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LTD Case Law Update - Fall 2018

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A) COVERAGE

MacIvor v. Pitney Bowes and Manulife 2018 ONCA 381 (CanLII) on appeal from (2017) ONSC 1550 (CanLII)

Appeal from a trial judgment holding that the appellant, "M", as a former employee of Pitney Bowes, had no coverage for his claim under a Manulife LTD policy.

M suffered a traumatic brain injury and a severe back injury during a company sponsored event in Costa Rica on April 16, 2005. M was unaware of the permanent and disabling nature of his brain injury until after he had resigned his employment with Pitney Bowes.

Three issues were presented on appeal: (1) whether M, as a former employee of Pitney Bowes, was entitled to coverage under the Manulife Policy; (2) whether M submitted a timely proof of claim; and (3) whether the one-year contractual limitation period in the policy barred M's claim.

Following his accident, M was off work for nearly four months and returned to work in August 2005. From the history set out in an Agreed Statement of Facts M's work performance deteriorated dramatically from what it had been. Paragraph 2 of the Agreed Statement of Facts set out M's employment history for the years preceding the accident where, between 1996 and 2005, he rose through the ranks, from junior sales representative to Division Sales Vice President at Pitney Bowes, managing over 130 sales representatives.

M "was a different man when he returned to his employment following the accident". Paragraph 5 of the Agreed Statement of Facts set out the difficulties M encountered in resuming his employment. M's responsibilities were continuously reduced and in frustration he quit his job at Pitney Bowes on August 11, 2008. Within days he took up employment with Samsung to perform a role similar to the one he held at Pitney Bowes before his accident.

The difficulties M experienced in job performance before leaving Pitney Bowes soon became apparent and he was fired from Samsung in August 2009. M asked Samsung about making an LTD Claim and was told that, because his injury occurred when he was working for Pitney Bowes, he would have to apply under that policy. (Note: It is unclear from the Court of Appeal's

decision if Samsung had a group LTD Policy or if such Policy precluded any argument of coverage under the Samsung Policy).

There was no issue that M had coverage with Manulife while he was employed. Manulife argued that: "M had access to LTD benefits if he applied while he was employed and, therefore, covered. Once he was outside of this coverage and/or failed to meet the Policy's terms, he no longer had entitlement to claim"; and that "the Policy indicates that coverage ends when employment ends".

The trial judge accepted this argument. She concluded that the Policy "states in clear terms that there is no coverage for persons who are not employed at Pitney Bowes".

Writing for the The Court of Appeal panel, Justice MacFarland wrote:

"The language of the Manulife Policy when considered as a whole is clear; it means only that coverage does not continue when an employee begins working for another employer or after the employee has retired. The "Termination of Coverage" language relates to future claims, not claims that may have arisen during the course of the employee's employment. In other words, if an employee's claim arises as the result of an occurrence that takes place during their employment, the policy provides coverage. The additional words "unless continuation of coverage is provided under the Extension of Coverage provision" supports this conclusion.

Moreover the Manulife Policy also provides:

A monthly Benefit will be paid if you become Totally Disabled while covered under the Long Term Disability Coverage and are under the continuing care of a physician.

The language of this provision confirms the entitlement to be paid a monthly benefit if the total disability occurs during the coverage period. I note that this provision contains no language indicating that it applies only to current employees.

Where the language of a policy is ambiguous, the general rules of contract construction must be employed to resolve that ambiguity: Ledcor v. Northbridge [2016] S.C.R. 23, at para. 50. These principles include that the interpretation "should not give rise to results that are unrealistic or that the parties would not have contemplated in the commercial atmosphere in which the insurance policy was contracted": Ledcor, at para. 50. If ambiguity still remains after applying the general principles, then the principle that coverage provisions are to be interpreted broadly, and exclusion clauses narrowly, may be considered: Ledcor, at para. 51.

These principles do not support Manulife's position. The Manulife Policy does not contain the type of exclusionary language that terminates coverage for undiscovered disability claims the employee had and that originated during their employment, when their employment ceases. To so conclude would leave former employees, like the appellant, in the untenable position of having no disability coverage from either their former employer or any new employer. Such a

result would be contrary to the very purpose of disability insurance and the plain meaning of the coverage provision.

