Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Appeal P03-00013

OFFICE OF THE DIRECTOR OF ARBITRATIONS

SVETLANA IANKILEVITCH

Appellant
Respondent by Cross-Appeal

and

CGU INSURANCE COMPANY OF CANADA

Respondent
Appellant by Cross-Appeal

BEFORE:	Nancy Makepeace
REPRESENTATIVES:	Henry Goldentuler for Ms. Iankilevitch Kadey B.J. Schultz for CGU
HEARING DATE:	June 15, 2004

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, **it is ordered that**:

1. Ms. Iankilevitch's appeal of the arbitration orders, dated October 4, 2002, October 30, 2002 and March 19, 2003, is allowed, and the orders are revoked. A new arbitration hearing shall be held in accordance with this decision.

2. I may be contacted within 30 days if the parties are unable to agree on appeal expenses.

August 31, 2004

Nancy Makepeace
Director's Delegate

REASONS FOR DECISION

I. NATURE OF THE APPEAL

This appeal concerns the interpretation and application of s. 33(2) of the *SABS–1996*,[1] which states that a benefit is not payable for any period before the insured person complies with her obligation to provide the insurer with information pursuant to s. 33(1). I find that the Arbitrator erred in law by dismissing Ms. Iankilevitch's claim for income replacement benefits ("IRBs") between August 20, 2001 and June 11, 2002 based on s. 33(2).

II. BACKGROUND

Ms. Iankilevitch was injured in an accident on November 16, 2000. She claimed IRBs at the maximum rate of $400 per week based on her pre-accident self-employment as a computer programmer through SIAN Computer Consulting ("SIAN"). CGU accepted that Ms. Iankilevitch was disabled from working, but was not satisfied by the income documentation she has provided. Through its accountant, Robert Pellegrini, CGU asked for additional source documents, as well as SIAN's financial documentation. Ms. Iankilevitch produced some of the information requested, but not all. The parties' disputes about the amount of IRBs owing and the appropriate scope of disclosure have been further complicated by procedural disputes.

The Arbitrator issued two decisions. A preliminary issue hearing was held on June 11 and July 24, 2002 on whether Ms. Iankilevitch was disentitled from receiving IRBs, pursuant to s. 33, because she failed to produce sufficient income documentation. In a decision dated October 4, 2002,

[1] The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

the Arbitrator found that Ms. Iankilevitch had not complied with CGU's reasonable requests for documents, and therefore she was disentitled from receiving IRBs beyond $185 per week from August 20, 2001 to June 11, 2002. The start date – August 20, 2001 – was the date of CGU's *Response to Arbitration*, in which the Insurer reiterated its previous requests for information and, for the first time, relied on s. 33 as a defence to Ms. Iankilevitch's benefit claim. Ms. Iankilevitch produced many of the remaining documents in the week or so before the hearing. However, the Arbitrator found she did not have a reasonable explanation for failing to comply with her obligations up to that time, and chose the start of the hearing, June 11, 2002, as the disentitlement end date. The Arbitrator did not make any orders about Ms. Iankilevitch's entitlement to benefits after June 11, 2002.

The Arbitrator's decision on the preliminary issue was released on October 4, 2002, three and a half weeks before the hearing on the remaining issues was to begin. Both parties appealed. Ms. Iankilevitch claimed that the Arbitrator erred in failing to follow *Kassa and Economical Mutual Insurance Company*, (FSCO P00-00053, July 26, 2001), which held that s. 33(2) authorizes a "suspension" of benefits,[2] and in concluding that she had not provided sufficient documentation to allow CGU to calculate her IRBs. CGU cross-appealed, taking issue with the Arbitrator's findings as to the period of disentitlement and the minimum benefit rate. CGU claimed the penalty should be applied from one week post-accident (taking the one-week deductible into account), and should extend beyond June 11, 2002.

Director's Delegate McMahon found that the order under appeal was a "preliminary or interim order that does not finally determine the issues in dispute," and rejected the appeal as premature, pursuant to Rule 51(2)(c) of the *Dispute Resolution Practice Code* ("the *Code*") . He had no authority to order a stay, given his rejection of the appeal, but noted that Ms. Iankilevitch conceded the *SABS-1996* does not provide for a minimum level of IRBs payable, except for IRBs payable after 104 weeks of

[2] Mr. Kassa's application for judicial review was dismissed without reference to this point: unreported decision of the Divisional Court (Blair, Kurisko and Lalonde JJ.) on November 1, 2002, Court File No. 94/02.

disability.[3] The parties also disagreed about the consequences of the Arbitrator's decision for Ms. Iankilevitch's claim for ongoing benefits. CGU argued he left the matter open to be decided another day, while Ms. Iankilevitch read the decision as an order for payment of the full amount of the benefits claimed after June 11, 2002. The Delegate concluded these questions should be resolved by the Arbitrator.

