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Recent court decisions impacting our industry

Munich Re, Canada (Life)

Munich RE

In this new issue of the Munich Re claims newsletter, we would like to draw your attention to some recent court decisions across the country that we believe will have an impact on the management of claims and litigation related to life, disability and critical illness.

Life Insurance

Principle of utmost good faith

Evidence of termination of a policy for fraud was demonstrated even though the insurance application did not cover the insured's unknown history.

History of decisions
C.A.O.: Mohammad v.The Manufacturers Life Insurance Company, 2020 ONCA 57 (C.A.)
O.S.C.: Mohammad v. The Manufacturers' Life Insurance, 2019 ONSC 3386 (summary judgment)

The Court of Appeal allowed the insurer's appeal, set aside the trial judgment granting the beneficiary the right to the payment of the death benefit, and substituted judgment dismissing the action.

In this case, the deceased failed to disclose his illegal immigrant status and his criminal and terrorist past in his life insurance application. The Court of Appeal confirms that these deliberate omissions are sufficient to establish fraud. Although the questions in the application did not cover criminal history and immigration status, the applicant had a general obligation to report any material information to the insurer.

The Court of Appeal of Ontario notes that under section 183 of Ontario's Insurance Act, an applicant has a duty of good faith and must declare any material information and fact essential to the insurer. The Court of Appeal states that in this case, the illegal immigration status and criminal history of the insured should have been disclosed, even if the application was not covering these topics.

This principle, linked to the utmost good faith demanded by the insurance contract, has equivalents in all the common law provinces and in civil law (1375 C.C.Q.).

The value of this decision also stems from the fact that the Court of Appeal upheld the termination of the policy even though the evidence of fraud applied and the life insurance policy under dispute had been in effect for over 25 years.

Disability Insurance

Full compensation for legal costs

The Supreme Court of Canada will not review the decision of the British Columbia Court of Appeal that upheld the order for the insurer to pay the full legal costs of the insured in Tanious.

History of decisions

S.C.C.: Empire Life Insurance Company v. Noha Tanious, 2020 CanLII 13154 (SCC)
BCCA: Tanious v. Empire Life Insurance Company, 2019 BCCA 329
BCSC: Tanious v. Empire Life Insurance Company, 2017 BCSC 85 and
Tanious v. Empire Life Insurance Company, 2016 BCSC 110

On February 20, the Supreme Court of Canada (S.C.C.) dismissed Empire Life's application for leave to appeal to the Supreme Court of Canada in response to the British Columbia Court of Appeal's decision.

Summary of Tanious judgments

At the trial level, the judge had exercised his discretion to order the insurer to pay special costs representing all legal fees incurred by the plaintiff in her claim for disability benefits under her group insurance contract. The Court of Appeal upheld this decision in the view that, given the particular circumstances of this case, full compensation was required to put the plaintiff back in the same position she would have been in if she had not had to hire a lawyer and have the contract enforced by legal action. The Court of Appeal ruled that the trial judge did not err in exercising his discretion with respect to costs "in the interests of justice in the particular circumstances of the case".

We will closely monitor the impact of this case in the common law provinces with respect to orders to pay special costs, despite the absence of misconduct on the part of the insurer. Its impact can already be seen in some applications instituting proceedings to claim the full refund of the plaintiff's legal costs. Insurers may also consider there to be an increased financial risk in challenging a claim in court.

Gathering information as part of a claim

The insurer is entitled to collect information related to non-medical aspects when assessing a claim.

History of decisions
Manufacturers Life Insurance Company "Manulife" (Re), 2020 CanLII 9595 (AB OIPC)

This judgment relates to a complaint to the Information and Privacy Commissioner of Alberta that the insurer (Standard Life, now Manulife) collected and disclosed personal information without the insured's consent in violation of the Personal Information Protection and Electronic Documents Act.

Two aspects were reproached to Manulife:

1. Having obtained information from the complainant's employer regarding a workplace conflict she was involved in; and,
2. Having shared information related to the disability claim with the employer's representative.

Manulife acknowledges that it collected the complainant's personal information by obtaining information from the employer about a workplace conflict. However, the insurer argues that it did so with the complainant's consent. The insurer collected information related to a workplace conflict as part of the complainant's disability assessment and, subsequently, provided personal information to the representative of the complainant's employer when it explained the criteria for accepting the claim.

The adjudicator acknowledged that the insurer was entitled to collect information on the workplace conflict in the context of its assessment of the claim, as it was covered by the authorization to disclose personal information signed by the complainant when the application for disability was submitted. The Privacy Commissioner noted, however, that sharing personal information with the employer was not covered by the same authorization since it was not relevant to the assessment of the claim and was not covered by the Personal Information Protection and Electronic Documents Act.