It would be most unfair, in my view, to permit the imperfect compliance with the 90-day proof of claim period to defeat the appellant's claim in the particular circumstances of this case. The appellant was injured during his employment when he was covered by a LTD Policy, but did not appreciate the significance of his injury during his employment. The respondent has conceded the appellant's total disability as of the date of the accident and that he enjoyed coverage under its policy at the time of his injury. The appellant left his employment some time after he was injured but before he was aware of the extent of his injury. The imperfect compliance with the requirement to file the proof of claim form may only be a matter of 10 days at most. His employer and the insurer were aware that he had suffered a serious injury that included a brain injury at the outset. All of the foregoing facts have been known to the parties for years now.

Although relief from forfeiture pursuant to the provisions of the Insurance Act, R.S.O. 1990, c. I.8, or the Courts of Justice Act, R.S.O. 1990, c. C.43, was not raised at trial, given the facts outlined above, it is in the interests of justice to grant that relief here.

It is arguably unclear whether the policy language required the appellant to commence this action within one year of November 1, 2010, the date that Manulife denied the claim, or whether the one-year period runs from September 9, 2010, the actual date the proof of claim was submitted. Because the Statement of Claim was issued on April 11, 2011, it is not necessary to resolve that question as regardless of how the one-year contractual period is to be calculated, it was met on the facts of this case.

In any event, in view of this Court's decision in Kassburg v. Sun Life Assurance Company of Canada, 2014 ONCA 922 (CanLII), 124 O.R. (3d) 171, it is unlikely that the one-year period of limitation would be upheld: see paras. 53-62.

The only reasonable available conclusion on this record is that the appellant could not reasonably have appreciated he had a cause of action until the end of August 2009. The claim was therefore not discovered until that time. Even on that basis his action was commenced well within two years of that date. I would also note that he did not receive his CPP disability pension until May 2011".

Note: *Manulife is seeking leave to appeal to the Supreme Court of Canada.*

B) SUBROGATION

Nova Scotia Public Service Long Term Disability Plan Trust Fund v. Kontuk (2018) Nova Scotia Supreme Court) 291 A.C.W.S. (3d) 858

Insured was injured in a motor vehicle accident in Ontario which disabled him from work, and he received LTD benefits - The Claim by the insured against the party responsible for his accident was settled - The Nova Scotia Public Service Long Term Disability Plan Trust Fund ("Fund")

claimed entitlement to a portion of the settlement award - Fund brought application for an Order fixing entitlement to Fund and amount of bi-weekly offset from LTD payments - Application granted - Insured received $112,968.15 from the Fund and was designated as permanently disabled, and currently received LTD payments of $688.96 monthly - Nothing in Ontario legislation prevented Fund from relying upon its rights as contained in Nova Scotia Public Service Disability Plan - No subrogation provision in Insurance Act (Ont.) prevented Fund from asserting its rights to income loss portion of settlement (The applicable legislation gave the Fund a contractual right of subrogation). Once a settlement was negotiated by an insured the onus shifted to such insured to account for the apportionment of the lump sum account over the various heads of damages to establish that no portion of the recovered amount fell within the deduction provisions of the legislation) and Fund did not require full indemnification of insured before Fund's contractual right to recover any benefits received by the insured was triggered - Overall settlement figure included some LTD disability benefit for injury for which third party could be liable, so the issue was the determination of what would be just quantification of wage loss component - Mere difficulty in breaking down the settlement did not relieve the insured of his obligation to account for wage loss, however, burden of proof was determinative factor only when basis upon which to calculate wage loss could not be determined on facts - Fund entitled to reimbursement of $2,533.00 by way of past wage loss in partial repayment of LTD benefits - Amount of $117.43 per month to be offset from Fund's payments until the insured's date of retirement.

C) AUTHORIZATION FORMS

Bozek v. Alberta, Long Term Disability Second Level Appeal Board, and Great West Life [2018] 294 A.C.W.S. (3d) 836 ABQB

This matter concerned a Judicial Review of the Appeal Board's decision to deny Mr. Bozek ("B") any further LTD benefits. B was a member of the Alberta Union of Provincial Employees. He was injured while working as a correctional officer and applied for LTD benefits.

The injury took place on May 2, 2014. B's initial Workers Compensation Board ("WCB") claim was accepted May 21, 2014. On September 11, 2014 B was granted LTD benefits. On December 14, 2015, over a year later, the third party administrator (Great West Life) determined that B was capable of returning to gainful employment. Consequently, B's LTD benefits were terminated as of March 14, 2016. On March 15, 2015 B had his first appeal of the decision. His appeal was denied on April 15, 2015, On April 20, 2016 B's employer's Second Level Appeal Board ("Appeal Board") upheld the decision of the first level adjudicator and B was again denied any further LTD benefits.

