Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Neutral Citation: 2004 ONFSCDRS 107

Appeal P03-00023

OFFICE OF THE DIRECTOR OF ARBITRATIONS

RBC GENERAL INSURANCE COMPANY

Appellant

Respondent by Cross-Appeal

and

ANNABEL ANTONY

Respondent

Appellant by Cross-Appeal

Before:	Nancy Makepeace
Representatives:	Neil Colville-Reeves for RBC David S. Wilson for Mrs. Antony
Hearing Date:	March 25, 2004

APPEAL ORDER

Under section 283 of the *Insurance Act,* R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. RBC's appeal of the arbitration decision, dated March 12, 2003, is dismissed.
2. Ms. Antony's appeal of the arbitration decision, dated May 26, 2003, is dismissed.

3. The parties may contact me within 30 days if they are unable to agree on appeal expenses.

Nancy Makepeace Director's Delegate	July 22, 2004 Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

This appeal is about an insured person's right to elect income replacement benefits ("IRBs") or caregiver benefits ("CGBs") under s. 36 of the *SABS-1996.*[1] In a decision dated March 12, 2003, the Arbitrator ruled that Ms. Antony's election of CGBs was not a valid election because RBC General Insurance Company ("RBC") did not comply with its information obligations under s. 32(2)(d). RBC appeals from that decision. Ms. Antony appeals from the Arbitrator's second decision, dated May 26, 2003, in which he ruled that she was not entitled to change her election as of right, if he was wrong in finding her first election was invalid.[2]

I find no error in the Arbitrator's first decision: RBC cannot hold Ms. Antony to her initial election because it failed to provide sufficient information. Ms. Antony's appeal of the second decision is also dismissed, though I approach s. 36 differently than the Arbitrator. I find that s. 36 allows an insured person to re-elect, subject to s. 31 and s. 32.

II. BACKGROUND

Ms. Antony was injured in an automobile accident on March 6, 2001. She testified she was the primary caregiver for her nine-month-old daughter, and had worked full-time as a packer and assembler for about three years before the accident, apart from a six-month maternity leave. On March 7, 2001, the day after the accident, she was visited at home by John W. Fox, an independent adjuster retained by RBC, who was accompanied by a Tamil interpreter. Mr. Fox left behind the standard accident benefits application package and some information brochures, and later provided an election

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[1] The *Statutory Accident Benefits Schedule —Accidents on or after November 1, 1996,* Ontario Regulation 403/96, as amended.

[2] On May 16, 2003, shortly before the release of the second decision, another Arbitrator dismissed RBC's request for an adjournment in order for Ms. Antony to attend certain insurer medical examinations. That decision has no bearing on the issues under appeal.

form. Ms. Antony completed and signed the election form on March 23, 2001, electing CGBs. On June 19, 2001, Ms. Antony, through her lawyer, Mr. Wilson, attempted to re-elect IRBs. By letter dated July 11, 2001, Royal refused to allow her to re-elect, taking the position that an election under s. 36 is irrevocable. Ms. Antony's CGBs were terminated on August 11, 2001, based on an occupational therapy assessment report dated June 28, 2001. She did not request a DAC assessment.[3]

Ms. Antony commenced mediation, followed by arbitration, claiming that her initial election was invalid because RBC did not comply with s. 32(2)(d), which requires insurers to promptly provide the insured person with "information on any possible elections relating to income replacement, non-earner and caregiver benefits." Alternatively, she claimed that even if her initial election was valid, she was entitled to change her mind.

The matter was heard on January 22, 23 and 28, 2003. The Arbitrator heard evidence from Ms. Antony, her husband (Thomas Antony) and Mr. Fox. The main factual dispute was about the information Mr. Fox provided when he visited the day after the accident.

In his first decision, the Arbitrator concluded that RBC had not provided information Ms. Antony needed to make her election. Therefore, he did not find it necessary to decide Ms. Antony's alternative argument that she was entitled to change her election as of right.

RBC appealed. I rejected the appeal as premature, under Rule 51.2 of the *Dispute Resolution Practice Code,* remitting the matter to the Arbitrator to be heard in the normal course. I also stated:

> In the interest of expediting the final disposition of this matter, the Arbitrator should decide the right to re-elect issue along with Ms. Antony's entitlement to caregiver or income replacement benefits, and any other outstanding issues.[4]

[3] Sections 37 and 43 of the *SABS-1996* gave Ms. Antony the option of requiring the insurer to arrange a disability assessment by a designated assessment centre ("DAC") appointed pursuant to s. 52.
[4] Letter of April 14, 2003.

