Blaney McMurtry LLP

PUBLICATION

Eric's LTD Update - Winter 2020

Date: January 21, 2020

This update contains a healthy number of new LTD related cases, thanks largely to counsel who sent me case law (their names appear at the end of this update).

Please keep sending me case law as this allows me to fulfill the purpose of this update: to present all decided cases and let you either pound the counsel table with cases supportive of your position, or think up ingenious ways of distinguishing cases which are unfavourable to you.

A) ADVERSE COSTS INSURANCE

Stewart et al v. Wood et al. 2019 ONSC 3931 (O.S.C.J.)

Following settlement of a personal injury lawsuit the issue of costs and disbursements was referred for assessment to the Superior Court of Justice.

Regarding adverse costs insurance Justice Tausenfreund wrote:

The Defendants state that it is settled law that such an insurance premium is not a recoverable disbursement. I disagree. There are conflicting opinions on this issue. Milanetti, J., Reilly, J. and Firestone, J. respectively in Markovic v. Richards, 2015 ONSC 6983, Foster v. Durkin, 2016 ONSC 684 and Valentine v. Rodrigues-Elizalde, 2016 ONSC 6395 each held that the premium for adverse costs insurance is not to be reimbursed by the Defendants as a compensable disbursement. I then turn to Armstrong v. Lakeridge Resort Ltd., 2017 ONSC 6565. Salmers, J. in that decision held that the costs insurance premiums was a compensable disbursement. Salmers, J. noted at para 21:

"Without costs insurance, the fear of a very large adverse costs award would cause many Plaintiffs of modest means to be afraid to pursue meritorious claims. It is in the interests of justice that Plaintiffs be able to pursue meritorious claims without fear of a potentially devastating adverse costs award."

I find adverse costs insurance to be an "access to justice": issue. For that reason, I hold it to be a compensable disbursement to be included as a costs obligation payable to the Plaintiffs. This amount is $1,458.

For a more detailed examination of this entire issue, please refer to Eric's LTD Update Issue 5 - Summer 2019.

In Ontario, there are now 4 Superior Court of Justice decisions which did not allow adverse costs insurance as a disbursement: *Markovic v. Richards; Valentine v. Rodriguez-Elizalde; Foster v. Durkin;* and *Little v. Floyd*; versus 2 decisions which allowed such disbursement: *Armstrong v. Lakeridge Resort Ltd.* and *Stewart v. Wood.*

Clearly this issue cries out for an appellate decision.

B) COLLECTIVE AGREEMENT JURISDICTION

Hutton v. Manulife 2019 ONSC 279 (O.S.C.J.)

Manulife brought a summary judgment motion to dismiss the plaintiff's action on the basis that the court lacked jurisdiction to deal with a claim that arose out of and was governed by the terms and conditions of a collective agreement between her union OPSEU and employer, Quinte Health Care ("QHC"), a matter exclusively within the arbitral jurisdiction of the collective agreement.

The plaintiff was a full-time employee of QHC, employed as a Laboratory Technician III. She was a member of OPSEU, the exclusive bargaining agent that represented all employees of the bargaining unit. QHC and OPSEU were parties to the collective agreement governing the terms and conditions of employment of all QHC employees, including the plaintiff.

The plaintiff, as a result of having her LTD benefits terminated, initiated a grievance against QHC filed December 17, 2013 in the following terms: "I grieve that the employer has violated Article 15 of the collective agreement, by denying my claim for long-term disability benefits."

In the OPSEU grievance form under the heading "Settlement Desired" the plaintiff stated: "Full redress, including approval for LTD benefits as well as anything else an arbitrator deems appropriate."

On September 2, 2014 the Union requested on behalf of the plaintiff that Manulife reconsider the termination of LTD benefits. Even though the deadline for appeal had passed Manulife accepted the request to conduct a review. On November 10, 2014 Manulife advised the plaintiff that notwithstanding consideration of additional medical evidence she provided, the termination of the LTD benefits was upheld and its decision would be final.

