

Private Long-Term Disability Insurers and the Canada Pension Plan

Michael Bromm

Factual Background

In Canada, long-term disability (LTD) benefits come from two primary sources: the Canada Pension Plan (CPP) and various private LTD insurers. All Canadian workers are covered by CPP, with premiums deducted from a worker's wages and remitted by the employer. Many workers also have private LTD insurance, usually paid for by the employer as part of a benefits package, but often purchased separately by self-employed people. However, although a worker is allowed to receive benefits from both the CPP and the private insurer, the private insurer and the CPP bear unequal portions of the financial responsibility.

Private LTD insurers can, and usually do, structure their insurance contracts such that any benefits a disabled worker receives from CPP are deducted from the amount the private insurer is obligated to pay. For instance, if a worker is entitled under a private LTD policy to \$2000 per month in LTD benefits, and CPP allows the worker a monthly benefit of \$1300, the private insurer will only pay the amount required to raise the worker's monthly LTD income to \$2000 – in this example, \$700.

This payment structure designates the CPP as a 'first payer' (Sue Lott, "Background on CPP and Private Disability Insurance" online: Office of the Commissioner of Review Tribunals < http://www.ocrt-bctr.gc.ca/pubs/suelott_e.pdf > [Lott, "Background"] at 1), meaning that CPP benefits are not calculated with reference to any other LTD benefits to which the insured might be entitled. For the purposes of this paper, the practice of

treating the CPP as a first payer and of indexing private benefits to CPP benefits will be referred to as “the Current Practice”.

Issues

1. Is the Current Practice of treating CPP as a first-payer lawful?
2. Is the *implementation* of the Current Practice of treating CPP as a first-payer lawful?
3. Is there a sound policy argument that the Current Practice of treating the CPP as a first payer should be changed?

Conclusions

1. *The governing legislation permits CPP to be treated as a first payer by private insurance companies.*

Deducting CPP benefits from private benefits payable is specifically permitted, although not required, by both section 65 of the *Canada Pension Plan Act* and section 76.1 of the *Canada Pension Plan Regulations* (the *CPPR* or the *Regulations*). These sections allow a private insurer that has advanced funds to a claimant while a CPP application is pending to be reimbursed directly for those payments by the CPP after the claim is approved. However, the fact that the statute permits the Current Practice does not necessarily mean that the implementation of the practice accords with principles of Canadian insurance law.

2. *The implementation of the Current Practice may not be lawful in all cases.*

However, the degree to which a particular contract is lawful must be assessed on an examination of the particular contract in question.

Insurance contracts are contracts that require the utmost good faith from both parties to the contract. Bad faith on the part of an insurer will open the possibility of punitive damages and damages arising from the breach of the obligation of good faith. In addition, courts have recognized that insurance companies are far more sophisticated than the parties they insure, and that contracts of insurance are generally offered on a take-it-or-leave-it basis. In that light, ambiguities in wording of a policy that cannot otherwise be resolved will be interpreted in favour of the insured. Insurers are often obligated to spell out in certain terms any clause that seeks to limit the recovery to which an insured is entitled under the policy. The methods by which these limitations are to be included in the policy are detailed in the British Columbia *Insurance Act*.

Finally, an agent is under a positive obligation to secure the appropriate coverage for the insured, to verify that the information given by the insured for the purpose of obtaining insurance is accurate, and to inform the insured in the event that the agent is unable to obtain the required coverage so that the insured can make appropriate allowances for the failure. An agent breaching this duty may be held liable in negligence. Employers can be agents of the insurance company for the purposes of the administration of group insurance plans, but whether a particular employer is an agent in a given situation is highly fact specific.

It is therefore important to examine the wording of each policy, the manner in which the agent has dispatched the duty of care, and the relationship between the employer and the insurer, as well as that between the employee and the insurer. Ambiguities or breaches may give rise to a legal attack on the validity of reductions in payment.

3. Policy arguments of varying strength suggest that the Current Practice should be revised. However, these arguments, if successful, will almost certainly cause a rise in insurance premiums and a corresponding drop in the number of people able to afford private LTD insurance.