Since this second issue was argued before the Arbitrator in the first hearing, he issued his decision on point without an additional hearing. He defined the issue as whether an insured person has an "absolute right" to re-elect, or is entitled to re-elect "as of right." This led directly to the question of prejudice, and he concluded an insured person does not have an "absolute" right to re-elect regardless of prejudice to the insurer. He concluded that whether Ms. Antony could change a valid election depended on considerations of "relative prejudice, consumer protection and legislative purposes."[5] He did not elaborate, and did not reach a conclusion as to whether Ms. Antony was entitled to re-elect.

III. ANALYSIS

A. If her initial election was valid, was Ms. Antony entitled to change it?

Because the question of irrevocability is fundamental to the issues on appeal, I will begin with that issue: assuming a valid initial election, does the *SABS-1996* allow re-election of weekly benefits, or is an election irrevocable?

Section 36, the election provision, does not say whether an insured person can re-elect. It reads as follows:

> 36(1) Only one of the following benefits may be paid to a person in respect of a period of time:
>
> 1. An income replacement benefit.
> 2. A non-earner benefit.
> 3. A caregiver benefit.
>
> (2) If a person's application indicates that he or she may qualify for more than one of the benefits referred to in subsection (1), the insurer shall notify the person that he or she must elect within 30 days after receiving the notice which benefit he or she wishes to receive.
>
> (3) The insurer shall deliver the notice under subsection (2) within 14 days after receiving the person's application.

[5] Arbitration decision, p. 6.

RBC's counsel at the arbitration hearing argued that the phrase "in respect of a period of time" is meant to allow an insurer to pay a weekly benefit while waiting for the insured person's election. On appeal, RBC's counsel agrees with Ms. Antony that the phrase prevents an insured person from receiving two weekly benefits for any particular period of time. I agree this is the more plausible reading of "in respect of a period of time:" it is intended to prevent double recovery. The phrase offers little help with respect to the issue on appeal.

RBC submits that irrevocability is implicit in the notion of an election. Otherwise, there would be no need for an election section, and an insured person could change her weekly benefit claim to her advantage at any time. For example, a CGB recipient who feared losing her benefits as her condition improved might re-elect IRBs if she felt a physically demanding pre-accident job and dim re-employment prospects might guarantee a longer period of entitlement. This would be prejudicial to an insurer that adjusted the claim based on the initial election, and must now assess the insured person's entitlement based on new criteria. If the re-election is retrospective, the prejudice is even greater, because the insurer has lost forever the opportunity to assess the claim based on reasonably contemporaneous information.

RBC relies on *Davis and Pafco Insurance Company Limited,* (OIC P97-00010, July 22, 1997), which concerned s. 76 of the *SABS-1994.* That section allows an insured person who is injured in a work-related automobile accident to claim workers' compensation benefits or elect to sue and claim accident benefits. After receiving workers compensation benefits for seven months, and having them terminated, Mr. Davis applied for accident benefits, claiming he was entitled to re-elect to sue the person responsible for his accident. Director's Delegate Draper confirmed the Arbitrator's ruling that Mr. Davis could not re-elect because the re-election was made primarily for the purpose of claiming accident benefits. RBC relied on Delegate Draper's comments about the nature of the election:

> The legislation is designed to allow this choice between compensation options, but only where the person is making a real choice. In my view, the intent is not to allow "forum shopping" on the question of disability.

> Someone who re-elects to sue after being unable to convince the W.C.B. that he or she was seriously injured in the accident is asking for a second opinion, not making a choice between viable compensation options.[6]

RBC concedes the context is different in this appeal. Amongst other differences, s. 76(2) of the *SABS-1994* expressly precludes a tort election "made primarily for the purpose of claiming [accident] benefits." Nonetheless, I agree that s. 36 of the *SABS-1996* is also intended to require "a real choice."

