COURT OF APPEAL FOR ONTARIO

CITATION: Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company), 2017 ONCA 395
DATE: 20170518
DOCKET: C62558

Strathy C.J.O., Laskin and Trotter JJ.A.

BETWEEN

Fadil Usanovic

Plaintiff
(Appellant)

and

Penncorp Life Insurance Company also carrying on business as
La Capitale Financial Security Insurance Company

Defendant
(Respondent)

Daniel J. Fife and Maple Anne Cameron, for the appellant

Vincent Genova, for the respondent

Heard: February 24, 2017

On appeal from the judgment of Justice David A. Broad of the Superior Court of Justice, dated July 15, 2016, with reasons reported at 2016 ONSC 4624.

Strathy C.J.O.:

[1] The motion judge granted summary judgment dismissing the appellant's action against his disability insurer because it was time-barred. He rejected the appellant's allegation that the insurer breached its duty of good faith by failing to

inform him of the limitation period when it terminated his benefits. The appellant re-iterates this submission on appeal.

[2] I would dismiss the appeal. Under the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B, the limitation period began to run when the claim was "discovered", as determined by s. 5. The insurer's duty of good faith did not require it to give notice of the limitation period to its insured. While the legislatures of some provinces have imposed a statutory obligation to that effect, there is no such requirement in Ontario. Whether there should be is a matter I would leave to the legislature.

A. BACKGROUND

(1) The Facts

[3] The appellant was a self-employed eavestrough installer. In 1999, he bought an insurance policy from the respondent. The policy insured him against disability arising from accidents. In 2004, he purchased additional coverage for disability arising from sickness.

[4] In September 2007, the appellant fell from a roof and suffered serious injuries. He received disability benefits until November 2011, when the respondent terminated its payments because he no longer had a "total disability", as defined by the policy.

[5] On January 12, 2012, the respondent's lawyer wrote to the appellant explaining that since benefits had been paid for 24 months, he was not entitled to receive further benefits unless he was unable to engage in any and every occupation for which he was reasonably fit by reason of his education, training and experience. A review of the medical information on his file did not support the conclusion that he had a total disability. Moreover, surveillance undertaken by the insurer was inconsistent with the limitations the appellant claimed to be suffering.

[6] The lawyer's letter added, "If you disagree with this decision, please submit, within sixty days of receipt of this letter, medical records in support of your claim for total disability from any occupation for which you are reasonably trained and educated".

[7] The appellant did not provide new medical records in response to the letter. He claimed in an affidavit that he had sent a letter to the insurer, dated February 3, 2011 [*sic*], protesting the termination of his benefits.[1] The insurer denied having received that letter.

[8] In cross-examination, the appellant admitted that he knew his benefits had been terminated, had received the lawyer's letter, had read the policy over, had discussed the matter with his wife many times and had considered hiring a lawyer, but could not afford to do so.

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[1] As the benefits had been terminated in November 2011, the date of the letter was obviously incorrect.

[9] In early 2015, the appellant consulted counsel, who told him that there was a two-year limitation period on his claim. The appellant alleges that, had the insurance company told him about the limitation period when it denied his claim, he would have brought an action earlier. He commenced this action in April 2015, more than two years after the termination of his benefits and receipt of the letter from the respondent's lawyer.

(2) The Policy

[10] The disability policy issued by the respondent to the appellant covers "total disability" arising from accident or sickness. For the first 24 months, the insured is entitled to benefits if he or she is "unable to perform any of the important daily duties pertaining to his occupation or profession" and is not otherwise employed. After 24 months, as noted above, the definition changes to cover only the complete inability to engage in any occupation for which the insured is reasonably fitted.

[11] The policy has "Statutory Conditions" attached. These include the following:

> LIMITATION OF ACTIONS: An action or proceeding against the Insurer for the recovery of a claim under this Contract shall not be commenced more than one year after the date insurance money became payable or would have been payable if it had been a valid claim.

[12] The respondent concedes that this provision is inapplicable as a result of s. 22(1) of the *Limitations Act, 2002*.

B. DECISION IN THE COURT BELOW

[13] Before the motion judge, the appellant argued, based on *Kassburg v. Sun Life Assurance Co. of Canada*, 2014 ONCA 922, 124 O.R. (3d) 171 and *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, that the respondent's denial was not sufficiently clear and unequivocal to trigger the limitation period. The motion judge found against him, holding that the limitation period began to run when the appellant received the lawyer's letter on January 12, 2012.

[14] The appellant did not pursue that argument before us.