The arbitration hearing resumed, as scheduled, on October 28, 2002. Ms. Iankilevitch brought three motions at the outset. In an early ruling, given by letter on October 30, 2002, the Arbitrator refused to admit an accounting report by Mr. Ian Wollach because it was produced to CGU on October 4, 2002, about six days short of the 30 days required by Rule 39 of the *Code*, and because he found it was being led to challenge his first decision on the adequacy of the information provided to June 11, 2002. However, he ruled that Ms. Iankilevitch's entitlement to IRBs after June 11, 2002 remained open. He made no ruling on the admissibility of the accountant's report for post-June 11, 2002 purposes, but deferred that ruling to the hearing of that issue.[4]

Ms. Iankilevitch then moved to withdraw her application for arbitration in order to commence a civil proceeding for accident benefits in which she claimed relief from forfeiture under s. 129 of the *Insurance Act*, a power enjoyed by judges, but not FSCO adjudicators. The Arbitrator gave an oral ruling granting the withdrawal on November 8, 2003, and issued written reasons on March 19, 2003. He allowed the withdrawal motion on three conditions. Ms. Iankilevitch was ordered to pay some of CGU's arbitration expenses for July 24, 2002 (the second day of the first hearing) because her belated decision not to testify that day made the attendance of CGU's accountant unnecessary, she was

[3] Section 6(1). The two prior accident benefits schemes did include a minimum $185 payment – s. 12(7)1 of the *SABS-1990* and (for more seriously injured claimants) s. 10(2) of the *SABS-1994*. Section 6(2) of the *SABS-1996* provides a minimum benefit of $185, but only for IRBs payable after 104 weeks.

[4] In a third ruling, not disputed in this appeal, the Arbitrator allowed Ms. Iankilevitch to withdraw her claim for medical benefits of $8,655 relating to treatment at Integrated Health Recovery, on condition that she pay CGU's related arbitration expenses. He refused CGU's request to bar Ms. Iankilevitch from renewing the claim, but ruled that she must pay the Insurer's assessment fee if she did so.

ordered to pay CGU's assessment fee if she recommenced another arbitration on any of the outstanding issues, and interest on outstanding IRBs was suspended as of October 28, 2002.

Ms. Iankilevitch appealed the second decision, and both parties renewed their appeals from the first. With respect to the second decision, Ms. Iankilevitch claims that the Arbitrator erred in excluding Mr. Wollach's evidence, refusing to reconsider his first decision, ordering arbitration expenses in favour of CGU, and suspending IRB interest.

The appeal was delayed because of the parties' disagreement about the appropriate forum. On November 13, 2003, Juriansz J. allowed CGU's motion for a stay of the civil proceeding pending the outcome of this appeal. He concluded that the relief from forfeiture issue was "in part, inextricably linked to the matters pending before FSCO." The date for the appeal hearing and the time lines for the parties' written appeal submissions were then agreed in an appeal pre-hearing telephone conference in January 2004.

III. ANALYSIS

A. "Piercing the Corporate Veil"

Ms. Iankilevitch submits that the Arbitrator erred in law by finding that SIAN's corporate documents were reasonably required to assist CGU in determining her benefit entitlement. She claims that "piercing the corporate veil" is only appropriate where the business was incorporated for an illegal, fraudulent or improper purpose or those in control expressly directed a wrongful thing to be done. She concedes that the Arbitrator was entitled to examine the corporate documents at the preliminary hearing because SIAN was a closely held corporation, but only for the purpose of determining whether there was illegal, fraudulent or improper conduct to justify piercing the corporate veil. As none was alleged or found, the corporate documents had no further role in the claim, and Ms. Iankilevitch was entitled to have her benefit based on her personal income.

The decisions Ms. Iankilevitch relies upon are not about income calculation for someone self-employed through a corporation. They concern the liability of a parent company for the civil wrongs of its wholly owned corporate subsidiary, the liability of the principals on a corporate undertaking in damages, and the proper parties on an action by a corporation for repayment of loan monies advanced by its principal.[5] Nor do I read these judgements as stating that illegal, improper or fraudulent purpose is an absolute prerequisite for disregarding the separate legal personality of a corporation. While rejecting a "just and equitable" standard and reaffirming that corporate personality is not to be disregarded lightly, these judgements recognize that the decision to pierce the corporate veil depends on context, and that the authorities do not support firm rules.

Employment and self-employment income are treated differently in all versions of the *SABS*, but employment and self-employment are not differentially defined. While the Commissioner's *Guideline for Identifying Self-Employed Individuals* sets out the indicators of a "traditional self-employment situation" in the accident benefits context, and states, "[i]f the individual derives his or her remuneration from an incorporated business, then he or she is considered to be an employee of the corporation,"[6] it does not purport to be an exhaustive statement of the law. That would be unrealistic, because deciding whether a claimant is self-employed or a corporate employee requires consideration of many factors.

