

INSURANCE LAW UPDATE 2003

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A. Introduction

This chapter summarizes notable British Columbia insurance decisions occurring in 2003.

1. The Insurance Act

The related cases of *KP Pacific Holdings Ltd. v. Guardian Insurance Company of Canada* (2003) 225 D.L.R. (4th) 193 and *Gore Mutual Insurance Company v. Churchland* (2003) 225 D.L.R. (4th) 202, were heard on February 18, 2003 by the Supreme Court of Canada. The judgment of the court in both cases was delivered by the Chief Justice of Canada. The Reasons for Judgment invite the British Columbia legislature to revise the *Insurance Act* R.S.B.C. 1996 c. 226 as an Act which was designed to address a paradigm of discreet categories of insurance policies which no longer exist and which is “incapable of incoherently addressing the modern multi-peril policy” (*KP Pacific Holdings* at p. 200).

The issue which arose in both cases was which limitation provision of the Act applies to losses said to arise out of fire insurance policies. Part 5 of the *British Columbia Insurance Act* R.S.B.C. 1996 c. 226 is the Fire Insurance Part of the Act. It prescribes statutory conditions, one of which, condition 14, provides that the applicable limitation period is one year from the date of the loss. Part 2 of the Act, the General Insurance Part, provides, in s. 24 that every action on a contract shall be commenced within one year after the furnishing of reasonably sufficient proof of a loss or claim under the contract. Part 2 also contains a provision, s. 4, which prevents parties from contracting out of the provisions of the Act except in circumstances where a statutory condition is applicable.

In *KP Pacific Holdings*, the Plaintiff insured was the owner of a hotel which was damaged by fire on June 6, 1997. An action was commenced more than one year after the date of loss but less than a year after the furnishing of a proof. The insurer, in its defence relied upon the statutory provisions of the Fire Part of the Act and in addition argued that even if Part 2, the General Part, applied, the contract of insurance specified a limitation period of one year from the loss which ousted the longer limitation period.

In the *Churchland* case the insured had suffered a loss as a result of a break-in and theft which occurred on December 16, 1991. More than one year after the break-in but less than a year after the filing of proof the insureds brought an action against the insurer and the insured took the position that the claim was statute barred because it was not brought within the limitation period under the fire part of the insurance act despite the fact that the claim did not arise out of a fire. In addition, the insurer relied upon the contractual incorporation of the short limitation period.

The *KP Pacific Holdings Ltd.* came on appeal from a judgment dismissing the appellant’s action which was upheld on appeal (2001) 202 D.L.R. (4th) 235. The *Churchland* case had been dismissed at the trial level but the dismissal of the action had been set aside on appeal by the British Columbia Court of Appeal (2001) 202 D.L.R. (4th) 210.

The difficulty in addressing the cases arose in part as a result of the amendments to the *Insurance Act* which have made Part 5 very difficult to interpret. Fire insurance was initially described, for the purposes of this Part as “insurance against the loss of or damage to property in the Province... caused by fire, lightning or explosion [including] sprinkler-leakage insurance...”. By amendment, words were later added to the definition which provided that, in order for a policy to fall within the purview of Part 5 the fire coverage provided by the policy must not be “incidental to some other class of insurance defined by or under this Act”. The Act was further amended to provide that the fire insurance part might apply to other policies by the addition of s. 119 of the Act which provides “this part applies to insurers carrying on the business of fire insurance and contracts of fire insurance, whether or not a contract includes insurance against other risks as well as the risks included in the expression fire insurance as defined by this act”. In 1957 a further amendment restated the exclusion from the Fire Part policies “where the peril of fire is an incidental peril to the coverage provided”. In the result all-risk policies appear to fall within the Fire Insurance Part of the Act unless insurance against fire is “an incidental peril”. That question was the focus of what had previously been the leading case in this area, *Dresser Supply Limited v. Laurentian Pacific* (1991) 77 D.L.R. (4th) 317 (B.C.C.A.).

Surprisingly, when the matter came on for hearing before the Court of Appeal again in the *KP Pacific* and *Churchland* cases, the decision of the Court of Appeal was founded upon consideration of the nature of the loss which gave rise to the claims. Despite the fact that both policies were multi-peril policies, the claim in *KP Pacific Holdings Ltd.* was barred by the provisions of the limitation whereas the claim in the *Churchland* case, which was not a fire claim, was not barred by the short limitation.

The Supreme Court of Canada rejected this approach as unworkable. The court was clearly not prepared to accept an approach where the outcome would depend on one's *ex-post* characterization of the triggering event" (*KP Pacific Holdings* at p. 199). For some purposes it is important to know what provisions of the Act apply to a policy before the occurrence of a loss. The Court also pointed out that the approach taken in *Dressen*, which was to rank risks in order to characterize some as incidental and others as primary, was inappropriate in the case of multi-peril policies in which there is no hierarchy of perils. In conclusion, the court found (at p. 200 in the *KP Pacific Holdings Ltd.* case) "one is driven to conclude that s. 119, despite its alterations, is based on the paradigm of discreet categories of insurance policies and is incapable of coherently addressing the modern multi-peril policy. It may have made good sense in the 1930's when insurance was offered in discreet packages, each containing its own special type of coverage. It makes much less sense now."

The court found that it could not conclude that the legislature intended a multi-risk policy to fall within the provisions of the Fire Part of the *Insurance Act* and that any insurance policy which does not fit into a specific category is governed by the section of general application. The court went on to find, as had the British Columbia Court of Appeal, that if an insurance policy does not fall within the Fire Part then the parties are not able to contract out of the statutory limitation period with a shorter limitation and that the contractual adoption of the statutory conditions is insufficient as a result in the short limitation period.

Both the *KP Pacific* and *Churchland* cases were remitted to the trial courts for trial. In the *KP Pacific* case this will require the parties to address issues arising out of a fire which occurred six years ago. In the *Churchland* case the parties will be required to address a theft claim which is now twelve years old. An even more difficult task, however, awaits the legislature which has now been advised that this very substantial piece of legislation is ill suited to the existing marketplace and an industry, which will now see that most common property and casualty insurance policies do not fall within the specific sections of the *Insurance Act* which were formerly applicable to them.

