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Disability Benefits Case Law Update: Appeals, Appeals and More!

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Presentation outline

- Recent cases on limitation periods
  - Nova Scotia - *Richards Estate v Industrial Alliance Insurance and Financial Services*
  - Ontario - *Western Life Assurance Company v Penttila*
  - Ontario - *Wiles v Sun Life Assurance Company of Canada*

- LTD coverage after resignation
  - *MacIvor v Pitney Bowes and Manulife*

- Under the regular care of a physician
  - *Wright v Sun Life Assurance Company of Canada*

Recent Cases on Limitation Periods

Richards Estate v Industrial Alliance Insurance and Financial Services

Facts

- Paul Thomas Richards became unable to work in late 2008 due to fatigue, depression, and other ailments. He received LTD benefits from Industrial Alliance until 2011, when he was advised by Industrial Alliance that he no longer satisfied the definition of total disability in his group LTD policy. Richards appealed the decision to terminate his LTD benefits, and his **appeal was denied in March 2012**.
- He passed away in September 2015. On **November 15, 2015**, Richards' two children sued Industrial Alliance , on behalf of the Estate and themselves. The Plaintiffs alleged Industrial Alliance breached the policy and acted in bad faith.
- Industrial Alliance brought a motion for summary judgment on the evidence, arguing that the Plaintiffs' claim was out of time due to the expiry of the one year limitation found in the policy and/or the one year statutory limitation period found in the Life Insurance Part of the *Insurance Act* (s. 209 – one year after the furnishing of the required evidence).

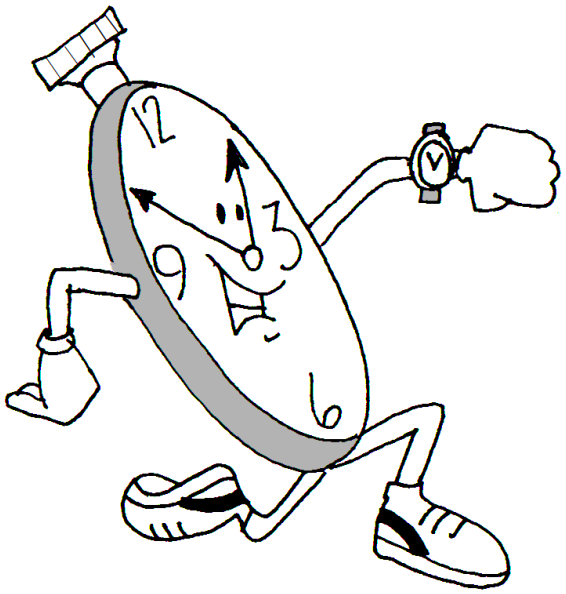
Richards Estate v Industrial Alliance Insurance and Financial Services cont.

- The policy had a limitation period similar to that found in many LTD policies, providing that actions against the insurer "…*shall be absolutely barred unless the action or proceeding is commenced within one year (or such longer period as is required under the applicable legislation of the jurisdiction of the action)*."
- The Plaintiffs argued that the limitation in the Life Insurance Part of the one year *Insurance Act* did not apply to disability claims, or alternatively that the one-year limitation period had the effect of shortening the two-year limitation period in the *Limitation of Actions Act,* which the Legislature could not have intended.

Main takeaways:

(1) The limitation period was one year, as found in the Policy and the *Insurance Act*

- The *Insurance Act* expressly includes disability insurance in the definition of “life insurance”.
- Justice Smith agreed with Industrial Alliance that section 209 “is applicable to disability insurance claims”.
- Therefore the one year limitation period for life insurance claims was also the limitation period for disability claims.



- The limitations clock started to tick on one of two dates in early 2012. The first possibility was January 13, 2012, when Richards furnished the required evidence. The second possibility was March 12, 2012, the date of the Industrial Alliance letter denying his appeal. According to Justice Smith, the latter "**was a clear and unequivocal denial of future benefits**."
- Justice Smith noted there was nothing in the letter that suggested a further appeal was available. "The letter contains no offer to review or accept any additional information, medical or other".

- Justice Smith did not have to decide the exact date (either January 13, 2012, when Richards furnished the required evidence, or March 12, 2012, the date of the Industrial Alliance letter denying his appeal) when the clock started ticking.
- The action was started in November 2015, almost three and a half years after the latest of the two dates, so it was out of time either way.
- Justice Smith also confirmed Industrial Alliance did not have a positive duty to advise Richards of the applicable limitation period.

(2) There was no applicable saving provision in the *Limitation of Actions Act* or the *Insurance Act*

- The Plaintiffs argued that Mr. Richards lacked capacity to bring his claim in time, relying on section 19 of the *Limitation Act* (limitation periods in the *Limitation Act* do not run while a claimant is incapable of bringing a claim because of the "claimant's physical, mental or psychological condition").

