACTS:** life insurance policy – deceased had arranged that premiums would automatically be deducted from bank account. Clear that policy was only intended to continue until deceased reached 70. Deceased turns 70 and bank continues to take out premiums. Estate argues the this means the policy was still in place

**ISSUES:** is there ongoing coverage?

**DECISION:** majority held that K was **not in place** at time of death because clear intention of the parties was to have coverage end when the deceased turned 70. The fact that continued withdrawals took place was an clerical error on the bank, it did not reflect the intention of the insured or IC to keep the policy in place.

- Even if viewed as an offer on the part of the IC for ongoing coverage, no evidence of acceptance
  - o Insured neither relied on it to her determinant not acted in reasonable expectation that coverage had not come to an end

**DISSENT:** continued withdrawal was an ongoing offer, and that deceased accepted by permitting the withdrawals to continue to take place

**NOTE: Issue turns on the court's analysis of intention**

- Majority: no evidence either party thought about this at all
- Dissent: assuming awareness, the intention would have been ongoing coverage

→ **Khosah v. Canada Life Assurance Co. (2013) BCCA**

**SUM:** have to understand the offer in order to be able to accept it. No evidence that P was intending to purchase temporary coverage

**It is not about the form being filled out, but what the parties intended in filling out that form**

**FACTS:** life insurance policy on P's life, premiums paid by automatic deductions from bank account. P takes extended trip to India – while gone business partner cancels automatic withdrawals. Policy lapses for lack of premium payment. IC sends letter to insured before lapse to warn the insured. Insured comes back, reads the letter, and sends the IC a cheque for more than what was owing to the IC. IC holds the cheque in suspension, and write to insured stating he has to fill out new application because of lapse. Insured fills in entire form, including section called 'temporary insurance agreement'. IC denies request for reinstating policy. Before becoming aware of this, insured dies.

**ISSUES:** issue turns on temporary insurance agreement – temporary coverage while IC is deciding whether to accept application or not. What there an offer for temporary coverage, and was the completion of the form acceptance of this offer?

**DECISION:** No offer – no reasonable person in the insured's position would have thought he had temporary insurance coverage. He just wanted his policy reinstated.

- Filling out this section of the policy, by itself, does not mean there is an offer to sell or purchase temporary coverage
- Just because one section was temporary insurance coverage doesn't mean they intended this to occur. **Courts look beyond form and into substance of what the genuine intention of the parties is**

→ **Brochu v. Vachon (2003) ABQB**

**SUM:** have to issue a financial responsibility card (pink card) that is *prima facie* evidence of an insurance contract NOT the same thing as there being a contract

**Depends on the facts of the case whether you can imply intentions of the parties from the face of the contract or not.**

**Formation of the contract is very fact dependent.**

**FACTS:** auto insurance = IP issued on ATV. Ds are the owners, and enter into K and are handed the pink cards at 4:20pm, April 17. Do not say anything about time, just state that the policy is in place as of April 17.

When they received policy document, it states that policy was in place as of 12:01am as of April 17. But 12 year old son using ATV at 1pm that day, and injures passenger who sues.

- IC makes 3 arguments: (1) despite fact pink card says 12:01am, there was no intention of the parties to backdate the coverage; (2) policy was based on mutual mistake – none were aware accident had already occurred; (3) IPs only cover fortuitous loss – this loss was certain
- **ISSUES**: Whether there is motor vehicle liability coverage in place on the ATV notwithstanding that the ATV was only added to the insured's policy after event in which the plaintiff sustained her injuries occurred?

**DECISION**: coverage is in place. There was no evidence to suggest there was an express agreement between insured and insurer agent as to the time the coverage was to commence or a common intention that the coverage was effective as at certain time

- Parties' intention: no evidence for discussion of actual time that the insurance coverage would take effect. Therefore no evidence to argue what is in the contract, which is 12:01am of April 17
- Mutual mistake: no mutual mistake because there was no discussion and no mutual intention for anything but insurance coverage starting at 12:01am; no common
- Fortuitous loss: taken care of by statutory provision (return here in CH. 4)

If IC wanted to leave open the effective start and end time of coverage, it could have drafted the certificate accordingly. Insurance company chooses language and terms.

**NOTE**: interesting decision because duration is supposed to be an essential term. Court is liberal here in allowing the contract to be read in the hour

#### IV. Duration of Cover

→ Duration refers to the **period of time during which the contract provides coverage for a loss**

- An insurance contract commences at the time the parties **intend for it to commence**
  - o But see: **IA ss. 522 (general)** and **649 (life insurance)**
- **An insurance contract terminates either**:
  1. By expiration of time period agreed upon by the parties
  2. Early, by mutual agreement
  3. Early, by unilateral action of the insured or the insurer (without the agreement of the other)

#### NOTE:

- **Termination is NOT the same as voiding a contract** (e.g. because of a breach by the insured): termination ends a contract; voiding a contract means that the contract never existed.
- **Reason for unilateral termination doesn't matter** for most contracts (except re auto where insurer's ability to terminate may be limited by s. 555 & *Adverse Contractual Action Regulation*).
- **Question**: Is there a "good faith" obligation for an insurer not to terminate a contract for unreasonable reasons?
  - o In some circumstances, not having to provide a reason could be problematic
  - o E.g. knowing a fire or flood is going to occur
  - o No case law that answers this question, but reasonable for a court to determine there is a good faith obligation if a risk is imminent to occur

#### Statute sets out procedures for unilateral termination:

##### **A. Unilateral termination by insured:**

- Governed by **s. 540 SC#5** (general) & **s. 556 SC#8** (auto):
  - o **Insured can terminate anytime upon request**
  - o Insurer must refund unused premium "as soon as practicable" (except for "minimum retained premium")

**B. Unilateral termination by insurer**: more onerous because their goal is to make sure the insured is not left without insurance, thus there is a delay

- Governed by **s. 540 SC#5** (general) & **s. 556 SC#8** (auto):
  - o **The insurer must provide the insured with 15 days notice of termination by registered mail or 5 days written notice of termination personally delivered**
    - \*15 days runs from date of delivery to insured's address (last known address)

- Insurer must refund unused premium along with the termination notice or “as soon as practicable” (except for “minimum retained premium”)

### C. Life Insurance: Statutory Grace Period

**s. 651 (3):** *If a premium, other than the initial premium, is not paid at the time it is due, the premium may be paid within a period of grace of*

- (a) **30 days** . . . after the day on which the premium is due, or
- (b) the number of days, if any, specified in the contract for payment of an overdue premium, whichever is the longer period.

**s. 651 (4):** *If the happening of the event on which the insurance money becomes payable occurs during the period of grace and before the overdue premium is paid, the contract is deemed to be in effect as if the premium had been paid at the time it was due and . . . the amount of the premium may be deducted from the insurance money.*

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

**SUM:** difference between mutually agreed termination and statutory unilateral termination = **statutory notice requirement only required under unilateral termination**

**FACTS:** Insured has standard automobile policy but IC decides there was misrepresentation making the contract void or that they had cancelled the policy previous to the accident. They give policy back and IC returns premiums to the insured.

- P argument: policy was still in force because 15 days notice was not given (time period for unilateral termination was not there).

**ISSUES:** do the facts here support a mutual or unilateral termination between the parties?

**DECISION:** distinguished between mutual and unilateral termination – insured agreed to the termination here. **Where the parties agree that the contract will come to an end, the unilateral notice period does not apply**

- Statutory conditions requiring 15 days notice of termination given by the insurer is only for unilateral termination and in this case it was mutual termination which occurred prior to the accident

#### → **1037466 Alberta Ltd. v. Intact Insurance Co. (2017) ABQB 172**

**SUM:** courts will interpret the statute on its face. **No requirement that the insured read/understand the notice – just a pure delivery requirement**

**FACTS:** unilateral provision that existed in our IA prior to 2012 (shows changes made in new statute). IC sends notice of termination to insured, because they have not been paying premiums = unilateral termination. Send notice to address given on November 30 with a stated termination date of December 20. Insured claims the notice never got to them. A fire occurs – insured claims policy was still in place because they never received notice.

- New provision counts 15 days from the date it is received at the insured’s address. Old provision counted from date it is received at the post office
- Insured’s argument was the reason this was changed is because it is what was meant under the old statute

**ISSUES:** was the policy properly canceled under the old provision of the IA?

**DECISION:** Yes. Court disagreed with insured – old provision was unambiguous therefore cannot interpret it to mean the changes in the new provision

#### → **Krupich v. Saveco Insurance Co. of America (1985) ABQB**

**SUM:** **Pure delivery requirement for notice, but practicable requirement for refund of premiums**

**FACTS:** fire insurance policy = IC sends notice of cancellation but does not refund the premiums. Notice never got to P and was returned to the IC. 3 months later, IC sends out cheque of premiums. Fire occurs. IC says they do not have to pay because the policy was terminated

**ISSUES:** (1) was the policy properly terminated before the date of loss? (2) were the premiums paid back in a practicable time?

1. **DECISION:** The policy was in force at the time of the loss and therefore the insured is entitled to damages

(1) Court is bound by upper SCC decision = even if IC gets notice back, as long as they can prove it got to the insured's provided address, that is sufficient. Do not have to prove real notice.

(2) Not refunded as soon as practicable. Court does not provide time period, but 3 month time period here was too long.

#### **IV. Interpretation of Terms**

**Case by case approach to** determine meaning of contractual term - "more art than science"

- **SFC vs Contracts of Adhesion** = reason there is a body of interpretation principles is because most ICs are contracts of adhesion i.e. drawn up by the insurance company
  - o Most principles are designed with the fact that the insurer has the responsibility in mind
  - o Different for SFCs (such as standard owner's policy) because these are government approved. Therefore, have to be less concerned of the responsibility of the insurer in these contracts

When talking about a coverage question...Duty of fairness comes in to play, which favors the insured over the 'big corporate insurer'

#### **A. GENERAL PRINCIPLES:**

- The **insured** has the burden of proving that a given loss falls within the **insuring agreement**;
- The **insurer** has the burden of proving that a given loss falls within a **policy exclusion**
- **Main Objective of Interpretation Principles is to give effect to the intentions of the parties** at the time the contract was entered into, even though most insurance contracts are **contracts of adhesion**.
  - o Problem is parties usually do not sit down and discuss contracts of adhesion, but the courts still try to determine their intentions

The SCC has established a **2 Step Interpretation Process** (*Ledcor v. Northbridge*):

→ **STEP #1:** Interpret contract provisions in a way that promotes the **reasonable intentions** of the parties at the time the contract was entered into.

- **Sub-principles:**
  - o (a) give undefined words plain & ordinary meaning;
  - o (b) if undefined words have more than 1 meaning, choose the one which is most reasonable in promoting the intentions of the parties;
  - o (c) interpret the contract as a whole, so as not to give an unintended benefit (i.e. a windfall) to either party

*Objective test = what reasonable parties would have intended in entering the contract. If terms are defined, that is the meaning the term will be given*

→ **STEP #2:** If application of Step #1 results in a finding that the contract term is ambiguous, **ONLY then** apply "**general rules of contract construction**" to resolve the ambiguity:

- Apply an interpretation that reflects the 'reasonable expectations' of the parties, supported by the text of the contract
- Avoid interpretations that provide unrealistic results (i.e. windfalls for one party)
- Strive for consistency with prior interpretations of similar provisions

→ **If ambiguity remains, apply contra proferentem / construe coverage broadly and exclusions narrowly**

- **Contra proferentem:** construe the contract against the party who drafted the contract (i.e. the insurance company)

**NOTE:** Reasonable expectations = at the time parties didn't think of this as a conflict, had they addressed it, what would they have expected in this commercial context?

- How is this different from reasonable intentions?
- Problematic doctrine = result oriented so the courts can find what they want to
- Almost always get to a point where the insurance company is going to lose

**- REMEMBER = do not look to reasonable expectations until after Step 1**

Cases apply the same test, but illustrate how the court proceeds in that application

- Determine whether there is an ambiguity
- What seem like ordinary terms can end up at the SCC

→ **Jesuit Fathers of Upper Canada v. Guardian [2006] SCC**

**SUM: societal context of the claim is irrelevant, Court must look to the commercial context of the contract itself**

**FACTS:** General liability policy that provided coverage for the operation of Indian Residential schools. Policy was written with “**claims made**” term in the coverage line within policy period. In 1994, people who suffered sexual abuse notified the insured that claims were going to be pursued. Insured contacts IC letting them know and informing there may be more claims. Company refuses to renew policy knowing there is potential for more claims. Insured argues that “claims made” does not mean *while* policy in place, but rather means events that spark *claims occurred during the policy period*, especially because victims are involved

**ISSUES:** Is the term ‘claims made’ in the above contract ambiguous?

**DECISION: SCC said no coverage because no ambiguity of claims made term.** On the very wording of the claim, it means claims that are brought *within the time the coverage is in place*. Not an occurrence-based policy.

- Cannot apply contra proferentum because not a contract of adhesion. Therefore applied ‘reasonable expectations’ so neither party receives a windfall

One of the arguments made by the insured is given the nature of the claims (‘long tail claims’) that public policy should step in and therefore there should be liability coverage for the victims suing

- Court does not accept this argument = may be societal concerns but need to apply well-established insurance principles that do not consider the social context of the claim, rather consider the *commercial* atmosphere of the contract
- A contextual unprincipled approach will render disservice to the industry the insured because of difficulties in coverage and compensation

→ **Brisette Estate v. Westbury Life Insurance Co. (1992) SCC**

**SUM: shows determining if an ambiguity is present may divide the court and that the interpretation relied on by the court is difficult to predict**

**FACTS:** Life insurance policy for spouses. Husband kills wife while policy was in place. Husband argues from public policy he cannot keep the life insurance proceeds, but argues that he can hold it in trust for his wife’s.

**ISSUES:** ca estate: n the contract of life insurance be interpreted for the husband to hold the proceeds in trust/wife’s estate if public policy bars payout to him?

1. **DECISION** SCC held that the IC does not have to pay the estate because the policy cannot properly be interpreted to give the policy payout to the estate. It was never the intention of the contract that payment should be made to anyone other than the deceased’s spouse = clear on the contract’s face.
- Courts have to interpret contract as whole that reflects intention of parties at time contract was entered into. If meaning is ambiguous, construe contract against IC and windfalls are to be avoided.
  - Public policy should be narrowly applied in avoiding payment
  - Applying public policy to a clear contract does not make the contract ambiguous because it is external to the contract. Just because it voids a term in the contract does not allow the court to reinterpret the contract
  - To apply constructive trust you are asking us to look outside the terms of the contract, but the terms of the contract are clear, no ambiguity.

**DISSENT:** contract is ambiguous. Sets out the principles of interpretation = applies them differently from the majority to the contract

- Notices in the contract that there are exclusions from specified causes of death; NO exclusion for murder
- If look at contract as a whole, Court does not know on the face of the contract if murder would be an excluded type of death = this is an ambiguity

- If the IC wanted to exclude murder, they should have. Should not rely on public policy to avoid payout

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

**SUM:** reasonable expectations and nature of contract can have significant effects on how the courts will interpret the contract = subjective analysis. Here, determined broad coverage was required to achieve purpose of contract. Discussions around formation of insurance K is not relevant

**FACTS:** standard form K to the owner of Epcor Tower that covers all work (contractors and subcontractors) for all direct physical loss or damage to the building. Contains an exclusion clause for 'making good faulty workmanship' unless talking about repairing physical damage (*coverage* → *exclusion* → *exception to exclusion*). Glass windows put all over building = cleaners are negligent and scratch windows. All windows have to be replaced. Cost of replacing windows is argued.