B sought a reversal of the Appeal Board decision on the basis that the Appeal Board improperly considered B's Worker's Compensation Board ("WCB") file. B takes the position that the WCB file could not be used without the consent of the WCB. Further, B contends that the Appeal Board made a jurisdictional error by not determining the admissibility of the WCB file and that it erred in law and breached the principles of natural justice and procedural fairness by considering the WCB file in its decision.

Essentially (the Court noted), this appeal turns on the interpretation of section 148 of the Workers Compensation Act, RSA 2000.

That section states:

The books, records, documents and files of the Board and all reports statements and other documents filed with the Board or provided to it are privileged and not admissible in evidence in any action or proceeding without the consent of the Board.

The Court held:

In this matter, on July 16, 2014 B signed an Authorization that included the following clauses which authorized:

Great West Life, any healthcare or rehabilitation provider, plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great West Life to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the LTD plan and performing independent assessments.

"B had a duty to cooperate with Great West Life. That duty included an obligation to provide his medical records to the insurer. He signed the appropriate consents and the medical evidence was examined. There is no evidence from the Worker's Compensation Board that it believes the file was improperly used by Great West Life or any of the adjudicators. Absent any evidence, I cannot find that the Worker's Compensation Board did not consent to the use of the file. The Appeal Board is required to consider the applicant's medical information. Section 15 (4) states that the Appeal Board will take into account medical information. The Worker's Compensation Board file that was incorporated into the Great West Life file was medical information. Therefore, the information contained in the file was properly before the adjudicators.

As a result of my finding that the file was properly before the adjudicators, it does not matter whether the standard for review is reasonableness or correctness. Under either standard, the decision of the Appeal Board would be upheld".

D) COLLECTIVE AGREEMENT

Morriseau v. Sun Life Assurance Company of Canada (2017, Ontario Court of Appeal) 280 A.C.W.S. (3d) 605

Insured was a unionized employee of a School Board - Under the terms of the collective agreement, insured was eligible for LTD benefits provided by Sun Life - Sun Life denied insured's claim for LTD benefits - Insured brought action against Sun Life - Sun Life successfully brought motion to dismiss action for lack of jurisdiction - Insured appealed - Appeal dismissed - Entitlement to LTD benefits was product of collective bargaining and any dispute was therefore

arbitral under the collective agreement - The motion judge did not err in concluding that the subject matter fell within Brown and Beatty category 2 as the language of the collective agreement supported the finding that the School Board was required to pay benefits under the collective agreement - School Board's obligation under collective agreement went beyond mere payment of premiums - Real dispute was between insured and school board, against whom insured may seek appropriate remedy through arbitration - There was no contract between the insured and Sun Life and there was no legal basis upon which to order that LTD benefits be paid by Sun Life as it was simply an agent of the School Board.

Note: *The Morriseau decision is entirely consistent with and reinforces existing case law on this subject as outlined in chapter 12 of Disability Law in Canada (Second Edition).*

E) LIMITATION OF ACTIONS

(i) *Pepper v. Standard Life Assurance Company*[2018] I.L.R. I-5996, O.C.A. on appeal from [2017] I.L.R. I-5957 O.S.C.J.

The insured ("P") was advised by letter from Standard Life dated August 15, 2007 that LTD benefits would be terminated September 19, 2007 at the change of definition date.

P appealed such termination by letter of October 31, 2007, enclosing new medical information. Standard Life denied the appeal in a November 19, 2007 letter, but advised P that he could appeal.

P sent further medical documents to Standard Life on December 11, 2007 and retained counsel January 4, 2008.

Standard Life wrote P February 25, 2008 advising it had not changed its position but that if P sent the clinical notes and records of P's treating physicians this would be considered a further appeal.

P did not follow up with Standard Life but deposed that he felt Standard Life was still adjudicating his file, no final decision had been made, and that he left matters with his lawyer.

On February 17, 2010, P commenced action versus Standard Life.

The trial judge wrote:

"I will analyze the case at bar on the basis that P's action is subject to a conventional single limitation period of two years' duration from the discovery of the claim.

Under a conventional single limitation period analysis, Standard Life submits that the limitation period for P's claim began to run on November 1, 2007, when Standard Life stopped making any LTD payments, and, thus, the February 17, 2010 Statement of Claim is untimely because P's claim is statute-barred.

