Attendant Care Benefits: The Use of Statutory Declarations and Examinations Under Oath in Establishing Claims

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Experienced practitioners know that Statutory Declarations and Examinations Under Oath can be used effectively as a sword or as a shield to advance or to investigate a claim for attendant care benefits. This session will discuss the information that insurers need to receive to process claims expeditiously, and the information that tort lawyers should be gathering to assess their own exposure to claims for attendant care benefits.

The Historical Approach to Attendant Care Benefits Claims

Under the prior version of the *Statutory Accident Benefits Schedule* ("*SABS*") before September 1, 2010, attendant care benefits were payable so long as the "reasonable need" existed for assistance from an aide or attendant.[1]

Caselaw from the Financial Services Commission confirmed that the onus was on the insured person to establish that the claimed amount of attendant care was reasonable and necessary pursuant to s. 16(2) of the SABS:[2]

> (2) The attendant care benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,
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> (a) services provided by an aide or attendant; or
>
> (b) services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital.

Following the *McMichael* decision, many counsel took the position that if an insurer's non-payment of attendant care benefits resulted in those services not being provided to the insured, then those amounts were "deemed" incurred, and nonetheless payable despite the fact that there were no out-of-pocket expenses.[3] In other words, if a vulnerable insured person did not have a support system in place and could not afford a care provider, then the amount of that "reasonable need" for attendant care should be paid by the insurer. However, the *McMichael* decision did not mean that an insured person could refuse to confirm the nature, duration and extent of any services that were provided, nor the identity or contact information of the person providing the claimed services.

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[1] *Belair Insurance Company v. McMichael*, 2007 CanLII 17630 (ON SCDC) ("*McMichael*").

[2] *Fernandes and Certas Direct* (FSCO Appeal P06-00030, February 14, 2008, Director's Delegate Lawrence Blackman).

[3] This *McMichael* approach has since been codifed in s. 3(8) of the current *SABS*.

In the context of verifying a claim for housekeeping and home maintenance benefits, Arbitrator Rogers commented in *Subramaniam and Wawanesa* (FSCO A09-002594, July 13, 2012) that the *McMichael* decision does not erode the insured's obligation to co-operate with reasonable requests for information to verify and confirm whether the claimed amounts are payable:

> *Mr. Subramaniam claimed to be receiving specific services and submitted a single statement, with little detail, covering a period of almost a year. In those circumstances Wawanesa was entitled to require Mr. Subramaniam to provide the details requested, pursuant to his obligation under section 33(1) of the Schedule. That section requires an insured person to provide information reasonably required to assist in determining entitlement to the benefit. McMichael does not erode that obligation.*

This paper and related presentation will discuss the proper use of s. 33 and s. 46.2 to verify and confirm that covered expenses are payable in accordance with the *SABS*. We will also consider the evidence generated within the accident benefits claim and the corresponding interaction with similar claims in a related tort action.

The New Regime: *SABS - Effective September 1, 2010*

With the September 1, 2010 changes to the *SABS*:

i) Attendant Care Benefits are not payable unless the insured suffers an impairment that is not a minor injury, regardless of whether the Minor Injury Guideline applies (s. 14(2));

ii) Attendant Care services must be:

   i) incurred; or

   ii) found by a FSCO Arbitrator or Court to have not been incurred because the insurer unreasonably withheld payment, *i.e.*, a reasonable need existed (s. 3(7)(e) and s. 3(8);

iii) To be "incurred", the insured must have "received" the service, paid or promised to pay the expense, and the service provider must have sustained an economic loss or performed the service in the course of the regular occupation they would have ordinarily been engaged in, but for the accident (s. 3(7)(e));

iv) Insurers have an obligation to request sufficient information to confirm whether Attendant Care Benefits are payable using s. 33 and s. 46.2;

v) A service provider has a "duty" to provide information that is reasonably required to assist the insurer, while "acting reasonably", to determine its liability to pay attendant care. This includes access to original receipts and invoices, a sworn statutory declaration "as to the circumstances giving rise to the invoice", and proof of their identity (s. 46.2); and

vi) If the service provider fails to comply with a reasonable s. 46.2 request, no interest is payable during the period of non-compliance (s. 46.2(3)), and the

> insured is not permitted to mediate (s. 55), arbitrate or litigate (s. 281(2) of the *Insurance Act*) the claim for attendant care benefits.

