



FSCO A08-000170

BETWEEN:

THERESE WEST

Applicant

and

AVIVA CANADA INC.

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Robert Bujold

Heard: August 15, 2008 at the offices of the Financial Services Commission of Ontario in Toronto.
Written submissions dated July 9, 22, August 8 and 14, 2008 were also received and considered.

Appearances: Robert Deutschmann for Ms. West
Cara Boddy for Aviva Canada Inc.

Agreed Facts and Issues:

The Applicant, Therese West, was injured in a motor vehicle accident on April 4, 2002. She applied for and received statutory accident benefits from Aviva Canada Inc. ("Aviva"), payable under the *Schedule*.¹

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

At the time of the accident, Ms. West was self-employed as an accountant/comptroller. Since the accident, Ms. West has tried doing tax returns for family and friends and has experimented with making videos on her computer and working with her photography equipment. She has not, since the accident, earned any income as a result of the above-noted efforts.

Aviva paid IRBs from April 12, 2002 at \$400 per week.

By Notice of Stoppage dated April 19, 2004, Aviva terminated weekly income replacement benefits ("IRBs") effective May 7, 2004, on the basis that the medical documentation in its possession at the time did not support entitlement to ongoing IRBs beyond 104 weeks post-accident. Ms. West disputed Aviva's decision and requested a Disability DAC assessment. A Disability DAC assessment was conducted in September and October 2004. The DAC concluded that Ms. West did not suffer from a complete inability to engage in any employment for which she was reasonably suited by education, training or experience. Aviva sent an Explanation of Benefits Payable dated November 1, 2004 confirming its initial decision that benefits were no longer payable and confirming that IRBs had been stopped.

Shortly afterward, in November and December 2004, Ms. West participated in a Pain Program at Hamilton Health Sciences, Chedoke Rehabilitation Centre.

On March 24, 2005, Ms. West submitted an Application for Mediation disputing Aviva's termination of IRBs and the Disability DAC's finding that she did not meet the disability test for entitlement to ongoing IRBs. The issue failed at mediation which was conducted on August 4, 2005.

Ms. West has never commenced a court proceeding or arbitration in respect of Aviva's termination of her IRBs nor does Ms. West dispute that the termination was proper.

Several months after the failed mediation, Ms. West underwent a psychological assessment over three days in March 2006. A further year later, in March 2007, Ms. West underwent a psychiatry assessment over two days. A further psychological assessment was conducted in April 2007.

By letter dated June 4, 2007, Ms. West's counsel requested that Aviva consider reinstating Ms. West's IRBs and enclosed reports relating to the psychiatry and psychological assessments that were conducted in March and April 2007.

Aviva denied Ms. West's request for reinstatement of her IRBs on the basis that her claim to further IRBs was statute barred by operation of the limitation period set out in section 281.1 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, and section 51 of the *Schedule*.

Ms. West disputed that her claim for further IRBs is limitation barred. Ms. West maintained that her condition has deteriorated and results in new circumstances for which she provided fresh notice and a fresh claim. Ms. West noted that she is only claiming IRBs from June 4, 2007, when Aviva received notice of her deteriorated condition and she requested reinstatement of IRBs. She does not seek IRBs for the period from the initial termination on May 7, 2004 to June 4, 2007.

The parties were unable to resolve their dispute through mediation, and Ms. West applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

The preliminary issue is:

1. Is Ms. West precluded from proceeding to arbitration on the basis that her claim is statute barred, pursuant to section 281.1 of the *Insurance Act* and section 51 of the *Schedule*?

Result:

1. Ms. West is precluded from proceeding to arbitration as her claim for income replacement benefits is statute barred, pursuant to section 281.1 of the *Insurance Act* and section 51 of the *Schedule*.

ANALYSIS:

Both parties agreed that the issue before me, as framed, is narrow. The parties framed the question as follows:

Can a person avoid an intervening limitation period with respect to a claim for income replacement benefits after a valid termination of these benefits by the insurer, via the submission of a new request for income replacement benefits based on a subsequent physical or psychological deterioration in the insured's condition post-termination?