The plaintiff commenced her action against Manulife on August 19, 2015. Before the arbitration was scheduled to commence on September 1, 2015 the plaintiff's grievance was settled as between QHC and OPSEU on behalf of the griever. Manulife was not involved in the Minutes of Settlement.

In the Minutes of Settlement at the outset it stated:

Minutes of Settlement between QHC and OPSEU 480 in the matter of the grievance by Leisa Hutton ("the griever") the parties, desirous of fully and finally resolving issues arising out of the grievance and the griever's application for LTD benefits, as against QHC agree as follows, without prejudice or precedent to any other matter between QHC and OPSEU:

The grievance is irrevocably withdrawn. The griever and OPSEU waive and release all rights to file a grievance in future in respect of the griever's eligibility for LTD benefits, regardless of the outcome of any contemplated or outstanding proceedings against Manulife.

In paragraph 8 it states: "these Minutes of Settlement are not intended in any way to preclude the griever from pursuing her claim against Manulife's Group Policy 48524..."

Justice O'Marra held: *The defendant takes the position that under the collective agreement the employer is obligated to provide LTD benefits. The plaintiff's rights to LTD benefits arise from the collective agreement. Any grievances may go to arbitration, and all agreements reached will be final and binding. The plaintiff settled her LTD claim by electing to go through arbitration with her employer, which according to the terms of the collective agreement is final and binding.*

The plaintiff's position is that the LTD claim is inarbitrable because QHC lacks legal and financial liability for benefit entitlement under a policy issued by Manulife, and the collective agreement lacks sufficient "degree in detail" to establish QHC's obligation to provide "certain…benefits". The remedy sought by the plaintiff in her LTD claim against Manulife is not within the arbitral jurisdiction to grant and accordingly the Superior Court retains inherent jurisdiction over the action.

The issue is whether the plaintiff's dispute about LTD benefits was within the exclusive arbitral jurisdiction under the collective agreement, or in the circumstances of this case, the inherent jurisdiction of the court.

In Weber v. Ontario Hydro, 1995 CanLII 108 (SCC), [1995] 2 S.C.R. 929 the Supreme Court of Canada on the issue as to whether the court has jurisdiction, or strictly an arbitrable matter, can be determined by asking, "whether the dispute, in its essential character, arises from the interpretation, application, administration, or violation of the collective agreement." If so, the dispute is within the sole jurisdiction of the arbitrator to decide. (See also Regina Police Association Inc. v. Regina (City) Board of Police Commissioners (2000) SCC 14 (CanLII), 183 D.L.R. (4th) 14 at para. 25).

In Barber v. Manufactures Life Insurance Company, 2017 ONCA 164 (CanLII) it was noted at para. 9 that arbitration jurisprudence has developed a well understood method of deciding the arbitrality of benefit entitlement claims by considering the four categories referenced in Brown and Beatty, Canadian Labour Arbitration, 3rd edition (1988), as adopted in London Life Insurance Co. v. Dubreuil Brothers Employees Assn. (2000), 2000 CanLII 5757 (ONCA), 49 O.R. (3d) 766, at para. 10:

1. *where the collective agreement does not set out the benefit sought to be enforced, the claim is inarbitrable;*

2. where the collective agreement stipulates that the employer is obliged to provide certain medical or sick-pay benefits, but does not incorporate the plan into the agreement or make specific reference to it, the claim is arbitrable;

3. *where the collective agreement only obliges the employer to pay the premium associated with an insurance plan, the claim is inarbitrable and*

4. *where the insurance policy is incorporated into the collective agreement, the claim is aribitrable.*

The defendant submits that the matter is arbitrable falling squarely within category 2, in that the essential character of the dispute relates to the defendant's termination/discontinuation of the plaintiff's claim for LTD benefits as provided in the collective agreement. The ambit of the collective agreement encompasses the plaintiff's entitlement to be paid LTD benefits directly from Quinte Health Care. The collective agreement specifically provides for the payment of LTD benefits in certain circumstances.