The changes to the 2010 *SABS* were intended to limit and reduce attendant care payments to non-arms length caregivers.

Those changes were fairly recently strengthened by the amended section 19(3)(4) of the *SABS*. Effective February 1, 2014, it provides that the amount of the attendant care benefit shall be limited to the actual economic loss of the non-professional service provider(s):

> … if a person who provided attendant care services (the "attendant care provider") to or for the insured person did not do so in the course of the employment, occupation or profession in which the attendant care provider would ordinarily have been engaged for remuneration, but for the accident, the amount of the attendant care benefit payable in respect of that attendant care shall not exceed the amount of the economic loss sustained by the attendant care provider during the period while, and as a direct result of, providing the attendant care.

Simser and Aviva **(FSCO A11-004610 and FSCO Appeal P13-0004)**[4]

At the initial arbitration hearing dealing with claims for housekeeping and attendant care benefits, Arbitrator Lee found that an "economic loss" requires a financial or monetary loss such as a loss of income that is more than a "*de minimus*" amount.

The Applicant claimed amounts for services provided by his separated wife and daughter for a period of time before he switched to using a professional service provider. The insurer paid that professional service provider in accordance with the Form 1, so no ongoing claims were in dispute.

Mr. Simser argued that the economic loss of his wife and daughter must be given a wide and expansive interpretation to include the opportunity cost of those service providers. But for the accident and having to provide services to the injured person, the service providers would have ordinarily been performing another activity. He argued that if the legislature intended for an economic loss to be a financial loss, it would have specifically indicated so in the *SABS*.

Arbitrator Lee accepted Aviva's argument that such an approach would result in a finding that every person who provides services suffers an opportunity cost economic loss, thereby voiding the "economic loss" requirement altogether.

Arbitrator Lee explicitly rejected Mr. Simser's argument that the cost of a bus ticket, gasoline or meals incurred by the service provider constituted an economic loss, as this would render the incurred expenses definition meaningless:

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[4] Currently under appeal to the Divisional Court.

> "If I were to accept Mr. Simser's submission, every service provider would be able to circumvent the amended regulations by purchasing a single meal in a restaurant, a tank of gas or as suggested by counsel, by paying " … $0.01 or a bus ticket". This interpretation would again render the amendment meaningless and superfluous."

During the course of adjusting the claim, Aviva requested proof that an economic loss had been incurred pursuant to s. 33 and s. 46.2, including copies of pay cheques to see if the spousal service provider's income from her full time job decreased as a result of providing the services. The service provider failed to provide that information during the course of the claim or prior to hearing. The daughter did not testify at all at the hearing. Arbitrator Lee drew an adverse inference that service providers had not suffered a loss of income and therefore had not sustained an economic loss.

On appeal, Director's Delegate Blackman did not go so far as to say that a loss of income is required to establish an economic loss. He confirmed that the insured failed to meet the evidentiary onus to establish that the service provider(s) suffered an economic loss. He also agreed with Arbitrator Lee that the insured failed to show that the minor amounts for meals and parking were expenses incurred as a direct result of providing reasonable attendant care services to the insured.

The Director's Delegate confirmed that opportunity cost is not an economic loss, as this would render the incurred definition meaningless. He went on to reiterate that s. 33 can and should be used by insurers to verify that a family member has sustained an economic loss as a direct result of providing reasonably required attendant care services.

Similarly, in *Henry v. Gore Mutual Insurance Company*, 2013 ONCA 480 (CanLII), the Court of Appeal confirmed that s. 33 of the *SABS* and related FSCO caselaw makes it clear "that an insurer can request information to verify that a family member has sustained an economic loss as a result of providing care to the insured."

FSCO Bulletin A-02/11

Early in 2011, FSCO also confirmed that insurers are expected to confirm and verify that the incurred requirement has been met before issuing Attendant Care Benefits:

> Verifying Invoices and Expenses
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> In some instances it appears that insurers are not taking the necessary steps to confirm, or appear to have difficulty confirming, whether a covered expense for goods or services or expense has actually been incurred.
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> The SABS expressly provides that covered expenses are payable by an insurer only if they have been "incurred." The SABS further provides that a covered expense is not "incurred" unless:
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> a) the claimant has actually received the goods or service to which the expense relates,

b) the claimant has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and

c) the person who provided the goods or services,

i) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or

ii) sustained an economic loss as a result of providing the goods or services to the claimant.