It is incongruous that the greatest burden owed to the insurer by the insured under the contract would arise at a time when the insured is so disabled as to be unable to work, yet this is the situation in Canada. Most private insurers require insureds to apply for CPP benefits, and to appeal denials of those benefits in order to continue to receive their private insurance. In addition, many insurers deduct the estimated amount of CPP benefits from the benefits paid to the insured, whether or not the insured qualifies for CPP. In addition, the full taxation of any CPP issued means that an insured that qualifies for both CPP and private benefits will never, even in theory, reach the amount for which the insured has contracted.

However, should insurance companies be forced to allow insureds to contract for any amount of benefit they pleased, premiums would inevitably rise to compensate for the increased risk of payout. The exact amount of this rise is not the province of this paper, but it would almost certainly result in some proportion of workers being unable to purchase private LTD insurance at all.

Discussion

1. Is the Current Practice of treating CPP as a first-payer lawful?

The statutes governing payments under the CPP are the *Canada Pension Plan Act* (R.S.C. 1985, c. C-8 [the *Act* or the *CPPA*]) and the *Canada Pension Plan Regulations* (C.R.C., c. 385 [the *Regulations* or the *CPPR*]). Each of these statutory instruments contains a permissive provision dealing with the Current Practice of treating the CPP as the first payer.

The overarching statutory provision is section 65(3) of the *CPPA*, which reads:

...where an administrator of a disability income program who is approved by the Minister makes a payment under that program to a person for a month or any portion of a month that would not have been made if a benefit under paragraph 44(1)(b) had been paid to that person for that period and subsequently a benefit becomes payable or payment of a benefit may be made under this Act to that person for that period, the Minister may, in accordance with any terms and conditions that may be prescribed, deduct from that benefit and pay to the administrator an amount not exceeding the amount of the payment made under that program.

The phrase “benefit under paragraph 44(1)(b)” refers simply to CPP benefits paid to a disabled person.

Since private insurers stipulate in their contracts of insurance that the private insurer will deduct CPP benefits from the amount payable, the effect of this section is to allow approved private insurers to recoup on benefits advanced to a claimant during the time that claimant’s CPP application was pending. This statutory provision is reinforced by section 76.1 of the *CPPR*, which reads:

(1) For the purposes of subsection 65(3) of the Act, the Minister may deduct an amount as described in that subsection from a benefit payable to a person under paragraph 44(1)(b) of the Act and pay that amount to an administrator approved by the Minister where the following terms and conditions are met:

(a) the administrator submits to the Minister a record of the payment made under the disability income program, together with the person's irrevocable written consent to the deduction and payment;

(b) the documents referred to in paragraph (a) are received by the Minister within one year after the date on which the consent is signed; and

(c) the amount exceeds \$50.

As with the *CPPA*, s.76.1 of the *Regulations* makes it clear that the Current Practice wherein the CPP is treated as a first payer is appropriate and anticipated under the governing statutory regime. There is no reference to the Current Practice under British Columbia's *Insurance Act* (R.S.B.C. 1996, c.226).

However, the fact that the Current Practice is permitted under federal statutes does not mean that it has been implemented according to general principles of Canadian insurance law. Insurers in Canada are bound to certain procedures and obligations arising from both statute and common law when they seek to limit amounts recoverable under the policies they sell. Although it may be unlikely that any one insurer consistently ignores major principles of insurance law in selling private LTD plans, each contract of insurance, together with the circumstances surrounding its issue, should nonetheless be examined with a view to finding irregularities that may allow individual insureds to challenge restrictive clauses in their own policies.

2. Is the *implementation* of the Current Practice of treating CPP as a first-payer lawful?

The fact that federal statute allows private insurers to treat CPP as a first payer does not mean that the implementation of the scheme is immune to the basic principles of

insurance law. Several well-known principles govern the sale and administration of insurance policies, in some cases restricting the insurer's ability to limit payments.

The overarching principle is that insurance contracts are contracts of the utmost good faith (Lott, "Background" at 10), with the insurer's and insurance agent's duties approaching that of a fiduciary in certain contexts. Further, courts recognize an imbalance of bargaining power and knowledge in the sale of an insurance contract to the average person. This unequal power distribution means that the courts will typically construe insurance contracts strictly against the insurer. An extension of this principle of *contra proferentem* is the obligation on the part of the insurer to specifically set out any limitation on the amount recoverable on the face of certain types of policy. Finally, various Canadian courts have recognized a positive obligation on the agent issuing the insurance to inquire into the needs of the insured and to make reasonable efforts to see that those needs are met by the policy issued.

i. Contracts of insurance are contracts of "utmost good faith".