The plaintiff submits that the dispute falls within category 3, because the collective agreement really only requires the employer to pay the insurance plan premiums, Article 15.02. Counsel contends category 2 is inapplicable because: i) the employer, QHC is neither the payor nor administrator of the long-term disability benefits at issue in the plaintiff's claim, it is the defendant, and ii) there is uncertainty as to the criteria applied by the insurer to determine eligibility of such benefits due to the different language used in the plan referred to in the collective agreement, HOODIP, and the policy.

Whether these differences (on the definition of disability) have any bearing on the plaintiff's entitlement to LTD benefits are matters which involve the interpretation, application, or

administration of the collective agreement and can be properly dealt with by an arbitrator. They do not negate the employer's obligation to provide certain benefits, or the employee's rights to those benefits under the collective agreement. The arbitrator can examine the plan and collective agreement and determine whether the plaintiff was entitled to the benefits claimed. Indeed, as a matter involving the interpretation of criteria and alleged violation of the collective agreement, the decision as to whether the matter was arbitrable should have been left at first instance to the arbitrator, as set out in the Labour Relations Act, s. 48 (1) and as permitted under the collective agreement.

It was noted in Morris v. Manulife at para. 17 that the Brown and Beatty categories are not water tight compartments. However, it is clear that in reviewing the terms of the collective agreement, the employer is obligated to do more than only pay premiums associated with an insurance policy. As such, it does not fall within category 3.

Here, Article 15 of the collective agreement requires the employer to provide LTD benefits. The collective agreement establishes the plaintiff's rights to LTD benefits. The specific terms of the plan are not set out in the agreement itself, but referenced as the HOODIP or equivalent.

In this instance, I am satisfied that the plaintiff's entitlement to LTD benefits provided by Article 15 of the collective agreement properly falls within category 2 of the Brown and Beatty categories, and, as such any dispute as to those entitlements under the collective agreement was properly within the jurisdiction of an arbitrator to determine. It was an arbitrable matter, which if submitted to an arbitrator to determine could have resulted in a legally binding remedy.

The defendant's motion to dismiss the plaintiff's action is granted.

C) LIMITATION PERIOD

Clarke v. Sun Life Assurance Company of Canada, 2019 ONSC 2942

Appeal heard: Clarke v. Sun Life Assurance Company of Canada, 2020 ONCA 11

The Plaintiff's claim for disability benefits in relation to any occupation benefits under the insurance policy with defendant was refused by letter. The Plaintiff contacted Sun Life and said she would appeal the decision but did not send medical information for appeal until three years later. When submitted, Sun Life rejected appeal for lack of information. The plaintiff started her action for denial of benefits one year after Sun Life rejected her appeal. Sun Life brought motion for summary judgment. Motion dismissed. The limitation period under s. 5 (1) of *The Limitations Act*, 2002 (Ont.) commenced with Sun Life's final rejection of plaintiff's appeal and plaintiff's action was not statute-barred. Sun Life had not established that the plaintiff knew or ought to have known that it was legally appropriate to issue a claim on or before the two-year period beginning with refusal letter.

The refusal letter was ambiguous as it invited plaintiff to send more information. Sun Life did not mention a limitation period and also declared that 'file was closed', but Sun Life later reviewed the plaintiff's appeal.