It is incumbent upon insurers to ask for documentation and information as necessary to verify that a covered expense was actually incurred within the meaning of the SABS before paying an invoice, and it is reasonable for an insurer to inform a claimant or his or her provider that an invoice will not be paid until it can be verified that the expense was incurred.

Insurers may wish to inform claimants and their providers at the time an OCF-18 is approved that they may be asked to verify that invoiced expenses have actually been "incurred" within the meaning of the SABS at the time the invoices are submitted.

It is incumbent upon insurers to ask for documentation and information as necessary to verify that a covered expense was actually incurred within the meaning of the SABS before paying an invoice, and it is reasonable for an insurer to inform a claimant or his or her provider that an invoice will not be paid until it can be verified that the expense was incurred.

…

Examinations Under Oath

There is a duty for a claimant to provide all relevant information to an insurer regarding any application for accident benefits. When an insurer is unable to determine entitlement to accident benefits, insurers have the discretion under section 33 (2) to request a claimant to submit to an examination under oath. Insurers must adhere to all the provisions set out in this section, including: the limit of one examination in respect of each accident; the claimant's right to be represented; scheduling a time and location that is convenient for the claimant; and limiting the scope of the examination to matters that are relevant to the entitlement of benefits. If a claimant fails to comply, an insurer is not liable to pay a benefit during that period.

Examinations Under Oath

Examinations under oath are a historically underused tool available to no fault insurers to verify and confirm whether an insured is entitled to accident benefits. At the same time, EUOs are also an excellent opportunity for an insured to clearly communicate with

their insurer and to explain why they are entitled to further benefits under the *SABS*. In this sense, an EUO can be both a sword and a shield.

In the no fault context, s. 33 EUOs are generally used for three purposes:

- to investigate fraud;
- to confirm priority of payment; and
- to gather reasonably required information to verify and confirm entitlement to accident benefits under the SABS.

Counsel are commonly retained by insurers to conduct EUOs to address priority, WSIB, loss transfer, “accident”, “incurred” and other benefit entitlement issues.

Section 33 examinations under oath were first introduced in 2003. A second priority EUO was added to the *SABS* in 2013. In 2011, FSCO confirmed with Bulletin A-02/11 that insurers have a public duty to verify and confirm that submitted expense and benefit claims are payable in accordance with the *SABS* and they have the discretion to use an examination under oath for that purpose.

Since the release of the *Balvers* trilogy of Superior Court decisions in 2007,[5] there has been no ambiguity or uncertainty that an insurer is entitled to conduct an EUO to ask all reasonably relevant questions of the insured in order to determine their entitlement to benefits under the *SABS*.

The broad scope of an EUO sometimes leads to challenges by counsel regarding the propriety of questions, and surprisingly, even the obligation to attend an EUO itself. However, the case law from the Financial Services Commission of Ontario confirms that unreasonable or unexplained refusals to comply with s. 33 will result in orders dismissing the claim or suspending entitlement to benefits.

Sections 32(10) and 36(4) may also apply to mean that an insurer is not obligated to pay any benefits until after the insured submits to the Examination Under Oath and supplies all reasonably required documentation requested pursuant to s. 33. Of course, if an insured has a reasonable explanation for any delay in satisfying the s. 33 requests, an insurer will pay all amounts withheld due to the delay.

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[5] *Aviva Insurance Company of Canada v. Balvers*, 2007 CanLII 17193 (ON SC), *Allstate Insurance Company v. Rivkin*, 2007 CanLII 17192 (ON SC) and *Allstate Insurance Company v. Gousseinova*, 2007 CanLII 17191 (ON SC). See also, *Baig v. The Guarantee Company of North America*, 2007 ONCA 847 (CanLII) and *Echelon General Insurance Company v. Henry*, 2011 ONSC 3673 (CanLII).

Against this background, there are four recent FSCO decisions which highlight the reciprocal duties of the insurer and insured under s. 33.