Both the British Columbia Court of Appeal and the Supreme Court of Canada have acknowledged the existence of a duty that applies to the conduct of both parties to a contract of insurance. This duty is one of the utmost good faith, one that "in certain circumstances, resembles a fiduciary duty but is always governed by fair play in every dealing." (*Adams v. Confederation Life Insurance Co.* (1994), 25 C.C.L.I. (2d) 180, [1994] 6 W.W.R. 662, [1994] A.J. No. 308 (Alta. Q.B.) [*Adams* cited to W.W.R.] at 685). The authorities are not clear as to whether the duty is ever a true fiduciary one, although the British Columbia Court of Appeal has rejected the

argument that the relationship between the insured and insurer is fiduciary for all purposes (*Fredrikson v. Insurance Corp. of British Columbia* (1990), 69 D.L.R. (4th) 399, [1990] 4 W.W.R. 637, [1990] B.C.J. No. 717 (B.C.S.C.) [*Fredrikson* cited to W.W.R.] at 667).

However, it is clear from the British Columbia Court of Appeal's judgment in *Warrington v. Great-West Life Assurance Co.* (1996), 139 D.L.R. (4th) 18, [1996] 10 W.W.R. 691, [1996] B.C.J. No. 1944 (B.C.C.A.) [*Warrington* cited to D.L.R.]) and from the recent judgment of the Supreme Court of Canada in *Whiten v. Pilot Insurance* (2002), 209 D.L.R. (4th) 257, [2002] S.C.J. No. 19 [*Whiten* cited to S.C.J.]) that contracts of disability insurance are different from most other types of insurance contracts, in that their purpose is, in large part, to avoid mental suffering. This may mean that certain remedies such as damages for mental distress that are not normally available may be appropriate, especially where the insurance company has violated the obligation of good faith [*Warrington, supra*].

In *Warrington, supra*, an insurer denied disability coverage to a claimant on the basis that he was not disabled within the meaning of the policy, despite numerous opinions from experts and adjusters that supported the insured's position. The insurance company recanted before trial, agreeing to pay benefits, but this was after a period of denial lasting over two years. The court ordered the company to pay \$10,000 in damages for mental distress, plus the claimant's costs up to the time benefits were paid. However, the court held that punitive damages were not in order because the conduct of the insurer, although in bad faith, had not been done maliciously.

Whiten, supra was a case where an insurance company denied coverage to a family whose house had burned down. In defiance of the reports of many inspectors and adjusters, the insurer maintained that the house had been destroyed by arson, and refused to indemnify the insured. The only evidence the insurance company could muster in its favour was that the family had been under financial pressure immediately before the fire had occurred. The court awarded punitive damages of a million dollars, in the process roundly condemning the insurance company's behaviour:

The respondent also argues that at the end of the day, it did not profit financially from its misbehaviour. This may also be true, but if so, that result was not for want of trying. The respondent clearly hoped to starve the appellant into a cheap settlement.

* * *

That it failed to do so is due in no small part to appellant's counsel who took a hotly contested claim into an eight-week jury trial on behalf of a client who was effectively without resources of her own; and who obviously could have been starved into submission but for his firm's intervention on her behalf. [at para. 131]

This is not to imply that insurance companies, in imposing limitations on the amount recoverable by an insured, violate the requirement of good faith. However, it is important to hold each contract and the conduct of claims under that contract up to the 'utmost good faith' lens. Insureds who file disability claims are frequently vulnerable and dependent on the insurer to do what it has contracted to do, and to pay claims according to the terms of the contract that exists between the two parties.

ii. The principle of contra proferentem means that ambiguous terms in contracts of insurance are construed strictly against the insurer.

Cases from the law of both contracts generally and insurance specifically make it clear that courts will apply the *contra proferentem* rule when construing policies.

This rule states that, where the wording of a contract of adhesion is ambiguous according to the normal rules of construction, the ambiguity must be resolved against the interests of the party who drafted the contract.