In resisting Standard Life's summary judgment motion, P submits that the limitation period began to run around the end of March 2008 because, before that time, Standard Life never made a clear and unequivocal denial of his LTD claim. Rather, he submits that in the circumstances of this case, he reasonably believed that there had not been a denial of his LTD claim that would have made litigation an appropriate recourse.

I believe that based on what Standard Life did and said, that P subjectively did not discover his claim against Standard Life until after he left the matter in counsel's hands to prosecute a claim. Objectively, however, based on what Standard Life did and said, P ought to have discovered his claim as of around the end of February, 2008. In my opinion, based on the evidentiary record, P ought to have known that his claim under the insurance policy would become statute-barred on or about March 1, 2009. Therefore, the February 17, 2010 Statement of Claim was timely and the claim is not statute-barred".

The Ontario Court of Appeal reversed the motion judge's decision holding…

As the motion judge noted, this policy of insurance provides no formal appeal process for when a claim is denied, and there is no alternate statutory appeal process.

There is no obligation on an insurer to advise its insured about statutes of limitation and, in this case, the dealings between the appellant and the respondent in attempting to resolve the claim do not give rise to an estoppel argument.

The motion judge in his reasons noted that it would have been "prudent" for the solicitor retained by the respondent to treat November 1, 2007 as the commencement date for the running of the limitation and (the trial judge) ought to have stopped his analysis right there. It was not just a matter of prudence but of legal correctness. The failure on the part of legal counsel and the motion judge to recognize November 1, 2007 as the date on which the limitation period commenced is an error in law.

On that date, the respondent had, in the language of the Federation Insurance Co. of Canada v. Markel Insurance Co. of Canada, 2012 ONCA 218 (Ont. C.A.) - a "fully ripened claim". That was the "appropriate" time to commence litigation. As Sharpe J.A. noted in Markel:

"…the word "appropriate" must mean legally appropriate. To give "appropriate" an evaluative gloss, allowing a party to delay the commencement of proceedings for some tactical or other reason beyond two years from the date the claim is fully ripened…would, in my opinion, inject an unacceptable element of uncertainty into the law of limitation of actions".

***Note:** Leave application to the Supreme Court of Canada was dismissed.*

***(ii)** Pentilla v. Western Life Assurance Company* (2017) 73 C.C.L.I. (5th) 210 O.S.C.J.

Western Life ("Western") wrote the insured ("P) February 19, 2013 that in light of the change of definition, LTD benefits would end March 7, 2013 but stated the insured could appeal, though

"in offering to review additional evidence, we are not waiving our right to rely on any statutory or policy provision including any time limitations".

New medicals were sent to Western on March 14, 2013, but Western wrote March 27, 2013 stating the prior decision to decline the claim remained. This March 27, 2013 letter did not refer to any additional or fresh right of appeal.

Further letters regarding additional medical evidence and a decision on the claim were exchanged between P and Western throughout 2013, until June 2015.

In analyzing whether the *Limitations Act* barred the lawsuit, the motions judge wrote:

"Taking into account the observation found in Federation Insurance Co. of Canada v. Markel Insurance Co. of Canada, that to proceed to court when additional material brought forward by the claimant could impact the insurer's evaluation of the claim would be to rush to litigation, 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 or damage and no basis to resort to the court. You cannot "discover" a loss until there is one.

As late as it's letter of November 13, 2013, Western Life Assurance Company was asking for more information which it continued to receive, at least until the letter from P dated December 11, 2013, which enclosed the note from the Nurse Practioner dated November 28, 2013. The process did not end until the letter of June 18, 2015, which represents the final decision of Western Life Assurance Company or the letter of October 21, 2014, which it may have intended to be the final decision but it does not matter which (letter was final). Only then was it accepted that the medical record was complete. Both dates are within two years of the date the Statement of Claim was issued.

It follows that either June 15, 2015, or October 21, 2014, was the date on which P would have understood that a proceeding was an appropriate means to seek a remedy and if she did not the reasonable person in her circumstance would have.

The Court of Appeal has cautioned that case law applying section 5(1)(a)(iv) of the Limitations Act, 2002 "depends on the specific factual or statutory setting of each individual case" and for that reason is of "limited assistance". Nonetheless I find confirmation for the finding that the Statement of Claim was in time in the case of Kassburg v. Sun Life Assurance Co. of Canada".

F) RELEASE - ENFORCEABILITY

Swampillai v. Royal & Sun Alliance Insurance Company of Canada, and Sun Life Assurance Company (2018) ONSC 4023

The Plaintiff ("S") worked for RSA from August 7, 2001 to December 2, 2007 under fixed term contracts without employee benefits. From December 3, 2007 until his employment was

terminated effective July 22, 2015, S was employed by RSA and received employee benefit coverage.