However, legislative evolution provides the critical evidence that the *SABS-1996* allows for re-election of weekly benefits in some circumstances. The predecessor to s. 36 is s. 61 of the *SABS-1994,* which provides for an election between income replacement benefits, education disability benefits and caregiver benefits. Subsection 61(7) expressly prohibits re-election except as described in s. 61(6):

> 61(6) If a person ceases to receive weekly caregiver benefits under Part IV because there is no longer anyone who meets the qualifications set out in subsection 18 (5) and the person meets the qualifications set out in paragraph 5 of subsection 7 (1), the insured person is entitled to elect to receive weekly income replacement benefits under Part II and the insurer shall notify the person of that entitlement.
>
> (7) Subject to subsection (6), an election under this section may not be changed.

The omission of the explicit irrevocability language of s. 61(7) is a strong argument in favour of Ms. Antony's position that s. 36 allows her to re-elect.

RBC does not interpret the change in the same way. It points out that both the *SABS-1994* and the *SABS-1996* offer a "post-caregiver" transition to other weekly benefits, though on different terms. Section 61(6) of the *SABS-1994* allows a CGB recipient whose child has turned 16 to claim IRBs if she meets the qualifying criteria in s. 7(1)5,[7]

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[6] At p. 13. Similarly, see *Mangat and Non-Marine Underwriters, Mbers of Lloyd's,* (FSCO P00-00020, August 1, 2000), on the appropriate approach to an insured person s choice of multiple forums.

[7] Under s. 7(1)5, the "post-caregiver" claimant qualifies for IRBs if she was employed at some point during the period that began 156 weeks before she first became a primary caregiver and ended on the day of the accident, and, as a result of the accident, is substantially unable to perform the essential tasks of the job in which she spent the most time during that period.

and to claim other disability benefits ("ODBs") if she does not.[8] In each case, the claimant must establish that she satisfies the applicable entitlement test. The CGB recipient does not have the option of a transition to IRBs in the *SABS-1996,* but s. 12(1)2 allows her to claim non-earner benefits ("NEBs") if she "suffers a complete inability to carry on a normal life," as defined in s. 2(4).[9] Reading s. 12(1)2 and s. 36 together, so RBC argues, supports its interpretation: the *SABS-1996* allows only one re-election – from CGBs to NEBs – and the re-election attempted by Ms. Antony is excluded pursuant to the implied exclusion rule *(expressio unius est exclusio alterius).*

I agree with Ms. Antony that s. 12(1)2 does not apply to her situation. On a plain reading, it allows any CGB recipient to qualify for NEBs where there is no longer a person in need of care.[10] It is a post-caregiver benefit, not an election or re-election, and it operates prospectively.

Ms. Antony's situation is different. Her children are still young, and she does not seek a transition to NEBs. She says she was mistaken in claiming CGBs, and she now wants to claim IRBs instead, as she would have been entitled to do at the outset of her claim. In the *SABS-1996,* the drafters chose to reduce the post-caregiver option by removing the possibility of an IRB transition. To allow Ms. Antony to re-elect IRBs prospectively would be to allow her to do indirectly what the *SABS-1996* prevents her from doing directly. I agree with RBC that the principle of implied exclusion suggests the legislature intended to prevent caregivers from doing just this. Does s. 36 prevent her from making

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[8] Section 19(1)(c) of the *SABS-1994.*

[9] Section 12(1) prescribes the eligibility criteria for NEBs. Reading the preamble together with paragraph 2, that provision states, "The insurer shall pay an insured person who sustains an impairment as a result of an accident a non-earner benefit if the insured person . . . . suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident, received a caregiver benefit as a result of the accident and there is no longer a person in need of care." Though I refer to the more typical caregiver situation (the parent whose child has reached the age of 16), "person in need of care" is defined in s. 2(1) to mean "in respect of an insured person, another person who is less than 16 years of age or who requires care because of physical or mental incapacity." Pursuant to s. 2(4), a person suffers a complete inability to carry on a normal life if she "sustains an impairment that continuously prevents [her] from engaging in substantially all of the activities in which [she] ordinarily engaged before the accident."

[10] Similarly, s. 12(1)3 provides for a "post-education benefit" for an insured person who was a student or had just finished school and remained underemployed at the time of the accident. (The *SABS-1994* provided a more generous weekly benefit for such claimants in s. 15.) An insured person who suffers a complete inability to carry on a normal life as a result of and within 104 weeks of the accident qualifies for NEBs under s. 12(1)1 if she does not qualify for IRBs.

a true (retrospective) re-election? Because of the evolution of the election provision, I agree with Ms. Antony that she may re-elect because s. 36 does not say she cannot.