Commission adjudicators have consistently taken a functional approach that prefers substance over form. Where the corporation is the claimant's alter ego, such that the claimant treats the company's revenues and expenses as her own, she will generally be treated as self-employed. The objective is to

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[5] Respectively, *Transamerica Life Insurance Co. of Canada v. Canada Life Assurance Co.*, [1996] O.J. No. 1568, 28 O.R. (3d) 423 (Ont. Ct. Gen. Div.), *642947 Ontario Ltd. v. Fleischer*, (2001), 209 D.L.R. (4th) 182 (Ont.C.A.), and *MT Dynamics Inc. v. Sona Innovations Inc.*, [2002] O.J. No. 3753 (Ont. S.C.J.).

[6] Commissioner's Guideline No. 4/96, *Guideline for Identifying Self-Employed Individuals*, effective October 19, 1996, issued under s.268.3 of the *Insurance Act*. According to s.268.3(2), guidelines "shall be considered in any determination involving the interpretation of the *Statutory Accident Benefits Schedule*."

ensure that the insured person receives an income replacement benefit that fairly and realistically reflects her actual income situation, avoiding both over- and under-compensation.[7]

Ms. Iankilevitch submits that her IRB should be based on her personal income because she was an employee of a corporation. The Arbitrator did not err in rejecting this position. He cited several good reasons for finding that CGU was entitled to go beyond the information included in her 1999 personal income tax return and notice of assessment. Ms. Iankilevitch now concedes the first point. Pursuant to s. 8(2) of the *SABS-1996*, she chose to have her gross annual pre-accident income based on SIAN's last fiscal year. CGU needed corporate documentation to ascertain the fiscal year.

The Arbitrator identified other reasons for requiring further income documentation. Initially, Ms. Iankilevitch provided her 1999 notice of assessment, but it only stated her total income, giving no information about its source or when it was earned, and it did not cover the 52 weeks before the accident or the business's last fiscal year. Ms. Iankilevitch only produced her 2000 personal income tax return in December 2001, and the notice of assessment in May 2002. SIAN's corporate income tax returns were finally produced the week before the first hearing, but the Arbitrator accepted Mr. Pellegrini's evidence that they contained certain anomalies that justified the accountant's reluctance to rely on them in the absence of source documentation.[8] Ms. Iankilevitch's delayed and piecemeal approach to disclosure appears to have added to the Arbitrator's skepticism about the documents produced.

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[7] There are many decisions. See, for example, *Meandro and Pilot Insurance Company*, (OIC P- 004433, May 7, 1997), *Malik and Allstate Insurance Company of Canada*, (FSCO P00-0007, July 17, 2000), and *Carr and Lombard General Insurance Co. of Canada*, (FSCO A00-000441, September 11, 2001). An exception is *Piper and Zurich Insurance Company*, (FSCO P-002585, May 1, 1996), in which the claimant, an electrician, was treated as an employee of the family company because of his longstanding practice of drawing a regular salary from corporate revenue, while leaving surpluses in corporate retained earnings.

[8] Arbitration decision, October 4, 2002, p. 22.

Apart from these specific concerns, I agree with the Arbitrator that it will generally be reasonable for an insurer to request some corporate documentation where the claimant is self-employed through a closely-held company, at least where, as appears to be the case here, the insured is the corporation's sole directing mind and alter ego. Indeed, it is difficult to know how an insurer could reliably assess income without access to corporate documents, where the insured has control of corporate revenues and expenses. As the Arbitrator noted, the Commission's Practice Note 4, *Exchange of Documents*, anticipates that self-employed claimants may be required to produce financial statements and source documents ("raw financial documentation").

The Arbitrator recognized that self-employed claimants like Ms. Iankilevitch may not be able to produce enough income documentation to satisfy a professional accountant. The goal, as Delegate Draper stated in *Mills and Canadian General Insurance Company*, is finding "a reasonable basis for making the calculation, not punishing poor record keepers."[9] Insurers should avoid indefinitely expanding request lists that make delay the initial determination of entitlement.

CGU's disclosure requests were substantial, but I have the impression the Arbitrator was heavily influenced by Ms. Iankilevitch's failure to promptly produce basic corporate documents at the outset of the claim, despite well-established Commission authorities on point. In these circumstances, I am not persuaded the Arbitrator erred in concluding that CGU's requests were reasonable and that Ms. Iankilevitch had not complied by the start of the hearing on June 11, 2002.

