

**Submissions in response to
Consultation on Proposed Regulations
for the Amended Alberta Insurance Act**

The purpose of this submission is to address several issues raised in the Consultation on the Proposed Regulations for the Alberta Insurance Act.

Background

#1 Disclosure of limitation periods (s. 511(1)(g.1))

Section 27 proposes to amend s. 511(1) (g) of the *Insurance Act* by adding (g.1) which provides:

(g.1) “requiring an insurer to notify a claimant before the expiration of the applicable limitation period in the prescribed circumstances and in the prescribed manner, and setting out the consequences and the remedies available to a claimant if an insurer fails to comply with the requirements”;

Submissions

When and how a limitation period is to be communicated to a claimant is a critical issue that goes directly to the heart of the public’s access to justice. However meritorious a claim may be, once a limitation period expires, the insured has absolutely no recourse before the courts and no remedy for what may be a clear breach of the insurance contract.

For this reason, the clearer the communication concerning a limitation period, the more likely it is that in the event of a dispute, an insured will have an opportunity to access the courts to resolve the dispute.

As counsel for insureds in life and disability insurance claims, it is my experience that claimants experience various barriers that impede their ability to act within the tight time frames of a one year limitation period. Insureds typically prefer to resolve differences without recourse to litigation, which is perceived to be highly stressful and at times prohibitively expensive. Consequently, if communications from the insurer can possibly be construed to leave open the possibility of a peaceful resolution to a disputed claim, insureds are very inclined to cling to this hope, trust in the good faith of the insurer to make the “right decision”, and not take legal action.

It is also my experience that individuals insured under a group policy are almost never provided with information concerning a limitation period. When they start their employment or become covered under a group plan, they are usually furnished with a booklet that outlines some of the features of the group policy. Although benefit booklets provide information about deadlines for filing a proof of claim, they rarely if ever include any reference to a limitation period.

Most insureds are unaware that there is another document, the group disability insurance policy, which sets out a limitation period. Even when advised of its existence, they do not know how to access the group policy. It is the writer’s experience that even when requested, the group policy

is not easily accessed. The insurer will advise the insured to request the policy from the employer and vice versa. Again, the courts (at least in BC) have assumed that insureds have knowledge of, and ready access to, the group policy, but this is not what actually occurs.

Consequently, in most cases involving group disability policies, persons suffering from illness and/or disability have no understanding or knowledge about limitation periods. They rely on the good faith of insurers to guide them through the adjudication process and are often shocked to discover that a limitation period has expired.

The suggestion that up to three notices be provided to the claimant also has considerable merit.

I have encountered several claimants (including lawyers) who, because of their high level of anxiety and an inability to cope with conflict, are not able to even open an envelope from the insurance company once they realize that their claim is or may be disputed. Other clients, suffering from depression, PTSD and other psychological / psychiatric illnesses are simply unable to cope with any dispute of a disability claim. I recently encountered a situation where the individual, who was an experienced CEO of a very successful company, failed to take action when denied benefits involving a disability insurance policy that paid \$5,000/month. The more emotionally disabled the individual is, the less he/she is able to take appropriate action in a timely manner.

Insureds with disabilities also often take a considerable period of time to take action. Their sense of the passage of time and their capacity to take action is often severely compromised. A requirement that the insurer provide notice of a pending limitation period at three stages of the process increases the likelihood that at least one of the communications will be received and understood by the insured, although it may be necessary for the warning to be posted in some form on the outside of the envelope (for example “Limitation Notice Inside”) in order for this information to come to the attention of the insured.

Notice on denial of claim - uniqueness of disability claims

The Consultation Paper noted that the second stage at which notice of the limitation period might be given is on denial of the claim.

In most insurance policies, the limitation period is based on a single triggering event or loss, for example, the loss of a life or a fire.

This does not necessarily apply to a disability claim, which is unique in that it involves a series of monthly losses or “events” (the state of being disabled) rather than a single loss/event.

Consequently, where any benefits have been paid after the initial onset of disability, a limitation period in a disability claim is triggered on *denial* of a claim, rather than on the event of disability. This means that the question of whether and when a limitation period has been triggered in a disability claim can become the source of considerable confusion.

Often the disability insurer pays a few months of disability benefits at the beginning of a claim, sometimes on a “without prejudice” basis, and stops paying benefits shortly thereafter. Almost invariably, insureds are invited to submit further information. Sometimes, when they do, benefits are reinstated.

When benefits cease to be paid, the communication of the insurer is usually polite and open-ended. Insurers use code words such as “your file is being closed” but couch their communications with offers to consider additional medical documentation if and when it is submitted. The implication of many insurer communications is that if further persuasive /objective information is provided, the insurer’s position with respect to the insured’s eligibility for benefits will change. Often insureds receive these communications when they are making their way through Canada’s public health care system which is often backlogged and which can involve significant delays in accessing appropriate specialists. Delays in access to medical experts can result in a delayed diagnosis (which is what happened in the *Esau*¹ case) and a missed limitation period. The difficulty where there is a delay in diagnosing the illness is that insureds sometimes lack sufficient medical support to make an informed decision as to whether there exists a medical basis for advancing a disability insurance claim.

When they receive these insurer letters, insureds usually believe that once a specialist determines the nature and extent of their disability, the insurer will re-instate their claim for disability benefits. They are content to rely on assurances of the insurer that their claim will receive careful reconsideration upon receipt of additional information.

Moreover, the courts in BC have held that it is consistent with an insurer’s duty of good faith to consider additional evidence². However, the courts appear to have overlooked the irony that, in almost every case that has been litigated, the insurer’s offer to consider additional medical evidence supporting the insured’s disability claim has enabled it to advance a successful limitation defence, irrespective of the merits of the subsequent medical documentation.