2. Conflict of Laws

In July, the Supreme Court of Canada rendered judgment in *Unifund Assurance Company v. I.C.B.C.* (2003) S.C.C. 40 (1 C.C.L.I. (4th) 1). The case arose out of a motor vehicle accident which occurred in British Columbia in August 1995 in which residents of Ontario suffered very severe injuries in respect of which they were paid statutory accident benefits by their Ontario insurer in the amount of approximately \$750,000. When action was brought in British Columbia, I.C.B.C. relied on the statutory provisions to reduce its liability to the Plaintiffs by the amount of the no fault benefits. The Ontario insurer which had paid those benefits then brought action in Ontario under the provisions of the *Insurance Act* RSO 1990 C.I. 8 to recover the statutory accident benefits from I.C.B.C. under the statutory mechanism for transferring such losses between Ontario insurance companies. Unifund was successful in having the Ontario courts require I.C.B.C. to appoint an arbitrator to address the issue of Unifund's ability to recover the statutory benefits as well as the question of whether or not Ontario was *forum non conveniens*. The majority of the judges of the Supreme Court took the position that while the arbitrator might have the authority to address the issues raised by I.C.B.C. it did not have the exclusive authority to do so and being empowered to rule on the constitutionality of the litigation in Ontario, the Ontario courts ought to have done so. On the merits, the court concluded that the provisions of the *Ontario Insurance Act* relied on by Unifund were constitutionally inapplicable to the Insurance Corporation of British Columbia because its application in the circumstances the case would not accord with territorial limits on Provincial jurisdiction.

B. Automobile Insurance

1. Structured Settlement

Section 55 of the Insurance (Motor Vehicle) Act R.S.B.C. 1996 c. 231 provides that the courts must order that an award for pecuniary damages in a motor vehicle action be paid periodically if the award is at least \$100,000 and the court considers it to be in the best interests of the Plaintiff or if the Plaintiff requests that the award be grossed up for tax purposes and the court considers that periodic payment is not contrary to the best interests of the Plaintiff. In *Lee v. Dawson* (2003) B.C.S.C. 1012 the court reviewed the cases in which the courts have ordered the establishment of a structure. In those cases where structures have been ordered there appears to have been either evidence of impulsive

or unreasonable behaviour on the part of the Plaintiff or a lack of specific plans for the monetary award. In the *Lee* case the court held that establishment of a structure would reduce the Plaintiff's flexibility in circumstances where it was not necessary that a structure be established. The Plaintiff satisfied the Court that a structured settlement was not in his best interests.

2. Statutory Liability of I.C.B.C.

The complex interplay of statutory immunity of police officers, vicarious liability of the Attorney General of British Columbia under the *Police Act*, the *Negligence Act* and the *Insurance (Motor Vehicle) Act* were all considered in *McVea v. B.T.* (2003) B.C.S.C. 958; (2003) 50 C.C.L.I. (3d) 219. In that case the Plaintiff suffered damages as a result of the negligence of a police officer and an uninsured motorist. Action against the police officer was barred by the provisions of the *Police Act*, but the Attorney General was vicariously liable for the negligence of the officer. I.C.B.C. took the position that as the Plaintiff could recover the entire loss from the Attorney General of British Columbia as one of the joint and several tortfeasors, there was no need to resort to I.C.B.C., in its capacity as the party responsible to pay for damages occasioned by uninsured motorists, to pay anything in respect of the negligent driver's contribution. The court accepted I.C.B.C.'s position that its liability in respect of uninsured motorists is liability which arises as part of a scheme amounting to "insurance of last resort". The court, however, found that I.C.B.C.'s obligation to pay \$200,000 in damages in respect of underinsured motorists was insurance available to the Plaintiff in the case and I.C.B.C. was required to pay that portion of the 90% of damages awarded against the underinsured driver.

3. Unidentified Motorist

The claim against the Insurance Corporation of British Columbia as a nominal defendant in respect to the negligence of an unidentified motorist may only be brought in circumstances where the insured has made all reasonable efforts to ascertain the identity of the unknown driver. In *Nelson v. I.C.B.C.* (2003) B.C.S.C. 121, 45 C.C.L.I. (3d) 259, such a claim was dismissed. The Plaintiff was injured as a pedestrian in a cross-walk when she was struck by a van. The driver of the van asked whether she was all right and, when she said that she was, departed immediately. The court held that it was not unreasonable for the Plaintiff at the scene of the accident to move to a position of safety on the curb before becoming fully aware of her injury. Subsequent to that time, however, no reasonable efforts had been made by the Plaintiff to ascertain the identity of the unknown driver until she retained counsel, who placed posters and advertisements at the scene of the accident some nine months later, much too late in the day. The court underlined that the obligation of the injured party in these circumstances was to make *all reasonable efforts* on a continuing basis to identify the driver at fault.

4. Temporary Total Disability Benefits

Section 80 of the *Insurance (Motor Vehicle) Act* R.S.B.C. 1996 provides for payment of weekly benefits to insureds in the event that injuries suffered in an accident totally disable them from engaging in employment and in the event that such disability results in a loss of earnings. Unfortunately these provisions have been read in a restrictive fashion so that an insured who preserves earnings by hiring additional help will not be entitled to any compensation in respect of additional expenses or the loss of net earning. This interpretation, paradoxically, makes it disadvantageous to an insured to mitigate damages. This appears to be the effect of the judgment in *Prato v. Insurance Corporation of British Columbia* (2003) B.C.S.C. 76, 45 C.C.L.I. (3d) 275.

