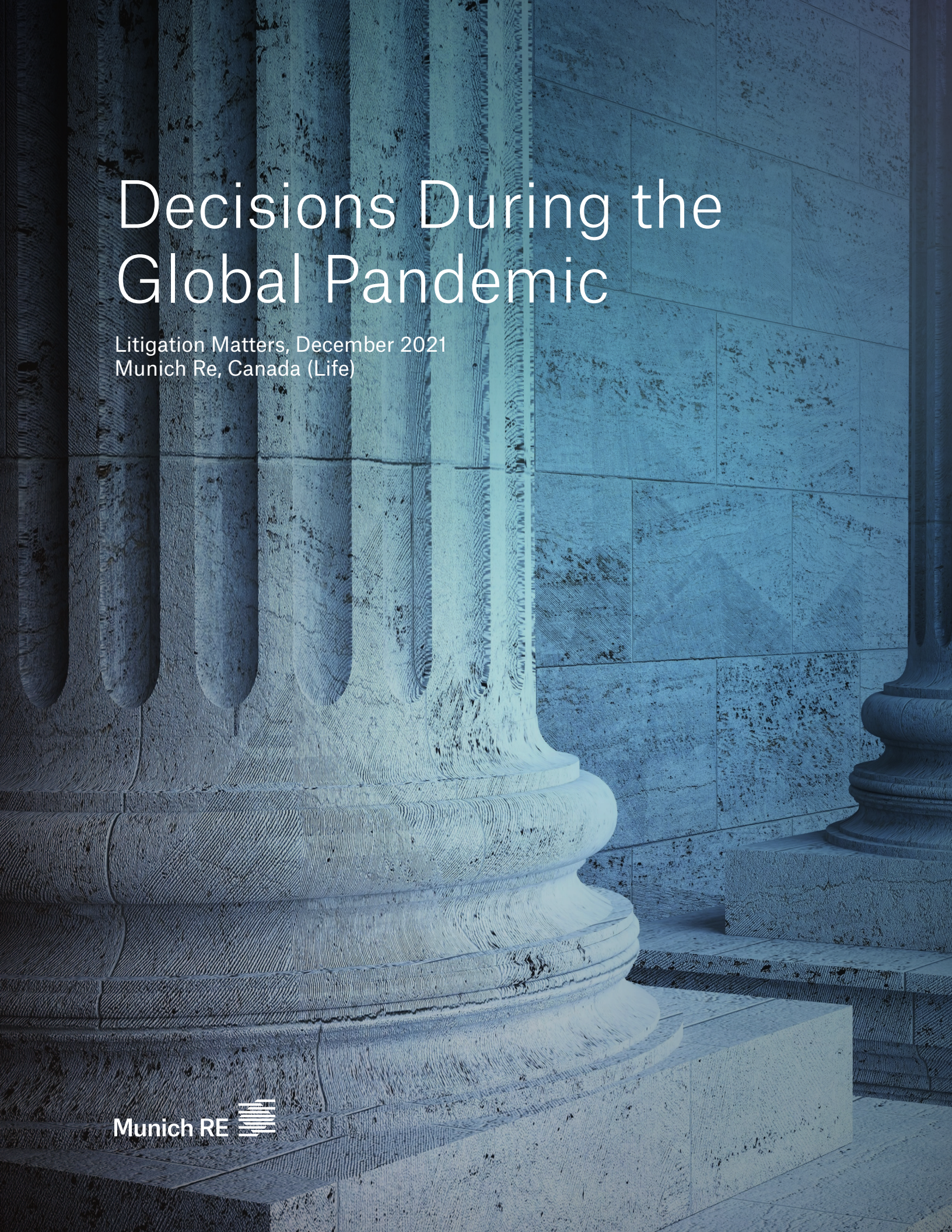

Decisions During the Global Pandemic

Litigation Matters, December 2021
Munich Re, Canada (Life)

Munich RE

Throughout the pandemic crisis, litigation had no choice but to adapt: discoveries, mediations and even trials were conducted virtually or in a hybrid format. There may have been some slowdown at the peak of the first two waves. Some Counsel & Litigation Specialists also noted an increase of case orientation toward mediation by Plaintiff Counsel, resulting in earlier case resolution.

From the comments we heard in the industry, it appears that the "new" normal may result in more mediations and discoveries conducted remotely, and therefore allow more flexible and less costly options that will result in quicker case resolution.