Ms. Antony's position also finds support by placing s. 36 in the context of Part X of the *SABS-1996,* "Procedures for Claiming Benefits." Applying for accident benefits is not simply a matter of the insured person filling out an application for accident benefits. The *SABS* prescribes complex rules for determining what benefits are payable, depending on a number of factors, including the insured person's accident-related impairments, her pre-accident employment or activities, her treatment and rehabilitation needs, and her vocational options, amongst other factors. The application process is designed to ensure that unsophisticated claimants provide the information insurers need to adjust the claim. To that end, the process is fluid and flexible, and imposes reciprocal obligations on insurers and insured persons at each stage.

I recently had occasion to review the three-step claims process in *L.F. and State Farm Mutual Automobile Insurance Company,* (FSCO P02-00026, June 3, 2004):

> Section 32(1) requires an insured person to give the insurer notice that he wishes to apply for a benefit within 30 days of the circumstances giving rise to entitlement, "or as soon as practicable thereafter." The next step, described in s. 32(2), is for the insurer to provide the appropriate forms and information for the application for benefits. Section 32(3) requires the claimant to submit "an application for the benefit" within 30 days of receiving the materials described in s. 32(2).[11]

Completion of the initial application may not be the end of the matter. Though an application for accident benefits is completed in every case, what other forms are "appropriate" may vary from claim to claim.[12] Both parties have obligations to disclose

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[11] At p. 20.

[12] The "application package" was approved by the Superintendent under s. 69 of the *SABS-1996, which states that the application forms referred to in s.* 32(2)(a) *shall be in a form approved by the Superintendent. The SABS-1996* accident benefit application package was published in Bulletin A-10/96, dated October 23, 1996. The cover page indicates that the package includes: the application for accident benefits (OCF-1/59), activities of normal life form (OCF-12/59), employer s confirmation of income (OCF-2/59), permission to disclose health information (OCF-5), disability certificate (OCF-3/59), and treatment plan (OCF-18/59). At the foot of the cover page is stated: "After the insurance company reviews your complete application package, you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you."

information throughout the history of a claim. I described the reciprocity of the process in *L.F.*:

> The three-step procedure prescribed in s. 32 makes a great deal of practical sense because at each step, the obligation is placed on the party in the best position to provide the information and documents needed. At the first stage, the insured person is required to give the insurer sufficient particulars of the claim or potential claim to allow it to commence its claims handling procedures. In response, the insurer is obliged to provide sufficient information, explanation and forms to enable the claimant to apply for benefits. That means providing the application package approved by the Superintendent. The claimant must complete and submit the pertinent forms within 30 days of receiving them.[13]

There are three additional steps where the insured person has an election, but they reflect the same general principles. Once the insurer is notified that the insured person wants to apply for accident benefits, s. 32(2)(d) requires it to provide "information on any possible elections," along with the appropriate application forms, written explanation of benefits available and information to assist the person in applying for benefits. If the insured person's application for accident benefits indicates she may have an election, the insurer must give the appropriate notice, within 14 days of receiving her application, pursuant to s. 36(3). Finally, s. 36(2) requires the insured person to make her election within 30 days of receiving the insurer's notice. In practice, these steps are often compressed where the initial information provided by the insured person suggests there is an election to be made.

Given the complexity of the *SABS* and the early stage at which elections are made, it is easy to imagine a situation where an insured person initially makes a disadvantageous election because she lacks the information required to make the smarter choice. Allowing such a person to re-elect is, in my view, no different than allowing an insured to correct inadvertent errors or provide supplementary information about, for example, her pre-accident income or employment history. Absent wilful misrepresentation or failure to co-operate, there seems little doubt a claimant is entitled to benefits based on the best available information. When interest begins to accrue is a separate question, though

[13] At pp. 22-23.

FSCO adjudicators have generally held that the insurer bears the risk of delay.[14] Conversely, s. 47 allows an insurer to demand repayment of benefits overpaid, even where the overpayment resulted from its own error or the insured person's innocent error. The insured person must repay benefits overpaid in the 12 months before notice is given. These provisions, allowing for ongoing adjustment of claims, encourage both insurers and insured persons to proceed based on the best information available.