Essentially, as I see it, the question is whether Ms. West can reapply for post-104 week IRBs on the basis that a deterioration in her condition has resulted in new circumstances that may now meet the disability test, even though it has been more than two years since the insurer refused to pay post-104 week IRBs based on circumstances as they existed at that earlier time.

As stated above, the parties agreed that the time to dispute Aviva's prior denial in 2004 had long expired pursuant to the limitation period set out in section 281.1 of the *Insurance Act* and section 51 of the *Schedule*. Those provisions provide as follows:

Section 51 of the Schedule

51. (1) A mediation proceeding or evaluation under section 280 or 280.1 of the *Insurance Act* or a court proceeding or arbitration under clause 281 (1) (a) or (b) of the Act in respect of a benefit under this Regulation shall be commenced within two years after the insurer's refusal to pay the amount claimed.

(2) Despite subsection (1), a court proceeding or arbitration under clause 281 (1) (a) or (b) of the *Insurance Act* may be commenced within 90 days after the mediator reports to the parties under subsection 280 (8) of the Act or within 30 days after the person performing the evaluation provides a report to the parties under section 280.1 of the Act, whichever is later. O. Reg. 403/96, s. 51.

Section 281.1 of the Insurance Act

281.1 (1) A mediation proceeding or evaluation under section 280 or 280.1 or a court proceeding or arbitration under section 281 shall be commenced within two years after the insurer's refusal to pay the benefit claimed. 2002, c. 24, Sched. B, s. 39 (6).

Exception

(2) Despite subsection (1), a proceeding or arbitration under clause 281 (1) (a) or (b) may be commenced;

- (a) if there is an evaluation under section 280.1, within 30 days after the person performing the evaluation reports to the parties under clause 280.1 (4) (b);
- (b) if mediation fails but there is no evaluation under section 280.1, within 90 days after the mediator reports to the parties under subsection 280 (8). 2002, c. 24, Sched. B, s. 39 (6).

The parties also agreed that the issue of whether Ms. West did or did not suffer a deterioration is not before me. In the event I find that Ms. West is not precluded from proceeding with her application on the basis of the narrow issue before me, the parties agreed that the determination of whether or not Ms. West, in fact, suffered a deterioration in her physical or psychological condition, and any other findings of fact that may affect Ms. West's claim, are matters for a full hearing on the merits.

The preliminary issue hearing proceeded on the basis of an agreed statement of facts. The essential facts have been set out above.

I will dispose of one argument put forward by Aviva before dealing with what I see as the heart of the issue. Aviva argued that Ms. West's attempt to advance an IRB claim after the expiration of a limitation period, on the basis that she suffered a relapse or deterioration in her condition, is an attempt to introduce the concept of discoverability. FSCO case law has found that engaging the discoverability rule is a power that resides in a court's inherent jurisdiction; a power that arbitrators do not possess.² I agree. However, I do not agree that the question put to me on this preliminary issue hearing invokes the discoverability rule. While there may be instances of impairments or underlying medical conditions not being reasonably discoverable until some later event, the agreed facts on this preliminary issue hearing suppose that there has been a deterioration of Ms. West's condition, not the late discovery of a previously existing condition. Therefore, I do not find the discoverability rule relevant to the preliminary issue, at least not on the agreed facts before me.

² *Elfeki and Non-Marine Underwriters* (FSCO A00-06978, July 14, 1997)

The leading case that deals directly with the issue of an insured person's right to reapply for weekly benefits, after those benefits have been terminated and the limitation period from such termination has expired, is the Ontario Court of Appeal case of *Haldenby v. Dominion of Canada General Insurance Co.*³

Haldenby was decided under the *Statutory Accident Benefits Schedule – Accidents before January 1, 1994*, R.R.O. 1990, Reg. 672 (hereinafter referred to as “the OMPP”). Under that scheme, an insurer is not required to pay a weekly income benefit “for any period in excess of 156 weeks unless it has been established that the injury continuously prevents the insured from engaging in any occupation or employment for which he or she is reasonably suited by education, training or experience.” (subsection 12(5)(b))