In *Gore and Deol* (FSCO A13-003801, September 3, 2013), Arbitrator Wilson confirmed that "there is no restriction on the timing of the examination under oath". Arbitrator Wilson found that so long as the elements of s. 33 are satisfied, no benefits are payable until 10 business days after the insured attends the s. 33 EUO, regardless of the reasonableness of the explanation for the non-attendance at a previously scheduled Examination Under Oath. Due to the Applicant's failure to comply with s. 33, no benefits were payable by the insurer.

In *Michaud et al and State Farm* (FSCO A11-004437, A11-004496 and A11-004497, March 5, 2014), Arbitrator Wilson similarly confirmed that the prerequisites for a s. 33 Examination Under Oath are limited to s. 33 of the schedule, namely, that:

1. the insurer shall attempt to schedule the EUO for a date, time and location that is convenient for the insured person; and

2. the insurer shall provide reasonable advance notice of:

    a) the date, time and location of the EUO;

    b) that the insured is entitled to be represented;

    c) the reasons for the examination; and

    d) that the scope of the examination will be limited to matters that are relevant to the insured's entitlement to benefits.

Most often, the “reason for the examination” is to determine whether the Applicant is entitled to benefits under the SABS. There is no obligation for an insurer to advise of the specific questions in advance of an EUO.

In *Chartis and Howell* (FSCO A12-00029, July 30, 2014), Arbitrator Kowalski dismissed a claim for Income Replacement Benefits as an abuse of process due to the Applicant’s failure to produce Income Tax Returns requested pursuant to s. 33 at his EUO. It was also the Applicant’s EUO evidence that he had not filed income tax returns since 2008, did not believe in filing income tax returns, and felt that he owed the government “nothing”. Arbitrator Kowalski confirmed:

> *Section 33 of the Schedule places a duty on an applicant to provide any information reasonably required to assist the insurer in determining the person’s entitlement to a benefit. When Chartis received Mr. Howell’s OCF-1 and OCF-2, it advised by Explanation of Benefits Form (OCF-9) dated November 23, 2009 that it could not determine his potential entitlement to IRBs because of defects in his application for benefits. Following Mr. Howell’s December 15, 2009 statement that he was paid in cash and did not report his income to the CRA, Chartis issued a further OCF-9 that explained it could not determine Mr. Howell’s potential*

> *entitlement to IRBs because his OCF-2 was incomplete and contained conflicting information. The OCF-9 also requested proof of his pre-accident income. Chartis continued to make multiple unsuccessful requests pursuant to section 33 requesting production of documentation to verify Mr. Howell's pre-accident income and to confirm whether he had declared any pre-accident income to the CRA.*
>
> *…*
>
> *Mr. Howell's then-counsel confirmed during the June 29, 2010 examination under oath that he was not pursuing his IRB claim. The withdrawal was confirmed on the record, followed by the position taken that Mr. Howell would take no further questions about his income, and that all productions requested pursuant to section 33 of the Schedule would be refused if they related to the IRB claim.*

Arbitrator Kowalski concluded the Applicant's conduct created irrevocable prejudice to Chartis' ability to adjust and defend the IRB claim. She found the conduct amounted to an abuse of process and the IRB claim was dismissed.

Most recently in *Singh and State Farm* (FSCO A12-007594, August 22, 2014), Arbitrator Bayefsky confirmed that the scope of the examination under oath is not limited to the benefits claimed at the time of the EUO. As a result of the Applicant's improper refusal to answer questions at an Examination Under Oath, Arbitrator Bayefsky adjourned the FSCO arbitration hearing until the Applicant attended a resumed EUO, ordered that no benefits were payable from the date of the refusal to answer questions at the first EUO and indicated the Arbitration would be dismissed if the Applicant did not attend the resumed EUO within 90 days.

With one exception,[6] the growing body of EUO caselaw confirms that the scope and relevance of questioning during an examination under oath is to be construed broadly with reference to the language and purpose of the *SABS* and not on the narrow basis of information provided by the claimant or on the basis of the benefits claimed by the claimant as of the date of the examination.

Thus, an insurer has the right to ask questions that are relevant to assist in the determination of entitlement to, and quantum of, past, present and future benefits, whether they are paid or not. This means that almost any question can be asked by an insurer and shall be answered by an applicant for benefits. The only requirement is that the question must be relevant to whether a benefit under the *SABS* may potentially be payable by the insurer.