5. Jurisdiction to Create Fraud Offences

In *R. v. Eurosport Auto Company* (2002) B.C.S.C. 1109, the Supreme Court, on an appeal from Eurosport's conviction in the Provincial court of five counts of making false or misleading statements or representations to I.C.B.C., contrary to s. 42.1 of the *Insurance (Motor Vehicle) Act* found that the section was ultra vires the Province because it created a criminal offence and was virtually identical to the fraud provisions of the *Criminal Code* (s. 380). The regulation was found to be indistinguishable from the provisions of the Code and related to a matter which was in "pith and substance" criminal legislation. On appeal to the Court of Appeal, the legislation was restored as intra vires the Province (*R. v. Eurosport Auto Co.* (2003) B.C.C.A. 281).

The Court of Appeal held that both the penalty and repayment provisions of the Provincial legislation are integral parts of the Provincial insurance scheme. “It cannot be said that s. 42(1) has a general criminal public purpose or object. Its purpose is not to suppress a public evil or safeguard public morals, rather it is aimed at ameliorating the deleterious effects on the Province’s insurance plan that occur when illegitimate claims are made against it.” In response to the submission that the regulatory scheme could not be differentiated from the provisions of s. 380 of the *Criminal Code* the Court of Appeal held that there is an important prosecutorial discretion in respect of the provisions of the Criminal Code and that that discretion is an important and relevant factor which may eliminate any conflict between Federal and Provincial enactments which appear to duplicate each other. There was also found to be a subtle distinction in the degree of *mens rea* required for conviction in respect to the regulatory and criminal offences. The Court of Appeal held that the language of the regulation permitted a conviction in circumstances in which a conviction might not be permitted under the Criminal Code provision.

6. Underinsured Motorist Endorsement

The nature and extent of I.C.B.C.’s mandatory minimum third party liability coverage was addressed in *I.C.B.C. v. Swiss Reinsurance* (2003) B.C.S.C. 893, 49 C.C.L.I. (3d) 226. In June 1995 an impaired driver struck and fatally injured a cyclist on Vancouver Island. The driver at the time had an I.C.B.C. policy which included third party liability of \$200,000 and an excess liability coverage issued by Family Insurance (whose liabilities had been assumed by Swiss Reinsurance Company of Canada at the time of trial). Judgment was rendered against the driver for a sum in excess of \$500,000. I.C.B.C. paid \$200,000 of that judgment and sought reimbursement from Swiss Reinsurance. The Family Insurance policy was said to be in excess of the I.C.B.C. primary limit but, surprisingly, did not contain any exclusion in respect of impairment. I.C.B.C. argued that because the driver was in breach of the I.C.B.C. coverage but not in breach of the Family policy, that the provision of the Family policy which said that it was excess to the I.C.B.C. primary limit was ineffective and that Family’s coverage should be “first dollar” coverage. The court held that to give effect to I.C.B.C.’s submission “is to write into the contract a ‘drop down’ provision”. The court held that the fact that the I.C.B.C. insurance became uncollectible because of the insured’s breach, should be irrelevant to the interpretation of the policy. I.C.B.C., in the position of the insured, could not advance any better claim to coverage than that which could be made by its insured, a party to the agreement with Family, which clearly provided that there would be a payout “only in respect of amounts over and above the I.C.B.C. primary limit”.

C. Life, Accident and Disability Insurance

1. Life Insurance - Accident

On March 21, 2003 the Supreme Court of Canada rendered judgment in *American International Assurance Life Company Limited v. Martin* (2003), 223 D.L.R. (4th) 1. The case had been argued in October 2002 and judgment had been reserved. The Plaintiff’s claim was brought under the provisions of a life insurance policy which included an “accidental death benefit provision”. The accidental death benefit was payable upon receipt of proof that the life insured’s death “resulted directly, and not independently of all other causes, from bodily injury effected solely through external, violent and accidental means...”. The life insured had died on October 29, 1996 in circumstances which led the coroner to conclude that he had overdosed on an intravenous injection of Demerol and Phenobarbital. The insurer argued that the self injection of medication was obviously a deliberate act and that given the necessary dosage which must have been taken the death could not be characterized as accidental. At trial (1999) 16 C.C.L.I (3d) 180, the court had concluded that given that the life insured was a physician, he must have been aware of the risks posed by injecting the quantity of intravenous drug which he must have used and the court concluded that the death was not “effected through accidental means”.

On appeal (2001), 86 B.C.L.R. (3d) 4, 196 D.L.R. (4th) 427, the Court of Appeal unanimously allowed the appeal on the basis that in the circumstances it could not be established that the life insured had intended to give himself a lethal dose and that an ordinary person looking at the circumstances of the death would conclude that death occurred accidentally. At the Supreme Court of Canada, the insurer placed significant emphasis upon the fact that the policy covered only deaths caused by “accidental means”. The position taken by the insurer was that this established a subclass of accidental deaths, some of which might be characterized as the unlooked for or unexpected result of

intentional acts and others of which might be characterized as the unlooked for or unexpected result of accidental events. The insurer argued that an injection of Demerol was an intentional act and if this was the means of death then the result, whether expected or not, could not be considered to be a death resulting from “accidental means”. The Supreme Court of Canada rejected this distinction, holding that “when death is the unexpected result of an action, we say that the death was “accidental” or that it was brought about by “accidental means” as opposed to “intentional means”. In ordinary language, then, “death by accidental means” and “accidental death” have the same meaning (at p. 7). The principal basis for rejecting the argument of the insurer appears to have been the view that drawing a distinction between deaths resulting from accidental means and accidental deaths would exclude a broad class of deaths which the ordinary person would unhesitatingly classify as accidental. The court held (at p. 9) that “the accidental nature of a particular means of death depends, in ordinary parlance, on the consequences that the *insured* had or did not have in mind.”

The Supreme Court of Canada acknowledged that there is some difficulty in borderline cases in determining whether or not a life insured has actually expected death to result and, in particular, that there will be difficulty in addressing cases where there was an apparent decision to court a significant risk of death. In addressing this question, the court looked to the manner in which the actions would be described by most people and asking whether most would consider the death an accident. “If we cannot be sure, as is often the case, then we may ask what a reasonable person endowed with the factual beliefs of the insured and placed in the circumstances of the insured would have expected” (at p. 11).