Also, subject to income received, a claimant is able to “accept, or return to, work at any time during the first two years following the accident for any period of time without affecting his or her benefits ... if, as a result of the accident, he or she was unable to continue ... in the occupation or employment.” (subsection 16(1)) Beyond two years following the accident, a claimant can still “accept, or return to, an occupation or employment for periods of up to ninety days without affecting his or her benefits ... if he or she, as a result of the injury, is unable to continue ... in the occupation or employment.” (subsection 16(2))

The limitation period under the OMPP requires that “a mediation proceeding under section 280 of the *Insurance Act* or an arbitration or court proceeding under Section 281 of the Act ... must be commenced within two years from the insurer's refusal to pay the amount claimed in the application for statutory accident benefits or, if the person has ... accepted, or returned to, an occupation or employment, as permitted by section 16, within two years of the insurer's refusal to pay further benefits.” (subsection 26(1))

³ *Haldenby v. Dominion of Canada General Insurance Co.* (2001), 149 O.A.C. 172 (Ont. C.A.)

In *Haldenby*, the applicant had returned to work within two years of the accident in issue. At the 156 week mark, in February 1996, Dominion terminated Ms. Haldenby's weekly IRBs because it was not established that "the injury continuously prevents the insured from engaging in any occupation or employment for which she is reasonably suited by education, training and experience."

A further year later, in January 1997, Ms. Haldenby was terminated from her employment due to her accident-related injuries. In October 1998, Ms. Haldenby wrote to Dominion and requested "further weekly income benefits." Dominion did not respond. The dispute over Ms. Haldenby's entitlement to further weekly IRBs proceeded to mediation in May 1999. Mediation failed and a statement of claim was issued in August 1999.

Ms. Haldenby argued that her return to work within two years of the accident had created, in effect, two limitation periods; one from the date of the insurer's initial refusal, and a second limitation period from the date of the insurer's refusal to pay further benefits after her return to work had ended and she reapplied for benefits.

The Court in *Haldenby* found that although subsection 26(1) contained two possible triggering events for the commencement of the two-year limitation period, it contemplated only one limitation period.

The Court also found that the return to work protections in subsection 16(1) did not afford Ms. Haldenby any right to receive more benefits than are provided for under section 12 which, as stated above, are limited to 156 weeks, unless the insured person is continuously prevented from working. Ms. Haldenby had not been "continuously prevented" from working.

However, this did not end the Court's analysis. The Court also noted as follows:

... there is no provision in the Act or the SABS which allows a claimant to reapply for further benefits after an insured person's benefits have been terminated by the insurer. The only remedy for the insured person is to appeal the termination of the benefits within the two-year period.

With respect to the implications of Ms. Haldenby's interpretation on the limitation period, the Court noted as follows:

[Ms. Haldenby] submits that under the second part of s. 26(1) and s. 16, a person receiving benefits can return to work for any period of time after the accident, receive the full 156 weeks of benefits and, if at some time thereafter the person is entirely unable to continue to work due to accident-related injuries, can reassert a claim for *further* benefits at any time, and the limitation period does not begin to run until the insurer refuses to pay the further benefits claimed.

The appellant's interpretation of s. 26(1) was properly rejected by David Evans, the arbitrator in *Shirani v. Wellington Insurance Co.* (F.S.C.O. File No. A96-000114, January 7, 1997) since it suggests that, in effect, there would be no limitation period. The appellant's interpretation of s. 26(1) would allow a person receiving benefits who has successfully returned to work, to apply for *further* benefits at any time in an undetermined future. The limitation period in s. 26(1) would only be engaged when such an application was refused.

As noted by the application judge (para. 8), the appellant's approach would extend a claimant's entitlement to benefits for an indeterminate period of time and is "inconsistent with the Supreme Court of Canada's rationale which underlined the common sense of, and the need for limitation periods." Indeed, as discussed above, such an interpretation of ss. 26(1) and 16 would unreasonably controvert the systemic need for finality, certainty and the principle of diligence.

