IN THE MATTER OF AN ARBITRATION UNER THE *ARBITRATION ACT, 1991*, S.O. 1991, C. 17

AND THE MATTER OF THE *INSURANCE ACT*, R.S.O. 1990, C.1.8. AND REGULATION 283/95

AND IN THE MATTER OF A CLAIM FOR ACCIDENT BENEFITS BY THENUSHA PARANIRAUPASINGAM RELATING TO A MOTOR VEHICLE ACCIDENT ON JUNE 29, 2014

BETWEEN:

ALLSTATE INSURANCE COMPANY OF CANADA

Applicant

-and-

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE NINISTER OF FINANCE (a.k.a. Motor Vehicle Accident Claims Fund)

Respondents

DECISION WITH RESPECT TO PRELIMINARY ISSUES

Counsel:

David Murray, Counsel for the Applicant, Allstate Insurance Company of Canada

D'Arcy McGoey, Counsel for the Respondent, State Farm Mutual Assurance Company

Murray Sydney, Counsel for Her Majesty the Queen

ISSUES:

1. Did Allstate Insurance Company of Canada ("Allstate") commence this arbitration as against State Farm Mutual Automobile Insurance Company ("State Farm") and/or Her

Majesty the Queen in right of Ontario as represented by the Minister of Government and Consumer Services ("The Fund") within the one year time limit as set out in section 7(3) of Ontario Regulation 283/95, and if not, what are the consequences?

2. Can Allstate claim recovery against the Fund for accident benefits paid to a person not involved in the accident but suffering psychological injuries from caring for the person injured in the accident?

DECISION:

1. Allstate did not commence the arbitration within the one-year limitation period as set out in section 7(3) of Ontario Regulation 283/95 and accordingly the arbitration is barred from proceeding as against both respondents.
2. Allstate cannot recover against the Fund for accident benefits paid to the person not involved in the accident but suffering psychological injuries from caring for the person involved in the accident.

HEARING:

The submissions in this matter were heard on July 7th, 2020.

FACTS and ANALYSIS:

This priority dispute arbitration arises out of a single automobile accident that occurred on June 29th, 2014. At that time Narjuram Papaniurpasingam was an occupant of the automobile and suffered injuries in the accident. Her sister, Thenusha Papaniurpasingam, was not involved in the accident however, on June 8th, 2016 she made an application for accident benefits to Allstate on the basis that she suffered drastic changes to her psychological well-being as a result

of carrying for her injured sister. Allstate, on July 25th, 2016, put the Fund on notice of a priority dispute. On August 29th, 2016, Allstate sent a further Notice of Dispute to both the Fund and State Farm. On August 29th, 2017, Allstate sent letters to both the Fund and State Farm demanding the appointment of an arbitrator and filed a Notice of Application for same with the Ontario Court of Justice.

The Fund and State Farm have now brought a preliminary motion to decide essentially two issues as set out above.

I will deal first with the limitation issue.

Limitation Period

In order to fully understand the limitation period arguments, it is first necessary to set out the relevant statutory framework. The timeline for notice and initiating a priority dispute arbitration are governed by Ontario Regulation 283/95, as amended. Pursuant to section 3 of that regulation, insurers are required to give notice of a priority dispute within 90 days of receipt of an Application for Accident Benefits. That section states:

> 3.(1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.
>
> (1.1) If the dispute relates to an accident that occurred on or after September 1, 2010, a notice required under subsection (1) must also be given to the Fund if the insurer claims the Fund is required to pay benefits.

Section 7(3) of the Regulation then requires that the arbitration be commenced no later than one year after the day the insurer paying benefits first gives notice under section 3. That section states:

> 7(3) The arbitration must be initiated by an insurer or the insured person no later than one year after the date the insurer paying benefits first gives notice under section 3.

As noted above, the first notice made by Allstate to the Fund was on July 25th, 2016, which was followed by a further notice to both the Fund and State Farm on August 29th, 2016. The Notice to Appoint an Arbitrator was received by the respondents and filed with the Court on August 29th, 2016. Therefore, the initial Notice of Dispute was outside the one-year limitation period to commence an arbitration, whereas the second was not. The question has arisen as to whether the Fund, which was put on notice outside the parameters of section 7(3), and State Farm who while put on notice within the time frame of the second notice can both rely on the one-year limitation period from the time of the first Notice of Dispute.