In so interpreting the policy of insurance, the Supreme Court of Canada appears to have been less concerned with the specific wording of the clause in question than with the expectations of a reasonable policy holder. This approach is underlined in the Court’s expressed view that if insurers wish to exclude death that results from a deliberate or voluntary action of a specific type then an explicit exclusion clause must be used to have that effect. The court concluded, in the circumstances, that there was significant evidence that the life insured did not intend to cause his death and upheld the decision of the Court of Appeal, allowing the claim for benefits under the policy.

The *Martin* case was followed in April 2003 by the Supreme Court of British Columbia in a case in which the estate of an insured brought a claim under an accidental death and dismemberment policy arising from the death of the insured as a result of a fall from a tree next to the South end of the Burrard Street Bridge. The insurer denied the claim on the basis of an exclusion which provided that no benefit would be payable “for a loss resulting directly or indirectly from, or in any matter or degree associated with... self inflicted injury, whether intentional or unintentional, sustained while intoxicated with a blood alcohol level of .08% or higher...”. At the time of his death the life insured was intoxicated with a blood alcohol level of higher than .08%. The court held that the death was accidental, on the one hand but the deceased was intoxicated, on the other hand. The difficulty was determining whether the injury was “self-inflicted”. While the court expressed doubt about what could possibly be meant by an unintentionally self inflicted injury, the trial judge concluded that the deceased had intended only to take a shortcut home and not to injure himself and the claim out of the policy was allowed.

2. Accident Insurance - Participation in Treatment

An interesting question which is unlikely to arise frequent but underlines the important reciprocal obligations of parties to an accident or disability policy was considered in *Sander v. Sun Life Assurance Company of Canada* (2003) B.C.C.A. 55. The Plaintiff in that case was a group insured under an accident and sickness policy which provided for replacement of lost income. The Plaintiff, Dr. Sander, was a dentist who suffered from a right eye cataract. He was of the view that he would have difficulty doing his job because he required stereoscopic vision. A consulting ophthalmologist expressed the view that cataract surgery with intraocular lens implantation was indicated and that such surgery was generally regarded as safe and very effective. There was nothing to indicate that he would be a poor candidate for surgery. The policy provided that during any period of disability the insured was obliged to make reasonable efforts to “recover from the disability, including participating in any reasonable treatment or return to work assistance program.

The position taken by the insured was that he would not undergo surgery until the cataract had progressed to the point where it affected his daily life. In the alternative it was argued that by paying benefits the insurer had lulled the insured into believing that he would continue to receive benefits and did not require his medical practice and that it

could be sold in reliance on continuing benefits. The trial judge held that there was no evidence to support this claim in waiver or an estoppel and that the insurer had done nothing to lead the Plaintiff to suppose that the terms of the policy would not be followed.

In respect of the insured's argument that while surgical treatment might be appropriate that the matter of its timing should be left to the insured and that disability benefit payments should continue so long as there was some basis for the insured's decision with respect to when to undergo surgery, the Court of Appeal held that there was evidence that the surgery was indicated before trial and that it was appropriate treatment. The appeal was dismissed unanimously.

3. Disability Insurance - Limitations and Onus of Proof

In *Balzer v. Sun Life Assurance Company of Canada* (2003) B.C.C.A. 306, the Court of Appeal had as much difficulty with the limitation provisions in the *Insurance Act* as did the Supreme Court of Canada earlier in the year in the *KP Pacific Holdings Ltd.* and *Churchland* cases [supra]. The provision which resulted in difficulty in the *Balzer* case was s. 22 of the *Insurance Act* which provides that an action on a contract must be commenced within one year after the furnishing of reasonably sufficient proof of a loss and that an action must not be brought for the recovery of money until the expiration of 60 days after the proof of the loss or the happening of the event upon which the insurance money is to become payable.

The Plaintiff, Betty Balzer, sought disability benefits as a result of absence from work commencing October 8, 1992. The six month elimination period under her group disability insurance policy expired in April 1993 and at that point the insurer began to pay the benefits provided for under the policy. During the term of her disability the insured provided additional information in support of her claim to the insurer. By October 1994 her "own occupation" coverage came to an end and the insurer took the position that she was not considered to be totally disabled from performing any occupation and benefits were discontinued. The insured was, however, invited to provide further information in support of her claim to the insurer and at that point she did provide further information and subsequently asked for a further review of her claim. As late as May 1996 the insurer requested the insured to provide a detailed medical report so that it could reconsider the insured's claim. At trial, the insurer sought to establish that the right to sue expired on one of three possible dates:

- 1.) December 1995, one year after the insurer wrote to inform the insured that it had denied her continuing claim, at which point the insurer says that the insured had provided reasonably sufficient proof of her continuing claim;
- 2.) October 1995, one year after the "own occupation" benefits were terminated; or
- 3.) April 1997, one year after receipt of the insured's last letter in support of her claim for continuing benefits.

There was no evidence that the insurer had suggested to the insured at any point that time was running against her claim to "any occupation" coverage.

The court was clearly troubled by the fact that the insurance policy in question contained no express provision with respect to proof of a claim to "any occupation" coverage. The form of the policy was to provide benefits following the initial proof and subject to continuing evidence of entitlement subject to a change in definition of disability after 18 months. There was no separate procedure identified in the policy for advancement of a claim at the expiry of the "own occupation" coverage.