B. Section 33(2): Suspension or Forfeiture?

Sections 31, 32 and 33 of the *SABS-1996*, which begin Part X, "Procedures for Claiming Benefits," lay the groundwork for the detailed procedural rules that follow. They set out a step-by-step claims

[9] (OIC P-005599, October 8, 1996), at p. 5. On the quality of income evidence required, see also, for example, *Agha and General Accident Assurance Company of Canada*, (OIC P-009703, February 27, 1997), and *Carr and Lombard General Insurance Co. of Canada*, (FSCO A00-000441, September 11, 2001).

process that imposes reciprocal obligations on claimants and insurers. While sections 31 and 32 follow similar provisions in the previous accident benefits schedules,[10] s. 33 is new. As its heading indicates, it is concerned with the claimant's duty to provide information to the insurer. It is one of several provisions introduced in the *SABS-1996* that expand the claimant's disclosure obligations and strengthen the insurer's enforcement options.[11]

Paragraphs 2, 3 and 4 of s. 33(1) allow insurers to impose specific new requirements on claimants (respectively, a statutory declaration, address and proof of identity), but paragraph 1, the provision at issue in this appeal, is more general. It requires a claimant to provide, on request, "any information reasonably required to assist the insurer in determining the person's entitlement to a benefit." The information must be provided within 14 days of the insurer's request.

Section 33(2) states: "The benefit is not payable for any period before the person complies with subsection (1)."[12] Whether these words authorize delayed payment or forfeiture of benefits is the main question in this appeal.

The Arbitrator considered s. 33(2) together with s. 35, which describes an insurer's obligation upon receiving an application for weekly benefits. Subsection 35(1) requires the insurer to "promptly determine whether a benefit is payable." If a benefit is payable, s. 35(2) requires the insurer to pay the benefit within 14 days of receiving the application. Section 35(3) creates an exception to s. 35(2), if the person failed to comply with s. 32(1), which requires her to notify the insurer that she wants to apply

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[10] Section 22 and 24 of the *SABS-1990* and section 59 of the *SABS-1994*.

[11] If an insured person has wilfully misrepresented material facts with respect to an application for a benefit, s. 48 authorizes the insurer to "terminate payment of the benefit." In addition, s. 47(1)(a), as amended, allows the insurer to recover benefits overpaid as a result of "error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud." FSCO adjudicators had held that s. 27 of the *SABS-1990* ("through error or fraud") and s. 70 of the *SABS-1994* ("through error, wilful misrepresentation or fraud") applied only where the error resulted from culpable conduct or misrepresentation by the claimant. These provisions are discussed in *Fisk and ING Insurance Company of Canada*, (FSCO P03-00028, April 21, 2004) and *Szabo and CAA Insurance Company (Ontario)*, (FSCO P03-00015, March 31, 2004).

[12] Section 33 was amended by Ontario Regulation 281/03, but neither party suggested the amendments apply to this appeal.

for benefits within 30 days after the circumstances arose that gave rise to the entitlement, or as soon as practicable thereafter. If the application is late, the insurer "may delay determining" entitlement for up to 45 days from receiving the person's application. The exception was presumably intended to allow for further investigation into delayed claims.

I agree with the Arbitrator that: "an insurer's strict obligation to promptly determine a person's entitlement to benefits and to promptly pay the person benefits [pursuant to s. 35] reinforces the importance of an insured's compliance with their obligation to promptly provide the information enumerated in section 33(1)." I am not convinced it follows that: "an insured's failure to comply with section 33(1) is intended to result in more than merely the suspension of a person's benefits."[13] In my view, the effect of s. 33(2) is to exempt an insurer from s. 35 until the insured person provides the information requested under s. 33(1). It likely delays the accrual of interest, since benefits are not "overdue," under s. 46, until the claimant complies with s. 33(1), and it almost certainly removes any risk of a special award, pursuant to s. 282(10) of the *Insurance Act*, based on unreasonable delay.

The Arbitrator also found support for his interpretation of s. 33(2) in s. 31(1), which states: "A person's failure to comply with a time limit set out in this part does not ***disentitle*** the person to a benefit if the person has a reasonable explanation" [emphasis added]. He found that "disentitle" suggests a forfeiture rather than a suspension of benefits, and noted that Delegate McMahon did not consider this argument in *Kassa*.

In my view, the argument based on s. 31(1) is weakened by the fact that the word "disentitle" also appeared in the *SABS-1990* and *SABS-1994*, before s. 33 was added. More importantly, "disentitle" is itself ambiguous. The Arbitrator understood it as a forfeiture of the benefits due during the period of the delay. But it can also refer to disqualification, invalidation or nullification of a claim in its entirety.[14]

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[13] *Ibid.*, p. 17.