[15] The appellant's alternative submission in the court below, and the one advanced in this court, was that the insurer's duty of good faith and fair dealing obliged it to advise its insured of the applicable limitation period on denying or discontinuing insurance benefits and that the two-year limitation period did not begin to run until the insurer gave this notice.

[16] The motion judge rejected this argument. He observed that, "in my view, the extension of the law proposed by the plaintiff would represent a substantial shift in the boundaries of the obligation of good faith and fair dealing on insurers as they are presently understood" (at para. 38).

[17] His core conclusions, at paras. 40-42, were as follows:

> It would appear that, at its highest, the obligation of good faith and fair dealing arguably carries with it a positive obligation on an insurer to inform its insured of the nature of the benefits available under the policy. There is a marked difference, however, between imposing on an insurer a positive obligation to advise with respect to rights and benefits internal to the policy and the imposition of an obligation to advise with respect to the application of law external to the policy, such as pursuant to the *Limitations Act*.
>
> In my view the court should be circumspect in extending the common law to impose positive obligations of general application on parties, particularly where the implications of so doing are unknown. The law of insurance is broadly occupied by legislation and in my view it should be left to the legislature to regulate, if it deems it necessary and appropriate, the nature and extent of information which must be given by insurers to their insureds upon denial of benefits, including the existence and details of applicable limitation periods.
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> I find that there was no obligation in law on the defendant to advise the plaintiff of the applicable limitation period in the *Limitations Act*.

[18] As will be apparent, I agree with these statements.

C. THE PARTIES' SUBMISSIONS

[19] As I have noted, the appellant concedes that his claim was discovered under the *Limitations Act, 2002* on January 12, 2012, more than two years before he started his action.

[20] The appellant submits, however, that the insurer's failure to inform him of the limitation period precludes it from relying on the limitation period to defend his claim. He submits that the insurer's common law duty of good faith and fair

dealing should require it to inform the insured of the existence of the limitation period.

[21] The appellant concedes that there is no statutory obligation to this effect in Ontario. He submits, however, that this obligation flows from the insurer's duty to give the same consideration to the insured's interest as it does to its own interests and can be imposed through the development of the common law and need not be based on statute.

[22] In support of this proposed development in the law, the appellant says that insurance law is consumer protection legislation and in applying that law the court should be concerned about the protection of consumers: see *Smith v. Co-operators*; *Esau v. Co-operators Life Insurance Co.*, 2006 BCCA 249, 55 B.C.L.R. (4th) 11, leave to appeal to S.C.C. refused, [2006] S.C.C.A. No. 307; and the companion case, *Pekarek v. Manufacturers Life Insurance Co.*, 2006 BCCA 250, 55 B.C.L.R. (4th) 1, leave to appeal to S.C.C. refused, [2006] S.C.C.A. No. 305.

[23] The respondent, on the other hand, submits that there was a clear and unequivocal denial of the claim by the insurer, payments ceased, the appellant knew that his claim had been denied, and the limitation period had begun to run. The motion judge found that the appellant received unequivocal notice of the denial of benefits through the lawyer's letter in January 2012.

[24] The respondent submits that the court should not impose a duty to inform the insured of the limitation period when the legislature has declined to do so. Insurance law is broadly occupied by legislation and it is up to the legislature to impose such requirements, if it views them necessary.

D. ANALYSIS

[25] There is no doubt that parties to an insurance contract owe each other a duty of utmost good faith: *Bhasin v. Hrynew*, 2014 SCC 71, [2014] 3 S.C.R. 494, at para. 55; *Whiten v. Pilot Insurance Co.*, 2002 SCC 18, [2002] 1 S.C.R. 595, at para. 79.

[26] This court has held that this duty requires an insurer to deal with claims by its insured in good faith. See *702535 Ontario Inc. v. Non-Marine Underwriters, Lloyd's London, England* (2000), 184 D.L.R. (4th) 687 (Ont. C.A.), at para. 27, leave to appeal to S.C.C. refused, [2000] S.C.C.A. No. 258:

> The relationship between an insurer and an insured is contractual in nature. The contract is one of utmost good faith. In addition to the express provisions in the policy and the statutorily mandated conditions, there is an implied obligation in every insurance contract that the insurer will deal with claims from its insured in good faith.

[27] The duty of good faith is not the same as a fiduciary duty: *Plaza Fiberglass Manufacturing Ltd. v. Cardinal Insurance Co.* (1994), 18 O.R. (3d) 663 (C.A.), at p. 669. In contrast to a fiduciary duty, the insurer is not obliged to treat the

insured's interests as paramount. However, the insurer must give as much consideration to the welfare of the insured as to its own interests: *Bullock v. Trafalgar Insurance Co. of Canada*, [1996] O.J. No. 2566 (Gen. Div.), at para. 101. This requirement is based on the recognition that the insured is typically in a vulnerable position when making a claim: *Bhasin*, at para. 55.