**ISSUES:** Clear windows is faulty workmanship, but what is the cost of 'making good' this faulty workmanship? Is the full replacement covered by the policy?

**DECISION:** Majority said coverage for the loss because falls within the exception to the exclusion. Making good faulty workmanship but with respect to repairing physical damage.

- If you have ambiguity = apply general principles to get commercially sensitive results (Step 1 then Step 2 above)

→ **Application of rules to the policy :**

- **Step 1:** decides the exclusion clause is ambiguous
  - Making good faulty workmanship must mean redoing the faulty work, but the exception could be interpreted different ways, therefore the exception is ambiguous
- **Step 2:** reasonable expectations/commercial realities/consistent with case law = there is coverage for the replacement windows
  - No evidence that parties addressed their minds to this issue in the SFC
  - Therefore have to start looking to the purpose of a general liability construction policy = which is to provide *broad coverage* for these projects
  - To interpret this term to not include the above coverage would not be consistent with the purpose of the policy

**Dissent:** finds its ambiguous but instead of resolving on reasonable expectations, he applies contra proferentem and comes to same outcome

→ **Sabean v. Portage La Prairie Mutual Insurance Company (2017) SCC**

**SUM:** **\*\*ambiguity definition = when there is 2 reasonable but different interpretations\*\*.**

**Ambiguity here was not present.**

**FACTS:** MVA where P is injured and sues party who causes accident. Gets judgment, but receives less than from party's IC because beyond maximum policy limits. Then sues own SEF 44 for rest of coverage. A clause in his SEF 44 states IC's obligation is reduced by any policy of insurance that provides disability insurance to prevent overlap. Part of P's claim is for future disability benefits, but Canadian Pension Plan (CPP) provides these benefits in the future.

**ISSUES:** are CPP policy payments that provide disability benefits overlap with insurance?

**DECISION:** SCC says no – reiterate 2 step process.

- In this case do not have to get Step 2, **resolved by Step 1** i.e. no ambiguity
- "Policy of insurance providing disability benefits" = plain reading by an ordinary person would not think the policy was not talking about CPP because CPP is not insurance
- Further reading of the K = clear by the whole K that this exclusion would only apply to another private policy of insurance
- The ambiguity does NOT give rise to 2 reasonable different interpretations of the policy

→ **Funk v Wawanesa Mutual Insurance Co. (2017) ABQB 308**

**SUM: Where a court must interpret an insurance contract, always cite the exact *same principles*, but the *application can be entirely different***

**FACTS:** Funk had insurance on Jeep. Involved in single MVA and suffers spinal injury. His explanation to the accident was that there was another vehicle driving right at him – no evidence of this. Makes claim under MV Claims Act but his injury caused damages far in excess of this. Goes to SEF 44, which says that this is not an accident with an unidentified vehicle. Instead, says the SEF 44 doesn't define unidentified automobile, but states that it is the same as Section B of the SFP#1, which says you must have come in contact with the unidentified vehicle.

**ISSUES:** assuming what Funk claims happened is true, what is required to satisfy the meaning of physical contact?

**DECISION:** Court is satisfied that there was a vehicle coming at him based on expert evidence

- (1) **Principles of interpretation:** Court says that this is not ambiguous, very clear what physical contact means = has a plain ordinary meaning i.e. touching of the 2 vehicles
  - On this interpretation, the loss is not covered because the vehicles never touched
- (2) **Section 545:** court can refuse to apply term of contract if they feel it is unreasonable in the circumstances
  - Problem = accident occurred in 2008 when s.545 did not apply to auto insurance (revised in 2012). No evidence in statute to apply it retroactively
  - Now, would it have applied? Unknown.
- (3) **Public Policy:** apply over and above strict contractual interpretation; here PP would favour interpreting the K so that people are incentivized to avoid a collision
  - If physical contact is required, Funk would be incentivized to let the car hit him instead of avoiding the collision

**NOTE:** Contrast with *Jesuit Fathers* = in that case talking about surrounding circumstances is of the contract, not societal context. In this case, the Court did the opposite and broadly considered public road safety i.e. societal context

\*\*\***For exams:** marks will not come from your conclusion, but how well you can support your conclusion based on precedent, the guiding principles, and the strength of counter-arguments

## **B. "USE AND OPERATION"**

**Standard Auto Policy insuring provisions:**

- **s. A:** provides indemnification for "loss or damage arising from the **ownership, use or operation** of the motor vehicle"
  - *Any harm (intentional OR non-intentional) that arises from use or operation of a vehicle*
- **s. B:** pays for bodily injury & death sustained "directly & independently of all other causes by an accident arising out of the **use and operation** of an automobile."
- **s. C:** pays for "direct and **accidental** loss or damage to the automobile"
  - *Does not require proof of use and operation = pays for direct and accidental*

**SEF 44 Family Protection Endorsement:**

Indemnifies an eligible claimant for amounts that the eligible claimant is legally entitled to recover from an inadequately insured motorist for damages relating to injury or death sustained "by accident arising out of the **use or operation** of an automobile."

**What constitutes use and operation of a motor vehicle is not always easily determined:**

- We know what the extremes look like in clear cases, but what about when some portion of the vehicle has a relationship to the loss?
- **ASK:** (1) what is the legal test? (2) what is the application of the test?

→ **Amos v. ICBC (1995) SCC**

**SUM: first decision by SCC to define use and operation in modern automobile context. Test is two part: purpose and causation (more than a but for test)**

**FACTS:** insured driving van, stopped at traffic light. Gang of people ran up to van and tried to break into it with use of gun. Gun went off and injured driver. Insured claimed under BC equivalent of s. B coverage. Court had to determine if this injury was related to the *use and operation* of the vehicle

- Wording of coverage in BC is *different* from AB = s. B in Alberta which references “direct” and “independent” causation
- Coverage under BC insurance for death/injury caused by accident “that arises out of the ownership, use or operation of a vehicle”

**ISSUES:** was the injury related to the use and operation of the vehicle?

**DECISION:** Amos has s. B coverage

- **2 Step “use and operation” test:**

- **Purpose:** Did the loss result from the ordinary and well known activities for which automobiles are used? (if yes, move to causation)
- **Causation:** Is there some nexus / causal relationship (not necessarily direct or proximate) between the loss and the use/operation of the vehicle?
  - Note the effect of AB’s new wording on this part of the test

In this case, SCC applied the test

- **Purpose:** yes – Amos was driving and not doing anything unusual with the vehicle
  - This part asks whether the vehicle was being used as a vehicle at the time
- **Causation:** more than a ‘but for’ test, the fact that the injury occurred within a vehicle is not enough – a causal relationship must be present
  - This is also met because the gang wanted to steal the vehicle, therefore the whole operation is about the vehicle. Amos was injured while gang was attempting to gain entry into the van
  - Gun going off as intervening event was not enough to break the chain of causality

**For S. A Coverage:**

- **Modified 2 Step “use and operation” test for liability coverage:**

1. **Purpose:** Did the loss result from the ordinary and well known activities for which automobiles are used?
2. **Causation:** Is the loss causally related to the use and operation of the motor vehicle as a motor vehicle? (*Unbroken chain of causation between driver’s use of the car as a motorist and the loss*)

→ Distinction from original *Amos* test, that required more than ‘but for’. But in *Amos* there is still an intervening act. **Under s. A, there cannot be an unbroken chain of causation, therefore more direct causation is required**

→ ***Citadel General Assurance Co. v. Vytlingham (2007) SCC***

**SUM:** SEF 44 - Section B is no fault insurance provision. SEF 44 and S. A are liability provisions. Modification of *Amos* test shown below only applies to S. A and SEF 44 provisions NOT s. B. SEF 44 requires that the tortfeasor whose conduct is the subject matter of the indemnity claim be at fault as a motorist. **ut for test doesn’t work, for coverage to exist there must be an unbroken chain of causation linking the conduct of the motorist as a motorist to the injuries.**

**FACTS:** parties drove boulders onto overpass and dropped them onto the roadway below. Hits car driven by V, who is injured. Sues the parties – his claim exceeds the parties’ s. A coverage, so V makes claim under own SEF 44.

**IC Argument:** Argument is boulders were thrown off overpass and vehicle is stopped, vehicle has nothing to do with loss (intervening act)

**ISSUES:** did this loss arise from the use and operation of the vehicle in order for the SEF 44 to respond? Or is the throwing boulder off of a bridge a sufficient intervening act?

**DECISION:** SCC found SEF 44 did not have to cover the loss; here the sympathy for the insured did not alter their decision because this is the type of coverage EVERYONE has

- **Amos test:** The vehicle here in question is the tortfeasors’ vehicle
  - o **Purpose** → yes, used for ordinary purposes. Doesn’t matter if being driven with criminal intentions, being driven to get to particular location
  - o **Causation** → Need an unbroken chain of causation between use of vehicle as a motorist and a loss

- Break in chain of causation here – what actually injured V was not TF’s use of vehicle as motorist would use it, but the hurdling of rocks over an overpass
- **Court says if they were to find otherwise that any connection to a vehicle is enough, will always trigger automobile liability coverage, which is not the purpose of the coverage**

**Vytlingham Modified 2 Step “use and operation” test for liability coverage (more direct link between use of vehicle as vehicle and the loss):**

- **Purpose:** Did the loss result from the ordinary and well known activities for which automobiles are used? Usually comes down to whether the vehicle was being used for transportation.
- **Causation:** Is the loss causally related to the use and operation of the motor vehicle as a motor vehicle? (Unbroken chain of causation between driver’s use of the car as a motorist and the loss).

→ **Lumbermens Mutual Casualty Co. v. Herbison (2007) SCC**

**SUM: if the intervening act has nothing to do with ownership, use or operation of vehicle then there is a separate, distinct and intervening act**

**FACTS:** insured drove truck to deer hunting site. In headlights believes he sees a deer and shoots it. Deer ends up being H. H sues and insured makes a claim under automobile insurance coverage.

**ISSUES:** does H’s automobile insurance have to respond under s. A coverage?

**DECISION:**

- **Amos test** (modified for s.A coverage)
  - Purpose: yes
  - Causation: intervening act of negligent shooting by insured that is independent from the use of the vehicle
- Causation in s. A is a *very narrow* application of the test – not many applications where the purpose component fails, but causation does
  - Cases give examples of when you will fail the purpose of the vehicle i.e. using it for purposes other than transportation/transporting things

→ **Arruda v. Allstate Insurance Company (2007) ABCA**

**SUM: the application of the Amos test is narrowed in Alberta by the wording of s. B coverage – requires that there be an unbroken causal link between the use of the vehicle and the injury**

**FACTS:** A driving vehicle and has accident. People from one of the vehicles shoot at A. A calls police and the other vehicles drive away. He leaves vehicle gets a bat and vehicle is running and is standing guard. They attack him while standing outside vehicle and he dies. Wife claims against insurer of Arruda for s. B benefits; death and funeral etc.

- **Alberta s. B provides for coverage for “losses caused directly and independently of all other causes by an accident arising out of the use and operation of an automobile.”**

**ISSUES:** Has the addition of the words “directly and independently of all other causes” altered the meaning or the phrase “an accident arising out of the use or operation of an automobile” as interpreted by Amos?

- Under the *Amos* test, there would be coverage because gives generous test of causation
- But does “directly and independently” alter the test?

**DECISION:** ABCA says addition of these words to s. B changes the application of the *Amos* test in Alberta. The addition now says there has to be an unbroken chain between use of the vehicle and the loss that occurred

- **Therefore in AB the test is the SAME whether claiming s. A or s. B coverage**
  - A because of modified test; B because of wording of the statute requires unbroken chain of causation

Here, the chain of causation is broken

- **NOTE:** Amos test is narrow in Alberta because caution has to be independently associated with the vehicle. Therefore, use and operation in Alberta is similar under s. A and s. B. **It’s the wording of the statute which modifies Amos for s. B not the case law**

→ **Derkson v. 539938 Ontario Ltd. (2001) SCC**

**SUM: SUM: how use and operation should be applied where there are multiple causes of loss. Where there are two concurrent causes of the loss, the exclusion clause is ambiguous on this. Since it is ambiguous they apply *contra proferentem***

**FACTS:** worksite where vehicle owned by contractor was parked. Employee of contractor lifting steel plate onto bed of truck, but does not secure it. Plate flies off of bed of truck and flies through window of bus, that injures 3 and kills 1 children. Families of children sue for negligence of operation of vehicle and other tortious act (negligent in cleaning site). Contractors had CBL policy for negligence in operations but excluded coverage for bodily injury or property damage arising out of the ownership, use or operation of an automobile and for bodily injury or property damage with respect to which any motor vehicle policy is in effect (because this coverage is expected to be in the auto policy)

**ISSUES:** SCC concluded there was 2 causes of loss – both negligent in cleaning and negligent in operating vehicle. Therefore, does the exclusion clause apply when loss is caused in part by the use and operation of a motor vehicle?

**DECISION:** ambiguous therefore interpreted against the insurance company = thus exclusion only applies if it is the singular cause of loss

- Court applies *contra proferentem*: insurers have language to them to remove all ambiguity in the event of two concurrent causes related to the loss. If insurer wishes to oust coverage in cases where covered perils operate concurrently with excluded perils, it has to expressly state that in the policy. **Coverage provisions should be interpreted broadly while exclusion clauses narrowly.**
- The failure to clean work site was a concurrent cause and a risk that was covered by the CGL policy. The exclusion clause is in play but only in respect to that portion of the loss that is attributable to the auto-related cause
- Use and operation as we've been talking about is satisfied but the question was whether exclusion clause would be applied if there were more than one cause.

**NOTE IN TEXTBOOK:** series of cases that have applied this phrase in particular incidences

- Provide more illustration when the court finds the loss arose from the 'use and operation' of the vehicle
- Highly litigated, **fact specific issue = always apply Amos test or some modification of it**

### C. "ACCIDENT"

#### Continuum of Intention:

- < - **Purely Fortuitous Event – Negligence - Gross Negligence – Recklessness - Intentional Act - >**
- From a fully intentional act to acts that have a degree of blameworthiness to them, to an act completely unexpected
- Loss caused by accident = how far down the continuum can you go before the act is no longer an accident?
  - o **Insurance policies are there to cover accidental loss, but courts cannot definitively say what is and what is not an accident**
- Policies can vary the meaning of accident
  - o E.g. **s. C coverage** = specific exclusion for loss caused by drunk driving – designed to take the continuum out of the analysis
- It is the claimants burden to prove that the loss falls within the coverage agreement's definition of accident = BOP never shifts
  - o But, tactical burden that shifts to insured – try to counter the insured's argument

**Martin v. American International Assur. Life Co. (2003) SCC:** *The plaintiff must therefore adduce evidence that permits the trier of fact to infer, on a balance of probabilities, that the insured's death was accidental, within the ordinary meaning of that word. The tactical burden then shifts to the insurer to displace these inferences. The burden of proof never shifts, but remains squarely with the plaintiff.*

#### → **Martin v. American International Assur. Life Co. (2003) SCC**

**SUM:** Loss can be accidental even if chain of causation can be traced to deliberate act. Question is not about chain of causation, but the **subjective intention of consequences, then objective reasonable person expecting the consequences.**

- **Expectation is different than intent = here was not expecting death**

**FACTS:** Dr. had life insurance policy that provided benefits for death by 'accidental means'. Beneficiaries arguing the death was caused by accidental means, therefore coverage. Dr. prior to death was addicted to

Demerol, which he overdoses on. Evidence showed prior to death he was happy, looking forward, etc. therefore was not trying to kill himself and that the amount of Demerol was barely over the overdosing limits. **ISSUES:** because his death was predictable, was this a death by 'accidental means' as worded by the life insurance agreement?