While both the Fund and State Farm claim the protection of section 7(3), their arguments are somewhat different. The Fund basically states that they received the Notice to Arbitrate more than one year after receiving the Notice to Dispute and that is the end of it. State Farm, while agreeing with the Fund's position, goes one step further and maintains that while it did not receive its' Notice to Dispute until August 29th, 2016, that section 7(3) refers to it and applies to the first notice under section 3 and therefore Allstate is barred from proceeding with this arbitration.

In response to the Fund's position, Allstate argues that for the purposes of section 7(3), the Fund is not an insurer and therefore the one-year limitation to commence an arbitration does not apply as against the Fund. In support of this position, counsel for Allstate set out the history of priority dispute resolution as it relates to the fund and more particularly regulation 283/95. He noted the decision of the Ontario Court of Appeal in Kalkine v Ontario, 2004 CanLII 48058, which found the Fund was not an insurer for the purposes of the Insurance Act and the Regulation, and also the subsequent decision of the Court of Appeal in Allstate Insurance v Ontario (Motor Vehicle Accident Claims Fund) , 2007 ONCA 61(CanLII) where the Court basically held that the Fund was an insurer for the purposes of the Regulation. Counsel then noted the amendments to Regulation 283/95 following the above noted decisions, which dealt with the position of the Fund vis-a-vis Regulation the most relevant being:

0.1 In this Regulation, ...

"Fund" means the Motor Vehicle Accident Claims Fund continued under subsection 2(1) for the *Motor Vehicle Accident Claims Act*; ...

(1.1) If the dispute relates to an accident that occurred on or after September 1, 2010, a notice required under subsection (1) must also be given to the Fund if the insurer claims the Fund is required to pay benefits

(2.1) If the dispute relates to an accident that occurred on or after September 1, 2010, the Fund, may give notice under subsection (1) after the 90-day period and is not required to comply with subsection (2).

(3.1) (1) This section applies to disputes relating to accidents occurring on or after September 1, 2010.
(2) Before giving a notice to the Fund under section 3, an insurer must,

(a) Complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund; and
(b) Provide particulars to the Fund of the investigation and the results of the investigation.

(7)(3) The arbitration may be initiated by an insurer or by the insured person no later than one year after the day the insurer paying benefits first give notice under section 3.

(4) Despite subsection (3), the arbitration may be initiated by the Fund at any time before or after the expiry of the time limit set out in subsection (3) if the Fund is paying benefits in respect of an accident that occurred on or after September 1, 2010.

Counsel argues that the effect of these changes, in essence, is that the Fund is not an insurer, at least for the purposes of the limitation period. He submits that the inclusion of the "Fund" in the definition of an insurer in section 3.1 and the exclusion of the Fund from the one-year limitation period in section 7(4) indicates that the Fund be treated differently than an insurer.

Counsel also submits that the principles of statutory interpretation require that the Regulation be given a fair, large and liberal interpretation and that the words of the Regulation be read in their entire context. I am in agreement with Counsel in this regard. I do not however,

agree with his submission that section 7(3) does not apply to the Fund. While I agree that the Fund is not an insurer under the Insurance Act, it is, in my view, under Regulation 283/95. While the Allstate Insurance v Ontario decision of the Court of Appeal, cited above, made this clear prior to the amendments, I do not think that the changes alter the situation for our purposes. If one looks at the Regulation in its entirety, there appears to be an intention that the Fund be included as an insurer. For example, section 2.1(8) specifically excludes the Fund as an insurer for that section, but by implication includes the Fund as an insurer for the other provisions that are not specifically included. In addition, excluding the Fund from the definition of insurer would mean that after the Fund receives notice under section 3, the Fund could not give a Notice of Dispute under section 10 to another insurer as that section only permits "insurers" who receive section 3 notice to provide their own section 3 notices to other insurers.

In my view, the Regulation includes the Fund as an insurer but it also gives the fund in certain situations, additional rights that the other insurers may not have. That is, for example, what the effect of section 7(4) of the Regulation is.

In support of this position I would refer to the decision of the Ontario Court of Appeal in Ontario (Finance) v Eschelon General Insurance Company, 2019 ONCA 629, where the court stated:

> "Since 2007 there has been no doubt that the Fund is an insurer under the Regulation. I observe that these amendments follow the 2007 decision in Kingsway and Allstate. Regulation 38/10 amends the Regulation to separate out more distinctly the Fund from other insurers and to add protections for the Fund, as the detailed analysis of the new provisions set out earlier amply show."