A contract of adhesion is a contract that is offered on a take-it-or-leave-it basis by one party, involving little or no negotiation as to its terms. The reason for applying the *contra proferentem* rule was discussed by a majority of the Supreme Court of Canada in *Manulife Bank of Canada v. Conlin*, [1996] 3 S.C.R. 415, [1996] S.C.J. No. 101 [*Manulife* cited to S.C.R.] at paras. 7 and 8:

In many if not most cases of guarantees a contract of adhesion is involved. That is to say the document is drawn by the lending institution on a standard form. The borrower and the guarantor have little or no part in the negotiation of the agreement. They have no choice but to comply with its terms if the loan is to be granted. Often the guarantors are family members with limited commercial experience. As a matter of accommodation for a family member or friend they sign the guarantee. Many guarantors are unsophisticated and vulnerable. Yet the guarantee extended as a favour may result in a financial tragedy for the guarantor.

* * *

In my view, it is eminently fair that if there is any ambiguity in the terms used in the guarantee, the words of the documents should be construed against the party which drew it, by applying the *contra proferentem* rule. This is a sensible and satisfactory way of approaching the situation since the lending institutions that normally draft these agreements can readily amend their documents to ensure that they are free from ambiguity. The principle is supported by academic writers.

Although *Manulife* was a case involving a surety agreement, the principle of *contra proferentem* applies to ambiguities in all standard form contracts, including contracts of insurance (*Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, [1993] S.C.J. No. 10 [*Reid Crowther* cited to S.C.R.] at para. 33).

Contra proferentem, however, is not the primary rule of construction. Mr. Justice Sopinka, writing for a majority of the Supreme Court of Canada in *Brissette Estate v. Westbury Life Insurance Co.*, [1992] 3 S.C.R. 87, [1992] S.C.J. No. 86 [*Brissette* cited to S.C.R.], summarized the rules of construction for insurance contracts at para. 4:

- (1) **The court must search for an interpretation from the whole of the contract which promotes the true intent of the parties at the time of entry into the contract.**
- (2) **Where words are capable of two or more meanings, the meaning that is more reasonable in promoting the intention of the parties will be selected.**
- (3) **Ambiguities will be construed against the insurer.**
- (4) **An interpretation which will result in either a windfall to the insurer or an unanticipated recovery to the insured is to be avoided.**

Therefore, the *contra proferentem* rule is engaged only where there is an ambiguity that cannot be resolved by applying another rule of interpretation to the language in the contract. However, in the case where an doubt exists as to whether the private LTD policy makes the deduction scheme absolutely clear, it would be worthwhile to argue that this ambiguity means that the insurer is not allowed to rely on the provision, since the doctrine of *contra proferentem* insists that the issue be resolved in favour of the insured.

iii. In some Canadian jurisdictions and types of insurance policies, clauses or provisions that limit the amount recoverable under the policy must specifically be brought to the insured's attention to be effective.

Related to the realizations that inform the doctrine of *contra proferentem* is the modern trend of legislatures to require insurers to mark clearly on the face of their policies any clause that limits the amount of money to which an insured may be entitled to recover under the policy.

Insurance companies are always sophisticated parties. Potential insureds are not always sophisticated, and are certainly less so than the insurer. Furthermore, there is a serious imbalance of power when the contract is negotiated, and, as noted in the previous section, contracts of insurance are usually offered on a take-it-or-leave-it basis. Further, the mass of verbiage and boilerplate that makes up the bulk of a contract is often something that no reasonable insured would take the time to read, or would understand. In that light, many jurisdictions have taken legislative steps to ensure that certain important pieces of information are spelled out clearly in the insurance contract.

For instance, s.299 of the *Ontario Insurance Act* (R.S.O. 1990, c. I.8) states:

[T]he insurer shall set forth in the policy every exception or reduction affecting the amount payable under the contract, either in the provision affected by the exception or reduction, or under a heading such as "Exceptions" or "Reductions".

This means that in order to rely on a provision so affecting the benefits available to an insured, the contract of insurance must make plain, in a prescribed way, the existence of these limitations.

The British Columbia has an even more onerous disclosure requirement in its

Insurance Act. Section 128 of that Act reads:

A contract containing

(a) a deductible clause;

(b) a coinsurance, average or similar clause, or

(c) a clause limiting recovery by the insured to a specified percentage of the value of any property insured at the time of loss, whether or not that clause is conditional or unconditional, must have printed or stamped on its face in bold type lettering at least 12 points in size the words "This policy contains a clause which may limit the amount payable", and unless these words are so printed or stamped the clause is not binding on the insured.