Though the election form that was signed by Ms. Antony indicates elections are irrevocable ("I realize my choice cannot be changed after this form is submitted to the insurance company"),[15] RBC concedes the regulation prevails in the event of a conflict. In *Smith v. Co-operators General Insurance Company,* [2002] S.C.R. 129, Gonthier J. dismissed the significance of the insurer's use of a standard form, stating "the use by the insurer of a prescribed form does not detract from its obligations under s. 71." Section 69 of the *SABS-1996* requires certain documents, including the election "notice" under s. 36, to be in a form approved by the Superintendent. This was likely enacted for purposes of consumer protection and administrative convenience. Nothing suggests it was meant to confer authority to amend the regulation by means of the forms approval process.[16]

RBC submits that elections are different from other parts of the claims process. It argues that without s. 36, there would be no election available to insured persons in Ms. Antony's situation. I disagree. Without s. 36, Ms. Antony would be eligible for CGBs because she meets the eligibility criteria under s. 13(1), and she would qualify for IRBs

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[14] See *Sebastian and Canadian Surety Company,* (FSCO P96-00032, July 28, 1998), decided under the *SABS-1990,* which provides that benefits become overdue 14 days (weekly benefits) and 30 days (medical and rehabilitation benefits) after the insurer receives a "completed application." *Bajic and Pafco Insurance Company Limited,* (FSCO P00-00050, June 5, 2001), and *Attavar v. Allstate Insurance Co. of Canada* (2003), 63 O.R. (3rd) 199 (Ont.C.A.), decided under the *SABS-1996,* followed earlier Commission authorities holding that interest under the *SABS* flows from entitlement, is compensatory, not punitive, and is intended to put the risks of delayed payment on insurers. For purposes of this appeal, I need not consider *Amoa-Williams and Allstate Insurance Company of Canada,* (FSCO P01-00052, July 17, 2003), and companion decisions, released concurrently: *Glinka and Dufferin Mutual Insurance Company,* (FSCO P01-00002), *Khaledi and Allstate Insurance Company of Canada,* (FSCO P01-00046), and *Langdon and Pafco Insurance Company Limited,* (FSCO P02-00017), which concerned post-DAC interest on medical and rehabilitation benefits.

[15] OCF-10 (Superintendent's Bulletin A-10/96, October 1996).

[16] The irrevocability warning was removed from the election form in August 2003 (Superintendent s Bulletin A-12/03).

under s. 4.2. She is entitled to apply for benefits for which she qualifies, and she does not require express statutory approval to apply for the more advantageous benefit. On the contrary, express language is required to deprive her of benefits for which she qualifies. The point of s. 36, then, is to prescribe the election process, including time lines, and to prevent double recovery.

If an insured person is entitled to elect amongst the weekly benefits for which she qualifies, it follows that she is entitled to change her mind, absent statutory language to the contrary. This does not mean the claims process is entirely open-ended. Time limits are prescribed for each step in the process, and the *SABS* prescribes the consequences of non-compliance. The insurer must give notice of election within 14 days of receiving the insured person's application for accident benefits, and the insured person must make her election within 30 days of receiving the insurer's notice.

If the right to re-elect is implicit in the right to elect, it follows that the same 30-day time limit applies to re-elections. Ms. Antony purported to re-elect about three months after her initial election. If RBC is prejudiced, it is prejudiced by her delay, not her re-election. Pursuant to s. 31, Ms. Antony is not disentitled from re-electing IRBs if she has "a reasonable explanation" for failing to comply with a time limit under Part X of the *SABS.* This decision requires consideration of a number of factors, including how much time passed between the initial election and purported re-election, the reasons for the delay, the insured person's reason for seeking to re-elect, the effect of re-election on the amount and duration of benefits, and whether re-election would prejudice the insurer's ability to investigate and assess the claim.

The parties agree that the Arbitrator should decide whether Ms. Antony may re-elect, considering the relevant factors. However, I need not remit the matter for a third preliminary issue hearing because I agree that Ms. Antony's initial election was invalid.

B. Did RBC meet its obligations under s. 32(2)(d) of the *SABS-1996?*

Ms. Antony argued that even if s. 36 makes elections irrevocable, her initial election was invalid because RBC failed to provide the information required by s. 32(2)(d), which

requires the insurer to "promptly provide the [insured] person with . . . information on any possible elections relating to income replacement, non-earner and caregiver benefits." Therefore, she argued she was entitled to re-elect IRBs from the outset of her claim.