Ms. West submitted that *Haldenby* is distinguishable as it was decided under a previous accident benefits regime, i.e. the OMPP. Ms. West stressed that the Court found it "determinative" that Ms. Haldenby was not entitled to benefits beyond 156 weeks because she had not been "continuously prevented" from working. No such restriction on receiving IRBs beyond 104 weeks is contained in the current *Schedule*. While this is true, as far as it goes, the Court also dismissed Ms. Haldenby's appeal on the two other bases noted above: the absence of any right to reapply for benefits once terminated, and the impact of Ms. Haldenby's interpretation on the limitation period. Both of these bases were integral to the Court's reasoning and decision, and were not *obiter*.

Ms. West admitted that there is no explicit provision in the current regime that recognizes a right to reapply for IRBs. However, Ms. West argued that there are significant differences between the application procedures under the OMPP and the current *Schedule*. Ms. West argued that, while not explicit, the right to reapply may be inferred from the provisions

contained in "Part X – Procedures for Claiming Benefits" of the current *Schedule*. At minimum, Ms. West submitted that the provisions of Part X, when read in the context of the regime as a whole, create an ambiguity that should be resolved in her favour.

In particular, Ms. West referred to section 32 of the current *Schedule* which requires a person claiming benefits to "notify the insurer... no later than the 30th day **after the circumstances arose that gave rise to the entitlement to the benefit**, or as soon as practicable after that day..." [emphasis added] Section 22 of the OMPP, on the other hand, provides that "the insured person... shall... give initial notice of a claim to the insurer, in writing, within thirty days **from the date of the accident** or as soon as practicable thereafter..." [emphasis added]"⁴

Ms. West argued that circumstances giving rise to entitlement to a benefit do not necessarily correspond with the date of the accident. For example, the need for vocational rehabilitation may arise after the insured person has healed to the point where they are able to participate in such a program. The implication is that circumstances can change or evolve over time with the result that circumstances giving rise to entitlement to a benefit may arise more than once and at different times.

Ms. West also noted that section 32 does not explicitly prohibit an insured person from making a further application for IRBs after a period where they did not satisfy the criteria for entitlement to IRBs; nor does section 35 (which deals with an insurer's obligations upon receipt of an application for IRBs) or section 37 (which deals with the procedure for a refusal or stoppage of IRBs) explicitly prohibit an insured person from reapplying for IRBs if new circumstances have arisen that would give rise to entitlement to the benefit. Finally, Ms. West noted that section 32 makes no distinction between Medical and Rehabilitation Benefits (for which multiple discrete applications are commonly submitted) and IRBs.

Aviva conceded that "the 30th day after the circumstances arose that gave rise to the entitlement to the benefit" does not necessarily refer to 30 days from the date of the accident. However,

⁴ I note that the regime that came between the OMPP and the current *Schedule* uses language similar to the current *Schedule* (see section 59(1) of Bill 164 - *Statutory Accident Benefits Schedule - Accidents after December 31, 1993 and before November 1, 1996*, O. Reg. 776/93).

Aviva did not deny Ms. West's claim for further IRBs on the basis that she did not provide proper notice of the circumstances giving rise to her entitlement. Aviva denied her further claim on the basis that it was barred by the passing of the limitation period.

Aviva also conceded that the *Schedule* does not contain an explicit prohibition against reapplication for IRBs. However, Aviva argued that even if Ms. West is permitted to reapply for IRBs (which it did not admit) any such right should not be interpreted to create fresh applications from which fresh limitation periods run nor should it relieve Ms. West from complying with the time limits to dispute the initial refusal. As Aviva noted, the decision of *Kirkham and State Farm Mutual Automobile Insurance Company*⁵ clarified that weekly benefits are to be "treated as an ongoing claim and once the insurer refuses to pay or to continue paying, the insured person has two years to dispute that decision through the courts or the dispute resolution process."

I generally agree with Aviva's position.

I am not persuaded that the differences between section 22 of the OMPP and Part X of the current *Schedule* (in particular section 32) are sufficient to distinguish *Haldenby* and *Kirkham*.