NOTE: In a just released decision, the Ontario Court of Appeal allowed Sun Life's appeal in part and ordered a new trial, holding that:

The motion judge erred in law by failing to apply the principle stated by this court in Pepper v. Sanimina-Sci Systems (Canada) Inc., 2017 ONCA 730, [2018] I.L.R. that an insured has a cause of action for breach of contract against her insurer when the insurer stops paying LTD benefits. In its February 24, 2014 letter, Sun Life informed Ms. Clarke that her disability benefits terminated as of April 25, 2013, which was the date the "Own Occupation" benefits period ended. Sun life went on to state that it would not pay "Any Occupation" benefits. Accordingly, by February 24, 2014, a "loss, injury or damage" had occurred that would have been known to a reasonable person with the abilities and in the circumstances of Ms. Clarke: Limitations Act, 2002, ss. 5(1)(a)(i) and (b).

I note that in reaching her conclusion on s. 5(1)(a)(i), the motion judge relied on the decision of the Divisional Court in Western Life Assurance Company v. Penttila, 2019 ONSC 14, 144 O.R. (3d) 198. The motion judge appears to have misapplied Western Life Assurance on the issue of when an insured knows that a loss, injury or damage has occurred. As that decision clearly stated, at para. 17, the parties agreed that for the purposes of s. 5(1)(a)(i) the insured knew that a loss had occurred on the date her benefits came to an end, which is the governing principle as stated in Pepper.

The motion judge next considered the issue of when a proceeding would be an appropriate means to remedy the loss, injury or damage: Limitations Act, 2002, ss. 5(1)(a)(iv) and (b). For the reasons that follow, I conclude that the motion judge failed to conduct the analysis required by the Act on this point.

The discoverability analysis required by ss. 5(1) and (2) of the Act contains cumulative and comparative elements.

Section 5(1)(a) identifies the four elements a court must examine cumulatively to determine when a claim was "discovered". When considering the four s. 5(1)(a) elements, a court must make two findings of fact:

i) The court must determine the "day on which the person with the claim first knew" all four of the elements. In making this first finding of fact, the court must have regard to the presumed date of knowledge established by s. 5(2): "A person with a claim shall be presumed to have known of the matters referred to in clause (1) (a) on the day the act or omission on which the claim is based took place, unless the contrary is proved", and

ii) The court must also determine "the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known" of the four elements identified in s. 5(1)(a).

Armed with those two findings of fact, s. 5(1) then requires the court to compare the two dates and states that a claim is discovered on the earlier of the two dates.

Accordingly, as part of her cumulative and comparative discoverability analysis, the motion judge was required to determine (i) the day on which Ms. Clarke "first knew… that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it" (s. 5(1)(a)(iv)) and (ii) the day on which a reasonable person with the abilities and in the circumstances of Ms. Clarke first ought to have known of that matter (s. 5(1)(b)).

The motion judge's reasons disclose that she failed to make any specific finding about either date.

Although the motion judge noted, that Ms. Clarke's three-year delay in providing additional medical information was "unexplained" and her evidence was "silent as to her knowledge, intentions or assumptions about the matter", the motion judge was not prepared to draw any inferences from this absence of evidence. Read as a whole, her reasons disclose that she was not able to determine when Ms. Clarke first knew that a proceeding would be an appropriate means to seek to remedy her injury.

Given the motion judge's failure to make the requisite findings of fact in respect of ss. 5(1)(a)(iv), (b), and (2), her conclusion that Sun Life had not established the elements of a limitation defence under ss. 4 and 5 of the Act lacked an adequate legal and factual foundation. For that reason, her order must be set aside.

I do not consider this to be an appropriate case to exercise this court's fact-finding powers under Courts of Justice Act, R.S.O. 1990, c. C.43, s. 134(4). No examinations for discovery or cross-examinations have been conducted in this proceeding. A fuller record is required to assess, for the purposes of the s. 5(1)(a)(iv) analysis, the significance of the informal appeal process offered by Sun Life and engaged by Ms. Clarke, including whether that process constituted an alternative process with a reasonably certain or ascertainable date on which it runs its course or is exhausted.

I would grant the appeal, set aside the order of the motion judge, and direct that the action proceed to trial.

