The Duty of Utmost Good Faith

Introduction

This paper will address the contractual duty of good faith as it relates to the Ontario insurance scheme, and specifically the Ontario *Statutory Accident Benefits Schedule*. In the context of insurance litigation, the courts described this as a duty of *utmost* good faith. The case which, for our purposes, began this journey, is *Smith v. Cooperators* at the Supreme Court in 2002.

In the decades that followed, courts have repeatedly grappled with the implications of the duty of utmost good faith, applying it to new and more varied situations. In the first party context, the principle is that of a mutual duty to behave honestly, and with fairness, that exists between an insurer and an insured.

This principle underscores the *Insurance Act*, and the *SABS*, and is driven largely by a purpose of protecting consumers, insureds, and/or claimants. This paper will address the case law from *Smith v. Cooperators* to the more recent case of *Tomec v. Economical*. It will also address questions such as how the duty of utmost good faith cuts both ways, how it applies in some practical scenarios, and whether the duty changes based on legal representation (or lack thereof) for the insured.

Smith v. Cooperators

All who practice accident benefits litigation are aware of this case. By way of brief factual background, it involved a motor vehicle accident in 1994. The insurer terminated benefits in May 1996 and advised the insured of her right to seek mediation (as was the old process at FSCO) should she disagree with the denial. When mediation failed in 1997,

the insured commenced an action for ongoing benefits in September 1998. The insurer moved for summary judgment on the grounds that the claim was barred; it had been more than two years since the denial was made.

This case addresses an important aspect of the duty of good faith, the requirement of insurers to communicate effectively with insureds. It held that because clear and effective communication is so important, the limitation period will not begin to count until/unless there has been a **proper refusal** to pay benefits.

The Supreme Court confirms that “one of the main objectives of insurance law is consumer protection”. Communication between insurers and their insureds takes place along a spectrum of reasonableness. The Supreme Court articulates a reasonable middle ground which communicates enough information, without overwhelming the laypeople who are likely to be reading these letters (the insureds).

The consumer protection nature of insurance law obliges courts to impose **bright line** boundaries between the permissible and the impermissible with respect to communications and timelines. This decision flowed into the further case law on the duty of utmost good faith, which is explored below.

Tomec v. Economical

In this case, the insured sustained injuries in a car accident in 2008 and applied for benefits for attendant care and housekeeping. The insurer denied those benefits in 2010 on the basis that she did not sustain a catastrophic impairment (the parties agreed on this point at that time). Although the insured’s condition deteriorated and she was eventually declared CAT in 2015, the insurer denied further payment. When the insured

attempted to dispute this denial, the insurer took the position that she was barred by the limitation period. It had been more than two years since the initial denial in 2010.

> "The Court of Appeal looked back to the language from *Smith v. Cooperators* and held that "the SABS is remedial and constitutes consumer protection legislation. As such, it is to be read in its entire context and in its ordinary sense harmoniously with the scheme of the [Insurance] Act, the object of the Act, and the intention of the legislation. The goal of the legislation is to reduce the economic dislocation and hardship of motor vehicle accident victims and as such, assumes an importance which is both pressing and substantial."

With respect to the issue of the insurer's refusal to pay a benefit, the Court of Appeal also relied on *Smith v. Cooperators* in holding:

> "The refusal to pay a benefit is clearly tied to the appellant's cause of action. Absent a refusal to pay the benefit sought, there cannot be a claim made for mediation or an evaluation. Thus, the refusal to pay a benefit and the ability to make a claim are inextricably intertwined in the cause of action. The refusal cannot be stripped out of the cause of action and treated as if it is independent from it.
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> The decisions below and Economical's narrow interpretation of the limitation are incongruous with the SABS' consumer protection purposes. The appellant falls within a small category of victims who suffer from lasting and very serious health impacts as result of a motor vehicle accident. The SABS is supposed to maximize benefits for that class of victims. A hard limitation period prevents the appellant from making a claim for the benefits the SABS are intended to provide.
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> I do not see how such a result could be consistent with consumer protection legislation designed to provide fair compensation and minimize economic disruption in the lives of accident victims. Given the choice of a statutory interpretation that furthers the public policy objectives underlying the SABS and one that undermines it, the only reasonable decision is to side with the former."