Although Ms. West is correct that Part X of the current *Schedule* draws no explicit distinction between an application for IRBs and the multiple applications commonly brought for Medical and Rehabilitation Benefits, I note there is similarly no distinction drawn in section 22 of the OMPP under which both *Kirkham* and *Haldenby* were decided. I received no evidence, nor have any reason to believe, that multiple applications for Medical and Rehabilitation Benefits were not the norm under the OMPP when *Kirkham* decided that IRBs are to be treated as an ongoing benefit and *Haldenby* decided that there is no right to reapply for IRBs.

Ms. West would still have me infer a right to reapply for IRBs based on the change in the wording of the requirement to provide notice from "30 days from the date of the accident" to "the 30th day after the circumstances arose that gave rise to the entitlement to the benefit."

⁵*Kirkham and State Farm Mutual Automobile Insurance Company* (FSCO P96-00069, January 27, 1997); Application to Divisional Court dismissed (Docket 510/97, March 31, 1998); Leave to Appeal to Court of Appeal refused (Docket CA M22347, July 9, 1998). *Kirkham* was decided under the OMPP.

I am not persuaded that the change in wording was intended to create a right to bring multiple applications for IRBs. I find it more likely that the change in wording was simply intended to recognize and clarify what was already understood, i.e. that entitlement to a benefit may not always arise within the first 30 days after an accident, such as in the case of Medical and Rehabilitation Benefits.

With respect to new circumstances that may arise during the adjustment of an IRB claim, it is important to distinguish between, on the one hand, “reapplying” for benefits for which the insurer has issued a proper denial and for which a limitation period has expired and, on the other, a reconsideration of benefits within the limitation period on the basis of new information. An insurer has an ongoing obligation to adjust its insured’s claims and consider new information as it becomes available. However, a reconsideration does not give rise to a new limitation period⁶ nor, in my view, does a relapse or deterioration in the insured person’s condition revive a claim that is otherwise already statute barred.

As I see it, however, the principal difficulty with Ms. West’s position is the implication her interpretation would have on the limitation period established in section 281.1 of the *Insurance Act* and section 51 of the *Schedule*.

In *Construction of Statutes*, 2nd Edition, (1983), at p. 87, Professor Driedger notes as follows:

Today there is only one principle or approach, namely the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

Professor Driedger’s words have been referred to approvingly in all levels of Courts and FSCO.⁷ In *Hope v. Canadian General Insurance*,⁸ Doherty J., for the Court of Appeal, also made the following comment:

⁶ See also, *Murty and Security National Insurance Company* (FSCO A98-001469, April 30, 1999); *Mohammed-Amin and RBC General Insurance Company* (FSCO A06-002188, June 25, 2007); *Mangos and Aviva Canada Inc.* (FSCO A06-000847, October 17, 2007)

⁷ At FSCO, see, for example, decisions going back as far as *Morin and The Personal Insurance Company of Canada* (FSCO P-000468, February 26, 1993)

⁸ *Hope v. Canadian General Insurance*, [2002] O.J. No. 16

Ambiguity cannot be determined by examining words in isolation from the text in which they appear. Nor is ambiguity established by demonstrating that if the legislature had intended a particular meaning, it could have used different language that would have expressed that meaning more clearly. Not all language that falls short of crystal clarity is properly labeled ambiguous.

While the *Schedule* must be interpreted from a consumer protection perspective,⁹ and limitation periods, like exclusion clauses, should be interpreted narrowly, I agree with Aviva that Ms. West's interpretation gives rise to the same problem identified by the Court in *Haldenby*. Reading Part X of the *Schedule* as permitting unlimited applications for IRBs would effectively eviscerate and subvert the purposes of the limitation period contained in the *Schedule* and the *Act*.

In *Haldenby*, the Court of Appeal was concerned that Ms. Haldenby's interpretation of subsection 26(1) of the OMPP "would allow a person receiving benefits who has successfully returned to work, to apply for *further* benefits at any time in an undetermined future."
[emphasis in original]

Here, the interpretation posited by Ms. West would apply to an even larger class of potential claimants and bring even greater uncertainty than in *Haldenby*. Though it wasn't entirely clear whether Ms. West was trying to frame her case as a possible return to work situation, I do not understand her position as placing any such prerequisite on the right to reapply for IRBs. The only requirement would be a change in circumstances, such that the insured person now meets the disability test for entitlement. A temporary return to work could be relevant to understanding the evolution of the insured person's circumstances, but it would not be a condition precedent to claiming further IRBs. In short, Ms. West's interpretation would permit an insured person to reapply for IRBs as often and as frequently as it could be reasonably argued that his or her circumstances had changed, notwithstanding the passing of a limitation period on a prior denial.