D) MEDICAL ASSESSMENTS

Baker v. Blue Cross Life Insurance Company of Canada Unreported (2019) O.S.C.J. Master Jolley (For a copy of this decision please e-mail Eric)

Blue Cross brought a motion seeking an order that the plaintiff attend a medical assessment with Dr. Mark Dowhaniuk, Neuropsychologist. It argues that it has not had an assessment of the plaintiff's condition in the context of this long term disability litigation, as its assessment to date, which was done by Dr. Kane, was done prior to the litigation and as part of its contract with the plaintiff. In addition, the plaintiff has claimed aggravated and punitive damages in this action, which expands the issues beyond those in the long term disability application for which she was assessed by Dr. Kane and also requires the defendant to review the plaintiff's entitlement on a continuing basis to ensure it is adjudicated in good faith.

The plaintiff has agreed to undergo a further assessment, but argues that the assessment should be carried out by Dr. Kane, who conducted a lengthy in-person assessment of the plaintiff on 7 March 2016 and who has also authored a further neuropsychological opinion report dated 2 May 2018. In that latter report, which was in the context of this litigation, Dr. Kane reviewed the neuropsychological evaluation report of Dr. Voorneveld submitted by the plaintiff, along with the raw test data of Dr. Voorneveld's examination, the plaintiff having consented to the release of that data to Dr. Kane. Dr. Kane was also asked to comment in her later report on three surveillance reports of the plaintiff and on a further neurology report by Dr. Gladstone.

It is clear that the right of an issuer to an examination under a contract of insurance is a right entirely separate from its right as a litigant to request a medical examination under section 105 of the *Courts of Justice Act*, R.S.O. 1990, c.C.43. However, it is equally settled law that the court may take into account the fact of the prior medical examination in exercising its discretion. I was pointed to a number of cases where the court exercised its discretion to order an examination under section 105, even where the defendant insurer had already obtained an assessment either under the terms of its contract with the plaintiff or under another statute, such as the *Insurance Act*. However, in each instance where a further assessment was ordered, the court ordered that it be carried out by the doctor who conducted the first assessment. (See, for instance, *LaForme v. Paul Revere Life Insurance Co.* 2006 Can LII 81803 (ON SCDC); *Kanani v. Economical Insurance* 2018 ONSC 3746 at paragraph 24; and *Gracey v. Skinner Estate* 2000 CarswellOnt 3405 at paragraphs 19 and 20). I was directed to no cases where the court permitted a further assessment with a second or new doctor when there had been a prior assessment by a doctor who remained available to carry out the second assessment and possessed the necessary qualifications.

The defendant argues that it requires an expert with fresh eyes such as Dr. Dowhaniuk to assess the plaintiff, which it says may be beneficial for both parties as it could result in a change of position by the defendant depending on the results of the assessment. While that is not an impossible outcome, it is not sufficient, in my view, to add a further expert to the defendant's roster. As the court noted in *Kanani*, supra, at paragraph 23, "to have another psychiatrist prepare another separate medical report would not be in compliance with the spirit of the legislation. The purpose is to provide defendants with an independent medical report, not necessarily another report by another psychiatrist of their own choosing".

On consent of the plaintiff, she shall attend a further medical assessment with Dr. Kane on a date to be mutually agreed.

E) MISREPRESENTATION

Batanova v. London Life Insurance Company, 2019 BCSC 1147

A life insurance case, but since the *Insurance Act* statutory misrepresentation provisions are identical for disability and life insurance, a case which is relevant for individual disability insurance applications.

In 2012, the life insured obtained a life insurance policy. The insured died of a heart attack in 2014, and the plaintiff beneficiary advanced a claim under the policy for the death benefit of $429,843.