The Arbitrator held that s. 32(2)(d) must be interpreted in light of the decision of the Supreme Court of Canada in *Smith v. Co-operators.* That decision concerned s. 71 of the *SABS-1994,* which required an insurer refusing to pay a benefit or reducing a benefit "to inform the [insured] person in writing of the procedure for resolving disputes relating to benefits under sections 279 to 283 of the *Insurance Act."*[17]

In that case, the insurer's refusal told the insured person she had a right to refer the dispute to mediation, but it did not mention the right to commence a civil proceeding or arbitration after a failed mediation, and did not mention the two-year time limit under s. 72 of the *SABS-1994* and s. 281(5) of the *Insurance Act.* With one exception not applicable to this case, those provisions require an insured person to commence mediation *and* to commence a civil proceeding or arbitration within two years of the insurer's refusal; there is no separate time limit for commencing a civil proceeding or arbitration that begins to run after the mediation.[18] In *Smith,* the insured person applied for mediation with the two-year limitation period, but did not commence her civil proceeding until about four months after the expiry of the two-year limitation period. The insurer successfully moved for summary judgement.

The majority of the Ontario Court of Appeal (Borins J.A. dissenting), held that the insurer could raise its limitation defence because its notice informed Ms. Smith about her right to seek mediation, and the Report of Mediator informed her about the limitation period. Sharpe, J.A., (with whom Catzman J.A. concurred) agreed with FSCO authorities holding that the two-year time limit does not begin to run until the insurer complies with the obligation to give clear and unequivocal written notice of refusal, with reasons. He also accepted that s. 71 is "a consumer protection provision," the purpose

[17] The successor provision is s. 49 of the *SABS-1996,* which requires the insurer to "provide the person with a written notice concerning the person s right to dispute."
[18] The successor provision, s. 51 of the *SABS-1996,* is identical in substance.

of which "is to require an insurer to tell an unsophisticated person, in a simple and easy to understand written form, the procedure for resolving disputes pursuant to the statute," and that, to be meaningful, this notice must be given at the same time as the refusal. However, he expressed concern that an expansive interpretation of s. 71 would "overwhelm claimants with a flood of incomprehensible detail." Therefore, he concluded that the insurer gave sufficient information by advising her about mediation, the next step in the process.

The decision was reversed by the Supreme Court of Canada (Bastarache J. dissenting). In the majority judgement, Gonthier J. reaffirmed that, "one of the main objectives of insurance law is consumer protection, particularly in the field of automobile and home insurance." He concluded that s. 71 requires the insurer to inform the insured person about the dispute resolution process described in ss. 279-283 "in straightforward and clear language, directed towards an unsophisticated person. At a minimum, this should include a description of the most important points of the process, such as the right to seek mediation, the right to arbitrate or lititgate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process. Without this basic information, it cannot be said that a valid refusal has been given."[19]

There was no dispute that when Mr. Fox visited Ms. Antony and her husband on March 7, 2001, he left each of them an accident benefits application package. Though there was some question whether he also left behind the information brochures produced by the Insurance Bureau of Canada ("IBC"), the Arbitrator accepted that he did, and Ms. Antony put forward no real basis for questioning this finding on appeal.

Mr. Fox testified that he told Ms. Antony she must elect caregiver or income replacement benefits, and could not claim both. Ms. Antony testified that Mr. Fox recommended she elect caregiver benefits. Mr. Fox denied this, and the Arbitrator preferred his evidence. RBC argued that it would be inappropriate for an insurer to offer advice or recommendations about elections. However, that was not the issue. As stated

[19] Paragraphs 11 and 14.

by the Arbitrator, the issue was whether RBC had provided the "information" required by s. 32(2)(d).

The three IBC brochures left with Ms. Antony[20] provide basic information about eligibility for accident benefits ("If you are in a car accident") and more detailed information about weekly benefits and medical, rehabilitation and attendant care benefits. The "Weekly Benefits" brochure explains who is eligible for income replacement benefits, caregiver benefits and non-earner benefits. It also explains the basic rules for determining the amount of each type of weekly benefit, and the duration of benefits (though the section on IRBs says nothing about the change in the entitlement test at 104 weeks). On the election, the brochure says the following, under the heading, "Which benefit is right for me?":

> You may be eligible for more than one weekly benefit. If your application for benefits discloses that you qualify for more than one benefit, your insurance company will notify you. However, you must choose one only. Your choice may be between the weekly income replacement, caregiver, or non-earner benefits.

