Recent FSCO Decisions Limit Consequences of Insurers' Technical Errors on SABS Claims

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Some recent
FSCO caselaw provides reassurance to insurers that accident benefits disputes should be resolved on their merits. Technical errors or breaches of the SABS should not and do not result in automatic benefit entitlement, regardless of whether the insured person meets the eligibility or disability criteria, *unless* the legislation very specifically provides for that consequence.

In the
arbitration decision in *Mrs. S. and Economical Mutual Insurance Company* (FSCO File A08-001275), Arbitrator Renahan dismissed the claimant's claims for income replacement benefits, housekeeping and home maintenance benefits and a Special Award. He agreed with the insurer that the claimant had simply made up the story of her employment at a restaurant prior to her accident, so she never met the eligibility criteria under section 4 of the SABS. There was no documentary evidence, such as a T4, or employer's human resources file, to substantiate the employment. There were no independent witnesses to corroborate her story of employment. There was no reported income on her tax return for the year the accident, even though she did file a return. There were many implausible features to her story. Arbitrator Renahan found the claimant was a person with limited intellect, who lacked the insight to realize that her evidence was implausible and not believable.

The difficulty for the insurer was that it was late
responding to the claim. Section 35(3) of the pre-September 1, 2010 SABS provided that within 10 business days of receiving a completed application for benefits, an insurer was to (a) pay the specified benefit, (b) send a request to the insured person [for more information or documentation] under subsection 33(1), or (1.1); or (c) notify the insured person that the insurer required insurer medical examination. Since this was a case of late report (the claimant's accident was November 22, 2006, but she did not notify the insurer until March, 2007, and did not

submit her
application until April 5, 2007), the insurer had a longer period of 45 days to make a decision on entitlement, based on section 32(6). Unfortunately, the insurer did not meet the deadline of May 21, 2007. It requested employment documentation on June 2, 2007, and notified the claimant of medical examinations on June 7, 2007.

At
arbitration, the claimant's counsel argued that she was entitled to income replacement and housekeeping benefits (because the insurer failed to comply with the time limits), either on an indefinite basis, or at minimum, for the period prior to June 2, 2007. Arbitrator Renahan rejected this. Had the claimant actually been entitled to the benefits, the remedy for the lateness would have been a Special Award and/or compound interest. There was no automatic benefit entitlement simply because the insurer had missed the deadline. The legislation did not provide for that consequence.

For reasons best known to herself, the claimant
appealed. This is surprising as factual determinations, in general, cannot be appealed, as appeals must be limited to questions of law. The facts as found by

Arbitrator Renahan were not favourable to the claimant. In any event, Delegate Lawrence Blackman dismissed the appeal on November 17, 2010. He agreed with Arbitrator Renahan that although the insurer had made a technical error by missing a deadline by about 15 days, this was in the context of the claimant not applying for accident benefits for almost four months after her accident. Furthermore, the legislation did not provide for automatic benefit entitlement, regardless of the merits, simply due to that error. Delegate Blackman commented that the SABS is not precisely tailored to every specific circumstance of individuals and unlike tort compensation, it is, to a significant degree, "off the rack" legislation. Its provisions are a compromise between sometimes competing legislative
goals, including providing a fair yet limited degree of compensation, being a payor of last resort, a trade off for statutory limitations on accident victims' third party tort recovery, playing claims on a no fault and consumer protection type basis in a timely manner, avoiding double recovery and preventing fraud or abuse of the system.

In order to
smooth out these rougher edges of the legislation, Delegate Blackman noted that the legislation provides some adjudicative discretion to arbitrators, mainly in the form of Special Awards (where the insurer has unreasonably withheld or delayed payments), interim orders and awards of legal expenses and interest. However, that adjudicative discretion did not go so far as to impose substantive benefit entitlement on an automatic basis, simply due to an insurer's breach. This would be an especially far reaching consequence, and ought to be imposed only if there was very specific legislative language to that effect.

Insurers can take
some comfort in this decision. Clearly, legislative timelines have a function in advancing timely compliance by both insured persons and insurers. If an insurer fails to comply with timelines, then in meritorious claims, it faces significant consequences, mainly in the form of mandatory interest and possibly a Special Award. On the other hand, disputes should be adjudicated on their merits and insurers should be able to resist clearly abusive or fraudulent claims, despite technical shortcomings in their adjusting of the file.

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