Held: Action dismissed. At the time of application, the insured was suffering from severe chronic back pain and severe arthritis causing back pain, and had been diagnosed with spina bifida occulta. The insured knew he had these conditions. The insured was also using large quantities of medical marijuana on a daily basis for his conditions. The insured did not disclose his medical conditions, his symptoms and treatment he was receiving (medical marijuana) on the insurance application. Evidence of London Life's internal and expert underwriting witnesses, which expert opinion was unchallenged, established that they would have responded to facts as to insured's health and marijuana use in considering underwriting of policy and would have, at minimum, rated his policy. London Life proved materiality in respect of facts not disclosed by insured and misrepresentations made by him. The court rejected the plaintiff's arguments that (i) marijuana is not a "drug" as asked for on the Application, (ii) that the deceased did not actually smoke the 40 grams per day of medical marijuana prescribed by his G.P. but rather that as he worked in the marijuana industry he needed to be able to possess and grow as much marijuana as possible and he did not actually use 40 grams per day, (iii) that the deceased did not know to answer the question regarding having a health problem by disclosing his severe arthritis in his lumbar spine.

F) SPECIAL COSTS AWARD

Tanious v. The Empire Life Insurance Company 2019 BCCA 329 (B.C. Court of Appeal)

The appellant, Empire Life appealed from a trial decision that it pay the respondent's special costs in the absence of any finding of bad faith or reprehensible conduct, arguing that the trial judge erred in departing from established legal principles, in holding that a disability insurance contract confers a contractual right to full indemnity costs, in awarding special costs in addition to aggravated damages for emotional harm, and in admitting an affidavit sworn by trial counsel. Plaintiff's trial counsel submitted that her hourly costs involving the 8 day trial would total $112,000 but that under her Contingency Fee Agreement, the total fee on unpaid past benefits and $15,000 for aggravated damages would amount to only $23,000 and that nothing was charged for legal fees regarding the award of ongoing periodic future LTD benefits. The trial judge held that plaintiff's counsel had provided high quality legal work, Empire Life's denial had been 'cursory', and the awarding of special costs was in the interests of justice.

Held: Appeal dismissed. The trial judge did not err in exercising his discretion to award special costs in the exceptional circumstances of the case. He did not base his decision on a contractual right to full indemnify costs or compensate the respondent twice for emotional harm. Rather, he held that special costs were warranted in the interests of justice. He also applied the correct legal test in determining whether the affidavit evidence was relevant and he was entitled to accept and rely on its content in support of the application for special costs.

G) TOTAL DISABILITY

PUNITIVE AND AGGRAVATED DAMAGES

LUMP SUM AWARD OF FUTURE LTD BENEFITS NOT ALLOWED

Gascoigne v. Desjardins Financial Security Life Assurance Company (Desjardins Insurance), 2019 BCSC 1241

The plaintiff worked as an adjuster at I.C.B.C. and went off work due to tennis elbow and tingling, numbness and weakness in her left hand.

Ulnar nerve decompression surgery on her left arm was performed September 2017. While such surgery helped reduce the numbness and tingling, she developed pain and a tremor in her hand and experienced minimal grip strength leading to ulnar nerve transposition surgery in December 2018. The plaintiff continued to experience numbness and tingling in her fingers and also developed depression and anxiety.

Desjardins was in contact with the plaintiff's employer who advised that modified work could be offered with limited keyboarding. There followed a series of exchanges between the plaintiff, the plaintiff's G.P. and Desjardins regarding the plaintiff's work restrictions and whether an ergonomic assessment of the work station was required before the plaintiff could return to work.

The Desjardins medical consultant opined that there were no medical contraindications to typing with the plaintiff's elbow condition although there may be stiffness, and a slight reduction in typing speed.

At trial, the plaintiff's G.P., psychiatrist and orthopaedic surgeon testified, as did the medical consultant for Desjardins.

Held: The plaintiff established a prima facie case that she was disabled under both the own and any occupation definitions of disability. A lump sum award of future benefits was not available as the evidence did not establish the plaintiff was permanently disabled from pursuing gainful employment. While the insurer's decision was clearly wrong and based on a fundamental misapprehension that it did not adequately investigate (what assistive devices could help the plaintiff return to work) its conduct was not as egregious as in other cases resulting in punitive damages being awarded and no such damages were warranted.