Mr. Fox conceded, in his testimony, that he did not calculate what Ms. Antony would receive in income replacement benefits.[21] Nor did he explain that the different disability test might mean Ms. Antony would be entitled to receive weekly income replacement benefits for a longer time than caregiver benefits. That omission was the critical point for the Arbitrator, who expressed concern that without this information, an insured person might be inclined simply to choose the higher weekly benefit, without considering long-term implications. Therefore, he concluded the information provided to Ms. Antony before her election was incomplete, rendering her election invalid.

On appeal, RBC claims that the Arbitrator erred in interpreting the phrase, "information on any possible elections," to include a requirement that the insurer advise the insured

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[20] Appeal Record of RBC, Tab 2. It appears the same information was included in the RBC form letter given to Ms. Antony, though a crucial page of the letter, probably covering elections, was missing from the evidence. The Arbitrator inferred that it contained the same information as the IBC brochures (Arbitration decision, p. 11, note 9; Arbitration Exhibit 1, Tabs 9, 10 and 11). This was a reasonable inference.

[21] The Employer s Confirmation of Income is one of the forms included in the prescribed package Mr. Fox left with Ms. Antony that day.

that the higher benefit may not be the benefit that pays the longest. In fact, RBC claims that result would only apply to Ms. Antony if her IRB rate were lower than her CGB rate, but her job duties were more onerous than her caregiving duties.[22] In order to avoid giving misleading information, the Arbitrator's interpretation would require an insurer to make detailed enquiries about the insured person's job duties and caregiving duties, her employment income and her accident-related impairment, an onerous requirement at this early stage of a claim. Otherwise, the required advice would be merely speculative or hypothetical. Moreover, RBC submits that insurers are not required to provide legal advice to insured persons. This would offend the "bright line boundaries" approach endorsed by the Supreme Court of Canada, because insurers enjoy superior bargaining power relative to insured persons. RBC submits that it provided the information about CGBs and IRBs that Ms. Antony needed to make her election, and she did so knowingly.

Ms. Antony submits that the Arbitrator properly interpreted s. 32(2)(d) in light of *Smith v. Cooperators,* but should not have focused on the narrow question whether an insurer is required to inform an insured person that the higher weekly benefit may not be the benefit that pays the longest. Instead, Ms. Antony argues the Arbitrator should have determined, first, what information RBC was required to giver her, under s. 32(2)(d), and second, whether RBC met its obligations.

Ms. Antony submits that RBC should have provided a Tamil version of the IBC brochure and the election form, or asked the Tamil interpreter who attended on March 7, 2001 to translate it for her, and it should have ensured the interpreter was accredited. The Insurer should also have suggested she seek legal advice before making her election. Further, she submits that RBC was obliged to inform her that the election was irrevocable (if it was), and should have explained the criteria for making the election, including the amount and duration of the benefit, and the eligibility criteria. She claims she was somehow led to believe she should choose the higher weekly benefit because of the information provided by Mr. Fox or the interpreter at the meeting.

[22] RBC's "matrix" describing the various scenarios also refers to a situation where caregiving duties are more onerous but caregiver benefits are payable at a lower rate than income replacement benefits, but does not argue this applies to Ms. Antony.

The insurer's obligation to provide information is the second step in the three-step claims process mandated by s. 32 of the *SABS-1996.* It is the precondition for the third step because an insured person cannot be expected to make a timely application for benefits unless she has been given the appropriate forms and information to enable her to do so. For example, in *L.F. and State Farm,* I confirmed the Arbitrator's finding that the insurer could not rely on the insured person's failure to apply for attendant care benefits within 30 days of receiving the application forms, as required by s. 32(3), because the insurer did not comply with its obligation, under s. 32(2), to provide information about attendant care benefits. The same principle applies with respect to elections: an insurer cannot hold an insured person to the 30-day time limit for election or re-election if the required information has not been provided. For the same reason, an insured person cannot be held to an election that is based on inaccurate or incomplete information provided by an insurer in contravention of s. 32(2)(d). A valid election is an informed election.

The difficult question is what information is required. In at least three recent arbitration decisions,[23] Arbitrators have applied Smith in the context of s. 32, holding that an insurer will not be able to rely upon the 30-day time limit for submitting an application for benefits unless it has given notice of the time limit and the consequences of non-compliance. The same reasoning suggests that an insured person must be advised about the consequences of an election, including any irrevocable elections. However, as I have held that elections are not irrevocable under s. 36, there is no need to consider the implications of RBC's failure to advise Ms. Antony that elections are, as it believed, irrevocable.