[14] Subsection 59(4) of the *SABS-1994*, the predecessor to s. 31(1), also uses "disentitle." Its predecessor, s. 22(2) of the *SABS-1990*, uses "invalidate a claim," which arguably has the even stronger sense of "disqualify" – that is, nullify a claim from the outset – rather than relieving the insurer of the obligation to pay benefits for only the period

Delegate McMahon's finding that s. 33(2) authorizes a "suspension" must be understood in this context. He understood the penalty as limited to the benefits due before the insured person complies with the request:

> To my mind, the [s. 33(2)] penalty is more in the nature of a suspension of a benefit that is otherwise payable, rather than a disentitlement. Amongst other difficulties, referring to the penalty as a disentitlement has a connotation of permanency, whereas the section is clear that the penalty is lifted once the person supplies the requested information. If the penalty is seen as a suspension rather than a disentitlement, then the need to establish the period over which the penalty operates becomes more obvious. This necessarily involves a consideration of when the suspension starts.
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> In this case, the arbitrator did not turn her mind to the period of the suspension. Instead, having found that he failed to comply, she ruled that he was disentitled to benefits. It is implicit in the ruling that the penalty was a complete bar from the inception of the claim onwards. (pp. 8-9)

Delegate McMahon was not required to consider whether the insurer had to pay the "suspended" benefits once the insured person complied, or was forever relieved of its obligation to pay those benefits. However, his order that the "suspension" would begin on the date of a letter that provided evidence of Mr. Kassa's attempts to block access to his medical records suggests he understood the s. 33(2) penalty as forfeiture of the benefits otherwise payable during the period of non-compliance.

The Arbitrator's main reason for reading s. 33(2) as a forfeiture provision was its plain wording, specifically the phrase "for any period."[15] If those words were omitted, so that s. 33(2) read "The benefit is not payable before [or until] the person complies with subsection (1)," the provision could easily be read as a delay provision.[16] I agree that "for any period" may suggest "for any *benefit* period," but this does not answer the question whether the benefits delayed are forever forfeited.

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of the delay.

[15] Arbitration decision, October 4, 2002, p. 16.

[16] *Ibid.*

Moreover, s. 33 is not limited to IRBs, which are paid on a periodic basis; along with sections 31 and 32, it also applies to benefits that are paid on a lump sum basis.[17] To my mind, the key word in s. 33(2) is "before." This section is concerned with the timing of payment, not entitlement.

In contrast, though the *SABS* uses several terms for forfeiture, the language is always explicit where benefits otherwise payable are forfeited because of an insured person's misconduct. For example, sections 42(8) and 43(3) state that if an insured person is non-compliant with an insurer examination or a DAC request, "the insurer may stop payment of the benefit" until the person complies, at which time "the insurer shall resume payment," and "no benefit is payable for the period" of non-compliance. Section 48 authorizes the insurer to "terminate payment of the benefit" if an insured person has wilfully misrepresented material facts in applying for it. And where an exclusion applies, s. 30 says the insurer "is not required to pay" benefits to which the claimant might otherwise be entitled. Section 33(2) says only that benefits are not payable "for any period before" compliance. Comparing it to the more explicit forfeiture language found elsewhere in the *SABS-1996*, I find it more likely that s. 33(2) was intended only as a delay provision.

The placement of s. 33 also supports my interpretation. It is found in the first few sections of Part X of the *SABS-1996*, which is concerned with the parties' procedural obligations at the earliest stages of a claim. Furthermore, the information that can be required under s. 33(1) – address, proof of identity, "a statutory declaration as to the circumstances that gave rise to the application for a benefit," and "any information reasonably required to assist the insurer in determining the person's entitlement to a benefit" – is information insurers typically request at the outset of a claim. These requests are aimed at initial determination of entitlement. Though I do not suggest s. 33 is limited to initial disclosure requests, I am not persuaded it is intended to operate as a penalty provision that affects ultimate entitlement.

[17] See, for example, *Totic and Primmum Insurance Co. (formerly Canada Life Casualty)*, (FSCO P03-00033, July 26, 2004), with respect to death benefits.

C. Application of Section 33 in Arbitration

As stated, s. 33 is a disclosure provision that imposes obligations on the insured person at the earliest stages of her claim. How it is to be applied in the context of an arbitration is less clear. Ms. Iankilevitch submits that the Arbitrator erred by finally disposing of her claim for the disputed period in a preliminary issue hearing and refusing to consider it in the second hearing. More specifically, she submits that by refusing to admit Mr. Wollach's evidence, the Arbitrator denied her a "reasonable explanation" hearing under s. 31(1).

The Arbitrator found that Ms. Iankilevitch had no reasonable explanation for not complying with s. 33(1) because she did not testify, though she was expected to do so, and provided no written explanation for not providing the requested documents beyond her "corporate veil" argument, which he rejected. Other factors were her failure to make that argument earlier, her belated production of certain documents despite previously having told CGU that everything had been produced, and his finding that the material produced to the date of the hearing remained insufficient and confirmed the reasonableness of CGU's requests.

On the record before me, it is not possible to ascertain whether the parties addressed s. 31 during the first hearing or in their pre-hearing discussions leading up to it, or whether the scope of Ms. Iankilevitch's expected testimony was discussed. In any event, I need not say more about the Arbitrator's s. 31 findings because I find that he erred by ruling that his first decision had finally disposed of Ms. Iankilevitch's claim for the disputed period. My reasons turn on the distinctions between the obligation to provide information and the burden of proof, and between interim and final orders.