In the absence of a formal procedure for making proof of a claim, the insurer took the position that for the purposes of certainty and application of the *Insurance Act* it remained necessary for the court to fix a date for the running of the limitation and urged upon the court the conclusion that it should fix upon the date upon which the insurer concluded that it had sufficient information to adjudicate upon the claim and so advised the insured. In the alternative, the insurer took the position that the court should conclude that a claim to benefits arose monthly and that a Plaintiff could not advance a claim for disability insurance benefits accruing in any period more than 12 months before the issuance of the Writ. The Court of Appeal was unwilling to fix the limitation period retrospectively from the issuance of the Writ. The court did however accept as "a proposition of general application" the rule that where a potential

claim is clearly and unequivocally rejected on the basis of information provided to the insurer on the insurer's behalf that the commencement of a limitation period under s. 22(1) of the Act is triggered. It did so in an attempt to solve "the conundrum posed by the entirely inadequate words the legislature has chosen to incorporate into every group accident and sickness policy by the convoluted provisions of the *Insurance Act*" (at para. 41). In the circumstances of the *Balzger* case, the court found that the insurer had not clearly and unequivocally denied the claim but had repeatedly advised the insured that the decision to deny benefits would be reconsidered on submission of further evidence by the insured. The court recommended that insurers wishing to avoid any doubt with respect to the commencement of a limitation period should make a clear and unequivocal denial and include in the denial letter an alert drawing the insured's attention to the limitation period in s. 21 and informing the insured that it would regard the denial as starting the running of time under the section. In the light of recent claims for aggravated and punitive damages, disability insurers will, no doubt, be reluctant to foreclose insureds from submitting further information in support of claims and this suggestion is problematic.

The decision in *Balzger* came shortly before judgment of the British Columbia Court of Appeal in *Watterson v. Sun Life Assurance Company of Canada* (2003) B.C.C.A. 305 (2003) 48 C.C.L.I. (3d) 172. The decision in *Balzger* was distinguished in *Watterson* by Madam Justice Huddart who wrote the judgment of the court in both cases in the following terms:

"While the application of Section 22(1) to income replacement insurance is often problematic, this is not such a case. The group policy makes clear a separate notice and a separate proof of claim are required for the long term 'any occupation' coverage. Mrs. Watterson understood that. She completed the required proof of claim forms and delivered them to the insurer. The insurer unequivocally denied her claim. She understood that too. There is no basis in the evidence for the application of principles of waiver or estoppel, or need for what the appellant called a "Plaintiff oriented approach" to the interpretation of either the statutory or contractual limitation provision. Nor is there any reason to apply the discoverability rule."

The action in *Watterson* was held to be statute barred and the appeal was dismissed.

In *Plouffe v. Mutual Life Assurance Company of Canada* (2003) B.C.C.A. 96, 45 C.C.L.I. (3d) 26, the Court of Appeal allowed an insurer's appeal from a judgment in favour of the insured under disability insurance policy. In doing so the court found that the trial judge had erred in not clearly making a distinction between "own occupation" and "any occupation" coverage and in appearing to have placed an inappropriate burden on the insurer. In the Reasons for Judgment the trial judge had concluded that he was "not persuaded that on the balance of probabilities there is an occupation within (the insureds abilities)."

4. Disability Insurance - Aggravated and Punitive Damages

In numerous cases since *Warrington v. Great West Life Assurance Company* (1996) 24 B.C.L.R. (3d) 1 (C.A.), British Columbia courts have made awards for aggravated damages, even in circumstances where claims for punitive damages have been dismissed. In *Nicholas v. Metropolitan Life Insurance Company of Canada* (2003) 1 C.C.L.I. (4th) 239, the British Columbia Supreme Court held that there is no apparent reason why those cases were not applicable to claims made by Plaintiffs against trusts created for the purpose of administering long term disability plans for unions but held that no claim was made out on the facts in that case as the Plaintiff had managed financially despite the denial of benefits and her ongoing disability. The court further noted that a claim for aggravated damages could not be made out by a Plaintiff who was herself responsible for significant delay in the advancement of her claim.

In *Asseltine v. Manufacturers Life Insurance* (2003) 1 C.C.L.I. (4th) 271, the judgments in British Columbia on aggravated and Punitive Damages in disability insurance cases may have hit a high water mark. The Plaintiff in that case was a 62 year old registered nurse who suffered from a very complex medical condition in respect of which she was advancing a claim under a disability insurance policy insuring the staff at the University of British Columbia. Ms. Asseltine was thought at various periods to be suffering from vertigo, multiple sclerosis, chronic fatigue and depression. In addressing the Plaintiff's subjective complaints, the insurer appears to have taken the sceptical position which has occasionally received the judicial imprimatur as, in *Mathers v. Sun Life Assurance Company of Canada* [1998] B.C.J. No. 554 and *Ditomaso v. Manufacturers Life Insurance Company* [2002] B.C.J. No. 674.

The Court, however, found that the insurer had not acted in accordance with its obligation to act in good faith and deal fairly with the insured and to balance the insured's interest against its' own interest. The court awarded aggravated damages of \$35,000 and punitive damages of \$150,000.

5. Disability Insurance - Settlement and Release

Disability insurers are loathe to settle disputed claims on terms which leave the underlying policy in full force and effect because of the difficulty in describing the extent of the claim released. An example of the difficulties which may occur in these circumstances was the claim considered in *Lehner v. Paul Revere Life Insurance Company* (2003) B.C.S.C. 251, 46 C.C.L.I. (3d) 131. The Plaintiff, Lehner, was a financial consultant who had previously been disabled as a result of pain and anxiety and depression associated with a temporomandibular joint disorder. That claim was settled by a release executed in April 1996. In 2001 Mr. Lehner underwent oral surgery and suffered an injury to a lingual nerve which caused associated chronic pain and again disabled him. He brought a second claim under the insurance policy and the insurer defended the claim on the basis that the release prevented the insured from advancing any claim "for any illness or disability arising out of or due to temporomandibular joint disorder and/or any mental/nervous disorder including anxiety and/or depression". The court held that the claim did not arise out of a TMJ Disorder and did not "originate with" any illness or disability arising out of a mental or nervous disorder. The court found that the "root cause" of the disability was the original nerve injury and the release was ineffective to bar the claim. The court resorted to the doctrine of reasonable expectations as discussed in *Reid Crowther and Partners Limited v. Simco & Erie General Insurance Company* [1993] 1 S.C.R. 252 and concluded that the reasonable expectation of the parties on entering into the release was that disability even a nervous disorder having its origin in any physical injury, other than the TMJ Disorder, would be compensable.