- IC argued insured is a Dr. and is aware of the risk – purposefully took the drugs. Even if not planning to die, should have understood that death is a possible consequence of taking the drug

**DECISION: Accidental death does not mean death excluding accidental deaths that are the natural result of deliberate action = not enough**

- Accidental means has to mean the *consequences* of the actions were unexpected, not that the method was or was not unexpected

**- 2 part expectation test:**

- o **(1) Subjective:** On a subjective basis did this insured expect to die as a consequence of his actions?
  - If yes, then not death by accident. If no, qualifies as accident.
  - If you cannot determine the subjective intention, go to second part
- o **(2) Objective:** Would a RP, in the position of the insured, have expected death as a consequence of the action?

Court concludes Dr. did not expect death to be consequence = had done it before, been happy, minimal amount of drug

**NOTE: this test favours the insured.** In most cases, if someone is 'expecting' to die, then they are trying to die. But McLachlin notes that ICs can define 'accident' however they want to get around the application of this test. Insurer remains free to limit coverage in the wording of these agreements.

- It is important to consider the point of view/perspective of the person in question, even when applying the objective test
- E.g. extreme risk taker, rescuer

→ **Co-operators Life Insurance Co. v. Gibbens (2009) SCC**

**SUM: accidental loss in the context of death caused by disease and how *Martin* applies to this instance. A claimant who can establish that death was unexpected does not thereby without more (miscalculation or misjudgement of an event) establish a valid accident.**

- **Disease situations require a different analysis from *Martin* and instead apply general insurance policies**
- **For disease, some consideration has to be given to the means at which the loss occurred, just because outcome was unexpected doesn't make it an accident**

**FACTS:** Mr. G was covered by policy that included loss caused by critical diseases and accidental disease, which included loss resulting from directly and independently from bodily injuries occasioned solely through external, violent and accidental means, without negligence? IC defined paraplegia as a disease, therefore under policy. **Question is whether he came to it by accidental means.** Received herpes through unprotected sex, which rendered him paraplegic

- Mr. G argued the *Martin* decision, saying he did not expect this disease and to be rendered a paraplegic by it

**ISSUES:** Was the paraplegia accidental?

**DECISION:** Unanimous SCC held that it was not caused by accidental means. Accidental disease does not cover disease that are transmitted in an ordinary way that doesn't involve mishap or trauma

- SCC rejected Mr. G's argument and went back to basic principles – need to interpret K to balance expectations of parties and to avoid windfall
  - o Therefore, give the term accident its plain and ordinary meaning = accident is a term that cannot be defined in every context but HERE parties would not expect naturally transferred diseases would be covered. Then, it would be a comprehensive health plan not a disability policy
  - o Narrows *Martin* and states it does not automatically apply to cases involving disease
- Just because the outcome is unexpected, doesn't mean there is an accident. Have to look at the context of the outcome

While paralysis was an unexpected outcome from herpes, he is not a paraplegic due to an accident

- However, a bodily function not in the ordinary course *might* be considered an accident

**NOTE: Kolbuck (ONCA)** – does not help with confusion

- Plasterer gets bitten by mosquito by working – gets West Nile virus, which causes him to become a paraplegic. Is the resulting paralysis an accident? ONCA found it was an accident (even though this is a disease caused by ordinary, natural causes)
- This case illustrates how far this analysis can go and that the courts can be inconsistent in determining whether a disease is caused by an accident or not

→ **Nelson v. Ind.-Alliance Pacific Life Insurance Co. (2012) ABCA**

**SUM: Triggering of pre-existing condition by normal activity does not constitute an accident.** It is death by natural means. Court relies heavily on definition of accident and what is considered an accident from *Gibbens*

**FACTS:** N had congenital heart condition and was insured under life insurance policy. Went swimming in cold lake, which triggered his condition. Had a heart attack and died

**ISSUES:** Whether the death of a swimmer from a heart condition triggered by immersion in cold water or exertion is a loss resulting from bodily injury caused by an accident?

**DECISION:** SCC held not an accident. N engaged in normal activity that triggered pre-existing condition, therefore death by natural means.

- In the case of a disease which pre-dates the event, there is no coverage if the event simply provided an occasion on which the pre-existing disease manifested itself

### Reading the cases together

- **Marten:** involves insured purposely engaging in activity that results in unexpected consequences (but the activity is high risk or unusual). Court calls it an accident because the consequence is unexpected but the court focuses on the fact that it was an unusual intentional act.
- **Nelson:** it is an intentional act but not as high risk, suffers an unexpected death, court said not an accident. **Distinguishing fact is that purposeful act of swimming triggers existing health condition which is in the ordinary course of things.**
- **Gibbens:** contracted illness from ordinary way in which illness is contracted so the court decided it was not an accident.

**SUM:** difficult to determine when the court will find an outcome to be caused by an accident

→ **Type of instances where disease may be found as accident : (NOT conclusive)**

1. Where there is a mishap external to a person that triggers a disease or illness that is likely to be viewed as an accident; e.g. car accident, slip and fall = break leg – leg gets infected – die from infection
  - o Consequences flow from accidental triggering event, therefore everything flowing from it is also captured by the accident
2. A mishap due to miscalculation of risk by the insured that results in bodily malfunction or disease, is an accident (**Martin**)
3. Disease or illness that itself is caused by a traumatic event; e.g. choking to death
4. Disease arising from ordinary way by which diseases are transmitted is NOT an accident (**Gibbens**)
5. A mishap that triggers an existing bodily malfunction or latent disease is NOT an accident (**Nelson**)

**Remember** – **companies can redefine accident in agreements differently**, so courts may find there to be an accident in favour of the insured, even if questionable, because company had the opportunity to change the definition

### D. INTENTIONALLY/WILLFULLY CAUSED LOSS

→ Now asking how far up the continuum can we go to determine if the act is excluded?

→ **Co-operative Fire & Casualty v. Saindon (1975) SCC**

**SUM: there is not a bright line whether intention exists or not, such as accident. One need to intend ONLY the consequences, NOT the full extent of the consequences**

- **What actually constitutes intention and what evidence need to be provided is case-by-case**  
For an exclusion clause of intentionally caused loss you only need to intend harm, not the extent of the harm

**FACTS:** 2 neighbours (S and X), do not like each other. X accuses S of cutting down their tree, and S approaches X with lawn mower and lifts it up. X lifts his hands up in protection and loses his hands as a result. S argues was only intending to scare X – meant to cause ‘some damage’ but not all the damage that was caused

**ISSUES:** Was the loss caused intentionally?

- Coverage had an exclusion clause for loss that is caused intentionally

**DECISION:**

→ **MAJORITY:** exclusion applies because although he didn’t intend the full extent of the loss, he intended some loss = **does not matter that the degree of harm exceeded original intention**

→ **DISSENT:** for the exclusion to apply, have to intended the actual loss that occurred. Not enough that some loss was intended

**E. CRIMINAL ACT** (\*\*remember **s. 533(2)** - unless the contract provides otherwise, a loss occurring from criminal act does not negate coverage unless there was intent to bring about the loss or damage)

- **Question:** What does IC have to say in K to show they want to revert back to common law?

→ **Wong Estate v. Liberty Mutual Insurance Co. (2009) ABQB**

**SUM: Words “criminal act” are sufficient to indicate that if you have committed a criminal act that caused loss, there is no coverage.**

**FACTS:** K provides an exclusion if loss is caused my criminal act. Child was killed at daycare by M – evidence showed M had dropped child with force and negligence. Estate of the child sued M for civil negligence, won, and tried to recover from her policy. Policy had exclusion for bodily injury/property damage if the loss being claimed related to a criminal act

**ISSUES:** does the policy apply to provide coverage? What does ‘criminal act’ mean – does the loss have to be intended or not? Was this exclusion to s. 533 sufficient?

**DECISION:** Court says criminal act is not ambiguous – exclusion means the policy does not apply.

- Provincial courts differ in whether negligent acts fall under the definition of criminal act or not
- The exclusion applies even without proof of intention to cause the injury or damage, so long as the act or omission that causes the harm is criminal in nature. **The words “criminal act” are clear and unambiguous and do not require a modifier for clarity.**
- **s. 533 says that IC can word policy to provide exclusion that says even where you didn’t intend loss to occur, a criminal act causing loss denies coverage.**

#### **F. VACANT OR UNOCCUPIED**

- At common law, vacant means without furnishings while unoccupied means no people
- Vacant or unoccupied can mean various things → fundamental principle of contract interpretation is to look at the contract definitions

→ **Coburn v. Family Insurance Solutions (2014) BCCA**

**SUM: the policy in question here has its own definition of vacant and unoccupied so the common law definition is not applicable here. Vacant or unoccupied can mean various things. Fundamental principle of contract interpretation is to look at the contract definitions.**

**FACTS:** Policy has exclusion for loss that occurred when property is vacant for more than 30 days. Policy defined vacant as occupant moved out with no intention to return OR property does not contain furnishings or household equipment sufficient to make it habitable. Property was rented out and tenant leaves the property. Insured tell IC that tenant has moved out. IC says your exclusion kicks in if vacancy is consecutive for 30 days, so we will add endorsement to contract if this occurs. IC issues endorsement after a month occurs. Insured then tells IC that they have new tenant so IC takes off the endorsement. New tenants did not take possession on date indicated, but they stored belongings in shed. Tenancy agreement did not allow them to move in until April, because they wanted to do renovations. While renovations were taking place the insured is there every day but only sleeps there once. Fire on property. IC refuses to pay because they say property was vacant for more than 30 days when loss occurred

**ISSUES:** was the property vacant? Does the exclusion clause apply?

**DECISION:** property was vacant therefore no coverage. Court says under principles of interpretation, look to the definition in the contract. Under this, all IC has to prove is occupant moved out/no furnishings. The fact the insured was around everyday, does not mean the property was occupied under the definition of vacancy

## V. CLAIMS ON THE POLICY

### PART 1: DUTIES OF THE INSURED

#### - **Post-loss obligations**

- Both duties of the insured and the IC are drawn upon the duty of utmost good faith, but at this point can say that the contract is in good place and the loss is covered by the contract
- Insured knows that loss happened and *how* that loss happened – their duty is to communicate this to the IC so the IC can investigate the loss and enforce any rights they may have

**\*\*For the most part, the duties are contained in the statute**

**(1) Notice of Loss:** obligation of the insured to report loss to the insurer so that the insurer can investigate & respond to the loss. Functions as a **condition precedent for IC to have an obligation in the contract**

- **s. 530, s. 540 SC#14 and s. 556 SC#9** explain **HOW** written notice may be sent to the insurer: by delivery or mailing to chief agency or head office in Alberta)
- SCs re property and auto specify **WHEN notice is to be given** (re the triggering event and the time frame)
  - o Life insurance: is usually set out in the contract
  - o Property Insurance s. 540 SC#6(1)(a): “On the happening of any loss or damage to insured property, the insured must, if the loss or damage is covered by the contract . . . **immediately give notice in writing to the insurer**”
    - Immediately assessed with reasonableness and depends on situation
  - o Auto insurance: s. 556 SC#3(1)(a): Re s. A Coverage: “The insured must **promptly** give to the insurer written notice, with all available particulars, of any accident involving loss or damage **to persons or property** and of any claim made on account of the accident” Auto Insurance: s. 556 SC#4(1)(a): Re s. C Coverage “When loss of or damage to the automobile occurs, the insured must, **if the loss or damage is covered by the contract, promptly give notice** of the loss or damage in writing to the insurer with the fullest information obtainable at the time”
- Idea behind notice provisions is that insured has to act reasonably which means notifying them immediately or promptly. SCC takes a reasonable person standard and applies to the facts of the situation.

**(2) Proof of Loss:** sworn evidence provided by the insured to allow the insurer to verify (among other things) that the loss occurred, the loss falls within policy coverage, and the value of the loss. **The loss occurred and**

falls within a valid policy coverage and the amount of the loss on a balance of probabilities – IC cannot know this information on their own

- Insurer's Obligation to Provide Proof of Loss Form = statutory obligations
  - o **s. 523(1):** *An insurer, immediately upon receipt of a request, and in any event not later than 60 days after receipt of notice of loss, must furnish to the insured or the person to whom the insurance money is payable forms on which to make the proof of loss required under the contract.*
  - o **s. 523(4):** *An insurer by reason only of furnishing forms to make the proof of loss is **not to be taken to have admitted that a valid contract is in force** or that the loss in question falls within the insurance provided by the contract.*
  - o Just giving a proof of loss form, the IC is NOT admitting that the loss occurred.
- Property Insurance s. 540 SC#6(1)(b): *"On the happening of any loss or damage to insured property, the insured must, if the loss or damage is covered by the contract . . . **Deliver as soon as practicable to the insurer a proof of loss in respect of the loss or damage to the insured property verified by statutory declaration . . .**"* including inventory of property, how and when loss occurred, confirming loss not intentional, details of other insurance, interest of the insured in the property, etc
- Property Insurance s. 540 SC#7: *"**Any fraud or willfully false statement in a statutory declaration in relation to the particulars required under Statutory Condition 6 invalidates the claim** of the person who made the declaration."*
  - o Entire claim will be vitiated by any fraud/willful false statement

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

**SUM: courts take the obligation to completely the proof of loss form honestly very seriously. Proof of loss requirement is very strict, the honesty of its contents is critical. Any fraud vitiates the entire claim, even the part of the claim that is not fraudulent.**

**FACTS:** D insured P for a building and its contents. Policy limits on the building was 20,000 and contents was 30,000. Fire destroyed building and the contents. P notifies D that loss occurs, D issues proof of loss forms. Part of the form is to attach list of inventory of contents that were lost. P notes 3 TV sets and lumber and metal shed, which were never actually lost – 'padding' the claim. Adding up the loss of contents, equaled 33,000 i.e. over the limits. D discovers the fraud on the proof of loss form and refused to pay anything under SC#7. P argued (1) D shouldn't be able to refuse payment because they breached conditions because legitimate claims anyways, (2) cannot vitiate the coverage on the building because separate policy limits, and (3) relief from forfeiture

**ISSUE:** How does SC#7 apply to intentional falsehoods?

**DECISION:** Court strictly applied provision and that the IC did not have to pay anything. P signed the form knowing it included contents that were never on the property.