What other information was the insurer obligated to provide? As it was required to do, RBC provided general information about eligibility criteria for IRBs and CGBs, the duration of each type of benefit, and the amount of the benefit. The Arbitrator decided the case on a rather narrow basis, finding that the insurer was obliged to advise that the

[23] *Horvath and Allstate Insurance Company of Canada, (FSCO A02-000482, June 9, 2003), C.R. and Lombard General Insurance Company of Canada, (FSCO A02-001057, December 22, 2003), and McIntosh and Allstate Insurance Company of Canada, (FSCO* A02-001277, *April 23, 2004), under appeal.*

higher benefit may not be the longer-lasting one. In my view, the Arbitrator dealt decisively and correctly with the key issue in this case. The SABS is complex, and what anyone making an IRB/CGB election wants to know is "what difference does it make to me?" The difference is not just in the amount of benefit, but the eligibility criteria and duration of the benefit. This should have been made clear to Ms. Antony. The evidence left the Arbitrator with every reason to believe Ms. Antony chose CGBs because she could claim a higher weekly benefit. I am not persuaded the Arbitrator erred in concluding the insurer was obliged to explain the other implications of her choice.

Ms. Antony asks me to set out general guidelines about the information required. I am reluctant to do so because, in my view, the generality of s. 32(2)(d) ("information on any possible elections") reflects legislative intent that insurers provide information that is appropriate and reasonable based on the particular circumstances of each insured person. Because of the early stage at which elections are made, and the high volume of claims handled by insurers, the information must be general. I agree with RBC that insurers are not required to recommend an election based on a full enquiry into the claimant's impairments and financial and personal situation. Their role is to explain the rules well enough to allow an unsophisticated insured person (and her representative, if she has one) to decide which benefit is best for her.

Finally, RBC submits that the missing information should have been available to Ms. Antony from other sources, including her husband and the paralegal they briefly retained on the day of the accident. In *Smith v. Co-operators,* Gonthier J. did not accept that the reference to the limitation period in the Report of Mediator satisfied the insurer's obligation under s. 71:

> As I have mentioned above, insurance law is, in many respects, geared towards protection of the consumer. This approach obliges the courts to impose bright-line boundaries between the permissible and the impermissible without undue solicitude for particular circumstances that might operate against claimants in certain cases.[24]

[24] Paragraph 16.

I read this as saying that the availability of other information sources does not reduce an insurer's notice obligations. This is consistent with FSCO decisions holding that "actual notice" is no answer to an insurer's non-compliance with the notice requirements in the SABS.[25] In any event, it appears the Arbitrator heard no evidence that anyone else gave Ms. Antony the information she needed before making her election.

In my view, this was not a case of an insurer deliberately withholding information from a claimant. Insurers deal with a very high volume of claims, and must do so quickly and efficiently, without straying into an inappropriate role. In many cases, it is reasonable for them to rely on standardized information brochures and relatively concise explanatory discussions with claimants. But they must also be prepared to explain the *SABS* to unsophisticated claimants with language and other barriers to access.[26] This case came close to the line, in my view, but I am not persuaded the Arbitrator erred in law in finding that RBC failed to provide the crucial information Ms. Antony needed to make an informed election.

IV. EXPENSES

If the parties are unable to agree on expenses, they may contact me within 30 days of this decision.

July 22, 2004

Nancy Makepeace
Director's Delegate

Date

[25] For example, *Turner and State Farm Mutual Automobile Insurance Company,* (FSCO P00-00046, February 1, 2002), overturned on judicial review without reference to this point, [2004] O.J. No. 731 (Ont.Div.Ct.), leave to appeal granted, [2004] O.J. No. 2601 (Ont. C.A.).

[26] Simply providing a copy of the *SABS,* or excerpts from it, would not be appropriate. This point was recognized by Justice Sharpe, who wrote the majority judgement for the Court of Appeal in *Smith v. Co-operators,* and by Justice Gonthier, who stated that "it is questionable" whether a verbatim reproduction of sections 279 to 283 of the *Insurance Act "would qualify as a valid refusal as it would surely run afoul of the consumer protection purpose of the legislation. However, we are not merely restricted to two options, both of which are at opposite ends of the spectrum of possible information. There is middle ground." (para. 13)*