D. Property and Casualty Insurance

1. Exclusions - Vacancy

The common vacancy exclusion in property insurance policies has been regularly considered by British Columbia courts. The provision again came under consideration in *Price v. Zurich Insurance Company* (2003) B.C.C.A. 72. The insured's claim for damages had been dismissed on an 18A application brought by the insurer and that judgment came on for appeal on January 8, 2003. The Court of Appeal unanimously upheld the judgment.

The claim arose out of a fire which occurred on March 26, 2000. The insurer had denied coverage on the basis that the policy excluded coverage for vandalism or malicious acts occurring while the insured structure was vacant. The second excluded loss or occurring after the dwelling had been vacant to the knowledge of the insured for more than 30 consecutive days.

The Court of Appeal rejected the insured's argument that the use of the words "with no intent to return" in parts of the definition of vacancy and not in other parts of the definition gave rise to an ambiguity. The policy was held to have defined vacancy as it might occur in different circumstances without any ambiguity. In doing so the court noted that it was necessary to read the definition of vacancy in the policy as a whole and not to isolate certain words or phrases and to give the definition the meaning which would be attributed to it by reasonable persons.

The court noted that in the *Price* case, as in most cases, the difficulties with the definition of vacancy in the policy "are not with respect to its meaning, but rather with respect to its proof" (at para. 22).

The court held that in the circumstances of that case the property manager's knowledge of vacancy was knowledge which could be imputed to his principal, the insured, and, that being so, the premises were vacant for more than 30 days to the knowledge of the insured at the time the loss occurred.

2. Actions for Coverage

In *Litchfield Holdings and Management Corporation v. Kingsway* (2002) B.C.S.C. 1665, 44 C.C.L.I. (3d) 238, the British Columbia Supreme Court in chambers considered issues which have apparently not previously been thoroughly addressed in British Columbia in the context of a tort claim settled between the parties prior to subsequent coverage

litigation. Litchfield Holdings and Management Corporation and others were parties to a civil lawsuit arising out of a fire which occurred in 1997 and caused approximately \$1,000,000 in damage. The claim was settled on terms which did not require the insureds to pay the settlement but which provided the insureds with a covenant not to sue. The subsequent lawsuit was brought for coverage by the parties to the settlement of the tort claim. On a preliminary application to strike out the defence the Plaintiffs sought to preclude the insurer from raising two issues in its defence. First, the insurer sought to challenge the reasonableness of the settlement of the underlying tort claim on the basis that the claim was apparently settled for 100% of its value, despite the fact that there was a significant liability issue and on the basis that the insured had no interest in disputing the quantum of settlement as its principal concern was obtaining a release in the form of the covenant not to sue. Second, the insurer sought to characterize the settlement of the underlying tort claim as collusive, a factor to be considered in addressing the reasonableness of the settlement. The court held that although there was a paucity of authority on these issues that it could not be said that there was no merit in these defences and they were allowed to stand.

3. Coverage - Definition of Insured

The appellate courts in British Columbia have regularly addressed issues arising out of transient or modified occupation of premises (see for example *Wright v. Canadian Group Underwriters* (2002) B.C.C.A. 254). In 2003 the issue of occupation was addressed in respect of a foster child in the care of the insureds. In *Riordan v. Lombard Insurance Company* (2003) B.C.C.A. 267, the insureds were caring for a 13 year old foster child who intentionally set fire to their premises in March 1998. The loss in the first instance was covered by AXA Pacific Insurance Company which had issued an insurance policy to the British Columbia Federation of Foster Parents Association which insured the Riordans against the damage intentionally caused by foster children in their custody. Having taken an assignment of the Riordans' cause of action against their insurer, Lombard Insurance Company, AXA sought a declaration that Lombard was obligated to pay the loss. Lombard took the position that it was not obliged to pay the claim as a result of an exclusion in its policy in respect of intentional or criminal acts by "any person insured" by its policy. Without addressing AXA's ability to obtain such a declaratory judgment in the name of the insureds (which is problematic, as noted in the *Pacific Forest Products* case, discussed below). The trial judge, in the first instance, held that the exclusion was inapplicable, finding ambiguity in the policy wording and holding that the exclusion applied only in respect of the intentional criminal acts of the named insureds. The ambiguity was said to arise out of the lack of any definition of "insured" in the policy and the varying usage of the words "you" and "your" in the policy provisions dealing with coverage and legal action. Relying on an enunciation of the principles of interpretation in the judgment of McLaughlin, J as she then was in *Reid Crowther and Partners Limited v. Simco & Erie General Insurance Company* [1993] 1 S.C.R. 252, [the contra proferentem rule, the principle that coverage provisions should be interpreted broadly and exclusion provisions narrowly and the desirability where the policy is ambiguous of giving effect to reasonable expectations of the parties] the trial judge found that the policy failed to clearly indicate to the insureds that the foster child was an "insured" within the exclusion clause.

On appeal, the Court of Appeal found that there were clearly provisions of the policy which provided insurance coverage to the foster child and that there was no ambiguity as to whether or not the foster child was within the exclusionary clause as being "any person" insured by this policy. The ambiguity addressed by the trial judge would only have arisen if the exclusion applied to damage resulting from any intentional or criminal act by "an insured". The Court of Appeal, finding that there was no ambiguity or uncertainty, held that the trial judge had fallen into error in engaging the principle of *contra proferentem* or any other principle of interpretation that could lead to the exclusionary clause not being applicable. In particular, the Court noted that resort to the doctrine of reasonable expectations was not necessary in the absence of apparent ambiguity. The Court of Appeal cautioned against an invitation to create ambiguities when none exist.