[28] The scope of the duty of good faith has not been precisely delineated or definitively settled: Barbara Billingsley, *General Principles of Canadian Insurance Law*, 2d ed. (Markham: LexisNexis Canada, 2014), at p. 52; *Kang v. Sun Life Assurance Co. of Canada*, 2013 ONCA 118, 303 O.A.C. 64, at para. 39. Although the assessment is fact-specific and will depend on the particular circumstances of each case, courts have recognized some general requirements of the duty of good faith.

[29] In *702535 Ontario Inc.*, at paras. 27-29, this court provided an overview of the insurer's duty of good faith to act promptly and fairly when handling claims by the insured:

> The duty of good faith requires an insurer to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its insureds.
>
> The first part of this duty speaks to the timeliness in which a claim is processed by the insurer. Although an insurer may be responsible to pay interest on a claim paid after delay, delay in payment may nevertheless operate to the disadvantage of an insured. The insured, having suffered a loss, will frequently be under financial pressure to settle the claim as soon as possible in order

> to redress the situation that underlies the claim. The duty of good faith obliges the insurer to act with reasonable promptness during each step of the claims process. Included in this duty is the obligation to pay a claim in a timely manner when there is no reasonable basis to contest coverage or to withhold payment.
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> The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith. [Citations omitted.]

[30] The motion judge observed that "at its highest, the obligation of good faith and fair dealing arguably carries with it a positive obligation on an insurer to inform its insured of the nature of the benefits available under the policy" (at para. 40). See, for example, *Atchison v. Manufacturers Life Insurance Co.*, 2002 ABQB 1121, 332 A.R. 72 and *Clarfield v. Crown Life Insurance Co.* (2000), 50 O.R. (3d) 696 (S.C.). The issue of whether an insurer breaches its duty of good faith when it fails to inform the insured of available policy benefits is not squarely before us and we need not decide it.

[31] In this case, however, we are asked to do something more than impose a duty of good faith on insurers to disclose the contents of the insurance policy. We are asked to extend the duty of good faith to require an insurer to disclose information outside the policy – namely, the existence of a limitation period.

[32] Some commentators have suggested that it would be severe and unfair for the insured to be denied benefits when the insurer was aware of the limitation period, but the insured was not: see, for example, Roderick Winsor, *Good Faith in Canadian Insurance Law* (Toronto: Thomson Reuters Canada, 2016), at para. 2.30. The appellant adopts this argument, submitting that it would be preferable, and simple, for the insurer to advise the insured of the limitation period when it denies the claim.

[33] The appellant acknowledges that no Canadian case has gone that far. Although two decisions of this court might have afforded an opportunity to address the issue, neither is directly on point: *International Movie Conversions Ltd. v. ITT Hartford Canada* (2001), 27 C.C.L.I. (3d) 102, aff'd on other grounds (2002), 57 O.R. (3d) 652 (C.A.) and *LeBlanc & Royle Enterprises Inc. v. United States Fidelity & Guaranty Co.* (1994), 17 O.R. (3d) 704 (C.A.).

[34] The British Columbia Court of Appeal has directly addressed this issue and concluded that the insurer is not obliged to advise the insured of the limitation

period, although some members of the court suggested that it may be advisable to do so.

[35] In *Balzer v. Sun Life Assurance Co. of Canada*, 2003 BCCA 306, 227 D.L.R. (4th) 693, the British Columbia Court of Appeal suggested that in order to trigger the start of the limitation period the insurer must give an unequivocal denial and the "preferred course of action" may be to bring the limitation period to the insured's attention. The court said, at para. 45:

> Any ambiguity in the communication of a refusal of benefits, as to whether it is a clear and unequivocal denial, should be resolved in favour of the insured. To avoid any doubt, the preferred course for an insurer intending to deny coverage should be to include an alert in the letter drawing the insured's attention to the one year limitation … and informing the insured that the insurer will rely on the denial as starting the running of time.

See also *Dachner Investments Ltd. v. Laurentian Pacific Insurance Co.* (1989), 59 D.L.R. (4th) 123 (B.C.C.A.), at pp. 130-31.

[36] In *Esau*, Thackray J.A. clearly rejected the argument that an insurer is obliged to notify the insured of the limitation period, holding, at para. 42:

> While I have sympathy for the plea of the appellant, this Court cannot, as acknowledged by the appellant, mandate the "ideal." It cannot order legislative changes. Nor can it mandate that insurers must advise insureds as to policy or statutory limitation provisions. It would clearly be advisable for insurers to advise insureds as to the existence of limitation periods, but even here caution must be exercised because there are

> different limitation provisions with inconsistent commencement dates. Insurers could not, therefore, as suggested by the appellant, "advise their insureds that their letter of denial … commences the running of a one year limitation period."