Even with the upheaval of the pandemic, litigation continues to set precedents.

This latest edition of Litigation Matters will discuss a few recent decisions from 2020-2021.

Recent Decisions of Interest Related to AD&D Coverage

Downey v. Scotia Life Insurance Company, 2020 ABQB 638 (CanLII)

In this case, the plaintiff sought payment from Scotia Life for $202,000, representing the benefits payable under two accidental death insurance policies. The two insureds and beneficiaries named in the policies were Mrs. Downey and her late husband.

The Facts

On September 27, 2015, Mr. Downey was on a boat on Moose Lake in British Columbia with his mother, Mrs. Richter. Mr. Downey was then 56 years, and Mrs. Richter was 80 years of age. Mr. Downey was a competent swimmer. While in the boat fishing, Mr. Downey clutched his chest and told Mrs. Richter that he could not breathe. He then slumped onto the side of the boat, which caused the boat to capsize. Mr. Downey and his mother were then thrown into the water. Mr. Downey surfaced at once and his mother encouraged him to swim to shore, but Mr. Downey said he could not swim. Mr. Downey then went under the water a second time and was not seen alive again.

An external examination of the remains was performed, and the coroner's report concluded that death was caused by asphyxia as a consequence of drowning. Myocardial infarction was listed as a significant condition contributing to death.

The applicable definition of accident:

> *Accidental Bodily Injury means bodily injury that is affected directly and independently of all other causes by an accidental, external, violent, and visible means and that occurs to You while Your coverage in respect of this Certificate is in force.*
>
> *PAYMENT OF BENEFIT AMOUNT Subject to all the provisions of the Group Policy, We will pay the Benefit Amount if You sustain an Accidental Bodily Injury that directly causes one of the following conditions:*
>
> *(a) Your death...*

What's Not Covered
No Benefit Amount will be payable if Your death or Hospital confinement resulted directly or indirectly from, or was in any manner or degree associated with or occasioned by, any one or more of the following, or if any one or more of the following contributed in any way whatsoever to Your death or Hospital confinement:
(a) any naturally occurring condition, illness or disease or bodily or mental infirmity of any kind, or medical or surgical treatment for any such condition, illness disease or infirmity;

The Court Decision

The Court did not accept that the presence of a pre-existing medical condition anywhere along the chain negates the coverage provisions of an accidental death policy. The Court referred to Co-operators Life Insurance Co. v. Gibbens, 2009 SCC 59 (CanLII), stating that it is sufficient for a claimant to demonstrate that an accident, such as a shipwreck, or a fall from a horse, was an important element along the chain of events which led to the loss. Applying the principles reflected in Gibbens, the Court found that the cause of death was accidental: Mr. Downey did not die from any naturally occurring internal condition such as a myocardial infarction. Although a cardiac event caused the accident, which prompted Mr. Downey to be thrown into the water, his death was caused solely by drowning and not by the myocardial infarction.

Since Ms. Downey met her onus of establishing that Mr. Downey's death falls within the initial grant of coverage, the onus then shifted to the Insurer to establish that the following exclusion clauses applied.

The Court did not find that the exclusion clause is so broad as to render the AD&D coverage unenforceable. The exclusion clause does not virtually nullify the coverage provided by the policies, and the policies continue to cover losses caused by accidental bodily injuries that are not connected to a naturally occurring disease or infirmity.

Given that the insured was not required to undergo any medical examinations to obtain coverage, excluding coverage for bodily injuries associated with or occasioned by pre-existing conditions would be contrary to the reasonable expectations of the ordinary person purchasing coverage.

The court argued that although the cardiac event did not itself kill Mr. Downey, it cannot be said that his death was not "in any manner or degree associated with or occasioned by" the cardiac event. The cardiac event also "contributed" to his death.

The court determined that the exclusion clauses, while exceptionally broad, were not so broad as to render them unenforceable. Therefore, the accidental death insurance benefit was not payable.

Malkhassian Estate v. Scotia Life Insurance Company, 2020 ABQB 173 (CanLII)

This case involved a motion for partial summary judgment by the deceased's Estate seeking payment of a $100,000 accidental death insurance benefit and damages for bad faith. Mr. Malkhassian purchased accidental death insurance coverage issued by Scotia Life in 2005 under the Scotia Accident Insurance Plan.