This is perhaps the most stringent of notice requirements, even specifying the font size that must be used to give the notice. This provision, however, is limited to contracts of fire insurance, which are contracts of indemnity. Contracts of indemnity reimburse the insured for loss of a certain thing with monetary value. A contract of fire insurance is an indemnity contract, since it will compensate the insured for actual value of the loss incurred, subject only to coverage limits of the policy. A contract of life insurance, by way of contrast, is a non-indemnity contract, since there is no empirical relationship between the amount payable and the value of the loss.

Contracts of disability insurance have traditionally not been contracts of indemnity, although that is changing due to the practice of indexing benefits payable to a percentage of the insured's pre-disability income (Lott, "Background" at 7). This practice raises both practical issues, discussed in this section, and policy issues, discussed later in this paper.

The practical problem with treating LTD insurance contracts as contracts of indemnity is that the integration of private and CPP LTD benefits is often implemented in a way that ultimately reduces the amount recoverable by the insured, either because the insured is required to pay tax on the amount received through the CPP, or because private insurers deduct the amount the insured *would have received from CPP, even if the insured does not qualify for CPP* (Lott, "Background", at 6).

This clearly means reduced benefits to the insured, compared to the amount that appears on the face of the policy. However, British Columbia does have some statutory provisions that force the insurer to provide the insured with a certain base level of information in the wording of the insurance contract itself.

Since many LTD contracts come packaged as part of an individual or group life insurance policy, the BC *Insurance Act* requirements for life insurance govern a large number of these contracts. For instance, s.33(2) of the *Act* states that:

An insurer must set out in the policy the following:

* * *

(b) the amount, or the method of determining the amount, of the insurance money payable, and the conditions under which it becomes payable;

This section deals with life insurance policies only (which usually include LTD benefits). Life insurance policies are purchased by the individual insured, and are contrasted with group insurance, which is a policy purchased by the employer for its employees.

In a contract of group insurance, the employer is the policyholder, and the employee is the beneficiary. The beneficiaries, however, have standing as parties to the contract (*London Drugs v. Kuehne & Nagel Ltd.*, [1992] 3 S.C.R. 299, [1992] S.C.J. No. 84 cited in Lott, “Background”, at 13). In BC, s.34 of the *Insurance Act* dictates that:

In the case of a contract of group insurance or of creditor's group insurance, an insurer must set out in the policy the following:

* * *

(c) the amount, or the method of determining the amount, of the insurance money payable, and the conditions under which it becomes payable;

It is clear, therefore, that the means by which the entitlement to benefits is to be calculated must be stated clearly in the wording of the policy, whether a life insurance or a group insurance policy.

This might seem at first glance to be a promising avenue of legal challenge if it were not for the fact that these statutory provisions are well known to insurers, most of which employ a legion of lawyers and the wisdom of decades of jurisprudence in drafting their contracts. It is unlikely that a modern policy will omit such important provisions. However, those provisions must be present in order for the insurance company to rely on them, and, because of the doctrine of *contra proferentem*, above, they must be expressed unambiguously or be resolved in favour of the insured party. In that light, it would be prudent to examine each policy closely for ambiguities or missing notices that are statutorily required.

iv. A failure on the part of an insurance agent to actively inquire into the needs of the insured, and to make reasonable efforts to ensure that the policy sold meets these needs, may sound in negligence.

When a customer and potential insured contacts an agent to negotiate the purchase of an insurance policy, the customer is at a disadvantage. The agent knows, or ought to know, the range of insurance products on the market, the way in which they are administered, and the relative strengths and weaknesses each carries with it. The insured, in contrast, usually has no such expertise. Often the insured is unsophisticated and may harbour unrealistic expectations about what a policy may offer. Seldom will an insured read carefully through the complicated wordings of the insurance policy, relying instead on the representations of the insurance agent as to the suitability of the policy to the needs of the insured.