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[6] See *Williams and State Farm* (FSCO A14-001463), currently under appeal, where Arbitrator Murray concluded that a s. 33 EUO was not permitted more than 10 days after the submission of the OCF-3 for the purposes of adjusting a specified weekly benefits claim. This decision does not address sections 33(2), 36(5) or 37(2)(f) of the *SABS* which permit a s. 33 request at any time to address entitlement to specified benefits.

The onus is on the insurer to ensure that s. 33 requests are clearly made in relation to a potential benefit under the *SABS*. The insurer must also be sure to advise the Applicant that any withheld amounts will become payable if the Applicant satisfies the request and provides a reasonable explanation for the delay.

An Applicant can refuse to comply with a s. 33 request, particularly if the request is clearly not relevant to whether benefits are payable in accordance with the *SABS*. An insurer's improper s. 33 suspension of benefits due to an unreasonable request for information or documents could give rise to a Special Award if that non-payment is an "unreasonable withholding" of benefits.

Last, s. 55 of the *SABS* provides that an insured person is not permitted to mediate a claim for benefits if they have failed to notify the insurer of the circumstances giving rise to the claim for benefits. The failure of an insured to provide reasonable and relevant information or documents regarding the claim may result in a finding that they are not permitted to mediate, arbitrate or litigate that disputed benefit.

Section 46.2 Statutory Declarations

In the new *SABS*, s. 46.2 allows an insurer to request additional information to adjust a claim for payment of expenses.

> Duty of provider to provide information
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> 46.2 (1) An insurer may request any of the following information from a provider:
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> > 1. Any information required to assist the insurer, acting reasonably, to determine its liability for the payment, including access to inspect and copy the originals of any treatment confirmation form, treatment and assessment plan, assessment of attendant care needs and other documents giving rise to the claim for payment.
> >
> > 2. A statutory declaration as to the circumstances that gave rise to the invoice, including particulars of the goods and services provided.
> >
> > …
>
> (2) The provider shall give the insurer the information requested under subsection (1) within 10 business days after receiving the request.
>
> (3) For the purpose of section 51, the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which a provider fails to comply with subsection (2).
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> Duty of insured person to provide information
>
> 46.3 (1) An insurer may request any of the following information from an insured person who submits an invoice to the insurer for payment for goods or services

under this Regulation, or from an insured person on whose behalf such an invoice is submitted:

1. Confirmation in writing that the goods or services were provided to the insured person.

2. A statutory declaration as to the circumstances that gave rise to the invoice, including particulars as to when, where and by whom the goods or services were provided.

(2) The insured person shall give the insurer the information requested under subsection (1) within 10 business days after receiving the request.

(3) For the purpose of section 51, the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which an insured person fails to comply with subsection (2).

Insurers are asking service providers to meet with a road adjuster or investigator for an in-person statement/statutory declaration. Alternatively, insurers are appointing counsel for the completion of a s. 33 EUO and then a s. 46.2 statutory declaration with the service provider immediately thereafter with the same court reporter.

In response to the greater utilization of s. 46.2 by insurers, some counsel are refusing to produce the service provider (an interesting approach given the conflict of interest between the insured and the service provider) for an in-person statutory declaration.

We are also seeing proactive counsel submitting a sworn statement or affidavit of the service provider with the initial OCF-6, along with copies of documents showing a loss of income. From both the insurer's and the claimant's perspective, this is likely a best practice.

So What Does All of This Mean for Your Practice?

From the claimant's perspective, if the attendant care service provider did not ordinarily provide attendant care in the course of their pre-accident occupation, then it is important to provide documentary proof of lost wages, lost overtime, or some other form of economic loss to establish that the incurred threshold has been met.

If the date of loss is after February 1, 2014, that same documentary evidence will be needed for any amount to be payable, not just to determine whether the incurred threshold has been met.

It remains open for debate regarding whether minor expenses for parking, mileage or meals are sufficient to meet the incurred threshold. The current FSCO caselaw is mixed. It does seem apparent, on a case by case basis, that an insured who fails to provide documentary evidence supporting an economic loss of the service provider is much less likely to succeed on the incurred issue. However, there are a handful of decisions, currently under appeal, where the insured or service provider credibly provided oral evidence regarding out of pocket expenses or other forms of lost

opportunity. In those cases, the arbitrator, without much analysis, accepted that the economic loss requirement had been met. It will be interesting to see the results on appeal.