The Facts

The insured was diagnosed in February 2012 with gallbladder cancer that had spread to his liver. He was admitted to the hospital in March 2012 after experiencing shortness of breath. While at the hospital, he suffered a heart attack and was admitted to ICU. While overnight in the ICU, he sustained a fall and banged his head on the floor when he left his bed to use the washroom. A CT scan showed evidence of an acute subdural hematoma. He was placed into a medically induced coma in the ICU until his death on March 15, 2012.

The Certificate of Medical Examiner in the section "Medical Cause of Death" listed in Part 1 the immediate cause of death as "(a) acute subdural hematoma" and states it was due to or as a consequence of "(b) a ground-level fall as an antecedent cause giving rise to the immediate cause of death." Part 2 listed other significant conditions contributing to death but not causally related to the immediate cause (a) in Part 1 to be "Anti-coagulation Therapy of Pulmonary Embolism, Metastatic Adenocarcinoma of Gallbladder" (blood-thinning treatment for blood clots in the lungs and gallbladder cancer). The bottom section of the certificate identified the manner of death as being accidental, the place of injury/incident as "Hospital", and the date of injury/incident as "2012/03/13".

Scotia Life denied coverage under the policy. Mr. Malkhassian's Estate brought an action against Scotia Life for payment under the policy and damages for bad faith.

The applicable AD&D group policy stipulations under which the claim was denied were as followed:

> *"Accidental Bodily Injury" as: "bodily injury which is effected directly and independently of all other causes by an accidental, external, violent and visible means that occurs while coverage under this Certificate is in force.*
>
> *The "Risks Not Covered" section of the policy stated that no benefit amount would be payable if death or hospital confinement is caused or contributed to, directly or indirectly from (a) natural causes, illness, disease of any kind, or bodily or mental infirmity, or medical or surgical treatment, therefore."*

The Court Decision

Estate of the deceased brought action against insurer for payment under policy and for damages for bad faith — Estate applied for partial summary judgment, seeking payment of $100,000 pursuant to the Policy.

In order to have granted partial summary judgment, the judge in the case said that he would have had to have decided that :

a. the deceased's other illnesses and symptoms did not cause his death independently of his accidental fall;

b. the deceased's other illnesses and symptoms were merely conditions in which his accidental fall occurred; and

c. the deceased's death was not "caused or contributed to, directly or indirectly" from listed causes in, including illness or disease of any kind.

The summary trial judge considered that there was conflicting information and evidence in the hospital records and in the Medical Examiner's Certificate as to what caused or contributed to Mr. Malkhassian's death, directly or indirectly, which did not permit finding the necessary facts to make this decision at the stage of a summary judgment. Therefore, the Court could not determine if the policy exclusion applied.

Consequently, the application for summary judgment was dismissed because the record was considered not sufficient to decide the application in a fair and just manner to both parties.

Quick takeaways from these two recent AD&D cases:

- The test to determine if a cause of claim is accidental is rather broad: an external event was one of the important elements along the chain of events which led to the loss.
- It becomes crucial to make sure that AD&D policies include appropriate exclusions that reflect the risk an insurer intends to cover.
- Courts confirmed that the exclusions and limitations of coverage usually found in the AD&D coverage do not virtually nullify the accidental coverage.

Recent Decisions of Interest Related to Group Life Coverage

Iacono c. Canada Life Assurance Company of Canada, 2021 QCCQ 2320

The Facts

This case involved a $25,000 Group Optional Spousal Life Insurance. Ms. Iacono requested a payment of $25,000 from Canada Life based on the Optional Spousal Life Insurance she allegedly took out in 2005 for her common-law spouse, Mr. Cleary, who passed away on August 5, 2006. Ms. Iacono alleges that she filed the enrollment form to obtain the Optional Spousal Life Insurance but was never advised that the coverage was not in force. She claims that she paid a premium for such coverage through her group insurance policy, specifically by using the benefit credit allocation granted by the employer.

Canada Life claimed that the Optional Spousal Life Insurance was never in effect. The application was completed, but the additional medical information requested from Mr. Cleary was not provided. Since the additional information was not provided, Canada Life closed the file and never collected premium for such coverage.

Both parties agreed that Canada Life never sent a confirmation that the Optional Spousal Life Insurance coverage requested had been accepted. However, on July 8, 2005, the insurer sent Ms. Iacono a letter stating that evidence of insurability had to be provided, further to the receipt of her enrollment in Spousal Life Insurance, and coverage would only be effective on the date of approval. On July 20, 2005, Ms. Iacono and Mr. Cleary provided evidence of insurability and the Medical and Lifestyle Questionnaire requested by Canada Life.