However, the insured knows far more than the agent about the many material pieces of private information on which the contract of insurance will be based, such as income expectations, medical history, and the type of occupation in which the insured

engages. What pieces of information are relevant, though, is the area of expertise of the agent alone. It is therefore important that if the insured is to receive the type of policy and coverage needed, that the agent ask the right questions, allowing a determination not only of the information needed for actuarial purposes, but also of the expectations and needs of the insured. The degree to which the insured obtains an appropriate policy depends in large measure on the diligence of the insurance agent involved.

Canadian law therefore demands that insurance agents pursue a contract suiting the client's needs with a reasonable degree of care and skill (*Weston Ornamental Iron Works Ltd. v. Continental Ins. Co.*, [1980] I.L.R. 1-1265 (Ont. H.C.), rev'd on other grounds [1981] I.L.R. 1-1430 (Ont. C.A.)).

In *Fine's Flowers Ltd. et al. v. General Accident Assurance Co. of Canada et al* (1977), 17 O.R. (2d) 529, (1977), 81 D.L.R. (3d) 139 (Ont. C.A.), aff'g (1974), 5 O.R. (2d) 137, (1974), 49 D.L.R. (3d) 641 (Ont. H.C.) [*Fine's Flowers* cited to D.L.R. (C.A.)], two greenhouses full of flowers were lost when a supply pump failed, shutting down heat to the buildings. The court held that the plaintiff had reasonably relied upon the insurance agent to secure adequate coverage for this eventuality:

Bearing in mind the nature of the business of the plaintiff and its location, loss due to failure of the heating equipment would be a reasonably foreseeable circumstance and it was reasonable for the plaintiff to look to the defendant to preclude such loss by way of insurance. The defendant agent was aware of the gap in the coverage as far back as 1964 and did not draw that gap nor the potential economic loss due to failure of the pumps to the attention of the plaintiff. Indeed, the plaintiff, by the conduct of the defendant agent, was deprived of the opportunity of either discontinuing his insurance entirely, except as to basic risks such as fire, or paying the premiums mentioned in the 1964 letter to which reference has been made above, or any other premium which might have been necessary to obtain the level of coverage needed to protect the plaintiff against the pump failure.

Therefore, the defendant Ault cannot avail himself of a defence by pointing out that if the pumps and motors had been included in the contract of insurance, the wear and tear exclusion would have prevented recovery. It was the duty of the defendant agent to either procure such coverage, or draw to the attention of the plaintiff his failure or inability to do so and the consequent gap in coverage. Having done neither, the defendant agent is liable in negligence, whether or not the instructions were to insure all "insurable" risks or to see that the plaintiff was "adequately covered with insurance" (at 143).

It is important to note that the court found a duty not only for the agent to secure the coverage the plaintiff required, but also to inform the plaintiff in the event that the appropriate coverage could not be acquired. The agent was under that duty regardless of whether the plaintiff had specifically requested coverage for all insurable risks, or had simply asked for "adequate" coverage. Interestingly, the court noted that it was unlikely that insurance could have been purchased to cover the failure of the pump in this case, arising as it did from wear and tear. However, the agent was liable because he had not sought to procure *any* coverage for the pumps at all, and had not advised the client of his failure to do so.

Fine's Flowers has been followed in most Canadian jurisdictions, and was imported as good law into British Columbia by a unanimous Court of Appeal in *Volkers v. Midland Doherty Ltd.* (1985) 17 D.L.R. (4th) 343, [1985] B.C.J. No. 2163 [*Volkers*]. In that case, Nemetz CJBC expressed the principle (at para. 12) that an agent has a duty to inform the principal of a failure to obtain necessary services so that the principal can take steps to secure those services elsewhere.

In *G.K.N. Keller Canada Ltd. v. Hartford Fire Insurance Co.* (1983), 27 C.C.L.T. 61, (1983), 1 C.C.L.I. 34 [*Keller*], the Supreme Court of Ontario considered the case of a general contractor that, in order to take on a contract, was required to carry comprehensive general liability coverage of \$2,000,000. The plaintiff contractor

spoke to its agent, Reed Stenhouse, who secured a contract of insurance it represented as being appropriate for the plaintiff's needs. The foundation built by the plaintiff later developed subsidence problems, necessitating a rebuild. When the owners of the building sued, the insurance company pointed to an exclusion clause that denied liability for the type of damage at issue, leaving the insured to defend the lawsuit alone and pay the eventual judgment. The court cited *Fine's Flowers, supra*, holding that the agent and the insurance company "were both aware of the needs of the plaintiff Keller and they were both experienced in the insurance field." The plaintiff had completely relayed its insurance needs to the agent, who had passed them on in totality to the insurance company. The insurance company, however, had provided a policy that excluded damage for subsidence, and the agent had not informed the insured that the policy contained such an exclusion. The court found "that the defendants were equally at fault for the failure to provide the insurance coverage which they knew the plaintiff required" (*Keller, supra* at para. 28).