⁹ See, for example, *Smith v. Co-operators General Insurance Company*, [2002] 2 S.C.R. 129; and *Galati and Certas Direct Insurance Company* (FSCO A06-001801, May 28, 2008)

In response to the potential for abuse by claimants who might seek to have their claims reheard under the rubric of a change in circumstances, Ms. West noted that the Commission may “make such orders or give such directions in proceedings before it as it considers proper to prevent an abuse of its processes.”¹⁰ Ms. West also pointed to an arbitrator’s powers to award expenses against an insured person and, in certain circumstances, the insured person’s representative as another deterrent against unfounded or frivolous claims. Ms. West also submitted that, in extraordinary cases, the Commission could order that an insured person not be permitted to apply for specified benefits without first obtaining leave of the Commission.

I do not find it necessary to determine whether, and to what extent, the various remedies suggested by Ms. West would provide an adequate response to the potential for abuse. As I see it, the problem with multiple reapplications for IRBs extends beyond the prospect of some potential abuse to the more fundamental concern for the lack of certainty and finality it engenders.

In conclusion, I find that Ms. West’s interpretation of Part X of the current *Schedule*, as contemplating and authorizing multiple applications for IRBs, would not be “harmonious with the scheme of the Act, the object of the Act, and the intention of Parliament” when read in its entire context. As in *Haldenby*, I find that Ms. West’s interpretation would be “inconsistent with the Supreme Court of Canada’s rationale which underlined the common sense of, and the need for limitation periods” and “would unreasonably controvert the systemic need for finality, certainty and the principle of diligence.”

Although I find that most of the same concerns that informed the *Haldenby* and *Kirkham* decisions also apply to and are determinative of the issue in this preliminary issue hearing, I will address the case of *Crossey and Farmers’ Mutual Insurance Company*¹¹ that Ms. West also relied upon in support of her position. *Crossey* was decided under the *Statutory Accident Benefits Schedule - Accidents after December 31, 1993 and before November 1, 1996*, O. Reg. 776/93 (hereinafter referred to as “Bill 164”).

¹⁰ *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, section 23

¹¹ *Crossey and Farmers’ Mutual Insurance Company* (FSCO A03-001643, September 28, 2005; Appeal P05-00028, June 8, 2007)

In *Crossey*, the insured person was injured in an accident in April 1994 and returned to work in November 1994. Her previous job was no longer available so she was given new tasks that met her medical restrictions. Farmers ceased paying IRBs in December 1994 and followed Ms. Crossey's progress until December 1995 at which point it closed her file. However, Ms. Crossey had not fully recovered. She experienced chronic pain and the pain got to the point where she could no longer do her job. Ms. Crossey stopped working in November 2000. In October 2001, Ms. Crossey requested reinstatement of her IRBs.

The arbitrator found that Ms. Crossey was entitled to reinstatement of her IRBs, notwithstanding the length of the delay between her return to work and her subsequent claim. This finding was made even though the arbitrator also found that Ms. Crossey was not substantially unable to perform the essential tasks of her pre-accident employment from April 1995 to November 2000. The decision was confirmed on appeal.

Ms. West maintained that her circumstances were almost identical to those of Ms. Crossey. As in *Crossey*, she received IRBs for a period and then her benefits were terminated. Also as in *Crossey*, she applied to have IRBs reinstated following a period where she was not entitled to IRBs. Ms. West argued that the most significant difference between her situation and the *Crossey* case is that Ms. Crossey was able to return to modified work on a full-time basis. Ms. West, on the other hand, had the challenges faced by a self-employed individual. She did not have an employer who could accommodate her medical restrictions.

For all of the apparent similarities, there are important distinctions between the *Crossey* case and the circumstances of this case.