**(1)** With respect to proof of loss duty, it is **a duty of utmost good faith.**

- Because of that, it does not matter that padding of the claim was over the policy limits. Rather it is about making sure the relationship between the insured and IC is one of utmost good faith

**(2)** Building and contents NOT separate → **SC#7 says entire claim will be vitiated**

**(3) Relief from forfeiture is equitable** → insured here has to come with clean hands. Not the case because they committed intention fraud

- Automobile Insurance: s. 556 SC#3(1)(b): *Re s. A Coverage "The insured must verify by statutory declaration, if required by the insurer, that the claim arose out of the use and operation of the automobile and that the person operating or responsible for the operation of the automobile at the time of the accident is a person insured under the contract . . ."*
- Automobile Insurance: s. 556 SC#4(1)(c): *Re s. C Coverage "When loss of or damage to the automobile occurs, the insured must, if the loss or damage is covered by the contract . . . Deliver to the insurer within 90 days after the date of the loss or damage a statutory declaration stating, to the best of the insured's knowledge and belief, the place, time, cause and amount of the loss or damage, the interest of the insured and of all others in the automobile, the encumbrances on the automobile, all other insurance, whether valid or not, covering the automobile and that the loss or damage did not occur through any wilful act or neglect, procurement, means or connivance of the insured."*

**(3) Duty to Cooperate:** may be imposed by **contract, by statute, or by common law.**

- Generally, includes obligation to provide notice and proof of loss, to provide information about the claim, to give evidence for trial (in a 3P claim on a liability policy or in a subrogated action), etc.
- **Greater duty for liability insurance policy**, where IC agrees to defend insured and to pay on their behalf any judgment awarded to the opposing party up to the policy limits
  - o Requires participation and duty to help the IC in the defence of the claim against
  - o This duty can include various things – evidence, appearing at trial, participation in litigation, etc.
    - Do NOT have to contribute any money, duty is non-pecuniary
- **s. 556 SC#3 – Re s. A Coverage**
  - o (1)(c) “The insured must . . . forward immediately to the insurer every letter, document, advice or writ received by the insured from or on behalf of the claimant”
  - o (2) “The insured must **not (a) voluntarily assume any liability or settle any claim except at the insured’s own cost, or (b) interfere in any negotiations for settlement or in any legal proceeding.**”
  - o (3) “The insured must, whenever requested by the insurer, **aid in securing information and evidence and the attendance of any witness, and must co-operate with the insurer, except in a pecuniary way, in the defence of any action or proceeding or in the prosecution of any appeal.**”
  - o (4) “The insured must **submit to examination under oath and must produce for examination at any reasonable place and time designated by the insurer or its representative all documents in the insured’s possession or control that relate to the matters in question, and the insured must permit extracts and copies of the documents to be made.**”
- Strict duty but *inadvertently* breaching duty courts have said is not good enough to deny policy
- **Practical Point:** as a representing lawyer, have to ensure that the position of the insured and position of the IC align
  - o Assuming valid contract where claim falls within policy limit, lawyer may come across information that pertains to the insurance contract
    - E.g. Conflict of interest = discover changes material to the risk (solicitor-client confidence) but the IC is the party that is paying for you. Have to act in a way that does not favour one party over the other – only give the facts to the IC. Up to the IC to determine if there is anything in the facts that changes their coverage position.
  - o You are responsible to provide liability defence, not to provide coverage opinion. That would require another lawyer

→ **Thorsen v. Merit Insurance (1963) ABSC**

**SUM: if IC tries to rely on failure of the duty to cooperate, they have to show some evidence of malice or bad faith on the part of the insured.**

**FACTS:** P gets into auto accident that injures another party and immediately reports and gives sign written statement to D. P then disappears. When injured party goes to sue them, cannot find them, and instead serve D. D argues they don’t have to do anything because P has breached their duty to cooperate

**ISSUES:** did the insured breach the duty to cooperate that would allow IC to deny coverage?

**DECISION:** No evidence that P was trying to breach their duty to cooperate, no bad faith. Before the lawsuit began, were very cooperative.

- Failing to notify of move has not breached contract in such a material respect so as to avoid IC liability under the policy, it did not amount to bad faith or wrong motives
- **Examples of failure of the duty:** arbitrary refusal to act, conditional cooperation, failure to notify the IC, friendly relations with the injured party, giving false testimony, interposing over the IC’s objections, confessing liability, refusing to allow the IC to file a defence in the name of the insured, varying testimony or willfully fabricating material facts

**NOTE:** This decision is consistent with SCC decision in duty to cooperate in subrogation found in *Somersall v. Friedman*

- **Why?** Want to prevent the breach to affect the innocent, injured party on a basis of the IC calling out minor, technical offences
- **Court is looking at duty to cooperate narrowly (having to prove bad faith or malice) because they are protecting innocent third party**

#### **(4) Limitation Periods**

Statute identifies period of time where insured can sue their IC. Statute sets the earliest time period which is some time after the date of loss (giving IC time to decide how to respond to your claim). **Generally, 60 days from date insured submits completed proof of loss.**

- **(i) After Proof of Loss:** Loss → Notice → P of L form provided → P of L form completed → Sue IC
  - o **General:** **s. 524** “**No action lies for the recovery of money payable under a contract until the expiration of 60 days, or of any shorter period fixed by the contract, after proof, in accordance with the provisions of the contract, (a) of the loss, or (b) of the happening of the event on which the insurance money is to become payable.**”
  - o **Property:** **s. 540 SC#12** insurance proceeds are payable within 60 days of insurer receiving POL
  - o **Auto** **s. 556 SC#6** (1) insurer must pay insurance proceeds within 60 days of POL or 15 days after dispute resolution process; and (2) insured may not sue unless SC 3 and 4 are complied with or amount of loss ascertained (by specified method)
  - o **Life:** **s. 674** Insurer must pay within 30 days after receiving sufficient evidence of the happening of the insured against event, the age of the person insured, the right of the claimant to receive the proceeds, and the name and age of any beneficiary.
- **(ii) On Actions:** Loss → Notice → P of L form provided → P of L form completed → Sue IC
  - o **Limitations Act:** applies UNLESS a more specific statutory provision applies (s. 2(4) of *Limitations Act*)
    - **So: Insurance Act limitation periods apply to insurance contract claims**
  - o **Fair Practices Regulation:** **s. 5.3** requires insurer to give written notice to a claimant of the applicable limitation period UNLESS the claimant is represented by legal counsel .
    - Positive obligation on ICs because they are deemed to be sophisticated
    - If failed, court will extend the limitation period
  - o **General:** **s. 526** Except re auto & hail insurance, an action “*against an insurer under a contract must be commenced (a) in the case of loss or damage to insured property, not later than 2 years after the date the insured knew or ought to have known that the loss or damage occurred, and (b) in any other case, not later than 2 years after the date that the cause of action against the insurer arose.*”
    - Narrows the window of time in which you can commence the loss
  - o **Auto:** **s. 558** “An action or proceeding against an insurer under a contract must be commenced
    - **(a) In the case of loss or damage to the automobile, not later than 2 years after the occurrence of the loss or damage, and**
    - **(b) In the case of loss or damage to persons or property, not later than 2 years after the cause of action against the insurer arose.**”
  - o **Life:** **s. 677** “... an action or proceeding against an insurer for the recovery of insurance money payable in the event of a person’s death must be commenced not later than **the earlier of (a) 2 years after the date evidence is furnished under section 674, and (b) 6 years after the date of death.**”

→ **Smith v. Co-operators General Insurance Co. [2002] SCC**

**SUM:** determines the issue of when we are counting from – **court is very strict in interpreting legislation in respect to limitation periods**

**Courts will be very hard on the IC to give notice to the insured on anything that may trigger a limitation period = in AB, must advise the insured of the limitation period if they do not have counsel**

**FACTS:** S injured in MVA on April 14, 1994 and claimed disability (s. B) benefits under policy. Shortly after, IC terminated disability coverage and told her she could apply for mediation. Went to mediation in August 1997, which did not resolve the dispute. September 1998 = S sues IC. IC defended on the grounds it was brought outside limitation period, which argued is 2 years after notice insurance is being terminated.

- **Insurance Act** = 2 years after IC's refusal to pay the benefits.

**ISSUES:** What does 'refusal to pay benefits' mean?

**DECISION:** Majority held the limitation period had never started to run despite notice and mediation of termination of benefits

- **Why?** Court said regulations require IC to give notice of termination. Majority read this as requiring IC to not only tell insured the benefits would be terminated/mediation but ALSO to tell the insured of the entire mediation process, a full explanation of how the issue could be resolved, and options if the mediation did not resolve the issue
- **IC has a duty to advise the insured in a straightforward clear manner directed to an unsophisticated person**

**DISSENT:** statutory limitation period does not link itself to the regulations – think majority read too much into the notification requirement

**Exceptions:** is it always fair for the IC to use a technical breach to get out of providing coverage?

- Both are ways the courts can excuse the insured from having to fulfill one of its duties

(i) **Relief Against Forfeiture:** equitable doctrine that focuses on the behavior of the insured; unfair to hold insured to obligations because insured's failure to comply was not serious

- Is whatever the insured did/did not do significant enough for the IC not to pay?

- **Involves issues of law and of fact:**

- o **Does the Court have jurisdiction to grant relief?**
- o **If yes, do the facts justify the granting of relief?**
  - Imperfect compliance (*gravity of the breach*) – extent of insured's failure
    - Distinguish between non-compliance and imperfect compliance
    - E.g. didn't put something in writing
  - Good reason for imperfect compliance (*conduct of insured*) – were not intentionally not complying; good faith reason
  - Limited prejudice to insurer (*comparison of value of insured's loss v damage to insurer*)

→ **2 places to find relief from forfeiture in statute:**

- **IA s. 520:** "If the Court considers it inequitable that there has been a forfeiture or avoidance of insurance, in whole or in part, on the ground that there has been **imperfect compliance with (a) a statutory condition, or (b) a condition or term of a contract as to the proof of loss to be given by the insured or the claimant or another matter or thing done or omitted to be done by the insured or the claimant with respect to the loss**, the Court may relieve against the forfeiture or avoidance on any terms it considers just."
  - o Imperfect compliance with a statutory condition OR with term in the contract as to any obligation relating to the loss – sounds like it is limited to post-loss obligations
- **Alberta Judicature Act, s. 10:** "... the Court has power to relieve against **all penalties and forfeitures...**"
  - o Much more broad – could rely on with respect to pre-loss obligations
  - o Courts state that you can use either statute to apply to insurance contracts
    - But test on the facts is easier to prove for post-loss obligations, because pre-loss obligations are things considered the by the IC to determine whether to provide coverage/premiums → greater prejudice on ICs

→ **Falk Bros. Industries Ltd. v. Elance Steel Fabricating Co. (1989) SCC**

**SUM: purpose of relief from forfeiture**

**DECISION: R from F is to prevent hardship to insured where insured has failed to comply with condition to receiving insurance proceeds and where leniency in respect of strict compliance will not result in undue prejudice to the IC.**

- It prevents the IC from relying on technicalities making it unfair to insured. SCC says that delayed notice of claims falls within s. 520 as its not serious and relates to proof of loss of other matter or thing required to be done or omitted by the insured with respect to the loss.
- Relief from forfeiture should be interpreted broadly, **thus the Judicature Act can apply.**

→ **Dams v. TD Home and Auto Insurance Co. (2016) ONCA**

**SUM: Courts power to use R from F is for matters required to be done in relation to the loss i.e. to instances of imperfect reliance after the loss has occurred**

**FACTS:** MVA accident – insured was injured while riding insured motorcycle. Bike falls on him and injures his ankle while trying to avoid other vehicle. Claimed for benefits. 10 months after accident, applied for benefits under uninsured driver relief. IC argued it was too late – according to policy, accident has to be reported to police in 24 hours and to IC in 30 days. Also argued RFF should not apply because statute said unless the notification obligations are complied with, there is no payment owing under the policy (those notice provisions are condition precedent to insurance coverage – therefore no room for imperfect compliance)

**ISSUES:** Does RFF apply to notification obligations?

**DECISION: RFF applies** – relied on *Falk* to say RFF is **remedial** therefore should be interpreted broadly in favour of the insured

- No reason to conclude it doesn't apply to post-accident compliance of the insured
- Here, saying because of the coverage was already in place (post-loss matters) providing relief from losing that coverage in instances of imperfect reliance after loss occurs

**NOTE:** cannot apply RFF to policies that do not exist – **cannot be applied to condition precedent of coverage because RFF cannot be used to create coverage where it doesn't exist**

→ **Sawyer v. Canadian Lawyers Insurance Association (2013) ABQB 616**

**SUM: Shows what a significant breach would look like. Gravity of breach is so great such that relief from forfeiture cannot apply**

- **Cannot create coverage from relief from forfeiture**

**FACTS:** P sued lawyer in negligence for failing to file statement of defence for MVA. Judgment against lawyer and now wants liability insurance to pay. Policy was issued on claims made basis – provides coverage for claims made during the policy period and notified to IC during the period. Lawyer failed to tell IC notice of loss, but claimed RFF to forgive the fact he did not provide notice

**ISSUES:** does RFF apply to failure to notify IC of claim under claims made policy?

**DECISION:** Court refused to apply RFF, based on their decision the failure to report the claim to IC was a *condition precedent* of coverage, not a post-loss obligation

- Coverage in this policy is issued on a claims-made basis = **notice is not a step you have to fill for coverage, coverage doesn't exist if notice is not given**
- Cannot use RFF to create coverage where none would otherwise exist

→ **Northbridge General Insurance corp. v. 943240 Alberta Ltd. (2013) ABQB**

**SUM: cannot create coverage from relief from forfeiture**

**FACTS:** fleet policy on many MVs – policy required insured submit an updated list of all vehicles by end of policy period to assess value. MVA – IC denied payment based on the vehicle not being included on the updated list of vehicle. Insured argued RFF.

**DECISION: Court states RFF does not apply to condition precedents to coverage.** In this instance, cannot look to *Insurance Act* jurisdiction because applies to post-loss, have to look to *Judicature Act* for authority

- Although authority exists, on factual analysis JA cannot be used to create coverage

**NOTE:** So why Falk says there is jurisdiction under JA to provide pre-loss coverage, it will not apply if the forfeiture is a condition precedent for coverage to be present in the first place

- **RFF does NOT apply to:** (1) Missed limitation period, (2) failure to pay a premium (necessary for a contract to exist)

(ii) **Waiver / Estoppel:** Insurer's conduct makes it unfair to hold insured to obligations; focuses on the **conduct of the IC** – both focus on IC good faith obligation to not mislead the insured

- Both generally say that IC cannot mislead insured about their obligations and then try to use that against insured. However the specific criteria (tests) of each are different
  - o **Same facts can be interpreted as a waiver or an estoppel but it depends on what the IC relied on and what the IC communicated to the insured**
- **Waiver:** a party intentionally (expressly or implicitly) consents to give up the right to rely on a privilege, right or power
  - o Know they have a particular legal right and purposefully do not rely on it/exercise it
  - o Consent has to be intentional but can be expressed or implied by conduct
  - o Effect of waiver is to prevent IC to rely on a breach by the insured
  - o *E.g. liability insurance = MVA and IC notices failure to report material change but continues to defend insured. Cannot then rely on the material change = implicit waiver*
  - o **Non-waiver agreement:** contract that IC enters into with insured, where insured agrees that they will not raise IC conduct as a waiver (IC use NW agreement to deny waiver or estoppel)
    - States may have reason to deny coverage in the future, but for the moment will supply coverage. But states current behavior does not waive future right to deny coverage and be interpreted as a waiver/estoppel
    - Also states that IC has to be paid back if proof to deny coverage arises
    - **Courts interpret these agreements strictly**
- **Estoppel:** a party cannot act in contraction to a representation of fact which it made and which another party relies on to its detriment
  - o Because of the detrimental reliance, it would be unfair to hold the insured to a different expectation
- **Statutory requirements:**
  - o **s. 521(1):** “The **obligation** of an insured to comply with a requirement under a contract is excused to the extent that
    - (a) The **insurer has given notice in writing that the insured’s compliance with the requirement is excused** in whole or in part, subject to the terms specified in the notice, if any, or
    - (b) The **insurer’s conduct reasonably causes the insured to believe that the insured’s compliance with the requirement is excused** in whole or in part, and the insured acts on that belief to the insured’s detriment.”
  - o **521(2):** Dispute resolution process participation, delivery of proof of loss form, and investigation or adjustment of any contract claim is not a waiver.