Delegate McMahon discussed the distinction between disclosure and proof in *Kassa*:

> The first step in considering an insurer's attempt to invoke s. 33(2), is to ask if the information demanded was "reasonably required." This will necessarily involve some consideration of what evidence the applicant will ultimately need to proffer if they are going

> to prove their entitlement to a benefit. However, a distinction must be drawn between the insured person's obligation to cooperate with the insurer's investigation, and the insured person's ultimate obligation to establish their claim. The insured person might cooperate fully with the insurer's investigation by producing all the requested information, but still, in the final analysis, fall short of proving their entitlement to a benefit at a hearing.
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> Conversely, and more to the point in this case, the mere fact that the information supplied by the insured person is insufficient to establish their entitlement, does not necessarily mean that they are subject to the penalty provisions of section 33. (pp. 6-7)

The Delegate concluded that s. 33 applies only in cases of misconduct, where the insurer proves "that the insured person is intentionally withholding information in an attempt to interfere with a legitimate investigation." He concluded that the Arbitrator had erred by failing to distinguish "Mr. Kassa's obligation to cooperate from his obligation to prove his pre-accident income." (pp. 6-7) In my view, the same error affected the decisions under appeal in this case.

Ms. Iankilevitch claims there was no evidence to support the Arbitrator's finding that she "sought to thwart, not to facilitate, the Insurer's assessment of her IRBs."[18] This was a strong finding, and the evidence about Ms. Iankilevitch's motivations was not clearly identified by the Arbitrator. However, I need not address this ground of appeal any further because I am inclined to doubt that s. 33 imposes a misconduct requirement. I agree with the Arbitrator that s. 33 requires the insurer to show "that its inquiries were reasonably required and that the insured failed to respond adequately to them." The onus then shifts to the insured person, under s. 31(1), to provide a reasonable explanation for failing to provide reasonably required information.[19]

Like Delegate McMahon, the Arbitrator also recognized the distinction between the claimant's duty to provide information and the Applicant's onus of proof at arbitration.[20] However, Ms. Iankilevitch

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[18] Arbitration decision, October 4, 2002, p. 25.

[19] *Ibid*.

[20] *Ibid*., p. 17.

submits that he confused the two at the second hearing. She argues that his decision of October 4, 2002 was an interim order only, and did not finally dispose of her claim or any part of it.
Counsel gave conflicting accounts of their expectations going into the preliminary issue hearing. As I understand his submissions, Mr. Goldentuler expected the Arbitrator's first order to decide whether the information Ms. Iankilevitch had disclosed up to June 11, 2002 was sufficient to satisfy s. 33 and allow her to proceed to a hearing on the merits, or whether the hearing must be delayed pending further disclosure. He claims he delayed asking Mr. Wollach for a report because he believed CGU bore the onus of proving further disclosure was required and had not met that onus. He finally requested the report because the Arbitrator's decision was still outstanding as the final hearing dates approached, hence the delay in producing the report to Ms. Schultz. I agree with CGU that parties are expected to bring forward their best case at first instance, and will not be granted a new hearing because of tactical errors or case-splitting. However, I am not satisfied that is what happened in this case.

Preliminary issue hearings serve a number of functions at the Commission. Some result in interim orders for payment of benefits or expenses, or interlocutory orders (about document disclosure or insurer examinations, for example) that may be revisited as necessary. Others result in summary orders that finally dispose of an application (for example, a ruling that the incident was not an "accident" as defined, or the matter was settled, or the application for arbitration was commenced beyond the limitation period) or set the stage for a second hearing by finally resolving an important underlying issue (for example, the parties may request a decision on whether the insured person was employed or self-employed before the accident, so they can frame their disability and benefit rate cases accordingly).

In most cases, the interim or final nature of a preliminary decision is clear. But disputes can arise. For example, in *Simpson and Allstate Insurance Company of Canada*, (FSCO P01-00057, June 6, 2003), I ruled that an insured person, having obtained an interim benefits order, cannot later withdraw her application for arbitration and obtain a final entitlement order that is protected by s. 287 of the

Insurance Act, based on the insurer's conceding present entitlement only, without a settlement order or a full hearing on the merits.

In *Simpson*, the insured person wanted a final order based on an earlier interim order. In this case, it is the Insurer that seeks a final (partial) disposition of the insured person's entitlement based on a preliminary ruling. Though both arbitration pre-hearing letters refer to the parties' s. 33(2) dispute, the record does not indicate whether the parties discussed the implications of a preliminary issue decision favouring the Insurer in advance of that hearing, or, indeed, at any time before the order was given on October 4, 2002.