Non-medical factors, particularly those related to work relations, are an important consideration when assessing a disability application because we know that they can have an impact on both the work cessation and the duration of the disability. It is therefore interesting to note that the Privacy Commissioner acknowledged in this case that non-medical factors are covered by the claimant's authorization if the action plan in the insurer's file demonstrates that they are relevant to the assessment of the claim.

3-year period and disability benefits

In civil law, there is no limitation period for disability insurance benefits that have been expired for less than 3 years at the time the action is brought to court.

History of decisions

C. A. Q: B.J. c. La Capitale assureur de l'administration publique inc., 2020 QCCA 615

S. C. Q: B.J. c. La Capitale assureur de l'administration publique, 2018 QCCS 5560

The Quebec Court of Appeal partially dismissed an insured's appeal of a Superior Court ruling rendered on November 30, 2018, in favour of La Capitale stating that the payment of disability benefits was prescribed.

In its ruling on May 4, 2020, the Court of Appeal explains that since the insurer had stopped paying benefits in 2014 and had notified the insured in 2013, the three-year limitation period provided for in section 2925 of the Civil Code of Quebec applies from the date of termination of benefits. The action taken by the insured in 2018 was therefore prescribed, as the insurer's obligation was extinguished because of the delay of more than three years. However, the Court of Appeal states that the trial judge erred in finding that the entire claim concerning the expired disability benefits was prescribed on the date the proceedings were instituted: as the disability insurance coverage is an obligation of successive performance from the time the disability arises, the limitation period runs from the time of the beginning of each of the monthly terms provided in the contract. As a result, the disability benefits that expired in the three years preceding the submission of the application to court are not prescribed.

Discussions may continue between the insurer and the insured following the denial or termination of benefits under disability insurance coverage. Both common law and civil law jurisprudence recognize that there is a need to delay the starting point for calculating the limitation period until the insurer's final denial, due to the premature nature of a court action when the parties are still in negotiations. However, this decision of the Quebec Court of Appeal puts a final stop to the prescription argument with respect to disability benefits that expire in the three years preceding the institution of proceedings, which is not found in the jurisprudence from the common law provinces.

Critical Illness Insurance

Application of the moratorium period exclusion clause

The 90-day moratorium period exclusion clause from the industry benchmark definition is not ambiguous and the onset of cancer during the moratorium period leads to its application.

Historique des décisions dans cette affaire
S.C.Q.: Talbot v. Industrial Alliance, Insurance and Financial Services, 2020 QCCS 193 (no appeal).

In this case, the insured was seeking payment of the critical illness benefit following a parotid cancer diagnosed after the 90-day moratorium period that applied from the effective date of the insurance coverage. Industrial Alliance denied the claim even though the diagnosis was made after the 90-day moratorium because the symptoms and investigations that led to the diagnosis of cancer began during the moratorium period.

The insured argued that the wording of the moratorium period clause was ambiguous and constituted a discrepancy between the application and the policy that the agent should have raised with the insured at the time of underwriting. The Superior Court judge dismissed these two arguments out of hand, by confirming that the content of the clause is clear, that it does not constitute a discrepancy and that it also allows for more advantageous pricing by excluding cancer diagnoses that occur within 90 days of coverage.

The application of the moratorium clause also resulted in a permanent exclusion for any future claims for another cancer diagnosis. This time, the court agreed with the insured's argument that the wording used by the insurer with respect to the exclusion for any future cancer diagnosis was ambiguous and the judge struck down this part of the clause.

This judgment from the Superior Court confirms a growing number of case law confirming that the wording of the moratorium period clause used in the benchmark definition is clear, and must apply if there is a direct or causal link between symptoms and/or investigations and the diagnosis.

List of decisions that have confirmed the validity of the moratorium clause

- Camiré v. Desjardins Financial Security, 2020 QCCA 749, which confirmed the decision of the first judge in Camiré v. Desjardins Financial Security, 2018 QCCS 1503;
- MacQuarrie v. National Bank Life Insurance Company, 2015 ONCA 100 which upheld the decision of the first judge in MacQuarrie v. National Bank Life Insurance Company, 2014 ONSC 1298;
- Provenzano v. Great-West Life, 2013 ONSC 5254;

- National Bank Life Insurance v. Tremblay, 2011 QCCA 629, which overturned the decision of the first judge in Tremblay v. National Bank Life Insurance, Q.S.C., December 21, 2009.

Observations
Talbot v. Industrial Alliance also held that where the moratorium period exclusion clause applies to a claim following a diagnosis of cancer, it is important to ensure that the consequence of applying the clause, whether it is a permanent exclusion for any future cancer diagnosis or the end the critical illness coverage , is clearly defined in the applicable contract and that the insured is informed of this when the denial is communicated in writing.

Comments

Do you have comments on this newsletter? Would you like us to write an article on a particular subject or are there any legal issues you would like us to discuss in a future newsletter? Tell us what interests you and share your comments by writing to jst-laurent@munichre.ca.

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