For these reasons, I am of the opinion that section 7(3) of the Regulation does apply to the Fund and to this fact situation. Accordingly, Allstate is barred from continuing the arbitration as against the Fund.

I now turn to the question of whether the initial Notice of Dispute sent to the Fund on July 25th, 2016, also applies to State Farm, or whether the Notice given to State Farm on August 29th, 2016 applies.

Counsel for State Farm points out that under section 7(3) of the Regulation, the arbitration is to be initiated one year after the insurer paying benefits first gives notice under section 3.

> " 7(3) The arbitration may be initiated by an insurer or by the insured person, no later than one year after the insurer first gives notice under section 3."

Counsel for State Farm points out that section 3 provides for notice to be given to an insurer and also if applicable, to the Fund. Section 7(3) does not refer to notice under section 3(1) but refers to section 3 notice as a whole. Thus, in State Farm's view, the limitation period begins with any notice under section 3.

Counsel for Allstate takes the position that "first gives notice" in section 7(3) should apply when notice is given to each insurer, so that if notice is given to a second insurer at a later date, the one year limitation commences against the second insurer once the second insurer receives its notice.

There would appear to be limited case law on this point. Arbitrator Bialkowski, in Economical v State Farm Mutual Automobile Insurance Company, (unreported decision dated December 22, 2014) dealt with a situation where the applicant, Economical, served the respondent, State Farm, with an initial Notice to Dispute which State Farm responded to by saying that the policy referred to had been cancelled prior to the accident. Economical then sent a further Notice of Dispute, referring to a different policy and a different insured, but still an insured of State Farm. The subsequent arbitration was commenced outside the one-year

limitation period as set out in section 7(3) for the first Notice of Dispute but within the one year for the second Notice of Dispute.

Arbitrator Bialkowski found that Economical had essentially abandoned the initial Notice of Dispute and served a totally new Notice of Dispute involving a totally different insured and policy, albeit still insured by State Farm. Interestingly, Arbitrator Bialkowski, in allowing the arbitration to proceed, stated:

> " If Kovac (the insured under the policy where the second Notice of Dispute was given), were insured with some other company as is often the case, there would be no limitation argument."

Counsel for State Farm in our case has referred to the decision in Allstate v State Farm Mutual Automobile Insurance Company and Her Majesty in Right of Ontario as Represented by the Minister of Finance an unreported decision of myself dated January 18, 2018. In that case, the applicant, Aviva, sent a first Notice of Dispute to Pafco/Allstate and subsequently a more detailed Notice of Dispute again to Pafco/Allstate, but also a notice to the Fund. The Fund then sent a Notice to Belair along with a Demand for Arbitration.

The initial Notice of Dispute to Pafco/Allstate was more than one year prior to the commencement of the arbitration, but the second Notice of Dispute was within the one-year limitation period. Unlike Arbitrator Bialkowski's case in Aviva, the second notice involved the same Pafco/Allstate insured and same policy. Essentially all it did was provide greater detail of the claim. In that case I found that the first notice applied and the second notice did not serve to create a new limitation period.

Our present case is somewhat different, in that it involves two different insurers, the first of which, the Fund, was put on notice more than one year after being provided a Notice of Dispute, and the second, State Farm, who was provided with a Demand to Arbitrate less than one year after receiving the Notice to Dispute. In some ways, our case is closer factually to the

Economical v State Farm case, however, as I stated in the Aviva v Pafco/Allstate decision, at page 9:

> "A literal reading of this section [section 7(3)] would suggest the limitation period for all those that the original insurer insured's claimed against would begin to run when the original notice went out... I do not believe, however, that Aviva, having given notice on January 2, 2015, can then give later notice to Belair and commence an arbitration against Belair outside the one-year anniversary of the first notice of Pafco/Allstate."

I am of the view that the same reasoning applies in our case and therefore Allstate is precluded, by section 7(3) from continuing the arbitration as against State Farm.

While this may seem harsh and even unfair, a plain reading of section 7(3) draws me to this conclusion. As the courts have stated on many occasions, the priority dispute regulation was enacted to deal with these matters in an expeditious and efficient manner and this would sometimes result in rough "justice". To allow different notices and therefore limitation periods to apply would take away from these objectives.