The plaintiff suffered mental distress, financial stress and marital issues, and was entitled to $30,000 in mental distress damages.

ERIC'S COMMENTS:

- The 24 page judgement of Justice Skolrood is excellent reading with voluminous case law cited.
- As Eric had already learned from bitter experience, the testimony of insurance company medical consultants who have not examined the insured is of limited use at trial.
- Aggravated damages awards are coming in in the $25,000 - $30,000 range even where, as here, the denial of LTD led to marital separation and in the judge's words "likely divorce".
- The decision contains an excellent discussion of the inability of a court to award a lump sum award of future benefits, so much so that it is repeated below:

“What is the Appropriate Remedy for the Defendant’s Breach of Contract?”

The plaintiff submits that the defendant’s denial of her LTD claim and breach of its duty of good faith constitute a fundamental breach of the contract of insurance and that the appropriate remedy is therefore to award a lump sum representing the present value of all future LTD benefits she would have been entitled to but for the breach subject to adjustment for contingencies.

This approach has been rejected in the jurisprudence. In *Warrington v. Great West Life Assurance Co.* (1996), 24 B.C.L.R. (3d) 1 (B.C.C.A.), the Court of Appeal upheld the trial judge’s refusal to award lump sum future benefits. Madam Justice Newbury said at para 26:

Nor can the trial judge be said to have erred in declining to declare the contracts of insurance between Mr. Warrington’s employer and Great West Life, as being at an end. For one thing, a. 202 of the Insurance Act only permits a third party beneficiary to enforce rights thereunder as if he were a contracting party – it does not give him the right to terminate the contract or to accept an insurer’s repudiation thereof. For another, there is wisdom in the trial judge’s reasoning that at some point in the future, Mr. Warrington may recover partly or completely from his present malady and find himself able to work again. I would therefore reject this ground of appeal.

Similarly, in *Cram v. Great West Life Assurance Co*., [1995] B.C.J. No. 778 (B.C.S.C.), Mr. Justice Williamson said at paras. 22-24:

The plaintiff’s argument that breach of the contract entitled him to a lump sum award for the present value of future benefits is based upon what counsel called “broad fundamental principles of contract law”. He says once the contract was breached, it was gone and the defendant could no longer rely upon its provisions. He says the remedy for a plaintiff who has succeeded in proving a breach of contract is the damages due to him at the date of the breach. He says that to put him in the position in which he would have been had the contract not have been breached, he must be paid a lump sum now. Counsel conceded, as I understood him, that to do so in these circumstances might well be to make new law.

Whether that be so or not, I am not persuaded. To pay a lump sum award for the present value of future benefits would be to put the plaintiff in a better position than he would have been in had the contract continued. The deal was that he would be paid these benefits, amounting to approximately $2,300 per month, until such time as he reached the age of 65 or died. Were he to be awarded a lump sum he would receive the fullest possible amount regardless of whether he lived to age 65. Plaintiff’s counsel counters that the Court can discount the award to take into account contingencies. Such a speculative course is unnecessary.

I am satisfied the appropriate remedy would be to order that all arrears be paid and that he continue to receive benefits pursuant to the contract.

The plaintiff submits that it is unfair to preclude an insured from claiming fundamental breach of a contract of disability insurance, particularly where the insurer has acted in bad faith. The

plaintiff testified about her concern for being put back on claim with the defendant given how she has been treated to date.

While the plaintiff may have well-founded reasons not to trust the defendant, I consider the law to be well settled that a lump sum award of future LTD benefits is not available.

Further, even if it was open to me to make such an award, I would decline to do so in the circumstances of this case. The evidence does not establish that the plaintiff is permanently disabled from pursuing gainful employment. Further, the Policy requires a claimant to submit proof of continuing disability from time to time as requested by the defendant. I agree with the observations of Justice Williamson at para. 22 of *Cram* that to award the plaintiff the lump sum value of future benefits would put her in a better position than she would have been in had the breach not occurred.