- However, the one-year limitation period was not established by the *Limitation Act*; it came from the Policy and the *Insurance Act*. For this reason, Justice Smith rejected the Plaintiffs' capacity argument. In any event, Justice Smith found that the Plaintiffs had not proven incapacity, as their supporting evidence was either inadmissible or irrelevant.

(3) Relief from forfeiture is not available to cure non-compliance with the contract

- The Plaintiffs also sought relief from forfeiture, under section 33 of the *Act*. Justice Smith rejected this argument, concluding the failure of the Plaintiffs to commence their action within the limitation period constituted **non-compliance with the contract, and therefore relief from forfeiture was not available**.
- The Court drew a distinction between non-compliance imperfect compliance (i.e. failure to give timely notice of claim) and non-compliance (i.e. failure to institute an action within the prescribed time period).

(4) A bad faith claim does not automatically extend the limitation period

- In May 2018, the Plaintiffs had amended their pleading to add allegations of bad faith against Industrial Alliance. The Plaintiff was arguing the bad faith claim would somehow extend the limitation period for benefits.
- Justice Smith recognized that “breach of an insurer’s duty of good faith or intentional infliction of mental distress can constitute an independent cause of action” in some cases.
- Justice Smith held that the allegations of bad faith and the claim that benefits were wrongly denied to Mr. Richards were “one and the same for the purposes of the limitation analysis”. As a result, the addition of the claim of bad faith did not serve to extend the limitation period which had already expired.

Holding:

- Industrial Alliance succeeded on its summary judgment motion, and the Plaintiffs' claims were dismissed with costs.

Western Life Assurance Company v Penttila

Recap of the Facts:

- On **February 19, 2013**, the Plaintiff was told her benefits would end as of March 7, 2013, and was invited to appeal. The letter stated **"In offering to review additional evidence, we are not waiving our right to rely on any statutory or policy provision including any time limitations."**
- The Plaintiff continued to provide information and received several more letters with invitations to submit further medical information, repeating the statement there was no waiver of time limitations.
- On **October 21, 2014** she was notified that her benefits remained terminated as it could not be concluded that she was unable to perform any occupation. This letter again contained the disclaimer that the ongoing appeal did not waive any applicable time limitations.
- The motions judge noted that these denial letters invited Penttila to submit additional evidence.

- In May 2015, the Plaintiff requested a letter containing the decision of the review of her file, and the insurer responded on **June 18, 2015** explaining that per the October 21, 2014 letter, her benefits remain declined.
- The Plaintiff filed an action against the Insurer on **June 6, 2016**.
- The insurer's statement of defence asserted that the limitation period began on either **February 19, 2013**, the date the Plaintiff was informed of the denial of benefits or **March 7, 2013**, the date on which the insurer ceased paying benefits, and pleaded that the action was statute-barred by the Ontario *Limitations Act* 2 year limitation period.

Decision:

- The motion judge dismissed the Defendant's motion for summary judgement.
- The continued offer by the insurer to review additional information was "founded on the realistic and legitimate understanding that the information that explained the claim might not be complete" and therefore indicated that no conclusive determination had been made.
- Justice Lederer concluded that it would not be "legally appropriate" to commence an action while it was unknown what the conclusive determination of the insurer would be. If the additional information meant that the claim would be recognized, there would be no loss and no basis to resort to the court.

- Regarding the insurer's use of a disclaimer (no waiver of the limitation period), Justice Lederer found that this simply confirmed that whatever limited period applied continued to apply, and **a disclaimer cannot override the statutory limitation period or serve to dictate the beginning of such period.**
- Justice Lederer held that the "end of the process", once all the "additional evidence" was complete or sufficient, came with the **last letter** of June 18, 2015 which was "**the decision**".
- Of note, this letter no longer invited Penttila to submit additional evidence.

Ontario Superior Court of Justice Divisional Court Decision (January 7, 2019)

- On appeal, the Divisional Court found that the motion judge was correct in holding that the triggering event for the commencement of the two-year limitation period was the date upon which it would be legally appropriate to commence legal proceedings to seek payment of disability benefits that the insurer refused to pay.
- The Divisional Court distinguished *Pepper v Sanmina-Sci Systems (Canada) Inc.*, 2017 ONCA 730, noting in *Pepper* the claimant had retained litigation counsel at the outset to deal with her claim for disability benefits.
- The Divisional Court placed special emphasis on the fact that Penttila's affidavit evidence (that she believed Western was considering her appeal until the final decision in June 2015) was uncontradicted.

- The Divisional Court commented there was a “specific and agreed right of appeal, a clear articulation of the process to be followed, and a specific decision in respect of the appeal”
- Given that right of appeal, it would be premature to commence legal proceedings until that process ran its course.

