COURT OF APPEAL FOR ONTARIO

CITATION: Sietzema v. Economical Mutual Insurance Company, 2014 ONCA 111
DATE: 20140211
DOCKET: C57368

Juriansz, Pepall and Strathy JJ.A.

BETWEEN

Tanya Sietzema

Plaintiff (Appellant)

and

Economical Mutual Insurance Company

Defendant (Respondent)

Jane Poproski, for the appellant

Lisa Armstrong and Shalini Thomas, for the respondent

Heard: January 28, 2014

On appeal from the order of Justice James W. Sloan of the Superior Court of Justice, dated June 21, 2013, with reasons reported at 2013 ONSC 4299.

ENDORSEMENT

[1] The motion judge granted summary judgment, dismissing the appellant's claim for statutory accident benefits as time-barred. She appeals.

[2] The appellant was involved in a car accident on November 11, 2005. On November 16, 2005, the respondent sent her an application package for benefits under the *Statutory Accident Benefits Schedule*, O. Reg. 403/96 (SABS), including application forms and a summary of the benefits available to her, subject to eligibility.

[3] The appellant filed an application for benefits on November 29, 2005. She was employed at the time of the accident and her application included an Employer's Confirmation Form, giving details of her employment and income. It also included a Disability Certificate, signed by her physician. That form described her injuries and included the physician's response to questions about the appellant's eligibility for various benefits. Under Income Replacement Benefits, the physician answered "yes" to the question whether the appellant was "substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident". This indicated that in the physician's opinion she met the "disability test" for Income Replacement Benefits. Under the category Non-Earner Benefits, the physician answered "No" to the question, "Does the applicant suffer a complete inability to

carry on a normal life?" This answer indicated that in the physician's opinion the appellant did not meet the "disability test" for Non-Earner Benefits.

[4] The respondent replied to the appellant's application on December 19, 2005. It sent her a form entitled Explanation of Benefits Payable by Insurance Company (OCF-9). This stated she was eligible for Income Replacement Benefits of up to $400 per week and that no benefit was payable beyond March 2, 2006, as her injury fell under the Whiplash Grade II Guideline. The form indicated that she was not eligible for Non-Earner Benefits because she was employed at the time of the accident.

[5] Although the appellant was not eligible for Non-Earner Benefits, the reason given by the respondent was wrong. She was not eligible for Non-Earner Benefits because she qualified for Income Replacement Benefits and the SABS did not permit her to receive both benefits. Although it was generally assumed in the insurance industry in 2005 that employment at the time of the accident precluded receipt of Non-Earner Benefits, this court's decision in *Galdamez v. Allstate Insurance Company of Canada*, 2012 ONCA 508, 111 O.R. (3d) 321, clarified that, rare though the situation might be, a person who was able to continue to work might nevertheless qualify for Non-Earner Benefits.

[6] The OCF-9 explained the appellant's right to dispute the insurer's assessment of her claim and to have the claim addressed through mediation

followed by arbitration, litigation or neutral evaluation. At the bottom of the page, under the heading, "WARNING: TWO YEAR TIME LIMIT", it explained she had two years from the insurer's refusal to pay a benefit, or from reduction of a benefit, to arbitrate or commence a lawsuit.

[7] The appellant returned to work on February 13, 2006. The respondent terminated her Income Replacement Benefits on March 2, 2006. The appellant had retained counsel in January, 2006, shortly after receiving the OCF-9. However, she did not re-assert a claim for Non-Earner Benefits until February 3, 2010, when her lawyer wrote to the respondent stating that the appellant had not been informed on the termination of her Income Replacement Benefits that she had a right to claim Non-Earner Benefits. The lawyer's letter took the position that there had been no "refusal" of Non-Earner Benefits and the limitation period had not started to run. There followed an unsuccessful mediation of the appellant's claim. The statement of claim in this action was issued on April 14, 2011.

[8] Section 281.1(1) of the *Insurance Act*, R.S.O. 1990, c. I.8, and s. 51(1) of the SABS establish a two year limitation period for the commencement of litigation or arbitration after the insurer's refusal to pay a benefit claimed.

[9] The appellant's submission before the motion judge and in this court is that the respondent misled her concerning her entitlement to Non-Earner Benefits. She thought she could never receive the benefits because she had been working

at the time of the accident, so she did not apply for them when her Income Replacement Benefits were terminated. At the time the respondent terminated her Income Replacement Benefits, she should have been told of her right to apply for Non-Earner Benefits.