From the insurer's perspective, FSCO Bulletin A-02/11 requires the insurer to verify and confirm that the requirements of the *SABS* have been met before issuing payment.

In the ordinary course of the claim, the insurer will request that the insured complete an Application for Expenses (OCF-6) form setting out the amount claimed, along with a sufficiently detailed description of the identifying information of the service provider as well as the timing and nature of the services provided each month. In addition, the service provider will be asked to provide proof of their ordinary occupation, and/or that an economic loss has been sustained.

In practice, the insured's first response to the request for further information under sections 33 and 46 will determine whether the insurer requests a more fulsome examination under oath of the insured or a statutory declaration from the service provider.

To avoid further scrutiny of the claim for attendant care benefits, counsel for an insured should pay attention to such a request at an early stage of the claim and then "put the moderately best foot forward" to establish entitlement for their client.

From a tort perspective, the s. 33 examination under oath should be avoided at all costs if possible (and reasonable). Your client will be examined for discovery some three or four years post loss. Memories fade with time. Your insured client's truthfulness and reliability is an important factor for assessing threshold and whether they will be a good witness in support of their claims at trial.

A prior transcript from a s. 33 examination under oath completed in the first six months after the accident usually does not assist the plaintiff's evidence or presentation as a witness. This is even more important since the introduction of discovery plans and routine production of documents in advance of examination for discovery.

Every tort discovery plan should include a request for the complete accident benefits file, including the transcript from the examination under oath and all statements or statutory declarations relevant to the tort claims.

If you are counsel for the tort defendants, those documents are essential to assessing the past claims for attendant care and other damages incurred prior to the service of the statement of claim (and before the plaintiff undergoes a defence medical or surveillance).

If you are counsel for the tort plaintiff, you need to know (ahead of time) whether there is a "surprise" waiting in the accident benefits file. Your client may be subject to difficult questions regarding those prior statements at discovery. Alternatively, your client's answers at discovery may be directly contradicted when the accident benefits file is produced post discovery in satisfaction of the undertaking.

The bottom line is that the accident benefits strategy for the no fault attendant care benefits claim can have a significant spill over effect into the tort claim.

If you can work proactively establish a clear economic loss from the outset of the attendant care claim, you can:

1) avoid your client being discovered twice;

2) create and preserve clear and concise evidence confirming your client's need for the provided attendant care services post accident;

3) ensure clear entitlement to monthly attendant care benefits while you are building your tort file/claim; and then,

4) argue the Form 1 rates or maximums do not reflect the market cost for attendant care (and therefore pursue the shortfall in the tort claim).

If the insurer withholds payment of attendant care benefits after you have supplied the service provider's employment records documenting a loss of income or some other form of meaningful economic loss, then a Special Award becomes a real possibility.

If there is one message that I hope you take away from today's presentation, is it this: proactive plaintiff counsel can limit the examination under oath to questions that are relevant to potential benefits under the *SABS* and/or avoid the attendance at the EUO entirely if sufficient information is gathered from the insured and the service provider from the outset of the claim.

Author's Bio:

Jason is an associate at Hughes Amys LLP, an insurance defence firm in Toronto, Ontario, which is a member of the ARC Group Canada and was recently listed by Canadian Lawyer Magazine as one of the Top 10 Insurance Defence firms in Canada.

After attending the University of Western Ontario and obtaining his B.A.(Hons) in Political Science (2003), Jason completed his LL.B. at the University of Windsor (2007) where he was awarded the Max M. Mousseau, Q.C. Memorial Award in Municipal Law. He also completed the Osgoode Hall Law School Written Advocacy Course (2011).

Jason's legal practice focuses primarily on statutory accident benefits, priority, loss transfer and WSIAT disputes. His published decisions include *Blagrove v. Whittington*, 2010 ONSC 3748 (CanLII), *Walsh v. Optimum*, 2012 ONSC 3013 (CanLII), *Unifund v. RBC* (Arbitrator Ken Bialkowski, August 2, 2012), WSIAT Decision No. 1285/14, 2014 ONWSIAT 1465 (CanLII), *Chartis and Howell* (FSCO A12-000029, July 30, 2014) and *TD v. Markel*, 2014 ONSC 6461 (CanLII).

Jason recently became a father and lives in North York with his wife Karina.