Finally, the Ontario Court of Justice, General Division applied the *Fine's Flowers* principle to the area of disability insurance in *Theophanous v. Mutual of Omaha Insurance Co.* (1991), 2 C.C.L.I. (2d) 107, [1991] I.L.R. 1-2718 (Ont. Gen. Div.) [*Theophanous*]. In that case, an insurance agent sold a private disability insurance policy to a couple newly immigrated from Greece. He represented to them that the policy would pay them \$1400 per month in the event of permanent disability, saying that the availability of this amount would be unrelated to benefits available to them from other sources. When the wife became totally disabled after an accident on the job, it became apparent that the policy contained a clause that limited the insured's

benefit to no more than 80% of her pre-disability income. In addition, that 80% was to be calculated with reference to any other sources of benefit to which the insured was entitled. The court held that the agent had been negligent in his duties towards the clients:

He owed her a duty to exercise a reasonable degree of skill and care to obtain the coverage which the plaintiff sought. He was aware that neither she nor her husband was sophisticated in insurance matters and that each had a limited capability with the English language. He represented to the plaintiff that coverage would be provided in the sum of \$1,400.00 per month independent of any other benefits which might be recovered. There was nothing in the application for insurance which indicated otherwise. When the policy was issued it was incumbent on him to make it clear to the insured that the policy contained such a limitation, in order that she could decide whether to accept the policy or reject the policy as was her right to do (at para. 40).

Both the agent and the insurance company were also under a duty to verify information provided by the insured:

The agent drew his own conclusion as to the amount of income which the plaintiff was earning. This conclusion could easily have been verified before the policy was issued. In my view it should have been verified. The defendant was well aware of the relationship between the actual income and the benefits payable under the policy. The defendant was quite prepared to accept premiums based on the higher income without seeking verification but when it came time to pay benefits verification was sought immediately (at para. 43).

Although no other courts have, as of the time of writing, considered the *Theophanous* decision, it is nonetheless clear that courts in Canada will impose a duty of reasonable skill and care on the part of the agent in pursuing the insured's interests. This includes a positive obligation to verify that information provided to the insurer is correct, to make reasonable efforts to secure the amount and type of coverage the insured needs and wants, and to inform the insured if the coverage actually available falls short of proper protection of the insured's interests. In addition, the Canadian Life and Health Insurance Association's Guidelines state that reductions should be

summarized in the disclosure statement that is delivered to the insured with the policy (Sue Lott, personal communication, 18 March 2003 [Lott, Personal Communication]).

In many contracts of disability insurance, the employer is the policyholder, and the employee beneficiary does not get a chance to negotiate the terms of the contract of insurance. There is limited Canadian case law to suggest that an employer is in fact an agent of the insured employee for some purposes (Lott, “Background” at 13). In *Tarailo v. Allied Chemical Canada Limited et al.* (1989), 68 O.R. (2d) 288, [1989] I.L.R. 1-2427 (Ont. H.C.) [*Tarailo*], the Ontario High Court of Justice held that an employee who gave notice to his employer that he was mentally ill could be deemed to have given notice to the insurance company, because the employer was the agent of the company in administering the disability plan. The employer had the disability applications, and the LTD brochure had been the result of a cooperative effort of the insurer and the employer. In the result, the insurer and the employer were held jointly liable for the LTD benefits.

The court was careful to mention that each case will be determined on its facts. The more cooperation and interaction evidenced between the employer and the insurer, and the less between the employee and the insurer, the more likely it seems that a court will be to find that an employer is an agent of the insurer.