The Divisional Court upheld the motion judge’s decision, dismissed the summary judgment motion and awarded costs to the Plaintiff.

Wiles v Sun Life Assurance Company of Canada, 2018 ONSC 1090 affirmed by the Court of Appeal, 2018 ONCA 766

Facts

- Teresa Wiles, was a long-time employee of Spaenaur Inc. In October 2015, she became totally disabled from working. On November 3, 2015, Spaenaur Inc. terminated her employment. On November 17, 2015, her lawyer requested an application for disability insurance coverage. On November 18, 2015, Spaenaur Inc. sent her lawyer a Salary Continuance Services Plan Members Package, including a blank Plan Member's Statement Salary Continuance Services.
- The Employer, Spaenaur Inc. was responsible to pay the Salary Continuance plan with Sun Life responsible for administering the Salary Continuance plan.
- On December 21, 2015, Wiles' lawyer submitted the Plan Member's Statement to Sun Life to apply for Salary Continuance. On December 30, 2015 and January 25, 2016, Sun Life requested Wiles submit an Attending Physician's Statement.
- On **February 16, 2016**, Sun Life advised Wiles that her claim for Salary Continuance had been closed for failure to submit an Attending Physician's Statement. Wiles spoke to her family doctor and was told that the Attending Physician's Statement had been sent to Spaenaur Inc.

Discussion and Analysis – ONSC

- Wiles and her lawyer took no further steps until **January 20, 2017** when a statement of claim was issued against Sun Life for damages for breach of a group “Disability Policy”. Spaenaur Inc. was **not** named as a Defendant.
- Sun Life was not legally responsible for paying the Salary Continuance and the Employer Spaenaur Inc. was not named as a Defendant
- There were LTD benefits available to Wiles, however, those benefits only became payable after Salary Continuance had been exhausted and required a separate application. Ms. Wiles had never made that separate application to Sun Life.
- Sun Life served its motion for summary judgment.

Discussion and Analysis – ONSC

- It was not until **after** receiving Sun Life's statement of defence and motion for summary judgment that Wiles' lawyer submitted a completed Plan Member Statement for LTD benefits on **May 17, 2017**.
- **After** the LTD Plan Member Statement was submitted, Wiles' lawyer submitted the Physician's Statement for Salary Continuance and an Attending Physician's Statement for LTD benefits on **July 17, 2017**.
- **After** the PMS and APS were submitted, Wiles amended her statement of claim to seek damages against Sun Life for failure to pay LTD benefits on **September 29, 2017**.

Decision at the ONSC

- **The judge granted Sun Life's motion for summary judgment and dismissed Wiles' action**.
- The Policy required Wiles to submit proof of her claim within 90 days after the elimination period. It was unclear to the Court exactly what this date would be, however, it was clear that Ms. Wiles was well past the deadline.
- The trial judge ruled that Wiles' claim against Sun Life for LTD benefits must fail, because **(1)** it was started past the one-year contractual time limit to sue under the terms of the Policy; and **(2)** Wiles' failed to submit the necessary documents to apply for LTD benefits within the required timeframe. The judge determined that the conduct of the Plaintiff did not justify relieving her of her obligations under the terms of the policy.

Appeal – ONCA

In a very short 4 paragraph decision, the Court of Appeal said:

- The appellant argues that the application judge erred in finding that the action was barred by a limitation period. In her submissions, the appellant maintains that this was an error and it infected the relief from forfeiture analysis regarding her late filing with the insurer of her LTD claim.
- We disagree. Although the respondent concedes that the application judge erred in his finding that the action was barred by a limitation period, the respondent maintains that the analysis of the relief for forfeiture issue which followed stands independent and separate from the limitation disposition.
- From our reading of the reasons, the application judge's analysis discloses no such tainting. We also disagree with the appellant's suggestion that the application judge erred in the exercise of his discretion in determining whether relief should be granted. The application judge correctly identified the legal principles that apply and his findings on the record that he had before him were available and are owed deference in this court.
- For these reasons, the appeal is dismissed. Costs to the respondent are fixed in the amount of $5,000 inclusive of HST and applicable taxes.

Lessons learned

Limitation periods:

- The addition of a bad faith claim does not automatically extend the limitation period for a claim for benefits (***Richards Estate***).
- The limitation period for commencing a claim at Court in the disability context only begins to run once there is a final, clear, and unequivocal denial of benefits (***Penttila***).
- Insurers should be wary about providing open-ended rights of appeal to insureds or offers to accept and review additional evidence.

- The insurer should be able to demonstrate that a final decision was made and that the decision was communicated to the insured in a way that makes the denial clear and unequivocal.
- Adding a disclaimer about no waiver of limitation periods is not effective if an Insurer continues to offer to review additional evidence.
- An Insurer does not have a positive obligation to advise its insureds of the applicable limitation period.