The parties' disagreement about the scope of the first hearing was evident in their submissions before Delegate McMahon on October 24, 2002 as to whether the first appeal should be acknowledged or rejected pending the second arbitration hearing. Ultimately, the Delegate characterized the Arbitrator's first decision as preliminary, not final, and rejected the appeal as premature pursuant to Rule 51.2(c) of the *Code*.[21]

CGU argues that Ms. Iankilevitch's *Notice of Appeal*, which indicated it was not a preliminary issue appeal, proves she then agreed the Arbitrator's order was final. I am not persuaded this is pertinent. Based on Delegate McMahon's letter, I have the impression both parties took understandable tactical positions in their respective appeals.

On October 28, 2002, the parties' long discussion about the effect of the Arbitrator's first order took up the better part of what was intended to be the first day of a four-day entitlement hearing. Their comments, recorded in the transcript of that day, reflect a lack of clarity about the purpose of the preliminary issue hearing and whether the Arbitrator's first order was an interim or final order. I am

[21] "An appeal may be rejected if . . . it is from a preliminary or interim order that does not finally decide the issues in dispute."

hampered by not having a transcript of the first hearing, nor, of course, the pre-hearings. Based on the arbitration record, I have the impression no one had fully considered the implications of the issue before that day.

Issued two days after the resumption of the hearing, the Arbitrator's letter of October 30, 2002 failed to resolve the ambiguity because it included, as reasons for not considering the August 20, 2001-June 11, 2002 period, "the absence of further disclosure by the Applicant" and "the appeals that have been filed." These factors would have been appropriate if this had been a second preliminary issue hearing arranged to reconsider an earlier interim order. A stay or adjournment of the entitlement hearing pending full disclosure would have been the appropriate remedy for a finding of continued non-compliance. Instead, the Arbitrator restricted the entitlement hearing to the period not dealt with in his first order, and both parties understood this as tantamount to a dismissal of the claim for the August 20, 2001-June 11, 2002 period.

The procedural difficulties were probably exacerbated by the relative novelty of the issue. *Tesfay and Allstate Insurance Company of Canada* was the first decision on s. 33, and, to my knowledge, the only prior decision to consider s. 33(2) on a pre-hearing motion.[22] In that case, the Insurer argued, *inter alia*, that the insured person failed to provide her pre-accident medical records, as requested. The Arbitrator did not accept that the request was reasonable, and dismissed the motion.[23] Given the documentation available to the insurer by the time it refused benefits, the Arbitrator was not satisfied the insurer also needed Ms. Tesfay's pre-accident medical records "at this stage", and criticized it for refusing to determine initial entitlement based on the information provided.

Relying on earlier authority concerning insurer examinations, the Arbitrator stated that determining the reasonableness of a request for information requires a balancing of the parties' interests. Where the

[22] (FSCO A97-001439, April 7, 1999).

[23] I rejected the appeal from the preliminary order as premature (FSCO P99-00023, June 21, 1999).

insurer seeks a stay of proceedings or a dismissal order, it is appropriate to closely scrutinize its request for information, keeping in mind the distinction between disclosure and proof.[24]

I adopt the purposive approach to s. 33 described by the Arbitrator in *Tesfay* and the Arbitrator in the decision under appeal:[25]

> In my view, section 33 should be interpreted in a purposive, rather than a punitive, manner. The purpose of section 33 is to ensure that insured persons facilitate the insurer's ability to obtain sufficient information to assess a claim for benefits.

This principle supports my interpretation of s. 33(2) as a provision that allows the insurer to delay its decision on initial entitlement where a claimant fails to comply with reasonable information requests without a reasonable explanation.

A s. 33(2) suspension order may be made pursuant to s. 279(4.1) of the *Insurance Act*, which gives Commission adjudicators authority to make an interim order pending the final order in any proceeding. An interim s. 33(2) order does not lack consequences. It defers payment of the disputed benefits pending a further arbitral order. It effectively operates as a production ruling and may be associated with a stay of proceedings or an adjournment pending compliance with the order. An interim s. 33(2) order may also affect the claimant's entitlement to interest and arbitration expenses, assuming she ultimately establishes her entitlement to the maximum amount of benefits.

I am aware of no other occasion in which a preliminary issue hearing resulted in the final dismissal of a claim (or part of a claim) based on s. 33(2). In *Kassa* and *Carr*, the insurers' s. 33 arguments were treated as defences in the main entitlement hearing. In both cases, the Arbitrator determined that the insured persons had neither satisfied their obligation to provide information reasonably requested under s. 33, nor satisfied the onus of proof at the arbitration hearing, and their failure to satisfy the onus

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[24] *F.S. and Belair Insurance Company Inc.*, (OIC P96-00039, June 11, 1996).