→ **Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance (1994) SCC**

**SUM:** defines waiver and estoppel in insurance situations – both are fact based analyses  
**Must give reasonable notice to withdraw a waiver – the reasonable period of time depends on the circumstances. Here, there was reasonable notice (i.e. instantaneous) because had no time to rely on the waiver**

**Relief from forfeiture is an equitable doctrine therefore the conduct of the insured must be examined**

**FACTS:** life insurance policy – P is beneficiary, issued by D. Policy is in place for number of years, and eventually beneficiary changes to deceased's wife. Premiums always paid by P. July 1984, P submitted premiums to pay for policy of next year. In August, received notification that more money was required. P sends extra funds. P sends a cheque for the difference but D not having received first cheque, they think they are shorted. IC sends letter making a late payment offer, as long as we receive payment before Sept. 8 we will keep policy in place). P doesn't respond, IC sends another letter addressed to the wife in November,

they don't hear anything, in February they send letter advising policy has lapsed and that you can apply for reinstatement but IC can ask for evidence of insurability. River hasn't replied because they are seasonal operation.

- In July, River sends cheque to IC for past year plus a cheque for coming year, IC refuses both cheques and takes position that policy lapsed.
- Insured is diagnosed with terminal cancer and dies in August. River sues IC for coverage and their argument is that IC waived its right to timely payment of premiums, and alternatively relief from forfeiture should be applied.

**ISSUES:** Did IC waive/estop its right to compel timely payment of premiums? Is RFF available?

**DECISION:**

**(1) Waiver: NO** - SCC held this was not a waiver because the waiver had been rescinded. A waiver can be cancelled upon reasonable notice to the insured

- **What is reasonable notice?** Question of timing - **depend on circumstance of case and degree of reliance on party who relied on waiver i.e. no exact time**
- Here, P got notice of both the waiver and the retraction at the same time (picked up letters all at once, even though sent 4 months apart) therefore no waiver

**(2) Estoppel: NO** - because you need detrimental reliance. P had no reliance because they didn't know because never read the letters

**(3) Relief from forfeiture:** is there authority of the court to grant this for an unpaid premium, and is it equitable in these circumstances?

- **NO** - court says even if they have/had authority – they would not use their discretion to enact the power based on the facts of the case
- Look at conduct of insured, gravity of breach, and disparity between the parties
  - o Insured's conduct was not reasonable – gave particular address to IC for communicating then don't check mail for several months
  - o Because of this, cannot rely on IC's forgiveness in the past to create an exception now
  - o It is the insured NOT the IC causing the problem
- This is a post-contract breach (payment of the premium) – cannot use *Insurance Act*. Therefore would have to go to the Judicature Act.

**NOTE:** since this case, in 2001 ONCA (p. 258) has said you cannot apply RFF to the failed payment of premiums. Even though Judicature Act says you technically can, you can't because payment is a condition precedent to the contract. Therefore would be applying RFF to a contract that technically isn't in place

- **S. 651/658 of IA:** 651 grace period for life insurance; 658 2-years of reinstatement for life insurance

**(5) Enforcement Mechanisms:** Punitive damages can be awarded against an insured where the insured breaches its obligations of utmost good faith.

- If the only punishment an insured has for breaching a term of the contract is they don't get money, there is not really a disincentive to do it...therefore why wouldn't you try?
- **Approach by AB courts to issue punitive damages against insured**
  - o In particular, for duties relating to the formation of the contract and acting fraudulently
  - o Creates a deterrent to not defraud ICs
- **REMEMBER:** require an independent wrong; therefore innocent misrepresentations/failure to report does not attract punitive damages

→ **RBC General Insurance Co. v. Field (2016) ONSC**

**SUM:** for punitive damages, must prove an independent actionable wrong

**FACTS:** F made claim under MV liability policy when license was suspended. Provided false statements and fabricated documents to prove story to IC. Was provided accident payout and benefits.

**ISSUES:** is there an independent actionable wrong so that punitive damages can be awarded?

**DECISION:** punitive damages awarded. F's false statements and fabricated documented constitute an independent actionable wrong. Amount of damages reflects the harm done

## Part 2: Duties of the Insurer

### We look at 3 duties:

- Duty to Respond to a Claim [*all policies*]
- Duty to Defend the Insured [*liability policies only*]
- Duty to Settle within Policy Limits [*liability policies only*]

### These duties may arise from / be defined by:

- **Utmost Good Faith (common law)**
- **Contract**
- **Statute**

### (1) **Duty to Respond**: governed by **contract** and by the duty of **utmost good faith**.

- **The contract establishes:**
  - The condition that triggers the duty (e.g. the insurer must respond to claims that fall within the coverage provided by the insurance policy).
  - The contract and the statute may also define some of the content of the duty.
- **The duty of utmost good faith establishes:**
  - The scope of the duty to respond (e.g. what conduct is required by the insurer to meet its obligation to respond) beyond the express requirements of the contract / statute.
  - According to the duty of utmost good faith, the **Insurer must act reasonably** when responding to a claim. This includes (but is NOT necessarily limited to):
    - **Treating the insured fairly** when investigating the claim
    - **Paying the claim within a reasonable period of time at a fair value**
  - Breaches of the duty of utmost good faith in responding to a claim (i.e. examples of “unreasonable” conduct) include:
    - Denying coverage without adequate reasons
    - Making the insured take unnecessarily onerous steps to prove the loss
  - Being belligerent towards the insured
- The **typical remedy for breach of this duty is punitive damages** payable by the insurer (may also be aggravated damages if the insured proves resulting mental / emotional distress)

### → TYPES OF DAMAGES

- Ordinary Damages (general / special): **compensatory** in relation to the damage **caused by the contract breach**; may include damages for emotional / mental suffering if within reasonable contemplation of the parties as a possible consequence of contractual breach (e.g. “*peace of mind*” contracts)
  - Designed to compensate whatever loss you suffered by contractual breach
  - **Peace of mind** = not just about the money, but also the emotional relief from the type of loss you suffered
  - Therefore, these damages will include coverage for both the loss and damage for emotional= mental suffering – but remember are still **compensatory** → requires evidence/proof
- Aggravated Damages: **compensatory in relation to emotional or mental suffering** (e.g. distress or humiliation) caused by an “**actionable wrong**” in addition to the contractual breach.
  - Not about the IC’s decision not to pay under the contract, but because of the way the IC treated you/responded to the claim
    - Same nature, but not arising just from the breach. Require additional suffering
  - E.g. belittlement, harassment, making you ‘jump through hoops’ = independent actionable wrongs
  - Again, are compensatory, thus require evidence
- Punitive Damages: **NON-compensatory**. Awardable against an insurer for an “**actionable wrong**” in addition to the breach of contract (i.e. independent). They are **exemplary**, designed to **punish and to deter** inappropriate conduct.

→ **Vorvis v. ICBC (1989) SCC**

**SUM:** NOT an insurance case. **Punitive damages are awardable for a breach of contract where the breach constitutes an independent “actionable wrong”**

**FACTS:** wrongful dismissal – employee of IC seeks punitive damages.

**DECISION:** important because SCC awards punitive damages for breach of contract. Idea before could not have punitive damages *on top* of breach of contract

- Can have it where actionable wrong independent to the breach → this case says in addition to that, court can go beyond contract and award punitive damages if there is an independent wrong

**NOTE:** What is an independent actionable wrong? (**Whiten**)

→ **Whiten v. Pilot Insurance Co. [2002] SCC**

**SUM:** **VERY IMPORTANT CASE** – stated that **punitive damages can be awarded in an insurance context where the IC has breached its duty of utmost good faith. Punitive damages are not compensatory, it is awarded to PUNISH the IC. Therefore must be an egregious breach, because it has the potential to create a windfall**

**FACTS:** home insurance policy – house burned down in middle of night and is destroyed. IC puts W family up in hotel for 5 days, and informs them they will not be covering loss because they thought the fire was arson. Investigator and fire department found no evidence of arson. IC became fixated on the notion this was arson – only evidence they found W family was in financial trouble. Felt if they held onto this even if it wasn't their case, thought they would get a lower settlement.

- In trial involving jury – included claim for breach of contract and for punitive damages. Jury awarded payment of coverage, interest, and 1 million in punitive damages
- ONCA – reduced punitive damages to 100,000

**ISSUES:** what is an independent actionable wrong, in the context of insurance contracts?

**DECISION:** SCC restored the 1 million punitive damage awards

(1) Are punitive damages an available remedy?

- An insurer's breach of its duty to respond to a claim in Utmost Good Faith is an **independent actionable wrong** that can support punitive damages, not breach of contract

(2) Should punitive damages be awarded in this situation?

- Punitive damages should be awarded **ONLY** in regards to **egregious breaches** of the utmost good faith duty

(3) What is the appropriate value of a punitive damages award?

- **Various considerations apply**, including the degree of blameworthiness, the vulnerability of insured, and the value needed to achieve deterrence by the IC
- Fact specific analysis that depends on the circumstances of each case = blameworthiness of IC conduct (planned or deliberate, intent and motive, persisted in conduct over time, concealed misconduct, awareness of wrong, profit, whether it was personal), degree of vulnerability of insured, proportionate to harm directed at plaintiff, deterrence from other IC's proportionate to advantage gained

**NOTE:** independent actionable wrong was not refusal to pay, but the treatment the W family received

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

**SUM:** must have a breach of utmost good faith to have a finding of an awarding of punitive or aggravated damages. If only a breach of contract, can award compensatory mental distress damages only

**FACTS:** disability policy for being unable to work. F was suffering disability and made claim. IC paid for benefits for 6 years, then terminated because they had sent investigator and determined she was doing activities she said she was unable to do. IC had no medical evidence, F submits own medical evidence. F sues IC and takes 5 years to get matter to trial. Just before trial, IC concedes and pays back all the disability benefits. F still goes to court and argues punitive damages

**ISSUES:** is denial of coverage during litigation process eligible for punitive or aggravated damages?

**DECISION:** awarded 20,000 for mental distress. Determine there is no independent actionable wrong in these circumstances, therefore no punitive/aggravated damages. Only compensatory

**No punitive damages:** The fact that an insurer has denied coverage for a loss which is later found to be within policy coverage does not necessarily mean that the insurer breached its duty to respond to the claim with utmost good faith. **(i.e. the wrongful denial of coverage does not necessarily equate to a breach of the duty of utmost good faith)**

- This is just a breach of the contract, therefore not an independent actionable wrong
- **What is part of the duty?** Assessing in a reasonable in balanced manner to determine their position of coverage; genuine position – cannot take advantage of the insured
- **What is NOT part of the duty?** Having to be correct i.e. has to be fair NOT correct

**General mental distress damages, are available for “peace of mind” contracts. To successfully claim for such damages, the claimant must demonstrate that:**

- (i) the object of the contract was to secure a psychological benefit so as to bring mental distress upon a breach within the reasonable contemplation of the parties; and
- (ii) that the degree of mental suffering caused was sufficient to warrant compensation

With respect to a disability insurance contract, peace of mind is firmly engrained – here can be awarded as **compensatory, NOT aggravated damages**

**No aggravated damages.** Aggravated damages are available if mental distress arises from an “independent actionable wrong.” (i.e. breach of utmost good faith duty). **Distinct from compensatory mental distress damages**

## → SUMMARY of DAMAGES / INSURER’S DUTY TO RESPOND

**(1) If an insurer wrongly denies coverage, the insurer:**

- Will be liable to pay the **coverage amount** owed under the contract
- May be liable to pay **compensation for mental distress** if contract is peace of mind and distress is significant

**(2) If the insurer breached its duty of utmost good faith in the manner it denied coverage (i.e. committed an independent actionable wrong), the insurer:**

- May be liable for aggravated damages if the breach of utmost good faith caused significant mental distress to the insured
- May be liable for punitive damages if the breach of utmost good faith was sufficiently egregious

**NOTE:** After *Whiten*, we saw that insureds would always throw in a claim for punitive damages as a “bargaining chip” because punitive damages are horrible for IC

- Page 289: 2 cases that raise questions about IC’s duty of utmost good faith. Both cases involve ‘post-loss underwriting’ = circumstances where contract is entered, claim is made, and the insured refuses the claim on the basis certain information was not disclosed
  - o Argument of insured is that the information was never asked of them
  - o Courts have frowned upon this and found it is within breach of the duty of utmost good faith to deny coverage on basis of information that they never asked for
  - o Issue by these cases is the court’s characterization of duty of utmost good faith (yet to be answered)
    - **Outstanding question:** if an IC engages in post-loss underwriting, can a court award punitive damages on this basis? Doubtful, but problem caused by the courts defining this as within the duty of utmost good faith

## Additional Statutory Duties of an Insurer when Responding to a Claim

- **Alberta Fair Practices Regulation, ss. 2, 3, 5.1, 5.2, 5.3:** overall purpose is to impose particular obligations on IC as matter of consumer protection
  - o **S.2:** entitled to know if IC takes position that the accident is your fault under auto liability policy
  - o **S.3:** IC has to tell insured they have right to estimate repair needs by whoever you want, unless the IC states they are going to pay for the repairs
  - o **S.5.1:** disclosure of policy limits relevant to automobile liability; as soon as injured party has a lawyer and tells IC about the potential claim, the IC has to disclose to the lawyer whether there is insurance present and the policy limits

- **S.5.2:** IC has to give notice to insured regarding dispute resolution process if there is a dispute regarding the value of the loss
- **S.5.3:** IC has to give notice to claimant of applicable limitation period UNLESS claimant is represented by legal counsel
- **Usanovic v. Capitale Life Insurance Co., 2017 ONCA:** involved lawsuit respecting disability benefits that began well outside limitation window.
  - **Issue: did IC have to tell insured about limitation period?**
    - ON does not have a s.5.3 therefore no statutory remedy
  - **Decision:** disclosing limitation period is not part of an IC's duty of utmost good faith
    - **Has to be imposed by statute (i.e. Alberta)**
    - Important because the breach of duty of utmost good faith leads to punitive damage awards = therefore in AB, if there is a breach the remedy is NOT punitive damages but rather extending the limitation period