One solution may be to reintroduce the concept of waiver, which is a very significant aspect of insurance law in the US, bringing an important element of fairness and accountability with respect to insurer conduct. At the present time, provincial insurance legislation in Canada contains a provision similar to that in the BC Insurance Act which states:

Waiver of term or condition

- 11 (1) A term or condition of a contract is not deemed to be waived by the insurer in whole or in part unless the waiver is stated in writing and signed by a person authorized for that purpose by the insurer.
- (2) Neither the insurer nor the insured are deemed to have waived any term or condition of a contract by any act relating to the appraisal of the amount of loss or to the delivery and completion of proofs or to the investigation or adjustment of any claim under the contract.

¹ *Esau v. Co-Operators Insurance Company* [2005] B.C.J. 1041 (C.A.)

² *Shewchuk v. London Life Insurance Co.* [1996] B.C.J. 1886 (S.C.)

It is noted that proposed section 511(1)(g.1)(c) states:

“In the event of non-compliance, the regulation will authorize the court to extend the limitation period or give such other remedy as the court deems necessary.”

It would be extremely helpful if the court were allowed to override the above waiver provisions in providing relief with respect to non-compliance.

Where insurers advise that a file is being closed pending receipt of further medical information, insureds rarely perceive the cessation of benefits or this veiled form of communication from the insurer (requiring additional proof of disability as a condition to further payments) as a termination of benefits or as an action that triggers a limitation period. Unfortunately, courts have interpreted these types of insurer communications to constitute “clear and unequivocal” communication of denial of benefits, even in the face of clear affidavit statements from insureds that, consistent with their actions, that the insured had absolutely no understanding that a limitation period had been triggered.

Consequently, limitation periods often expire on legitimate claims as a result of the confusion generated by obscure communications from insurers. It is the natural tendency of people with disabilities who have little or no resources to litigate to believe that the best way to proceed is to exhaust all avenues with the insurer before considering litigation. There is a desire to avoid stress, which comes with litigation. Even lawyers are prone to conclude that a limitation period is not triggered where there remains a possibility, based on communications from the insurer, that benefits will be reinstated upon submission of further medical evidence.

Although I have often requested reconsideration of a decision on behalf of a client, it is also my experience that the occasions when an insurer reverses its decision based on additional information are quite rare. I am unaware whether any statistics are maintained by insurers as to the success rate of internal “appeals” and if so, whether these are accessible to any level of government.

For these reasons, it is strongly recommended that the communication of the limitation period spell out the specific deadline. For example, the communication could state:

“This is to advise that the limitation period for starting a lawsuit will expire on _____(specific date). If a lawsuit has not been started by this date, your claim will be permanently barred. This limitation period applies regardless of any outstanding requests or discussions concerning resolution of your claim.”

Notice at least 60 days but no more than 120 days before the limitation period expires

For all of the reasons outlined above, it would be very helpful to include a final notice during the 2-4 month period prior to the expiry of a limitation period. My only suggestion is that reference to a limitation period be put on the outside of an envelope as well as in the letter itself. Once

again, it must be made clear that the limitation period expires regardless of any outstanding offer to consider additional medical evidence.

Facilitation of electronic transactions: Amendment Act s. 548(b)

The issue outlined below may not fall into electronic transactions, but it is an area of increasing concern as insurers have, over the years, drafted increasingly detailed applications for life and disability insurance policies.

In the last year, I encountered a situation involving tele-underwriting, where the manner in which the tele-underwriting process unfolded appeared to have resulted in the loss of coverage under a life insurance policy. The individual had been encouraged by his broker to purchase a different life insurance policy. He agreed to do so, and filled out a brief life insurance application form. He lived in an isolated area and arrangements were made for the policy to be tele-underwritten. He was advised that he would receive a telephone call enquiring about his health status.

Late one day, after returning home from work, he received a telephone call. He was asked whether he was available to answer some questions. The caller did not advise the individual of the nature or scope of the questions that would be asked. The insured was never advised that if his answers were incorrect or incomplete, however innocent, the policy could be voided. Over the ensuing 45 minutes, the individual and his wife then attempted to answer a series of medical questions by telephone. The questions were often quite convoluted (see Appendix A). Unfortunately, some details were missed. The questions were transcribed, but never sent to the insured to review and sign.

The insured was never advised by the insurer of the legal requirements concerning his life insurance application, or the law concerning misrepresentation. He was never given an opportunity to review his application for completeness and accuracy.

Within a year of purchasing the policy, the insured died. His widow applied for life insurance benefits. The insurer then requested the insured's medical records for the previous several years and denied the widow's application on the basis that the insured had omitted some information during the telephone call.

With the dramatic increase in information required in insurance applications, the threshold for what is material to the contract has been commensurately eroded and the potential for a policy to be voided for misrepresentation and/or nondisclosure has increased. It should be a requirement, in all insurance applications, that the right of an insurer to void a policy for misrepresentation, including innocent non-disclosure (if this continues to be the law), be expressly brought to the attention of the applicant and the applicant be given a full opportunity to review their answers in writing before an application is effective.

Other proposals - the remaining proposals are supported.
Faith E. Hayman

APPENDIX A

Have you ever been treated for or had any known indication of any disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system: such as shortness of breath, emphysema, asthma, bronchitis, pleurisy or tuberculosis?

Have you ever been treated for or had any known indication of any disease or disorder of the Nervous system such as: Paralysis, multiple sclerosis, seizures, dizziness or fainting?

Have you ever been treated for or had any known indication of any disease or disorder of the Heart or Blood vessels such as:

Stroke, TIA, heart attack, angina, chest pain, heart murmur, abnormal blood pressure, palpitations, irregular pulse, rheumatic fever or elevated cholesterol?