The Court of Appeal ultimately held that there was no risk of evidence going stale in this case. To the contrary, a hard limitation period would bar potentially meritorious claims based on current evidence. It also held that a hard limitation period would not ensure the

insured's diligence in pursuing a claim, because the insured has no claim to pursue until a CAT designation is made.

When Legislation is Ambiguous, how is it resolved and who benefits?

Courts in Canada have adopted a "purposive approach" to statutory interpretation (see *Re Rizzo & Rizzo Shoes Ltd.*). This means that when legislation is ambiguous, it will be resolved by reference to the purpose of the Act. Given the above, it is clear that the *Insurance Act* and the *SABS* have consumer protection of insureds as a primary purpose.

The case of *Ayr Farmers Mutual Insurance Co v. Wright* (2016 ONCA) involved the *Insurance Act* and the *SABS* and is a good example of the courts applying this purposive approach. Mr. Wright claimed that he had been injured when he tried to close his garage door after backing out of his garage. The insurer in this case took the position that the injuries were not the result of an "accident" as defined within the *SABS.*

When Mr. Wright's benefits were denied, he applied for mediation under s. 279 of the *Insurance Act*. While this is no longer the process in Ontario, the decision is valuable in analyzing the way in which ambiguous legislation is interpreted. Rather than attend the mediation, the insurer elected to apply directly to the court for an answer to the legal question of whether an "accident" had occurred.

The court held that the mediation scheme created by the *Insurance Act* and *SABS* had the purpose of incentivizing claimants to refer their disputes to mediation and arbitration, rather than to litigation. In this case, the insurer had attempted to bypass the *SABS* and mediation and referred the case directly to the courts for a preliminary determination of the issues.

The court held that this ran entirely counter to the purpose of the legislation; the insurer's Appeal and Application were dismissed. Typically, we expect that where there is ambiguity in the legislation, the consumer protection purpose of the legislation means that it will be the insured who benefits.

The Shifting Burden of Proof when an Insurer asserts an exclusion from coverage

In the ordinary course, the burden of proof lies with the claimant to establish facts which support their claim. If the insurer wants to rely on an exclusion clause (such as material misrepresentation) or allege that fraud has occurred, the burden of proof shifts to them to establish those facts.

In the case of *Demetriou v. AIG Insurance* (2019 ONSC), the insurer argued that it was incumbent on the insured to establish that a theft had actually occurred in order for coverage to apply. Justice Gray held that in making that argument, the insurer was ostensibly arguing that the insured was lying about the theft having occurred (ie. fraud or material misrepresentation).

The insurer sought to rely on the holding from *Shakur v. Pilot Insurance Co.* (1990 ONCA) which held:

> "It is fundamental insurance law that the burden of proof rests on the insured to establish a right to recover under the terms of the policy. In this case, the burden rested on the respondent and remained on the respondent to prove on the balance of probabilities that a theft of her jewellery had occurred."

Justice Gray rejected this argument on the grounds that the insurer had repeatedly changed its position throughout the litigation with respect to whether or not they were alleging fraud. Justice Gray held that reliance on fraud was necessary to advance the

above argument. Since the insurer had expressly disclaimed reliance on fraud prior to the hearing, the argument was invalid.

There is some confusion on this issue now, as a reading of *Shakur* actually shows that the insurer was not clearly relying on fraud as a defence. All that's stated in *Shakur* on the issue is that the insurer "implied allegedly that the respondent was fraudulent in putting forward the claim."

Thus, while it is unclear whether a formal advancement of fraud is necessary to avoid the shifting burden of proof, we can conclude that insurers who formally **disclaim** a reliance on fraud will be precluded from relying on this argument. The burden of proof will shift to them, to prove that fraud took place.

How the Duty of Utmost Good Faith Cuts Both Ways

The reciprocal nature of the duty of utmost good faith is often traced back to the Supreme Court case of *Whiten v. Pilot Insurance Co.* (2002 SCC). This case also established the concept that a breach of this duty of utmost good faith is an independent actionable wrong, for which punitive damages can be awarded.

The case of *Ruffolo v. Sun Life Assurance Company of Canada*, involved a dispute over whether an insurer had acted in bad faith in deducting CPP dependant benefits from payments to their insured. The insurer argued that the insured had regularly been antagonistic, abusive, and uncooperative throughout the life of the claim, and that he had breached the reciprocal duty of good faith.