On August 2, 2005, Canada Life sent a further letter to Mr. Cleary. In order to assess the spousal application for life insurance submitted with his enrollment form and to determine if he was admissible to life insurance, “Mr. Cleary was asked to provide detailed medical information from his attending physician, including a health history, blood pressure, pulse rate, urinary tests, and complete details regarding the treatment of his throat cancer. The Insurer advised in the letter that the file will be closed if Mr. Cleary does not provide the requested information within 45-day delay.”

Mr. Cleary did not follow up on Canada Life’s inquiry to provide the requested information.

A copy of this letter wasn’t sent to Ms. Iacono based on Canada Life’s legal duties regarding rights to privacy, and Ms. Iacono testified at trial that she wasn’t aware of this letter.

Canada Life also pleaded that it is not possible to pay such insurance with the employer’s benefit credit allocation, that Ms. Iacono never paid a premium for a spousal life insurance coverage, and that she made her claim to Canada Life 13 years after her husband passed away, even though she was the liquidator of his estate.

The Court Decision

The Court concluded that the evidence submitted by Canada Life has probative force and offered a better answer to the question on spousal life insurance coverage compared to the assumptions made by Ms. Iacono. The information requested by Canada Life to establish insurability and premium was not provided. Medical coverage in the Group insurance plan did not include Spousal Life Support, and no premium was ever paid for such optional coverage. As a result, the coverage was not in force when Mr. Cleary passed away.

The application for a claim of Life Insurance Policy was dismissed.

Patry v. Compagnie d'assurances du Canada sur la Vie, (Canada Life) 2020 QCCS 4551

The Facts

In this case, a payment of $120,000 under a group life coverage from Great West was requested. The employee was laid off on January 5, 2018 and passed away on August 23, 2018. The claim was denied because the employee had been laid off for over six months by the date of his death. The applicable group policy stipulated that the life coverage remains in force for six months following a layoff made by the employer, thus, the employee wasn't insured when he passed away.

The beneficiary argued that this limitation to coverage could not be asserted to deny coverage because this policy clause was not included in the coverage summary booklet provided to the employee. It contradicted the expectation of coverage.

The Court Decision

The question in dispute before the Court was whether the deceased was still covered by the group life insurance policy at the time of his death.

The decision conducted a review of the applicable case laws related to discrepancies between the group contract wording and content of a summary booklet remitted to the employees. The Court reminded the parties that both documents must be read in a co-ordinated way. The fact that the booklet does not state a condition does not equate to contradiction with the policy. Summary booklets do not typically copy the complete policy wording as long as they don't contradict each other. Following these established principles, the Court confirmed that the limitation related to the employee's layoff was enforceable as it did not contradict the booklet wording.

The Court also confirmed that if the notion of reasonable expectation of coverage is applicable in group coverage, it is the expectation of coverage of the life insured that needs to be considered, not the beneficiary. In this case, there is no evidence that the life insured had expectations of coverage based on the information available to them. Therefore, it cannot be determined whether the life insured expectations of coverage were reasonable or not.

The application was dismissed.

Recent Decision of Interest Related to Group CI Coverage

Manley v. The Manufacturers Life Insurance Company, 2020 ONSC 399 (CanLII)

The Facts

Under the Group policy issued to the Canadian Bar Insurance Association ("CBIA"), Manulife issued to Mr. Manley a certificate for term life insurance and coverage for critical illness insurance, under a critical illness rider, in December 2009. From December 1, 2009, to March 1, 2017, Mr. Manley paid the premiums for $500,000 in critical illness coverage. On March 13, 2017, Mr. Manley sent a letter to CBIA's customer service providing adequate direction to cancel his life and critical Illness insurance coverage effective April 1, 2017.

On June 13, 2017, Mr. Manley sent a claim notification to Manulife advising of his kidney cancer diagnosis. In the Claimant's statement, Mr. Manley indicated his date of diagnosis as May 23, 2017. However, he also provided information from the treating physician indicating that the kidney tumour had been growing slowly for many years and that the cancer was undoubtedly in existence for months before its detection and diagnosis.

Mr. Manley's position was that, as the condition upon which he based his claim arose during the period when premiums were being paid, he was entitled to the insurance benefit payment. He submitted that it did not matter that he was diagnosed after the end of the period in which he was paying premiums.