In 2013 S received short term STD benefits. Effective July 22, 2013, S received LTD benefits until July 2015. On March 31, 2015, S received a letter from Sun Life (the ASO administrator for LTD benefits) advising him that he did not meet the definition of disability for "any occupation" benefits, and that his LTD benefits would cease on July 22, 2015. On May 12, 2015 S appealed the decision and provided updated medicals to Sun Life. On June 2, 2015, S received a second denial letter from Sun Life maintaining its decision to close his claim effective July 22, 2015. The letter also stated that S could appeal such decision and that the appeal period ended on October 27, 2015, after which time Sun Life's decision would be considered final.

By letter dated June 24, 2015, RSA confirmed S's employment would cease effective July 22, 2015. RSA offered S a severance offer in exchange for S agreeing to sign a full and final Release. The letter stated that if S did not sign the Release, the offer would expire and S would receive only his "statutory minimum entitlements".

In a telephone conversation, S spoke to a representative of RSA about the calculation of his termination package. RSA decided to enhance S's severance package; he was given until July 29, 2015 to accept and return the signed Release. Once again, he was told that if he did not do so, the offer would expire and only his statutory minimum entitlements would be provided to him.

In a June 24, 2015 letter to S, RSA noted that "you will continue to receive your benefits until July 21, 2015".

S executed the Release on July 14, 2015. The Release included benefit coverage including STD and LTD. S commenced this action on June 13, 2017.

The Court held that the Release did not include S's claim for LTD benefits. S received no consideration for a potentially large LTD claim. S was still dealing with Sun Life regarding an appeal of his denial, and Sun Life knew nothing about S negotiating with RSA regarding a Release of LTD.

The Court wrote:

"The issue is this case is whether the Release should be set aside and rendered unenforceable as it relates to S's claim for LTD benefits on the ground that it is unconscionable.

This is not a situation where a claimant wishes to assert a claim that had never before been made, after a settlement. RSA and Sun Life knew that S was suffering from a disability which made him incapable of performing the duties of his own occupation with RSA. RSA and Sun Life knew that S was appealing the denial of his LTD benefits by Sun Life according to the "any occupation" definition of disability. Sun Life had been provided with medical information in support of S's appeal. Sun Life knew that S had been told that the denial would not become final until October 22, 2015. No one from RSA, or from Sun Life, discussed with S whether he

intended to continue his appeal of the denial of his LTD benefits. S's position was he would never have released a potentially large LTD claim as part of a release of employment benefits which totalled 43.2 weeks salary. RSA's position is that the appeal/denial of LTD was something that Sun Life would deal with. Sun Life's evidence is that it did not discuss settlement of S's LTD claim with him, and that it did not find out about the RSA Release until after this litigation had started.

In these circumstances, I conclude that the settlement of S's LTD claim on terms that provided for payment of nothing in exchange for a release of this claim as part of an overall settlement of claims in respect of the termination of his employment with RSA, in circumstances where RSA and Sun Life knew that S was appealing the denial of his LTD benefits, was grossly unfair. I also conclude that for S to release his claim for LTD benefits in these circumstances was clearly improvident".

ERIC'S COMMENTS:

In many ways this update contains what could be termed the fairness cases.

The Ontario Court of Appeal in ***MacIvor v. Manulife*** did not find it fair that a disabled insured who seemingly did not know the extent of his disability should be denied the LTD coverage he had in place had he only made a more informed/timely claim. And the same Ontario Court of Appeal did not find it fair for the insured in ***Pepper v. Standard Life*** to be allowed to miss a limitation period when a prudent solicitor would have issued a Statement of Claim.

Finally in ***Swampillai v. Royal and Sun Alliance and Sun Life***, the Ontario Superior Court of Justice found it unconscionable to find that an insured negotiated away a potentially large LTD claim by signing a modest severance Release with his employer while still believing that his LTD appeal with Sun Life was ongoing.

For any questions on these, or other LTD case law, feel free to e-mail Eric at eschjerning@blaney.com

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Eric Schjerning is a mediator of LTD disputes and the author of 2 editions of Disability Insurance Law in Canada. To look for available mediation dates or to book a mediation with Eric, visit: https://www.blaney.com/schjerning-mediation, or simply e-mail Eric at: eschjerning@blaney.com.