The appropriate remedy is therefore an order declaring that the plaintiff is disabled within the meaning of the Policy and a further order that she is entitled to past LTD benefits from February 1, 2017 to the date of trial and ongoing benefits in accordance with the Policy".

H) Punitive and aggravated damages

Collective Agreement Jurisdiction

Greig v. Desjardins Financial Security Life Assurance Company, 2019 BCSC 1758

A case with 2 distinct issues: (i) whether the Court had jurisdiction over an LTD benefits trust plan existing as a result of a collective agreement and (ii) whether punitive and aggravated damages could be awarded.

Regarding the first issue, the applicable LTD benefits trust plan provided LTD benefits to eligible members pursuant to the Plan Text and existed as a result of a collective agreement between B.C. school districts and CUPE.

The lawsuit also sought a declaration of eligibility for LTD benefits. However, the parties agreed that the Court had no jurisdiction because the plaintiff was subject to the terms of the collective agreement and the Plan Text.

Desjardins argued that the Plan Text provides for a specialized LTD eligibility dispute revaluation by a Medial Appeal Panel and that any dispute was to be resolved through the grievance arbitration procedure.

The Court in *Greig* analyzed the *Weber* decision and heard extensive evidence to conclude that there was no recourse under the collective agreement for claims for punitive and aggravated damages and if the Court did not exercise its inherent jurisdiction the plaintiff would have no recourse to such damages. (Please note that Justice Young's analysis of *Weber* and the evidence leading her to conclude she needed to exercise her inherent jurisdiction runs some 14 pages and it is not possible to do more in this update than touch the surface).

Also of note are the comments by Justice Young regarding the argument advanced by Desjardins that the plaintiff produced no objective evidence of treatment. Justice Young held that objective evidence was not required under the Policy, that complaints of depression are always subjective, and that the plaintiff had made his best efforts to follow all medical treatment recommendations.

Regarding punitive and aggravated damages the Court awarded $50,000 in aggravated damages (partly because the plaintiff and his wife were forced to live for 6 weeks in a minivan) and $200,000 in punitive damages (for failure to fully investigate obvious mental aspects of the plaintiff's disability; improperly requiring objective evidence of physical injury, relying on an unsupported allegation of lack of motivation of the plaintiff in rehabilitation; and the failure to properly adjudicate medical evidence of disability which was received by Desjardins pursuant to the lawsuit. (Note: This case is under appeal).

Eric felt it may be useful to list here the case law on aggravated damages set out by Justice Young at pages 48 and 49 of her decision in *Greig*:

C.P. v. RBC Life	$10,000
Fidler v. Sun Life	$20,000
Asseltine v. Manulife	$35,000
Eddie v. UNUM Life	$15,000
McIssac v. Sun Life	$8,500
Evans v. Crown Life	$20,000
Godwin v. Desjardins	$30,000
Clarfield v. Crown Life	$75,000

And on punitive damages (pages 52 to 55):

Asseltine v. Manulife	$150,000
Fernandes v. PennCorp	$200,000
Manning v. UNUM Life	$0
McIssac v. Sun Life	$0
Warrington v. Great West Life	$0
Godwin v. Desjardins	$30,000

Acknowledgements and Mediation Statistics

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ERIC'S MEDIATION STATS:

Total LTD Mediations settled since 2013 - 424

Settlement rate for all LTD Mediations 2018-2019 - 212 settled out of 226 - 93.8%

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

For any questions on these, or other LTD case law, or if you have a case you wish to share, please e-mail eschjerning@blaney.com.

The information contained in this article is intended to provide information and comment, in a general fashion, about recent cases and related practice points of interest. The information and views expressed are not intended to provide legal advice. For specific legal advice, please contact us.