LTD Coverage After Resignation

MacIvor v Pitney Bowes, 2018 ONCA 381

MacIvor v Pitney Bowes

Facts

- The Plaintiff, Mr. MacIvor, suffered a traumatic brain injury while at a work event in 2005. While he eventually returned to work, he grew frustrated with job performance issues that were caused by his injury. He then quit Pitney Bowes in 2008.
- A few days later, he started a new job at Samsung, a completely different company. Mr. MacIvor suffered the same performance issues at the second job, and was fired in 2009.
- When he tried to claim LTD benefits from the second employer, he was told that he was not eligible, because the injury had occurred prior to his employment.
- He then made a claim under the insurance policy of the first employer. The insurer, Manulife denied his claim. The Policy stated that Mr. MacIvor's coverage would cease on "**the day on which [he ceased] to be Actively Employed**."
- The Trial Court dismissed MacIvor's claim on the basis that his coverage had ended when he ceased to be actively employed by Pitney Bowes.
- MacIvor appealed.

Policy did not exclude undiscovered claims

- The Appeal Court found the “termination of coverage” language applied only to future claims, not claims that may have arisen during the employee’s employment.
- The Appeal Court also noted that the policy did not clearly apply only to current employees. Nor did the policy clearly exclude coverage for undiscovered claims that originated during an employee’s employment, after employment ceased.
- The Appeal Court held that, in the absence of clear exclusionary language, Mr. MacIvor’s coverage did not end when he quit his job in 2008.
- In particular, the Court noted that the insurance policy did not contain “exclusionary language that terminates coverage for undiscovered disability claims … that originated [during employment]”.

No failure to submit timely proof of claim

- The policy required proof of claim within 90 days of the date “benefits would begin”.
- The Court noted benefits only begin when an employee is no longer receiving employment income.
- The Court stretched out the period he received employment income to include his termination package of 8 months from Samsung (employer #2).
- The Court concluded he was therefore only a few days late.

- The Court held that, even if Mr. MacIvor's claim was not in perfect compliance with the timeline set out in the policy, it would be "most unfair" to permit that "imperfect compliance" to defeat Mr. MacIvor's claim.
- Even though relief from forfeiture had not been raised at trial, the Appeal Court granted relief from forfeiture.

Court found 1 year contractual limitation period did not apply

- Manulife relied on the one year limitation period in the policy.
- The Court referred to *Kassburg v Sun Life Assurance Company of Canada*, 2014 ONCA 992. In *Kassburg*, the Court considered whether the one year limitation period in the policy overrode the 2 year statutory limitation period. In *Kassburg*, Sun Life argued the Policy was a "business agreement" and therefore the parties had contracted out of the statutory limitation period. The Court held the policy was not a "business agreement" but rather a contract for "personal purposes".

Decision:

- Mr. MacIvor was successful on appeal.

Aftermath:

- Manulife’s leave to appeal to the Supreme Court of Canada was denied.

Lessons learned:

- The Courts are more than willing to interpret a policy to the Plaintiff's benefit.
- Insurers should consider adding language to the Policy to make it clear that coverage ends when an employee is no longer actively working, which includes claims for "undiscovered disability claims that originated during employment" with the Plan Sponsor.

Under the Regular Care of a Physician

Wright v Sun Life Assurance Company of Canada, 2019 BCCA 18

Summary

- Dentist commenced claim in 1998 seeking damages from Sun Life for breach of group disability policy.
- Plaintiff suffered injuries while skiing in 1993, including a concussion, fracture of the left humerus, hyperextention injury to cervical spine, and exacerbation of pre-existing low back pain.
- Plaintiff alleged that chronic pain progressively worsened and rendered him unable, as of March 1995, to perform the essential duties of his occupation as a dentist.
- Sun Life paid benefits to September 2001, but argued the Plaintiff was no longer entitled to payments thereafter because he was not under the regular care of a physician as required by the policy.

- The trial judge found that the Plaintiff was “neither a credible or reliable witness”.
- The policy was one which protects the insured from income loss during the treatment phase of sickness causing total disability and in the event the insured suffered one of four forms of permanent disability (loss of speech, hearing, sight or use of two limbs).
- Visits to doctors after October 2001 were for occasional conditions or routine matters and were not “as a result of any injury suffered in the accident”. As a result, claim was dismissed.

- On Appeal – Plaintiff argued that Trial judge erred in excluding medical evidence which should have been considered at Trial.
- Court of Appeal concluded that none of the excluded evidence would have established that the Plaintiff was under the care of a physician in any event. Appeal was dismissed.

Lessons learned:

- Insurers can benefit from clear and unambiguous policy provisions. The Court will take a close look at the wording of the policy which defines the reach and scope of coverage and the risk accepted by the insurer.

Questions?

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