In the case of a clause integrating private LTD benefits with those provided by CPP, or a clause that indexes the recoverable benefits to a certain percentage of the insured’s former income, the agent is probably under a positive obligation to make the insured aware of these provisions, since the integration or indexing of benefits

inevitably results in a reduced income available to the disabled party. A failure to do so may sound in negligence for which the agent may be liable. In certain cases, the agent may be the employer, and if the employer has not met its agency duties to the employee, the employer may be liable for the negligence.

3. Is there a sound policy argument that the Current Practice should be changed?

Many questions have been raised as to the advisability of treating CPP as a first payer. It is clear that the regimes imposed on insureds by private LTD insurers result in less money actually making it into the hands of the disabled person than is implied by the wording of the insurance contract. Not only are most LTD plans indexed to provide only a percentage of pre-disability income (Lott, “Background”, at 2), but most also deduct the amount of CPP LTD benefits to which the insured may be entitled. In fact, some deduct the amount of CPP LTD benefits to which the insured would be entitled, even if the insured does not qualify for them, or if the insured fails to apply for CPP or to pursue an appeal to the insurer’s satisfaction. In addition, where a private insurer has paid out benefits to an insured during the period after the insured has become disabled, but before the insured’s CPP benefits have come through, CPP will reimburse the insurer directly for the amount of CPP benefits to which the insured was entitled during that period. This reimbursement is contemplated under s.65(3) of the *CPPA* (discussed earlier). However, despite the fact that the insured never sees the money paid by the CPP to the insurer, the insured is still fully taxed on the amount of the reimbursement (Lott, Personal Communication).

The obvious problem with a scheme like this is twofold. First, it requires a person who is already disabled, possibly very sick, to go through an application process that can be extremely taxing. If the application process fails, the required appeals take up more of the insured's time and energy. There is something untoward about forcing a person who is unable to go to work to jump through beaurocratic hoops in order to receive the full amount of benefit for which that person has contracted.

Even more importantly, there is a strong argument that, because CPP benefits are fully taxed (Interview of Sue Lott by Garth Materie, n.d. online: CBC Saskatchewan < <http://sask.cbc.ca/archives/cpp/media/lott.ram> > [Lott, *Interview*]), whereas private LTD benefits are not, insurers must be under a duty to specifically warn insureds that, should they become disabled and qualify for CPP as well as private LTD benefits, they will be unable even in theory to collect the full amount for which they have contracted. It might be argued that, should an insurer fail to disclose the fact that the taxation of CPP benefits will deprive the insured of the stated level of benefit for which that person has paid premiums, the insurer is obligated to pay the amount by which taxation reduces the benefits that reach the insured's pocket.

Finally, both Richard Hayles and Sue Lott have raised the question of whether the indexing of private LTD benefits to a person's income has transformed LTD policies from non-indemnity contracts to indemnity contracts (Richard Hayles, *Disability Insurance: Canadian Law and Business Practice* (Scarborough: Carswell, 1998) [Hayles, *Disability Insurance*] at 277). That is to say, LTD benefits are being provided on the basis that they replace an asset that was lost (the cash value of a \$4000 car, for instance), as opposed to providing the insured with a set benefit

conditioned upon the occurrence of a particular event (for example, a life insurance policy worth \$100, 000). Why, they ask, should an insured not be allowed to purchase coverage that will provide a set benefit upon disability?

The problem with this question, and with all the questions raised in this paper, is that one must be careful that one wants to get what one has asked for. Insurance companies are ever mindful of the premiums they charge. In fact, premiums are so low, industry wide, that companies would lose money if their only source of income were the premiums charged on insurance policies. This is referred to as ‘underwriting loss’ (Anthony Saunders, Lecture, University of British Columbia, January 2003 [Saunders]). Insurers follow exacting actuarial principles that give them a sophisticated knowledge of the risk pool, but they never charge more than is absolutely necessary as a premium; this is how they stay competitive. The profit in the insurance business comes from the gap in time between the payment of premiums and the payout of benefits, during which time the insurer invests this ‘float’ money at a high rate of return (Saunders).

If insurers were suddenly forced to write contracts that would provide significantly higher benefits to insureds, the premiums they charge would skyrocket to adjust for this increased risk. The degree to which the increase of premium would offset the added benefit to those workers who become disabled would be one that varied with the individual of employer, but the net effect would almost certainly be that fewer people would receive LTD coverage.