In an Endorsement, Master MacLeod held that if the basis of the Plaintiff's claim were a systemic failure to properly adjust a claim and pay benefits, the behaviour of the Plaintiff

would be irrelevant. However, if the claim arose out of both negative treatment from the insurer, and a refusal to pay benefits, then the behaviour of the Plaintiff could be relevant.

Another example of breach of good faith by the insurer is the case of *Phan v. Jevco*. Here the insured was rendered paraplegic in a motorcycle accident and subsequently found to be catastrophically impaired. Despite this, it appears that Jevco did very little to properly adjust the insured's claim and provide necessary benefits.

Justice Echlin held that the "handling of Phan's claims rings out with the sounds of incompetence, lack of care, indifference, neglect, outrageous arrogance, or alternatively speaks of a calculated course of conduct designed to discourage and dishearten a claimant." As a result, a second punitive damages award was made against Jevco, this time in the amount of $50,000.

With respect to punitive damage awards against the insured, for a breach of the duty of utmost good faith, the case of *RBC General Insurance Co. v. Field* is a good example. The insurer brought an action against the insured alleging that the insured made false statements and committed fraud with respect to claims for insurance benefits following a car accident. Along with a repayment of all benefits paid to the insured, the insurer also sought $100,000 in punitive damages for a breach of the duty of good faith.

The court here relied on the Supreme Court's decision of *Bhasin v. Hrynew*, which re-affirmed the mutuality of the duty of utmost good faith. In that case, the Supreme Court held "there is a doctrine of mutuality that imposes a duty on an insurer and an insured party to act in good faith when dealing with each other".

The court went on to say “this mutuality arises from the reciprocal duty of an insured to act fairly, honestly, and in good faith when making a claim, and of an insurer to act fairly, honestly, and in good faith when adjusting that claim.

In both cases, the courts’ finding that the insured acted dishonestly and in bad faith when making their claims, through the dishonest reporting of facts or the providing of fabricated documents, the courts held that punitive damages were appropriate as against the insured.

The case of *Ridi v. Dominion of Canada* held that the consumer protection purpose of the *SABS* is not unlimited. The Divisional Court held that “It is also basic to the purpose and intent of the Statutory Accident Benefits Schedule that there are limits on compensation.” The Divisional Court went on to say that “the scheme of the Schedule is to set out certain defined benefits and limits”.

Practically speaking, how must [the duty of utmost good faith] influence the course of conduct of the accident victim and the insurer?

As set out above, the duty of utmost good faith must influence the conduct of both the insured and the insurer. From the insured’s perspective, their duty is to act honestly, fairly, and in good faith in the making of their claim for benefits or payment under the policy.

The LAT case of *R.L. (Litigation Guardian) v. Intact Insurance Company* illustrates this principle well. Here the insurer terminated the insured’s claim for non-earner benefits and argued that the insured was barred from commencing a LAT claim more than two years later.

In this case, the insured argued that the insurer did not do anything to investigate the claim after receiving an OCF-3, and failed in its duty of good faith. The LAT held that the duty generally involves two requirements:

1. The insurer must pay a claim in a timely fashion if there is no reason to contest it; and
2. The insurer must treat the customer fairly throughout the process of investigating and assessing the claim.

However, the LAT also held that the insurer is not a fiduciary, and "the duty to act in good faith does not mean the respondent has to advance the applicant's case".

The insured must provide honest reporting of the factual circumstances of the accident or the reason for the claim. They must provide honest and accurate documentation when requested (maintenance records, towing invoices, etc.). Evidence that these documents have been fabricated or altered, with the insureds' knowledge, may result in a finding of bad faith.

From an accident benefits perspective, one of the most common places that insureds' give evidence regarding the results of an accident are to medical professionals when reporting their symptoms. While the above cases deal with more direct factual dishonesty (provision of fabricated documents), it is possible that evidence of an insured lying to medical professionals to inflate a claim for accident benefits would also be considered bad faith.

From the insurer's perspective, it is in the adjusting process that they must behave in accordance with the duty of utmost good faith. The facts in *Whiten v Pilot* give a good

example of what not to do. In that case, the court found as a matter of fact that the insurer's denial of the claim had been intentionally designed to force the insured to make an unfair settlement for less than she was entitled to.