**(2) Duty to Defend:** relevant to **liability insurance contracts**

- When the insured gets sued by injured party, **IC has promised two things:**
  - **(1) Promise to defend within policy limits**
  - **(2) If injured party is successful in judgment against the insured, IC will indemnify the insured up to the policy limits**
    - This duty only arises *after* the injured party has sued the insured = must be something to indemnify against
    - But duty to defend arises before duty to indemnify
- Insured can go to court and receive an application for the duty to defend before there is a ruling on the insurer's obligation to indemnify
  - What does this mean? **2 different tests →**
    - Defend: what has the injured party claimed? What is the insured *alleged* to be liable for?
    - Indemnify: is the duty to pay the judgment within the coverage? On what basis was the insured *actually* found liable, and is this liability within the policy?
- **Re s. A of Standard Auto Policy, Alberta Insurance Act, s. 564 (b):** "Every contract evidenced by a motor vehicle liability policy must provide that . . . the insurer must . . . **Defend in the name of and on behalf of the insured** and at the cost of the insurer any civil action that is brought against the insured at any time on account of loss or damage to persons or property."
- **What triggers the duty to defend?**
  - Example: if policy covers loss caused by "use and operation" of the insured motor vehicle, is the insurer's obligation to defend triggered by the third party's allegation that the loss was so caused or by a judicial finding that the loss was so caused (i.e. a judicial finding on liability that triggers the insurer's duty to indemnify the insured)
    - Answer: the **duty is triggered by the allegations** (NOT actual liability) in the pleadings in the action commenced against the insured by the injured party (i.e. the underlying action). [**Nichols v. American Homes (1990) SCC**]
    - Problem: the injured party controls coverage based on what they allege. And they want maximum coverage for a maximum judgment
  - **Nichols Test**: if you assume the allegations are true, do they fall within the policy's coverage?
    - An insurer is required to defend a claim where the facts alleged in the pleadings, if proven to be true, would require the insurer to indemnify the insured for the claim

→ **Non-Marine Underwriters v. Scalera, (2000) SCC** (consider **before** applying *Nichols* test)

- **To avoid parties triggering coverage by drafting pleadings on the basis of coverage considerations, courts must determine:**
- If the allegations are properly pleaded?
- If any of the allegations / claims are "derivative" of others?
- If coverage is provided for the properly pleaded, "non-derivative" claims?

- Then → apply *Nichols* test

**FACTS:** sexual assault tort claim. P sued bus driver for sexual assault. Driver made claim under home owner's liability policy. Court looked carefully at pleadings.

**DECISION:** excluded from coverage.

- Sexual assault by nature is intentional, only a question of consent NOT of negligence. Cannot refer to negligence, only reason it was claimed this way was trigger the policy coverage. Therefore a derivative claim to stretch out the pleadings to trigger the policy.

→ *Progressive Homes Ltd. v. Lombard (2010) SCC*

**SUM:** replaced *Nichols* and *Scalera* as case that gets cited for duty to defend principles

This duty is broader than the duty to indemnify → duty to defend arises as soon as an allegation is made that falls within policy coverage

**FACTS:** P, general contractor building condo complex. Water leaks after built. BC housing sued P for negligence in construction and P made claim against liability insurer, L. L initially defended claim but partway through withdrew defence.

- Reason for withdrawing defence had to do with wording of contract. Coverage for accident didn't apply here and there was an exclusion clause for faulty work.

**ISSUES:** Does L IC owe a duty to defend the claims made against P?

**DECISION:** Court applies test from *Nichols*: **If the facts set out in the pleadings are true (if they could be proven as alleged), would coverage exist under the policy?** Then you get into the interpretation of the contract. Test for determining if IC has duty to defend.

- Before *Nichols*, look analytically at the claims made (*Scalera* test):
- If the allegations are properly pleaded?
- If any of the allegations / claims are "derivative" of others?
- If coverage is provided for the properly pleaded, "non-derivative" claims?

→ *Riocan Holdings Inc. v. Intact Insurance Co. (2017) ABCA*

**SUM:** application of *Progressive Homes* test in Alberta

**FACTS:** injury from slip and fall on icy sidewalk. Injured party sued property owner, P. In addition, sued snow removal company hired by P (TJA). Contract between P and TJA included term saying that TJA would "hold harmless the property owner any claims that occurred from condition of sidewalk and required TJA to obtain liability insurance that would cover both TJA and P"

- IC argument: denied coverage to P and refused to defend him on basis 'hold harmless' clause was about things related to snow removal. The claim against P was not about snow removal, but about occupier's liability.

**ISSUES:** is the duty to defend triggered?

**DECISION:** IC has duty to defend. Apply *Progressive Homes* test to ensure everything has been properly pled and if coverage under contract exists.

- Allegations against P are about P as an occupier, but everything about it being an occupier relates to the snow removal = cannot separate the allegations as IC is trying to do
- Therefore, any negligence relates to the snow removal and is covered by the contract

→ *Urbanmine Inc. v. St. Paul Fire and Marine Insurance Co. (2017) MBCA*

**SUM:** Look at what the statement claim is directed at, and assume that it is true

**FACTS:** Employer sued various employees/sub-contractors with respect to fraud, theft, and misappropriation of nickel. Allegation was this nickel product had been stolen, and P knowingly bought it. P had liability coverage, including compensatory damages for bodily injury/property damage arising from an accident.

**ISSUES:** is the duty to defend triggered?

**DECISION:** Court said no duty to defend – clear on policy wording of 'accident' that it only covers unintentional loss. Although claim was for conversion, and negligent conversion is possible, must look at the pleadings it is all about intentional fraud.

What if you have some claims that fall within coverage, and some that do not?

- E.g. injured party sues for both negligent and intentional action
  - o Duty to defend test assumes that both are true = IC does have to defend against the allegations that are covered under the contract
  - o To the extent that it is possible, IC has to cooperate = one litigation process, therefore one lawyer, but intentional/negligent allegations must be paid separately by each party
- E.g. Gets more complicated if allegations contradict each other
  - o IC may say to insured to hire lawyer, and that the IC will pay a portion of the legal costs

### **(3) Duty to Settle Within Policy Limits**

- Relevant **liability insurance**

→ **Dillon v. Guardian Insurance (1983) ONHC**

**SUM: An insurer has a duty of utmost good faith not to leave its insured exposed to an uninsured loss if the insurer could have reasonably settled the claim within policy limits.**

**FACTS:** D, insured, involved in accident where he hits an infant. Insured by SAP that has Section A limits of 50,000. Amount of claim valued at 100,000, IC steps in to represent D and move towards trial for accident. Just before trial, lawyer for infant tells IC lawyer they will settle claim for 46,000 (i.e. just within policy limits). IC instructs lawyer to reject settlement offer. Claim goes to trial. IC had assessed claim at 43,000. Court awards the injured party 77,000. IC provides 50,000, leaving D to pay 27,000 of judgment over the policy limit. D sues IC for refusal to settlement and thus for exposure to a judgment above policy

**ISSUES:** (1) Can the IC be liable for failure to settle the claim within the policy limits? (2) What standard should be applied to this imposed duty?

**DECISION:** IC ordered to pay the 27,000 of judgment above policy limit

**(1)** IC can be liable for more than policy limits if it fails to settle within the policy limits, if it is their fault that the insured is exposed to uninsured judgment

**(2) 3 approaches to the standard issue:**

1. Absolute liability
2. Reasonability standard
3. Only liable if act in bad faith

**Court does not address which standard is the best because on the facts of this case, IC would be liable under any of the standards**

Despite this, subsequent cases have said IC owes a duty of good faith to settle a liability claim within policy limits if it is reasonable to do so i.e. look out for the interests of the insure *over and above* the policy limits Cannot act in a way that prejudices the insured's interests, and if this duty is breached, IC may be ordered to pay more than the policy limit An insurer has a good faith duty not to leave its insured exposed to an uninsured loss if the insurer could have reasonably settled the claim within policy limits.

**NOTE:** still remains leading decision on point and changed conduct of ICs and their lawyers drastically  
As lawyer for IC = look to see if claim is within policy limits, (2) if it exceeds the policy limits, advise the insured that the claim exceeds policy limits, and if IP is successful in the entirety of their claim, insured will be personally exposed to judgment over and above the policy limits (3) because of this exposure, insured may want to retain own lawyer

### **What if there is an SEF 44, is there still a duty to settle within policy limits?**

- Excess insurance has right of subrogation, therefore the liability insurer has the **same obligations** of good faith in settling within policy limits
  - o SEF 44 may sue the insured through subrogation or may have reason to deny injured party coverage
- The duty comes from the right to subrogate NOT a duty owed to the SEF 44 IC

## THIRD PARTY CLAIMS

### I. ASSIGNEES

**Remember:** Insurance is a personal contract that does not “run” with the transfer of the insured property or the subject-matter of insurance

- When can someone else try to get the benefit of the personal, insurance contract? Ordinary rules of privity say you must be a party to the contract before you can receive its benefit
- **Assignees:** people who are assigned the rights of an insurance contract
  - o Comes up most often in respect to the sale of property – cheaper/faster

**So:** In the insurance context, it is necessary to distinguish between an **assignment of proceeds** and an **assignment of the insurance contract**.

**Assignment of Proceeds:** assigns **post-loss payment** (\$) to a third party.

- **Does not require insurer’s consent** because it only changes the recipient of insurance funds: no change is made to the personal nature of the contract (risk factors)
  - o Post-loss assignment – therefore IC does not care who they pay the money too
- The contract is not changed so the insurer’s obligation to pay the assignee **is subject to any defences insurer could raise against the insured**, including policy breaches by the insured
- **Problem:** if you are the person who has been promised the proceeds of an insurance payout, depends on the IC actually paying out. If insured breaches contract, they do not have to pay anything

**Assignment of the Contract:** assigns (transfers) **the insurance contract** (i.e. coverage) to a new insured

- **Requires insurer’s consent** because the insured person (the risk) changes
  - o If they do not consent, no assignment of the contract
- Once insurer consents, the assignment results in a **contract de novo**, so is **not subject to defences the insurer might have otherwise raised against the original insured**
  - o IC cannot look past the date of assignment for any breaches by the insured
- An assignment of the contract is a substitution for the purchaser of the property obtaining its own insurance contract
  - o Assignment may be easier / faster – E.g. husband/wife
- Because the assignee must have an insurable interest in the assigned contract for the assignment to take effect, **the assignment must take place contemporaneously with the property transfer**
  - o Before/after transfer = no insurable interest for one of the parties

→ **Peters v. General Accident Corp. (1938) Eng. C.A**

**SUM: cannot assign an insurance contract without the consent of the IC**

**FACTS:** MVA liability insurance policy (equivalent S.A coverage). Covers owner of vehicle and anyone driving with their permission. Here, vehicle owner sells the vehicle to someone else who drives it and is involved in a MVA.

**Argument of insured:** if S.A covers anyone driving with permission, if I sell it that person is driving it with my permission

**ISSUES:** Does IC have to payout? Is this an assignment?

**DECISION:** Policy does not travel with sold property i.e. the motor vehicle. No evidence of assignment of the contract.

Even if it is sold to someone who might have had permission under S.A coverage when insured was the vehicle owner

Auto policy is one in which there is an inherent personal element of such a character as to make it assignable. There are different risks of each driver and the IC makes inquiries and decides coverage based on that

→ **Springfield Fire and Marine Ins. v. Maxim (1946) SCC**

**SUM:** If IC consents to assignment of contract, they cannot rely on any breaches of the original insured

**FACTS:** transfer between H and W. H took out fire insurance policy on home. At the time of application, made numerous misrepresentations, including whether or not had previous fire. After policy is in place, H sells property to W and assigns the contract to his W and the IC consents to the assignment. After all of this, a fire occurs that damages the home

IC argument: refuse to pay based on misrepresentations H made on initial application

**ISSUES:** does the IC have to pay the policy on the face of misrepresentations?

**DECISION:** IC has to pay the loss. Upon consenting to the assignment of a contract, the IC is creating a novation with the new insured. As a result, IC can only raise actions on the new insured to deny coverage. Any defences IC would have had under original contract for breaches by the original insured can no longer be raised

**Why?** Because IC is always free before consenting to an assignment to deny the assignment, ask any questions, or enter into completely new contract. Therefore, agreeing to assignment is forfeiting the right to deny coverage to the original insured

**NOTE:** only difference between new contract and assignment, is the assigned contract is just picked up wherever it was left off by the original insured

## **II. MORTGAGEES**

**Mortgagee:** a party who, in exchange for providing a loan, takes a **security interest** in property owned by the borrower (the mortgagor).

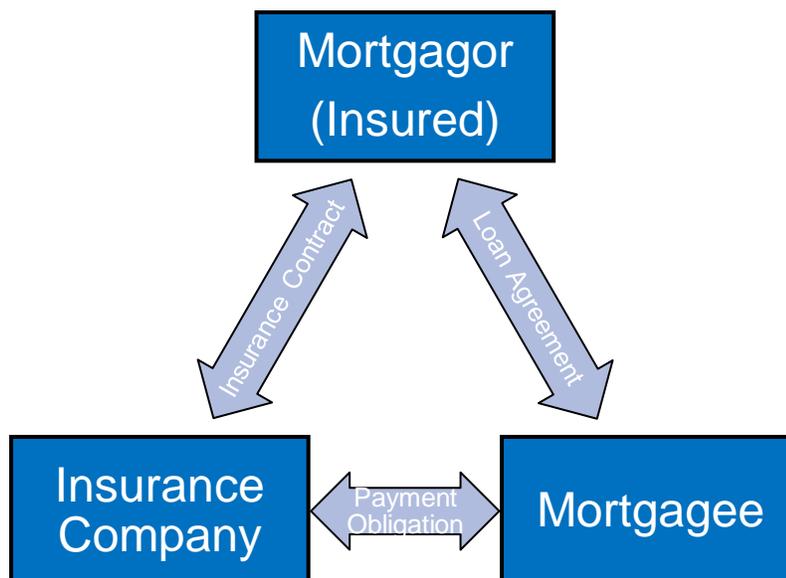
**Problem:** if the property is damaged / destroyed such that its value is affected, the mortgagee loses the value of its security.

**Options for solving this problem:**

- Mortgagee obtains its own insurance contract on the mortgaged property
- Mortgagee obtains an assignment of proceeds from the mortgagor
- Mortgagee is protected under a **Standard Mortgage Clause**

**Features of the Standard Mortgage Clause**

- Is added to the mortgagor's insurance contract
- Creates a collateral contract between the mortgagee and the mortgagor's insurance company
  - o Its existence means the mortgagee has a direct cause of action against the insurance company = overcomes any issues of privity



- Costs additional premium
- Obligation of insurer to pay the mortgagee lasts only as long as the mortgagee retains an insurable interest in the property
  - o Makes insurance money payable to mortgagee even if mortgagor has breached the policy
- Contribution principles apply in relation to the insurer's obligation to pay the mortgagee and that of any other insurer obligated to pay the mortgagee
- Mortgagee is obligated to tell the insurer of changes that increase the hazard if the mortgagee is aware of same.