[10] The motion judge held that although the appellant may have been personally misled, she had hired a lawyer in early 2006 to advise her of her rights as a result of the accident and this would have included her right to accident benefits. Her lawyer would have known that limitation periods were running. The OCF-9 contained a clear refusal to pay Non-Earner Benefits, and this triggered the limitation period in s. 51(1) of the SABS, which required mediation to be commenced "within two years after the insurer's refusal to pay the amount claimed."

[11] The appellant says the motion judge erred. The fact that she retained a lawyer in 2006, and did not commence an action until 2011, is irrelevant and has no effect on the insurer's duty to provide complete information to its insured. She relies on *Smith v. Co-Operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, in which the Supreme Court of Canada emphasized the importance of consumer protection in insurance law and the need for "bright-line boundaries between the permissible and the impermissible" (at para. 16). In that case, a majority of the court held the limitation period did not begin to run because the

insurer had failed to notify the claimant of the limitation period as a feature of the dispute resolution process.

[12] Here, the appellant submits the insurer breached its duty to provide her with a written explanation of the benefits available and to assist her in applying for them: SABS, ss. 32(2)(b) and (c). We disagree. The information package sent to the appellant complied with the SABS and stated the test for Non-Earner Benefits as it was then understood, including the requirement that the claimant suffer a complete inability to carry on a normal life as a result of the injuries sustained. The appellant's physician stated that she did not meet this "disability test". The appellant's real complaint is that she was given an incorrect reason for her ineligibility for Non-Earner Benefits.

[13] That argument is answered by this court's decision in *Turner v. State Farm Mutual Automobile Insurance Co.* (2005), 195 O.A.C. 61. In that case, this court held that clear and unequivocal notice given by the insurer, cancelling the insured's benefits, was sufficient to trigger the limitation period, notwithstanding the insurer gave legally incorrect reasons for cancelling the benefit. The court stated, at para. 8:

> We also conclude that the Divisional Court erred in requiring that the reasons for cancelling the benefit must be legally correct. Section 24(8) of the *Statutory Accident Benefits Scheme* obliges the insurer to give the insured "the reasons for the refusal". It does not provide that the reasons must be legally correct. The

> purpose of the requirement to give reasons is to permit the insured to decide whether or not to challenge the cancellation. If the reasons given are legally wrong the insured will succeed in that challenge. Requiring that the reasons be legally correct goes beyond both the requirement in the relevant regulation, and the purpose of such a notice.

See also *Katanic v. State Farm Mutual Automobile Insurance Co.*, 2013 ONSC 5103, [2013] O.J. No. 3605; and *Sagan v. Dominion of Canada General Insurance Co.*, 2013 ONSC 7886, [2013] O.J. No. 6022.

[14] Here, the OCF-9 sent to the appellant clearly stated that she had been approved for Income Replacement Benefits, which would terminate on March 2, 2006, and that the respondent had determined she was not eligible for Non-Earner Benefits. The form gave her clear notice of her rights to mediation, followed by arbitration, litigation or neutral evaluation if she wished to dispute the refusal or reduction of benefits. It also gave her clear notice of the two year limitation period. She admitted on cross-examination that when she received the OCF-9 she knew she was being denied Non-Earner Benefits. The limitation period began to run when the appellant's claim for Non-Earner Benefits was refused.

[15] There is nothing in the *Insurance Act* or the comprehensive SABS regime to require an insurer, on termination of benefits, to give the claimant a further notice advising that he or she may have a right to renew a claim for a benefit that

had previously been denied. As this court observed in *Haldenby v. Dominion of Canada General Insurance Co.* (2001), 55 O.R. (3d) 470, at para. 30,

> there is no provision in the [*Insurance Act*] or the SABS which allows a claimant to reapply for further benefits after an insured person's benefits have been terminated by the insurer. The only remedy for the insured person is to appeal the termination of benefits within the two-year period.

[16] If we accepted the appellant's argument, the limitation period for making a claim for Non-Earner Benefits never began to run. This would defeat one of the primary purposes of the SABS regime, namely, to ensure the timely submission and resolution of claims for accident benefits.

[17] For these reasons, the appeal is dismissed, with costs to the respondent in the agreed amount of $6,000.00, inclusive of applicable taxes and disbursements.

"Russell G. Juriansz J.A."
"Sarah E. Pepall J.A."
"G.R. Strathy J.A."