[37] Similarly, Levine J.A. held, at para. 52:

> The British Columbia *Insurance Act* includes no such statutory obligation [to advise of limitation periods], and, as my colleague points out, it is not within the power of this Court to require insurers to provide specific information regarding limitation periods. But the judicially imposed requirement to provide a "clear and unequivocal denial," … reflects the same principle: that insurers have an obligation to provide clear information to insured persons, who are consumers, about their claims under the policy.

See also *Falk v. Manufacturers Life Insurance Co.*, 2008 BCSC 173, 80 B.C.L.R. (4th) 347, at para. 61.

[38] While no court has imposed a duty on the insurer to inform the insured of the limitation period, some legislatures have done so. In British Columbia, a regulation introduced in 2012 requires the insurer to give written notice to the claimant of the applicable statutory limitation period when it denies the claim or within a short time thereafter: *Insurance Regulation*, B.C. Reg. 403/2012, s. 4. There are exceptions for claimants represented by legal counsel and those making certain types of claims. If the insurer fails to provide the requisite notice, the running of the limitation period is suspended.

[39] Alberta has also adopted specific notice requirements. Pursuant to a 2012 amendment to the *Fair Practices Regulation*, Alta. Reg. 128/2001, s. 5.3, an insurer must give written notice of the applicable limitation period within five business days of denying a claim. The notice is not required when the insurer is aware the claimant is represented by counsel and for certain types of claims. If the insurer fails to give that notice, the court may, on application of the claimant, order that the applicable limitation period be extended and grant any other remedy that the court considers appropriate: s. 5.3(7).

[40] In *Dhillon v. Anderson*, 2014 ABQB 609, 597 A.R. 189, the Alberta Court of Queen's Bench held that this amendment was more than procedural; instead, it fundamentally altered a substantial defence available to a defendant. Further, "[i]t imposes a new obligation on insurers to provide advice to claimants, an obligation that did not exist previous to the introduction of the *Regulation*" (at para. 34).

[41] Ontario has not gone as far as Alberta and British Columbia. However, the *Insurance Act*, R.S.O. 1990, c. I.8 was amended in 2012 to require life, disability and creditors insurers to include the following statement in the insurance policy and certificate:

> Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

[42] This amendment came into force on July 1, 2016.

[43] The appellant relies on *Smith v. Co-operators* in support of his argument for imposing a duty on an insurer to advise the insured of the limitation period when the claim is denied. In that case, the Ontario regulation pertaining to the Statutory Accident Benefits Schedule required the insurer to inform the insured, in writing, at the time a claim was denied, of the statutory procedure for the resolution of disputes. That statutory procedure specified a two-year limitation period. The Supreme Court held that the effect of the regulation was to require the insurer to inform the insured "of the most important points of the process, such as the right to seek mediation, the right to arbitrate or litigate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process" (at para. 14; emphasis added). Without providing that information to the insured, it could not be said that the insurer had given a valid refusal and the time limit did not begin to run.

[44] There is no statutory provision in this case similar to that considered by the Supreme Court in *Smith v. Co-operators*. Further, as Gonthier J. cautioned in *Smith v. Co-operators*, "it is not the role of this Court to set out the specific content of insurance refusal forms. This task is better left to the legislature" (at para. 14).

[45] The Ontario legislature might have gone further than it has, for example, by adopting the approach taken in Alberta or British Columbia. It presumably chose not to do so and, in my respectful view, the court should not impose consumer

protection measures on insurers, outside the terms of their policies, that the legislature has not seen fit to require. A properly crafted regime, such as those in effect in Alberta and British Columbia, would not only have to specify the requirement to give notice, but also the consequences of failing to do so.

[46] The consequences of the appellant's proposed expansion of the duty of good faith are significant. The appellant's interpretation would effectively judicially overrule the provisions of the *Limitations Act, 2002* by making notice given by an insurer to an insured the trigger for the limitation period, rather than discoverability of the underlying claim. This would defeat the purpose of the statute and bring ambiguity, rather than clarity, to the process.

E. CONCLUSION AND ORDER

[47] For these reasons, I would dismiss the appeal with costs to the respondent in the amount of $15,000, inclusive of disbursements and all applicable taxes.

Released: "G.R.S." May 18, 2017

"George R. Strathy C.J.O."
"I agree John Laskin J.A."
"I agree G.T. Trotter J.A."