**Insurer is obligated to pay the mortgagee notwithstanding a breach of the contract by the mortgagor**  
**BUT**  
**the insurer is entitled to recover from the mortgagor to recover amounts so paid** (i.e. subrogation: the insurer stands in the position of the mortgagee to recover from the insured mortgagor).

**S. 539: Statutory Treatment of the Standard Mortgage Clause**

- Insurer must give the mortgagee **notice of cancellation or alteration of the contract** to the prejudice of the mortgagee
- For termination, the mortgagee is entitled to the **same notice that the insurer** is required to give to the insured under the statutory conditions

→ **Co-operators Gen. Ins. Co. v. Nat. Bank of Canada (1988) ABCA**

**SUM: Mortgage clause brings the insurer and mortgagee into privity, to convert the mortgagee into a party to the contract of insurance to give the mortgagee separate and distinct protection as to his interest, to create in him an interest in the policy distinct from the of the property owner**

**FACTS:** D gave loan to C which was secured against property owned by C. Loan required C to insure and make the loss payable to D, specified under a mortgage clause. C asks for that, but IC forgets to put mortgage clause in policy. Fire occurs and C is charged with arson.  
IC argument: do not have to pay C because of arson and do not have to pay D because there is not mortgage clause in the contract  
**ISSUES:** does IC have to pay the mortgagee in the absence of a mortgage clause?  
**DECISION:** YES - Court said no reason to apply rectification because you can have mortgage clause by agreement orally. Mortgage clause was in existence because IC, insured and bank all agreed it would be provided  
 A mortgage clause is collateral to main contract and creates separate rights. The arson or breach of insured has no impact on IC obligation to pay the bank. Where IC contains mortgage clause, there is two contracts of insurance in place (1 between lender and IC and the other between insured and IC; they are treated completely separate).

→ **Royal Bank of Canada v. State Farm (2005) SCC**

**SUM: mortgagees don't have an obligation under SC#4, their obligations are in the collateral contract**  
**Insurer's obligation to pay mortgagee applies irrespective of breaches by property owner, whether breach of SC or some other contract term**

**FACTS:** insured has fire policy and 2 mortgages on home. Default on mortgage and leave home. Mortgagees do not foreclose but each takes turn monitoring the condition. No one tells IC that it is vacant. Fire occurs.  
IC argument: refuses to pay mortgagees because they failed to comply with SC#4 – reporting changes material to the risk  
**ISSUES:** does SC#4 permit the IC to void coverage granted to mortgagee by the SMC in the event of a change material to the risk within the control and knowledge of the mortgagee of which the IC is not notified?  
**DECISION:** conflict between SC#4 and SMC - only way of resolving it is to say that **when SMC says IC will pay regardless of any breach that includes a breach under SC4**  
 IC should have drafted clear terms if it wanted to void mortgagees contract based on failure to report material change

→ **Hum v. Grain Insurance and Guarantee Co. (2009) ABQB**

**SUM: SMC insulates the mortgagee from conduct of the mortgagor which would vitiate coverage under the policy. Terms of the policy that conflict with the SMC including exceptions to the mortgagors coverage do not affect the mortgagees coverage.**

**FACTS:** exclusion that says no coverage if loss caused by deliberate act of insured – not a breach, but no coverage. Loss causes when tenant set fire to property. Contract included SMC.

**ISSUES:** can IC rely on exclusion to not pay the mortgagee?

**DECISION:** IC still has to pay mortgagee, because **under terms of SMC says have to pay despite any act by insured**. Therefore exclusion clauses about action of the insured cannot be relied upon to withhold payment from the mortgagee

### **III. AUTOMOBILE LIABILITY CLAIMS**

- **Insurance Claim #1:** tortfeasor will claim compensation from their insurance company for the damage to their car under **s. C of his insurance policy**
  - o **FIRST PARTY** insurance claim (*Insured v Insurer*)
  - o Insurance company may be able to legally avoid paying this claim if prove any of the following:
    - K was not in existence on date of loss → terminated, expired, parties not *ad idem*
    - Policy does not cover the loss (e.g. impaired)
    - Insured breached the contract
- **Insurance Claim #2:** injured party will claim compensation from their insurance company for damage to their car under **s. C of his insurance policy**
  - o **FIRST PARTY** insurance claim (*Insured v Insurer*)
  - o Insurance company may be able to legally avoid paying this claim if prove any of the following:
    - K was not in existence on date of loss
    - Policy does not cover the loss
    - Insured breached the contract
  - o **TORT CLAIMS:**
    - **(1)** After paying under s. C, the insurance company may bring a subrogated action against the tortfeasor
    - **(2)** Injured party may sue damages related to personal injuries which were not fully compensated by own s. B benefits
    - Because of the **single cause of action rule**, injured party and their insurer would have to coordinate in bringing this action
- **Insurance Claim #3:** under s. A of their policy, tortfeasor will claim defence costs and indemnity from their insurance company in respect to the above tort claims
  - o **FIRST PARTY** insurance claim (*Insured v Insurer*)
  - o Insurance company may be able to legally avoid paying this claim if prove any of the following:
    - K was not in existence on date of loss
    - Policy does not cover the loss
    - Insured breached the contract
  - o But if insurer can avoid indemnifying, then innocent third party will not have access to insurance funds to satisfy a judgment he obtains in the tort action
    - **This is especially unfair if Henson is able to avoid indemnifying tortfeasor because of a breach of contract by the tortfeasor**
- **Insurance Claim #4:** to rectify this potential unfairness, **s. 579(1)** of the Insurance Act provides that, **after obtaining a judgment against the party who caused the accident, a person injured in a motor vehicle accident can claim directly from the tortfeasor's insurer for payment of the judgment**
  - o So, after successfully suing the tortfeasor, the injured party can claim directly from Henson for payment of the tort judgment.
  - o **THIRD PARTY** insurance claim (*Injured Party* (non-party to contract of insurance) v *Tortfeasor's Insurer*)
    - Claim is only triggered after a judgment is obtained in the tort action, injured party must become a **'judgment creditor'**

## Judgment Creditor Action

- **Limitations:** injured party's ability to claim from tortfeasor's insurer directly would be useless if insurer could raise any of the tortfeasor's breach of contract as a defence to the JCA. So, the **statute limits the defences** that can be raised by the tortfeasor's insurer in a judgment creditor action.
  - o CANNOT rely on the **insured's breach of contract** (e.g. non-disclosure, misrepresentation, failure to report a material change, failure to notify the insurer of the loss, etc.) **in respect of the first \$200,000** (statutory minimum limits) of the judgment (**ss. 579(4) & 579(11)**)
  - o CANNOT rely on the **insured's lack of insurable interest in the vehicle (s. 579(5))** and CANNOT raise **s. 556 SC #2** (prohibited use of the vehicle) for any portion the claim (**s. 579(11)**)
- **NOTE:** any defence which the insurer can rely on in the Judgment Creditor Claim is subject to the same considerations of **Relief from Forfeiture, Waiver and Estoppel** as would apply in a first party claim between the tortfeasor and the insurance company
- **Question:** How does the insurance company involve itself in defending the tort action without triggering waiver or estoppel in regards to its right to deny coverage to the insured? **TWO OPTIONS**
  - o **Non-Waiver Agreement:** can be used even if the insurer is undecided as to its coverage position.
    - **The Agreement should clearly provide the insurer with:**
      - (1) The ability to defend and settle the tort claim on behalf of the insured "without prejudice" to its right to later deny coverage
      - (2) The right to recover defence costs and indemnity from the insured (assuming the insurer can prove a policy breach by the insured)
    - o **Apply to the court to be named as "Third Party by Order" (s. 579(14) – (16))**
      - Can only be obtained if the liability insurer has denied coverage to the insured
      - **Upon being made a Third Party by Order, the insurer:**
        - Participates in the tort action as though it was a defendant
        - Is entitled, upon the third party obtaining judgment against the insurer in the Judgment Creditor Action, to recover defence costs and indemnity from the insured
      - An insurer becomes a Third Party by Order only via a court order

## Statutory Recovery Action

- JCA → tortfeasor caused the accident and breached his insurance contract but is not held financially accountable for the loss to Kermit
- To rectify this potential unfairness, **s. 579(13)** states that, if a motor vehicle liability insurer has to pay a judgment creditor because it is prohibited from raising the insured's conduct as a defence, the insurer is entitled to recover from its own insured the amount paid to the 3<sup>rd</sup> party claimant
- It gets around the rule that an insurer cannot recover insurance payout from its own insured

→ 3 possible consecutive actions arise from a loss caused by a tortfeasor in a motor vehicle accident:  
Tort Action  
Judgment Creditor Action (s. 579(1))  
Statutory Recovery Action (s. 579(13))

## The Payout

- **Scenario A:** if insurance company has denied coverage to their insured because of a misrepresentation on the application form or failed to report a material change or failed to give notice of the loss (*any breaches we have talked about*)
  - o **Then:** Assuming IC can prove the policy breach, in a judgment creditor action, IC will have to pay injured party the statutory minimum limits of \$200,000 (ss. 579(4) & 579(11))
    - Then, injured party can go to their SEF 44
- **Scenario B:** If insurance company has denied coverage because on the date of loss the insured was operating the vehicle in violation of s. 556 SC#2.

- **Then:** even if IC can prove this violation, cannot rely on the violation to deny payment to the injured party in a judgment creditor action by Kermit (s. 579(11)) → have to pay entire judgment
  - SEF 44 would not be triggered
- **Scenario C:** if insurance company has denied coverage on both above grounds
  - **Then:** even assuming that the IC can prove both defences, they will have to pay the injured party \$200,000 (it cannot rely on scenario B at all but it can only rely on scenario A for the claim over \$200,000). (ss. 579(4) & 579(11)).

In each of the 3 scenarios, IC would be able to recover from their insured by relying on EITHER:

- Non-waiver agreement (if one was signed by insured);
- Statutory recovery action (s. 579(13)) (provided that a judgment was obtained in a Judgment Creditor Action)
- If injured party's SEF 44 coverage is triggered, their IC will also seek recovery from tortfeasor using the subrogation provisions of the SEF endorsement.
- **Scenario D:** If insurance company has denied coverage to insured on the basis that the insurance contract was not in existence on the date of loss
  - **Then:** Assuming can prove this defence, IC does not have to pay injured party anything
    - Can claim \$200,000 from the Motor Vehicle Accident claims fund.
    - Can claim under SEF 44 → the fund administrator can claim repayment from injured party's IC (*MVA Claims Act*, s. 5(4)) and IC can claim repayment from tortfeasor using the subrogation provisions of the SEF 44 endorsement.

**REMEMBER:** if judgment exceeds the amount payable by the policy (or the MVA fund) and the SEF 44 Insurer then injured party will also be pursuing tortfeasor personally for any unrecovered portion of the judgment → i.e. their IC (or the MVA fund), injured party's IC (as SEF 44 insurer) and injured party would all be unsecured judgment creditors pursuing tortfeasor for recovery

- **Scenario E:** if insurance company has denied coverage to tortfeasor on the basis that the loss did not result from "use and operation" of the insured vehicle
  - **Then:** assuming can prove this defence, IC does not have to pay injured party anything.
  - Injured party cannot recover from the Motor Vehicle Accident Claims Fund OR from his own SEF 44 if the loss was not caused by use or operation of a motor vehicle

### Summary

- There are **3 separate actions** relevant to third party auto claims:
  1. **Tort Action** – establishing liability & damages for the motor vehicle accident
    - Insurance has nothing to do with the substance of the tort action or determining the liability of the party - insurance comes into play after
    - Insurance companies anticipate that there will be an action, and potentially a JCA. Therefore, do not want to outright deny representation → therefore conduct at tort action influences conduct at JCA and RA
  2. **Judgment Creditor Action** – permitting the judgment creditor from the tort action to claim recovery directly from the defendant driver's liability insurance company
  3. **Recovery Action** – permitting the defendant driver's liability insurance company to recover from its own insured \$ paid to the judgment creditor in Action #2.
- In the **Judgment Creditor Claim**, the insurance company is **limited in the defences it can raise**, both in respect of the statutory minimum coverage and the claim above the statutory minimum
  - **It can raise defences going to the existence / application of the contract:**
    - The parties never entered into a contract because they were not ad idem on essential terms
    - The contract was terminated prior to the loss
    - The loss did not arise from use and operation of the motor vehicle

- The **Recovery Claim** allows the insurance company to **recover from its insured \$ it had to pay to the Judgment Creditor because it was statutorily prevented from raising certain defences** against the Judgment Creditor that it could have raised against its own insured
  - o To recover from its insured, the insurer has to **successfully prove those defences**

**Statutory Provisions to Note in addition to s. 579:**

1. **S. 556 SC#2:** Prohibited uses
  - o Can NEVER be raised against a judgment creditor
2. **S. 563:** an unnamed insured can claim coverage under s. A of SPF #1
3. **S. 571:** sets the S. A. statutory minimum limit
4. **S. 576:** enables insurer to enter into an agreement with the insured to have the insured repay the insurer (i.e. non-waiver)
5. **S. 187 of the Traffic Safety Act:** makes a motor vehicle owner liable for loss or damage caused to a third party by anyone operating the motor vehicle with the owner's consent or by anyone who is living with and as a member of the owner's family.
  - o If someone steals the vehicle = no coverage and no vicarious liability
  - o **S. A of the SAP:** provides coverage to the named insured and anyone driving with the named insured's consent (required by s. 559(1) of the IA).

**Case Law**

**1. The Tort Action**

→ **Lenkewich v. Landry (2004) ABPC**

**SUM: cannot claim for deductibles and premiums in the tort action**

**FACTS:** P is injured third party in MVA caused by D. P sues in tort action and claims cost of increased insurance premiums against D.

**ISSUES:** can you seek costs for increased premiums?

**DECISION:** PC said no – cannot claim increased premiums. Possibility would be there but cannot prove only reason premiums went up is because this 1 MVA – very high burden because ICs consider many factors when determining premiums. Close in time does not meet this standard.

→ **Halifax Insurance Co. v. Williams (1966) ON Co. Ct.**

**SUM: non-waiver/reservation of rights:**

- 1) **Strictly construed by the courts because insured is waiving rights and are drafted by the IC therefore must be clear and there is no reading in by the court**
- 2) **IC's conduct is also significant – is there misrepresentation/are they fully expressing to the insured what the agreement means?**
- 3) **Must mutually agreed upon to be enforceable**
- 4) **Difference between NWA and reservation of rights order**

**FACTS:** D (Williams) had auto policy with P. D's friend stole car and got into MVA. In order to protect friend, D told P that friend was driving with consent. Adjustor for IC got D to sign NWA but they told him it was an 'investigation formality'. D did not know the NWA meant IC could claim against him. IC settled third party claim and then tried to claim back from D under terms of NWA. The IC thinks there is consent, so there basis of breach is SC#2 which says you cannot lend car to uninsured driver (friend didn't have license)

**ISSUE:** can the IC rely on the NWA

**DECISION:** NO – insured didn't understand the terms of the NWA and they were not explained to him = **misrepresentation by the IC to insured**

- IC prejudiced insured by settling when insured had his own claim because did not give friend consent
- **NWA is not binding on insured unless the insured understands what it means.** In particular, it will not bind when the IC does not inform them of rights and obligations under it

→ **Allstate Insurance Co. v. Foster (1972) ON Co. Ct.**

**SUM: IC cannot unilaterally give themselves the ability to claim the money they spent back against their insured.**

**FACTS:** D involved in MVA, 3<sup>rd</sup> parties are H/W that sue D. Because of accident, D was convicted of impaired driving. At time of case, this breach was a defense (NO LONGER). IC settles the claim with H/W who never had judgment against TF. Then IC tried to claim back settlement from D based on reservation of rights letter sent to D.