4. General Principles - Duty of Disclosure

In *Bell Pole Company v. Commonwealth Insurance Company* (2003) B.C.C.A. 7, the Court of Appeal addressed a very interesting claim arising out of inadequate bylaw coverage. The difficulty in predicting potential bylaw expenses and the apparent hesitancy of insureds to pay the premiums associated with adequate coverage in respect of bylaw expenses has given rise to significant recent litigation of which this is one example. Commonwealth Insured the Bell Pole facility at Carsland, Alberta which was destroyed by fire on May 1, 1995. At the time of the loss the brokers had

obtained for the insured a policy without a sub-limit with respect to bylaw coverage on the condition that the insured would estimate the approximate exposure under the bylaw coverage and declare that value in a Statement of Values. The Statement of Values would identify the maximum anticipated claim for bylaw coverage which could arise from any one loss and the premium would be calculated upon the value so declared. The standard conditions attached to the policy included standard condition 3:

“When applying for insurance hereunder, if the insured has intentionally given, to the prejudice of the insurers, a false description of the property to be insured... this contract is void as to any property in relation to which the misrepresentation or omission is material.”

The learned trial judge, after hearing 30 days of evidence, much of which was found by the Court of Appeal to have been parol evidence, which was disregarded in the interpretation of the policy, that the insured had knowingly underestimated the significant potential bylaw expenses in the Statement of Values. Whereas the policy described the maximum anticipated bylaw expense at \$250,000 the insured had incurred bylaw expenses following the fire in the range of \$1,100,000. At trial the insured was awarded judgment for the sum of \$250,000 in respect of the bylaw expense. An appeal was brought from that order for the balance of the bylaw expenses, and the insurer cross-appealed the judgment on the basis that there had been an intentional misstatement of the potential bylaw exposure by the insured which vitiated coverage. The trial judge found that the insured had deliberately underestimated bylaw expenses but had done so with the intention of establishing a sub-limit of coverage under that heading rather than with fraudulent intent.

Madame Justice Southin for the Court of Appeal held that if both parties had sought to establish that there was a sub-limit in respect of bylaw coverage it would have been appropriate to order rectification of the policy but the insurer did not seek rectification and neither party could create a sub-limit in the absence of some provision in the contract permitting it to do so. On the other hand, there was no provision in the policy which would result in avoidance of coverage as a result of an inaccurate estimate of potential bylaw expense even where the insured knew that estimate was grossly inadequate. The attribution of an amount to “bylaws” in a Statement of Values could not be considered to be a “description of property”.

The court accordingly had resort to the obligation of the insured to exercise good faith in its dealings with its insurers and held that intentional under-statement of a risk was a breach of that duty which disentitled the insured to recover anything under the bylaw coverage in excess of the described risk of \$250,000. The Court of Appeal does not address at any length the insurer’s position that the misstatement of the risk ought to preclude the insured from advancing *any* claim in respect of bylaw coverage. The Court of Appeal simply concluded that “the insurers took the appellant’s money, they are better off than if the appellant had paid a premium for bylaw coverage of \$1,000,000 and it ill-becomes them to resist paying the \$250,000.”

This judgment is troubling, however, in that it permits the insured to obtain a sub-limit of coverage on terms which might not have been acceptable to the insurer. Insurance in general is underwritten on the basis that the insured will insure to full values and the profit earned by insurers is greater on the last dollar of premium income than on the first. The premium charged might have been greater if it had been clear to the insurer that the insured was seeking a sub-limit of coverage far below its potential exposure. If it was open to the court to find that there was a breach of the duty of good faith to the insurer, it is arguable that it was inappropriate in the circumstances to permit the insured to achieve exactly the ends which it sought to achieve by the misrepresentation.

5. Subrogation

A very interesting subrogation issue was commented upon but not resolved by the British Columbia Court of Appeal in *Pacific Forest Products Ltd. v. AXA Pacific Insurance Company* (2003) B.C.C.A. 241. In a number of recent cases, commonwealth courts have addressed issues on the frontier between claims for contribution amongst insurers and subrogated claims. The full complexity and scope of this litigation is discussed in *Caledonia North Sea Limited v. London Bridge Engineering* [2000] S.L.T. (1st Div.) 1123, affirmed at [2002] 4 H.L.J. No. 4. The issue which was wrestled with in that case was the extent to which a party who is obliged contractually to indemnify another may bring a claim under that party’s insurance policy against an insurer. Clearly, one insurer is not entitled to sue another in the name of the insured for a claim under its policy where the appropriate remedy is for the insurer to seek contribution in its own

name against the other insurer. As the *Caledonia North Sea* case illustrates, there are complex circumstances in which the court must order claims for indemnity and draw a line beyond which claims are properly characterized as claims for contribution rather than subrogation.

The *Pacific Forest Products Ltd.* case was not, however, such a case. Pacific Forest Products held a forest licence and contracted with GBA Logging Ltd. to perform logging activities. The contract required GBA to carry certain insurance coverage and GBA obtained that coverage from the Defendant, AXA Pacific Insurance Company. Pacific itself was insured by Lumberman's Underwriting Alliance. In 1996 Pacific incurred expenses in fighting a forest fire which broke out in the licenced area and was indemnified in respect to that claim by Lumberman's. Lumberman's then brought a subrogated action in the name of Pacific against AXA, rather than GBA. On a summary trial, AXA took the position that the claim brought in Pacific's name was subrogated and that having been indemnified by Lumberman's Pacific had no remaining claim, in excess of its deductible, against AXA. Pacific was an unnamed insured under the AXA policy. No wrongdoing on the part of GBA was alleged. The court held that the alleged liability of AXA was "as a co-insurer of Pacific, such that AXA's liability depends on the terms of the insurance policy, not the commercial contract between Pacific and GBA. That being so, I am of the view that the action, as it relates to a subrogated claim, is misconceived" (para. 28). If Lumberman's had a claim against AXA it was a claim in contribution and as the action was framed as a subrogated claim, the extent to which Lumberman's might be entitled to contribution from AXA could not be determined in the context of the subrogated action. The court quite properly held that a claim for contribution might raise issues in respect of which there had not been appropriate discovery to be addressed before contribution issues could be resolved.