The insurer's conduct was found to be deliberate and planned; the jury found that, from the outset the insurer knew that its arson defence was contrived and unsustainable.

In the case of more common claims, such as for accident benefits after a car accident, it is the duty of the insurer to adjust claims "fairly" and "honestly". There are many borderline situations, where questions of how to balance tactical considerations against the duty of good faith arise. These questions must always be answered on a case-by-case basis. It will often be safer to err on the side of good faith, than to open an insurer to a potential claim for punitive damages for a breach of the duty of good faith.

How consumer protection and the duty of utmost good faith impact our interpretation of the legislation (intent, meaning, scope)

As the court discussed in *Tomec*, the consumer protection purpose of insurance legislation, as well as the duty of utmost good faith, lead to important interpretations of the legislation. The courts have widened their reading of legislative provisions which work to the advantage of the insured, while narrowing their reading of provisions which work to the advantage of the insurer.

As in *Tomec*, the court held that the insurer had a "narrow interpretation of the limitation" which was found to be incongruous with the *SABS*' consumer protection purposes. In this way, they adopted a wider understanding of the legislation in order to achieve the consumer protection purposes.

At the same time, with respect to provisions regarding the establishment of “hard limitation periods” the court narrowed their own reading of those provisions. They held that because there was “no risk of evidence going stale”, and because “a hard limitation period will not ensure the insured's diligence in pursuing a claim, a hard limitation period was not appropriate.

The purposive approach does not mean that provisions will always be read widely, or narrowly. Instead, the court may read some provisions widely, and others narrowly, sometimes even within the same case (as in *Tomec*). As long as it reasonable to conclude that a particular reading of a provision works to further the consumer protection (or other) purposes of the legislation, it is likely that such an interpretation will be accepted.

Does it matter if an applicant has legal representation or not?

The existence, or lack thereof, of legal representation does not change the duty of utmost good faith, but it certainly does require more care on the part of the insurer when dealing “fairly” and “honestly” with the insured. As set out in the case of *Ozdemir v Economical Mutual Insurance Group*, the court upheld that the duty of good faith is an “ongoing duty” that applies even when there is litigation proceeding.

Where insureds are self-represented plaintiffs or applicants, it can be the case that insurers have to give more clear information and/or direction to the insureds, as they are not receiving advice or direction from their own counsel.

It is equally important that the duty be maintained by the insureds, even when they are self-represented. In the above case, Mr. Ozdemir continued to be bound by his duty of good faith to the insurer. In failing to provide the insurer with honest reports/documents

about the nature and cost of his treatment and benefits, he made it impossible for the insurer to accurately adjust his claim.

Ultimately, the lack of legal representation by the insureds does not change the nature or the mutuality of the duty of utmost good faith. It likely requires more care on the part of the insurer, as insureds who lack representation rely more heavily on honest adjusting by their insurer.

In a practical sense, this means that an insurer will have to take more care when communicating with the insured; there will have to be clear communication to the insured on reliable avenues, such as by email, regular mail, and telephone.

It must be made clear to the insured that whatever means of communication are used, they must be responsive to those. They cannot simply make the excuse that they “didn’t check their mail” or “didn’t check their email” for weeks on end while the insurer is attempting to adjust their claim.

Conclusion and Recap

The duty of utmost good faith is a mutual and reciprocal duty between insurers and insureds. As a result, the “independent actionable wrong” principle established in *Whiten v Pilot* applies to both insurers and insureds. While it is certainly rarer for a court to award punitive damages against an insured, it is not impossible.

From the insurer’s perspective, what is most vital to keep in mind is that the adjusting of the claim must proceed with fairness and honesty, in order to avoid a breach of this duty.

Lastly, while the nature of the duty does not change when an insured lacks legal representation, the conduct of the insurer may have to be modified. What the courts will consider “fair” and “honest” adjusting of a claim may be different when an insurer is dealing exclusively with an insured person, rather than with a legal representative.

In those cases, extra care should be taken to ensure that communication is clear, concise, and appropriate for laypeople (rather than relying on extensive “legalese”). While the duty of good faith is mutual and reciprocal, the resources and experience of insurers will certainly be taken into account when evaluating whether the adjusting of the claim was fair and honest.