Manulife's position was that the Group Policy is straightforward: the triggering event for entitlement to the insurance is the occurrence of a diagnosis. Manulife argued that the diagnosis upon which a claim is based must be made during the period in which premiums are being paid. As a result, Mr. Manley was not entitled to the insurance benefit payment.

Mr. Manley sought damages of $500,000 for breach of contract or relief from forfeiture. Mr. Manley brought forward a motion for summary judgment, and Manulife responded by requesting that summary judgment be granted in its favour and that the action be dismissed.

The Applicable Policy's Stipulations

The "Terms of Coverage" set out in section 9.04 of the master group policy titled, "Critical Illness Insurance Rider" provided that "subject to satisfactory proof of claim and any exclusions and limitation, the Company will pay the Amount of Insurance for Critical Illness to the beneficiary of this Rider if the Insured Person suffers a Diagnosis and is alive after the Survival Period ends." Section 9.01 defined "diagnosis or diagnosed" as being: "The certified confirmation by a physician of the existence of a Covered Condition that meets all the requirements contained in the description of the Covered Condition, subject to any exclusions and limitations....For some Covered Conditions, the Diagnosis must be made in Canada and must be made by a specific type of Physician, as the Company may specify."

The Court Decision

The substantive issues raised before the court were:

1. Was Manulife in breach of the contract of insurance by virtue of its denial of Mr. Manley's claim under the Rider?
2. If the answer to Issue No. 1 is "no", was Mr. Manley entitled to relief from forfeiture?

The Court found that the diagnosis was made and given to Mr. Manley in May 2017 and there was no ambiguity in the policy wording. Based on the evidence and on a reasonable interpretation of the policy wording, the Court determined that Mr. Manley was not entitled to the Insurance.

The Court found that the "date of Diagnosis provides certainty and predictability for both the insured and Manulife. The making of a diagnosis by a physician – and the receiving of a diagnosis by the insured person – is a clear, undisputable event which validates the existence of a Covered Condition."

The second issue before the Court was Mr. Manley's entitlement to relief from forfeiture. The court found that Mr. Manley was unable to comply with the provisions of the Rider because the Rider was terminated by the end of March 2017. Therefore, in the circumstances, Mr. Manley had not lost the right to anything because he had forfeited nothing, and the Court found that Mr. Manley was not entitled to relief from forfeiture precisely because there was no coverage available to him under the Rider.

Manulife's denial of Mr. Manley's claim for payment under the critical illness rider was upheld. Mr. Manley's motion for summary judgment was dismissed.

References

1. Iacono c. Canada Life Assurance Company of Canada, 2021 QCCQ 2320 (CanLII), <https://www.canlii.org/en/qc/qccq/doc/2021/2021qccq2320/2021qccq2320.html?searchUrlHash=AAAAAQASaWFjb-25vIENhbmFkYSBMaWZlIAAAAAAE&resultIndex=3>
2. Patry c. Compagnie d'assurances du Canada sur la Vie, 2020 QCCS 4551 (CanLII), <https://www.canlii.org/fr/qc/qccs/doc/2020/2020qccs4551/2020qccs4551.html?searchUrlHash=AAAAAQAcUG-F0cnkgQ2FuYWRhIHN1ciBsYSB2aWUgMjAyMAAAAAAB&resultIndex=1>
3. Manley v. The Manufacturers Life Insurance Company, 2020 ONSC 399 (CanLII), <https://www.canlii.org/en/on/onsc/doc/2020/2020onsc399/2020onsc399.html?searchUrlHash=AAAAAQAPTWFub-GV5IDIwMjAgMzk5AAAAAAE&resultIndex=1>
4. Downey v Scotia Life Insurance Company, 2020 ABQB 638 (CanLII), < https://www.canlii.org/en/ab/abqb/doc/2020/2020abqb638/2020abqb638.html?searchUrlHash=AAAAAQAXRG93bmV5IFN-jb3RpYSBsaWZlIDIwMjAAAAAAAQ&resultIndex=4>
5. Malkhassian Estate v Scotia Life Insurance Company, 2020 ABQB 173 (CanLII), < https://www.canlii.org/en/ab/abqb/doc/2020/2020abqb173/2020abqb173.html?searchUrlHash=AAAAAQATTWFsa2h-hc3NpYW4gRXN0YXRlIAAAAAAB&resultIndex=1>

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