E. Marine Insurance

The British Columbia Supreme Court considered a significant point with respect to which there is apparently a dearth of authority in *North Coast Sea Products Ltd. v. ING Insurance Company of Canada* (2003) 47 C.C.L.I. (3d) 142. In that case the insured had incurred expenses to recover trays, which were insured, containing oysters, which were not insured, when the trays containing the oysters had been cut loose from the insured's oyster farm. The insurer took the position that it is a basic principle of the construction of a "sue and labour" clause in a marine policy "that expenses incurred for the purpose of averting or diminishing a loss not covered by the policy are not recoverable" and that by analogy to cases involving underinsured losses and total losses that the insurer should be required to pay the insured a rateable portion of the expenses incurred which corresponded to the ratio of the value of insured to uninsured losses avoided by the expense. To do otherwise, the insurer argued, would result in the insured being indemnified in respect of expenses incurred to avoid an uninsured loss, which would be in the nature of a windfall. Mr. Justice Goepel dismissed this argument, in favour of the insured's position which was that the matter must be determined based on the terms of the contract that was entered into between the parties. The contract provided for shared expense in only certain limited circumstances and there was inadequate authority in the common law for the principle advanced by the insurer. In the result, the Plaintiff having been obligated to take such measures as might be reasonable to avert or minimize a loss and there being no issue with respect to the reasonableness of the expenses incurred the Plaintiff was entitled to recover the full amount thus expended.

F. Insurance Agents and Brokers

1. Liability of Agent and Contributory Negligence

In *Sportsman's RV Resort Blind Bay BC Ltd. v. Capri Insurance Services Ltd.* (2003) B.C.C.A. 310 the Court of Appeal considered an appeal from trial judgment in which the insured had recovered from its agent the shortfall on an insurance claim which resulted from the application of a co-insurance penalty. The claim was brought by a corporate entity as a result of an uninsured loss arising out of a fire which occurred on March 25, 1996. In defence of the claim the broker had argued that one of the principals of the insured company had previously suffered an uninsured loss as a result of the application of a co-insurance penalty and that a second such loss did not occur as a result of any act or omission on the part of the broker but as a result of the insured's own fault in failing to insure property to its full replacement cost when it knew or ought to have known of the effect of the co-insurance clause. The insurance in question had been renewed by another principal of the company on the last two occasions before the loss and the

court held that there was some basis upon which the trial judge could have concluded that different or additional insurance coverage would have been arranged had the broker discussed the co-insurance penalty with that representative of the Plaintiff company. The appeal was allowed to the extent of reducing the award by fifty percent to account for the contributory negligence of the insured in failing to bring an appraisal to the attention of the broker. The evidence was that if the property had been insured to the value set out in the appraisal then no co-insurance penalty would have been applicable. The insured acknowledged that that appraisal was not brought to the attention of the broker as a result of an oversight on its part. The judgment follows a number of other cases in which courts have described the broker's duty to bring a co-insurance clause and its consequences to the attention of a client but also reflects the approach taken in other recent cases against insurance brokers, such as *Crown West Steele Fabricators v. Capri Insurance Services Ltd.* (2002) B.C.C.A. 417 in allocating significant fault to the insured for shortcomings in insurance coverage.

G. Practice

1. Costs

In *Price v. Zurich Insurance Company* (2003) B.C.C.A. 72, the Court of Appeal held that it was an error for the Chambers Judge to refuse to hear submissions made by the counsel for the insurer with respect to costs and on hearing those submissions permitted the insurer to recover costs other than those associated with the time spent addressing an issue in respect of which the insurer was unsuccessful.

2. Jury Trials

The rules provide that a trial shall be heard by a court without a jury where the sole or principal question at issue is alleged to be one of construction of an enactment, will, deed, oral or written contract or other document (Rule 10(1)(b)). This rule has commonly been relied upon by insurers seeking to have a jury notice set aside in cases where the principal question at issue is the coverage afforded by the policy. Coverage issues, of course, usually involve questions of mixed fact and law and cases on this point usually require the trial judge to exercise a discretion by weighing the importance of the factual versus the legal issues. Some guidance may be provided to the courts in this regard by the decision of McEwen, J in *Nelson Marketing International Inc. v. Royal & Sun Alliance Assurance Company of Canada* (2003) 47 C.C.L.I. (3d) 236, where the court held that where the findings of fact substantially dispose of the issues to be tried, then the case may be heard by a jury "but if, after the facts have been found, a genuine question remains as to the significance of those facts within a Rule 10(1)(b) issue, it will be the 'principal question in issue' within the meaning of the rule, regardless of the relatively length or complexity of the fact finding exercise itself."

In the *Nelson Marketing* case, an appeal from a Master's order, the Supreme Court refused to interfere with the exercise of the discretion of the Master in setting aside the jury notice where it was clear that the coverage issues would not be resolved by the findings of fact.

In *Sanders v. Clarica Life Insurance Company* (2003) 47 C.C.L.I. (3d) 285, Mr. Justice Hutchison of the Supreme Court reviewed the same cases to which the court had been referred in the *Nelson Marketing* case and held that a jury trial was inappropriate in a case where the principal issue is whether an insured is "totally disabled" as defined by a policy of disability insurance.

Mr. Justice Hutchison also followed a now growing line of British Columbia cases including *Wonderful Ventures Ltd. v. May Lam* (2001) 91 B.C.L.R. (3d) 319 (B.C.S.C.) and *Read v. Insurance Corporation of British Columbia* (2002) B.C.J. No. 2617 in holding that in cases where an insured under disability insurance policy alleges bad faith and seeks punitive damages in respect of the conduct of litigation arising out of the entitlement to disability benefits that the bad faith action should be severed pending resolution of the coverage issues so as to permit the insurer to resolve the coverage issues with counsel of its choice without the loss of solicitor and client privilege which might be a consequence of the bad faith claim.