**ISSUES:** is a unilateral letter suffice to constitute a reservation of rights?

**DECISION:** court said can reserve rights for estoppel/waiver with unilateral letter, but cannot unilaterally give yourself the ability to claim my money spent back against your insured

- To do this, requires bilateral agreement with insured that the insured understands
- Silence is NOT agreement to the letter - NWA needs to be intended to be a mutual reservation of the rights of the parties

→ ***Giese v. Hunking (1971) ABCA***

**SUM: in order to successfully make such a court application, the IC must deny coverage to its insured. This is a prerequisite to becoming a third party by order.**

**FACTS:** D is insured by IC. D gets in MVA with injured P. D doesn't report accident. P sues D and D does nothing. P gets default judgment against D because they did not litigate, not a determination on the merits. P brings a JC action against the IC – IC is surprised because did not know about the judgment. IC wants to be added to tort action and apply to set the default judgment aside. IC applies to open up the default action and be a third party by order. In IC's affidavit, they do not say anything about grounds for denying coverage to D.

**ISSUES:** can IC become a third party by order without denying their insured coverage?

**DECISION:** NO - Court says in order to be made third party by order in tort action, IC needs to deny coverage to insured.

- Since not mentioned, Court said no and the IC was stuck with the default judgment.
- **(1) Deny coverage → (2) Third party by order**

→ ***Re Perfaniuk (1961) MNCA***

**SUM: default judgments can be set aside and IC can be made third party by order after the fact to defend judgment**

**FACTS:** injured P gets judgment against TF – TF didn't tell IC. Default judgment is issued – IC applies to set judgment aside and be third party by order. P argues cannot be made third party by order because judgment is already issued, application has to be done before judgment.

**ISSUES:** can the judgment be set aside?

**DECISION:** Court said P's argument is true in all cases except for default judgments, because it is not a judgment on the merits. If it was an actual judgment, could not

- It would be unjust to deny the IC who had no knowledge of the action until after judgment, the right to be entered as a third party
- Insured did not defend but this should not prejudice IC their right

## **2. The Judgment Creditors' Action**

- **Class action right** → everyone injured shares this action who has a claim against the TF and must obtain a JUDGMENT
- **Limitation period** → must be commenced within 1 year of the injured party obtaining judgment against the tortfeasor

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

**SUM: JCAs are absolutely distinct from the tort action - different both in separately commenced AND what the IC can argue in each one**

**FACTS:** P obtains judgment against TF then sues TF's IC directly under JCA. In response, S.A liability insurer raised defences – (1) insured had breached a SC, therefore breached policy, (2) volenti, (3) P was contributorily negligent

**ISSUES:** can any of these defences be raised?

**DECISION:** court said IC could not raise all these defences: (1) is an insurance defence therefore depends on how s.579 applies. But the other (2) and (3) defences go to TF's liability – part of the tort action, therefore cannot be re-argued.

- Cannot raise tort defences in the JCA – the judgment is already given.

**What kinds of defences can be raised in JCA?** Apart from issues of breach (579(4) and (11)), IC could argue absence of judgment, there was never an IP, doesn't fall within the policy, even though judgment was issued it has been paid – therefore no creditor, or policy defences subject to the statutory limits

- The JC action is an action based on the judgment previously obtained by the injured party and on the statutory right to sue to have the insurance money payable on that judgment. Accordingly, IC cannot raise defences which would be available if the action were based on the insured negligence or misconduct or on the policy

→ **Bartkow and Walder v. Merit Insurance (1963) BCCA**

**SUM: JCA is a class claim – all injured parties have to be a part of the action and that there should be a minimum of 200,000 to compensate the injured parties, but this must be shared amongst the injured parties. I.E. 200,000 per event**

**Payment of insurance proceeds from JCA is only available to those who have received judgment**

**FACTS** TF gets into MVA and injures 5 people and all sue – 3/5 lawsuits are settled. The other 2 proceed to trial and get judgment against TF and pursue JCA. Section A liability insurer have statutory minimum and had been involved in tort action through NWA. IC argues because class action, whatever is left of statutory minimum from settlement goes to the 2 judgments.

**ISSUES:** are settlements considered in dividing statutory minimum among injured parties?

**DECISION:** Court said NO = statutory minimum to judgment creditors. Statutory minimum is split between these 2 people, does not take into account any settled actions. Applies to people who have issued judgments against the TF.

- ICs have to be very careful when multiple 3PS are injured = cannot settle with some and not settle with some – will result in them paying more than the statutory minimum.
- Reduce the settlement to a 'consent judgment' so it counts to the class action of judgments

→ **Limited Defences available to the Insurer:**

- **579 (4)** The right of a person who is entitled under subsection (1) to have insurance money applied in or toward the person's judgment or claim is not prejudiced by
  - (a) an assignment, waiver, surrender, cancellation or discharge of the contract, or of any interest in or of the proceeds of the contract, made by the insured after the event giving rise to the person's claim under the contract,
  - (b) any act or default of the insured before or after that event in contravention of this Subpart or of the terms of the contract, or
  - (c) any contravention of the Criminal Code (Canada) or a statute of any province or territory or of any state or the District of Columbia of the United States of America by the owner or driver of the automobile,
 and nothing mentioned in clause (a), (b) or (c) is available to the insurer as a defence in an action brought under subsection (1).
- **579 (5)** It is not a defence to an action under this section that an instrument issued as a motor vehicle liability policy is not a motor vehicle liability policy.

→ **Jivraj v. Edwards (1999) ABCA**

**SUM: insurable interest defences cannot be used as a defence in judgment creditor actions because of 579(5). But if characterized as a misrepresentation, can be raised as defence over the statutory minimum**

**FACTS:** injured parties were V/J and were in accident with vehicle owned by E; driver was G. V/J sue G and got judgment against driver. Then proceeded to JCA against G's liability insurer; the claim was within policy limits (200,000). Insurer argues insurable interest and therefore do not have to pay and V/J have to go to their MVA claims fund.

**ISSUE:** can lack of insurable interest be used as a defence in a judgment creditor action?

**DECISION:** In JCA, the TF's insurer cannot raise insurable interest as a defence because it is like saying 'the policy is not really a MV liability policy' – unavailable because of **579(5)**

**BUT** = both G and E knew that G was the actual owner of the car – arrangement to get low insurance premiums. G's license was suspended, but this cannot be raised as a defence.

- ONCA says when you have this problem, **can analyze sham ownership in a variety ways: (1) misrepresentation** – cannot be raised under 579(4); **(2) lack of insurable interest**; **(3) no coverage** because accident causer was not driving with consent of owner, because E technically does not own the car; **(4) not an owner's policy of insurance**, so 579 wouldn't apply, because not issued to the owner
  - **Last two are disguised as insurable interest. Therefore, collapse them all together.**
  - **ABCA agrees with ONCA, where under 579 the insurable interest argument cannot be raised**

Administrator therefore does not need to be brought in because no defence, therefore no fund

**REMEMBER:** this says cannot be raised for ANY AMOUNT. However, because you could raise it as a misrepresentation, can raise it above 200,000 under 579(11)

→ **Winch v. Kedgh (2006) ONCA**

**SUM: coverage issues can be raised as a defence under s. 579 → injured party cannot recover if insured has no coverage**

**FACTS:** Injured party is W in MVA with K, who has insurance with R IC. Policy had provision that said coverage for driving own vehicle or any other vehicle as long as weighed less than 4500kg. In the accident, K is driving another vehicle that is over the prescribed weight. C

**ISSUE:** can the IC raise the exclusion provision as a defence in the JCA, if it was a precondition of coverage?

**DECISION:** court said YES - can raise this defence and because can raise it successfully, do not have to play the claim

- **Under 579, 2 Qs have to be answered: (1) is there coverage under this insurance K? If no, STOP. If yes, (2) was there a breach of the K and can it be relied upon?**

In this case, not a breach, **a coverage question.** Therefore can be raised under 579

- There can be no recovery by a third party unless the insured could have been entitled to recover under a MV liability policy that the **limitations on IC defences only apply after the possibility of indemnity to the insured has been established**
- The policy does not provide coverage for the claim advanced, there is no possibility of indemnity

→ **Ashton v. Tu (1998) ONCA**

**SUM: IC cannot raise the defence that the policy was not a MV liability policy because of a fraudulent misrepresentation**

**FACTS:** Daughter in law of T applied for insurance to insure T's vehicle. Asked insurer to backdate IP to the preceding Friday. DIL is aware that an accident has already happened. Agent has issued policy. Injured party sues T and insurer denies coverage. Injured seeks payment through JCA

- **IC Argument:** do not have to pay because policy was obtained via fraud and therefore K did not exist

**ISSUE:** what is the existence of the contract vs. what is a breach?

**DECISION:** Insurer has to pay – cannot rely on the fraud because even in face of fraud, had issued MV liability policy, under 579(5) cannot say the policy does not exist

- Therefore if on its face policy exists and the loss falls within the coverage, cannot argue the contract exists or any questions whether it is a valid insurance contract (i.e. insurable interest)

→ **Defences Available in Excess of Statutory Limits:** IC can raise defences as to reasons why policy will not apply to the loss. (4) is modified by (11) which says any restriction on ability to raise defences on insured only applies to statutory minimum. If claim exceeds minimum you can start raising the defences.

→ **Markus v. Western Union Insurance (1964) ABCA**

**SUM: With respect to any defences the insurer can raise above the minimum, its obligations to the injured parties are exactly the same as its obligations to their insured.**

**FACTS:** M injured in accident caused by N. N did not tell insurer that she was sued and did not appear at trial. Before matter concludes, insurer finds out and denies coverage to N and becomes third party by order. Judgment is issued and injured party commences JCA against insurer, that is for >200,000 and the coverage that exists is above minimum.

- IC argument: N breached terms of K by failing to report the loss and help them defend action (duty to cooperate).
- M argued relief from forfeiture.

**ISSUE**: Insurer eventually got notice and acted, therefore where is the prejudice?

**DECISION**: If the insured can successfully raise RFF, the injured party can also rely on it in the JCA.

- IC has to pay, as insured would have been able to rely on RFF

→ **McKinnon v. Canadian General Ins. Co. (1976) SCC**

**SUM**: Section 579 is a “per-policy” exercise - until each insurance pays up to the statutory minimum, cannot rely on defences that fall outside of the statutory minimum.

**FACTS**: M injured in MVA, tortfeasor vehicle owned by C and operated by S – both had MV liability policy, owner’s policy and driver’s policy, each with limits of statutory minimum. M gets judgment in excess of one of the policies. C’s insurer pays out to the policy limits. M wanted the rest of the judgment from S’s insurer.

- S had a defence against their own insured, but could not be raised within the statutory minimum 579(4)

**ISSUE**: since M has already obtained statutory minimum amount, can defences that would otherwise be unavailable within the statutory minimum be raised?

**DECISION**: SCC rejected argument. When looking at defences over statutory minimum, that is PER insurance company, not PER claim. Until each IC pays up to their statutory minimum, cannot rely on these defences.

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

**SUM**: can raise misrepresentations by insured over statutory limits - if can raise successful defences against own insured, can raise the same defences in a JCA

**FACTS**: insured misrepresented several facts on application form for insurance about number of cars, number of drivers, and ownership

**ISSUE**: can IC rely on defence of breaches over the 200,000 statutory limit in a JCA?

**DECISION**: Court says yes under 579(11). Over and above statutory limits you can raise any defence if those defences would be against the insured, then they can be used for JC action

- Beyond the statutory limit, the basis upon which an IC can deny coverage to a third party JC is the same as a denial to the insured. IC was entitled to rely on misrepresentations without further investigation and are able to deny insurance coverage on that basis.

**3. Recovery by the Insurance Company against their Insured**

- Exception under JCA
- Key difference between relying on a Non-Waiver Agreement and relying on 579(13) → with NWA can settle tort action, with 579(13) it is predicated on their being a judgment in the tort action
  - **Without a judgment against TF, insurer cannot collect on the basis of 579(13)**

→ **Terrigno v. Peace Hills General Ins. Co. (2011) ABQB**

**SUM**: for IC to have right of recovery it is either: they have entered into a NWA OR there has been a judgment which allows them to exercise OR something other than NWA that indicates that insured went along with agreement understanding they would allow recovery

**FACTS**: insured’s son driving and injures party. Provision in policy that says son was not allowed to drive policy. Insured told insurer not to be involved in tort action because they not making an insurance claim. But knowing JCA is possible, insurer paid injured party i.e. settled claim and did not obtain NWA. Then claimed settlement amount from own insured.

**ISSUE**: without a NWA, can the IC claim back the settlement amount from their insured

**DECISION**: insurer was not entitled to claim back where there was a settlement UNLESS insured somehow acquiesces in the settlement (know there is a settlement AND know the amount AND ‘ok’ it) – depends on the facts of the case for evidence of this. But insurer cannot do this blind.

→ **State Farm Mutual Automobile Insur. Co. v. Mawere (2012) ONSC**

**SUM: the liability of the insured must be first ascertained by a judgment before the insurer could pay it and recover from the insured**

**FACTS:** insured injures party in MVA. Insurer pays party and then tries to recover from insured based on breach. There was no judgment obtained, it was settled.

**ISSUE:** can the insurer pursue their own insured?

**DECISION:** No - **in order to cover from own insured, need 1 of 3 things: (1) judgment by third party claimant against the insured (tort action and JCA); (2) NWA; (3) assignment of injured party's action**

**ADDITIONAL:**

- (1) In tort action → how much of the limits respond to the property damage and how much go to the personal injury?
  - o **Answered by 571** = of the statutory minimum amount, 10,000 is prioritized for property and the rest goes to personal injury
- (2) SEF 44 and MVA Claims Fund only apply to personal injury
- (3) **Under the fair practice act, liability insurer has obligation to tell injured party what the policy limits are.** If IP finds out insurance is less than claim, has to go to SEF 44 as soon as he knows. Also, helps for settlement purposes
- (4) Liability insurer of TF has **duty of good faith to settle tort action within policy limits if can do so.** Becomes relative because even if insurer has good defences for above statutory minimum, should do best to settle within policy limits
  - o **Only a duty of utmost good faith NOT a fiduciary duty.** More than a regular contract relationship, but not fiduciary duty, where there interests must be put ahead of your own
  - o **Utmost good faith = interests are on equal footing, do not have to prioritize**
- (5) **SEF 44: coverage available if →**
  - a. Driving own vehicle with SEF 44.
  - b. Passenger in own vehicle covered by SEF 44
  - c. Pedestrian and has car at home with SEF 44
  - d. Passenger in someone else's car