While the remaining issue as to whether the Fund is responsible to pay for benefits arising out of the claim made for psychiatric damages arising out of her sister's accident is moot because of my ruling regarding the limitation period, I will never the less address it given the considerable and able submissions of counsel in this matter.

As stated above, Allstate received a claim from the sister of the person actually involved in and injured in the accident and now takes the position the Fund is responsible for any payments to be made to her.

Entitlement to Statutory Accident Benefits arise pursuant to section 268 of Insurance Act which states:

"Every contract evidenced by a motor vehicle policy.... Shall be deemed to provide for statutory accident benefits set out in the schedule... Subject to the terms, conditions, provisions, exclusions, and limits set out in that schedule."

Section 268(2)(1) of the Insurance Act provides for a cascading series of priorities outlining which insurer is responsible for payment of the accident benefits mandated by section 268(1), above. Paragraph 268(2) (iv) provides that in the case of non-occupants "if recovery is unavailable under subparagraphs i, ii, or iii, the non-occupant has recourse against Motor Vehicle Accident Claims Fund."

Essentially, Allstate takes the position that section 268(2) applies, and the Fund is therefore responsible for payments to or on behalf of Thenusha Papanirupasingam.

The Fund's obligation to pay accident benefits arises pursuant to section 6 of the Motor Vehicle Accident Claims Act, R.S.O. 1990, c.41, which states:

"6(1) Any person who has recourse against the Fund for statutory accident benefits under section 268 of the Insurance Act may make application, in a form approved by the Superintendent for the payment of benefits out of the Fund.

(2) If a person has recourse against the Fund under section 268 of the Insurance Act,
(a) references to an insurer in the Statutory Accident Benefit Schedule shall be deemed to be a reference to the Fund and a reference to an insured person shall be deemed to be a reference to the person who has recourse against the Fund."

In my view, it is not sufficient for an applicant to simply qualify under section 268 of the Insurance Act, and then go straight to the "priority ladder" setting out which insurer should pay. Section 268(1) of the Insurance Act makes it very clear that entitlement is still "subject to the terms, conditions, provisions, exclusions, and limits set out in that schedule".

Mr. Justice Matheson in Unifund Assurance Company v Security National Insurance Company, 2016 ONSC 6798 made it clear that one does not simply look at the priority ladder. First the requirements and limitations of the Insurance Act and the SABS must be met. In that

case, the claimant was injured while riding on an ATV. The owner of the ATV had an automobile policy with Security National which included an endorsement covering ATVs. At the same time, the claimant was a named insured under an automobile policy with Unifund. That standard policy did not include ATVs. The arbitrator at the hearing found that determination whether there was an accident provided recourse to statutory accident benefits by simply considering the terms of the policies in issue. On appeal, Mr. Justice Matheson held that one must also look at the provisions and limitations set out in the SABS. More specifically, he found that when examining the Unifund policy, the ATVs was not an automobile as required by SABS and therefore there was no entitlement under the Unifund policy.

Adopting the approach taken by Justice Matheson, the Fund takes the position that Thenusha Papanirupasingam does not satisfy the conditions to receive benefits under the SABS. Counsel for the Fund refers to the definition of "insured person" as set out in section 3(1) of the SABS as one of the requirements that the applicant must meet. That section states:

> 3(1) "Insured Person" means, in respect of a particular motor vehicle liability policy,
> (a) The named insured, any person specified in the policy as a driver of the insured automobile and, if the named insured is an individual, the spouse of the named insured and a dependent of the named insured or his/her spouse,
> (i) If the named insured, specified driver, spouse or dependant is involved in an accident inside or outside Ontario that involves the insured automobile or another automobile, or
> (ii) If the named insured, specified driver, spouse or dependant is not involved in an accident but suffers psychological or mental injury to his/her spouse, child, grandchild, parent, grandparent, brother, sister, dependant or spouse's dependant,
> (b) A person who is involved in an accident involving the insured automobile, if the accident occurs in Ontario...

When examining this definition, one must also take into account section 6(2) of the Motor Vehicle Accident Claims Act, which states:

> 6(2) " If a person has a recourse against the Fund under section 268 of the Insurance Act
> (a) A reference to an insurer in the Statutory Accident Schedule should be deemed to be a reference to the Fund and a reference to an insured person

shall be deemed to be a reference to the person who has recourse against the Fund.

(b) Section 274 and 279-282 of the Insurance Act apply with necessary modification."