[25] Arbitration decision, October 4, 2002, p. 13.

related directly to their failure to provide the required information. Since the insured persons were found not to have proven their claims, there was little need for the Arbitrator in either case to engage in the difficult exercise of drawing a distinction between what is reasonable for an insurer to request at a given stage of a claim and what is required for the insured person to prove the claim.[26]

In my view, this will generally be the preferable approach in all but the clearest non-disclosure cases. While production issues can be dealt with efficiently at preliminary issue hearings, a cautious approach to interim suspension orders is appropriate. For the same reasons, Commission adjudicators have awarded interim benefits only in limited cases.

D. Conclusion

In summary, I find no error in the Arbitrator's decision that CGU's requests, including its requests for SIAN's corporate documents, were reasonable. However, I find that he erred in law by finding that s. 33(2) authorizes forfeiture of benefits otherwise payable to Ms. Iankilevitch until she complies. The remedy given by s. 33(2) is delay, not forfeiture.

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[26] See also *Green Estate and Kingsway General Insurance Company*, (FSCO A02-000215, October 30, 2002), in which the Arbitrator allowed the estate to withdraw the claim on condition that it pay the insurer's arbitration expenses and assessment fee because the estate had not provided the insurer with "the most basic" medical and income documents to support the claim. In *Tenkorang and Wawanesa Mutual Insurance Company*, (FSCO A01-001278, March 6, 2003), the Arbitrator turned to the insurer's s. 33(2) defence after dismissing the insured person's claims on their merits. She refused to consider s. 33(2) because it was raised for the first time in the insurer's closing submissions. In addition, she found that *Carr* and *Iankilevitch* were distinguishable on the basis of findings that the insurer had made detailed and repeated requests for information to assist in the determination of the insured person's income from self employment" (p. 14). In *Tenkorang*, the insurer had made a single request for pre-accident income documents for one year pre-accident, and the insured person had partially complied; there was no evidence that the insurer had requested more information or given notice it had insufficient information. Most recently, in *Totic and Primmum Insurance Co.* (FSCO P03-00033, July 26, 2004), the Director's Delegate held that s. 33 "is aimed at helping an insurer make an early assessment of a claim," and could not be relied upon where the insurer demanded documentation of household expenses that would have been "impossible" to provide, much less within the 14 day period described in s. 33(2). In determining what documents can be reasonably requested, he held that the timing of the request and the nature of the claim are relevant. This was the parents' dependency claim for death benefits.

The Arbitrator also erred in law by treating his order of October 4, 2002 as a final order and refusing to consider Ms. Iankilevitch's entitlement to benefits for the disputed period at the hearing in October 2002. This affects his ruling given by letter dated October 30, 2002 and restated in his decision of March 19, 2003.

I considered whether the Arbitrator's order of October 4, 2002, rather than being revoked, should be varied to indicate it is an interim suspension order, not a final order dismissing Ms. Iankilevitch's claim for benefits between August 20, 2001 and June 11, 2002. However, Ms. Iankilevitch concedes, and I find, that the Arbitrator erred in law, probably by inadvertence, in limiting his disentitlement order to benefits beyond $185 per week. For that reason, his order cannot stand, even as an interim suspension order. The Arbitrator said little about his reasons for limiting forfeiture to the benefits beyond $185 per week, and may have accepted that Ms. Iankilevitch was entitled to at least that level of benefits, despite his finding that she failed to disclose sufficient documentation for her claim of the maximum weekly benefit of $400. It is not appropriate for me to second-guess the Arbitrator's assessment of Ms. Iankilevitch's entitlement, and I have no basis for substituting some other benefit rate. I have no option, therefore, but to revoke the order in its entirety and remit the matter for re-hearing. Therefore I need not consider CGU's cross-appeal of the same order.

The first paragraph of the Arbitrator's March 19, 2003 decision allows Ms. Iankilevitch to withdraw her application for arbitration on terms. This also was in error. If the Arbitrator's first decision was a final order, as the Arbitrator held, there was no application to withdraw in respect of Ms. Iankilevitch's claim for benefits between August 20, 2001 and June 11, 2002 – the Arbitrator had already disposed of that claim. In any event, the reason for Ms. Iankilevitch's withdrawal motion – the Arbitrator's orders of October 4, 2002 and October 30, 2002 – will be revoked. Therefore nothing remains of the Arbitrator's orders of March 19, 2003, and they will be revoked. Ms. Iankilevitch may wish to reconsider her next steps.

The matter will be remitted for a new arbitration hearing of Ms. Iankilevitch's claims.

This appeal raised difficult interpretive and procedural questions concerning a relatively novel section of the *SABS-1996*. To avoid further delays, an arbitration pre-hearing should be arranged to clarify the status of the matter, identify all remaining issues, and ensure all required documents are exchanged before the hearing.

IV. EXPENSES

The parties may contact me within 30 days of this decision if they are unable to agree on appeal expenses.

August 31, 2004

Nancy Makepeace
Director's Delegate