As noted above, Ms. Crossey returned to work approximately seven months following her accident. Subsection 14(1) of Bill 164 provides that "a person receiving weekly income replacement benefits... may return to or start an employment at any time during the 104 weeks following the onset of the disability... without affecting his or her entitlement to resume receiving benefits under this Part if, as a result of the accident, he or she is unable to continue in the employment."

The current *Schedule* contains an almost identical provision. Section 11 provides that “a person receiving an income replacement benefit may return to or start an employment at any time during the 104 weeks following the onset of the disability... without affecting his or her entitlement to resume receiving benefits under this Part if, as a result of the accident, he or she is unable to continue in the employment.”

Ms. Crossey requested reinstatement of IRBs after a temporary, though lengthy, return to work. She exercised a specific right afforded to her pursuant to subsection 14(1) of Bill 164. Although there is a dispute as to whether Ms. West’s attempts to engage in certain work-related, but non-remunerative, activities post-104 weeks should be characterized as a “return to work,” the point is that, even if those attempts did constitute a return to work, the attempts did not take place within the two years provided for in section 11 of the current *Schedule*.¹² *Crossey* is clearly distinguishable on that basis alone.

Further, unlike *Crossey*, Ms. West’s IRBs had been terminated prior to her return to work-related activities. The recent decision of *Grosicki and Non-Marine Underwriters, Mbrs. of Lloyd’s*¹³ confirms that the protection afforded in section 11 applies to “a person receiving an income replacement benefit.” Consistent with *Haldenby*, *Grosicki* found that a person who has already had their IRBs refused or terminated before a return to work attempt does not get to reapply for IRBs following a return to work attempt and thereby trigger a second limitation period by operation of section 11. I agree.

Finally, Ms. West noted that, in order to qualify for loss of earning capacity benefits (LECBs) under Bill 164, an insured person only has to establish that he or she continues to be substantially unable to perform the essential tasks of his or her employment at 104 weeks of disability. Under the current *Schedule*, LECBs were eliminated and, in order to continue receiving IRBs after 104 weeks of disability, an insured person needs to meet the stricter test of suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience. Ms. West submitted that the trade-off for the elimination of the LECB

¹² I note that Bill 164 also affords some limited protection for a return to work attempt after 104 weeks of disability (see subsection 14(2)). There is no similar protection afforded in the current *Schedule*.

¹³ *Grosicki and Non-Marine Underwriters, Mbrs. of Lloyd’s* (FSCO A08-000248, November 21, 2008)

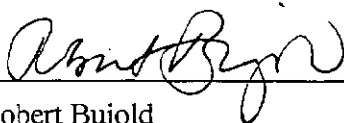
provisions and the imposition of a stricter disability test beyond two years under Bill 59 is the right to reapply for IRBs at any time, so long as the insured person is able to meet the stricter test due to a deterioration of his or her condition.

While Ms. West makes an interesting argument, I find no support for the proposition that Part X of the current *Schedule* was drafted to permit fresh applications for IRBs at any time as a trade-off for imposing a stricter post-104 week disability test. In my view, the stricter disability test as well as the more restricted protections afforded a temporary return to work suggest that the drafters of the current *Schedule* intended to restrict, not expand, access to benefits.

For all of the above reasons, I find that Ms. West's application for payment of IRBs is statute barred pursuant to the provisions of section 281.1 of the *Insurance Act* and section 51 of the *Schedule*

EXPENSES:

The parties did not make submissions on expenses. I encourage the parties to resolve this issue between themselves. If they are unable to do so, either party may request a determination of entitlement to or quantum of expenses pursuant to sections 75 to 79 of the *Dispute Resolution Practice Code*.



Robert Bujold
Arbitrator

December 18, 2008

Date



FSCO A08-000170

BETWEEN:

THERESE WEST

Applicant

and

AVIVA CANADA INC.

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Ms. West is precluded from proceeding to arbitration as her claim for income replacement benefits is statute barred, pursuant to section 281.1 of the *Insurance Act* and section 51 of the *Schedule*.

A handwritten signature in cursive script, appearing to read 'Robert Bujold', written over a horizontal line.

Robert Bujold
Arbitrator

December 18, 2008

Date