The question then becomes, when making application to the Fund, must the applicant meet the definition of an 'insured person' as defined by section 3(1) of the SABS, and if so, does the present applicant meet the criteria set out therein.

Counsel for the Fund submits that section 3(i) (a) (ii) should not apply to the Fund because the applicant is not a named insured and the Fund does not issue policies as required by the subsection. In addition, counsel submits that section 3(2)(a)(ii) requires the psychological injuries to be the result of an accident. Dealing first with the latter point, an 'accident' is defined in section 3(1) of the SABS and states:

> " "accident" means an incident in which the use or operation of an automobile directly causes an impairment or directly causes damage ..."

Thus, while I note that pursuant to section 3(1)(a)(ii) of the SABS, an applicant does not have to be involved in the accident, they must suffer the psychological injury as a result of the accident. The definition of accident requires the use or operation of the automobile to directly cause the impairment. In our case, as the Fund notes, the applicant's impairment does not arise so much from the accident, such as observing it, but rather from caring for the person physically injured in the accident.

Even if I accept that the applicant meets the criteria as set out in subsection 3(a)(ii) there is still the issue of whether the applicant would qualify as a "named insured or any person specified in the policy". Clearly, the Fund does not issue policies and the applicant was not a named insured. Accordingly, I find that the applicant does not meet the requirements of an "insured person" as defined by the SABS.

The question then becomes whether this is a precondition to obtaining benefits from the Fund. The Fund suggests that there are numerous instances where certain benefits are available to some parties and not to others. It submits that the legislation and regulations recognize that certain groups, that actually purchase an automobile insurance policy may be entitled to benefits that are not available to those who do not. They note, in a similar vain, that persons can purchase additional optional benefits that are available by paying an additional premium.

Counsel for Allstate points out that if the Fund's position is upheld, it would significantly reduce the number of persons able to access benefits and the Fund is, as set out in their website, in essence the insurer of last resort, where persons involved in an accident have no recourse to automobile insurance.

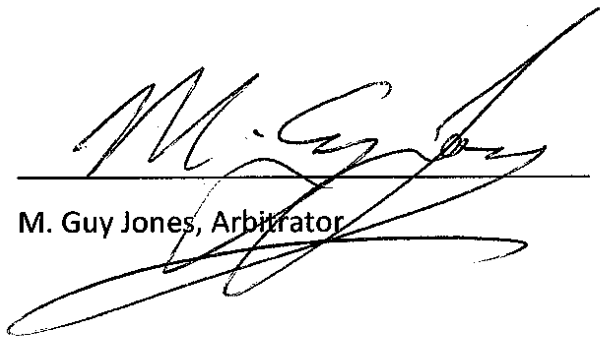
Arbitrator Bialkowski dealt with issues similar to our own in Allstate v MVAC, (unreported decision dated April 18th, 2017). In that case, an individual was involved in a single car accident and badly injured. He was a listed driver under an Allstate policy. His three children applied to Allstate for accident benefits as a result of psychological injuries arising from their father's injuries/death. Allstate served the Fund with a Notice of Dispute, which took the position that the applicants were not entitles to the benefits as they did not meet the criteria as set out in the SABS. Like myself, he found that the applicants did not qualify as "insured persons" under section 3(1) of the SABS. He found that Allstate was therefore not liable to pay the accident benefits. Arbitrator Bialkowski reviewed, at some length, previous arbitration decision which considered entitlement from the Fund pursuant to section 268(2)(2)(iv) of the Insurance Act (the priority ladder). After considering the case law, Arbitrator Bialkowski held that the definition of "insured person" found in section 3(1) did not apply to the Fund as it only restricts access to policies of insurance, which clearly the Fund does not issue. I agree with Arbitrator Bialkowski. I also agree with his conclusion that this does not mean there are not restrictions and limitations on what the Fund must pay. Clearly, there are. One of these

requirements is that the individual must "suffer an impairment as a result of an accident". As noted above, "accident" is defined in section 3(1) of the SABS as:

> "an incident in which the use or operation of an automobile directly causes an impairment...".

In our case, the applicant did not suffer an impairment directly caused by the accident and therefore would not be entitled to accident benefits and accordingly for these reasons, as well as the limitation argument, the Fund is not liable to pay accident benefits to Thenusha Papanirupasingam.

Date at Toronto, this 5th day of January, 2021.



M. Guy Jones, Arbitrator