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Count(s)     Word(s)    Char(s)    Char(s) (WS)
Section 1     3335     16530    19876
Total         3335     16530    19876
Answer-to-Question-_1_

A.

1. an undertaking by one party (the insurer)
2. to indemnify another (the insured)
3. for an agreed consideration
4. for loss or liability arising from a described event
5. the happening of which is uncertain

B. The main distinguishing factor between an insurance contract and a wager is the existence of an insurable interest. The existence of an insurable interest means that the insured has a stake in the object. Under an insurance contract, the insured's interest in the object exists apart from the insurance contract itself, it is not created by it (as with a wager). Furthermore, in wager, the party hopes to gain from an event taking place and hopes that the event will take place. While under an insurance contract, the insured wishes to avoid the event and its goal is indemnification/compensation, not profit.

2. The four cornerstones of insurance are:

1. Insurable Interest
2. Indemnity
3. Subrogration
4. Utmost Good Faith

3. Somersall v Friedman was the Supreme Court of Canada authority stating that an insured's subrogration rights are of "little value if any at all to the insured." It upheld an insured's ability to essentially "sign" away its insurers subrogration rights by entering into a limits agreement with a
liable third party. Somersall does not remain good law in Alberta by virtue of section of the insurance act which requires that an insured obtain the permission of the insurer before entering into any settlement/limit agreements with any liable third parties.

4. The essential elements of an insurance contract are:

1. Nature of Risk
2. Duration of coverage
3. Amount of Premium
4. Policy Limits

5. According to s. 652 (1) of the Insurance Act, an applicant for insurance and a person whose life is to be insured must disclose to the insurer in the application...every act within the applicant or person's knowledge that is material to the insurance.."

Potential claim #1: The holistic treatment-

Although the insurer may have had a claim under s. 652 based on Sally's failure to disclose the wholistic treatment, this claim would be barred by section 635 (1) of the Insurance act. Section 653 sets a two year incontestability period on claims for against an insured for failure to disclose facts under section 652 (1), unless it can be proven that they were made fraudulently. Sally gave the information to the insurer over 5 years ago and thus the insurer must successfully prove that her non disclosure was fraudulent if they wish to now deny her coverage on that basis. The insurer would likely not be successful in proven fraud for Sally's failure to mention her attendance with the wholistic
healer because her failure to disclose that stemmed from her belief that it was not "medical"

Potential Claim #2: The lung infections

Sally's non disclosure of her lung infections would likely be basis for the insurer to deny Sally coverage.

To begin, the non disclosure took place within the past 2 years and thus the s. 653 incontestability period will not apply.

Secondly, 652 (1) requires that an applicant for life insurance disclose every material fact within their knowledge. The only question here would then be whether Sally's lung condition was a "material fact." The test for materiality is; had the information had been disclosed, would it have caused a reasonable insurer to deny coverage or raise premiums? (*Mutual Life v Ontario Metal Products*). The fact that Sally's mother had reported similar treatment to another insurer and had been denied coverage, lends support for the finding that it would likely meet the reasonable insurer test. In any event, according to *Henwood v Prudential*, under the reasonable insurer test, the testimony of the insurer in question will suffice as testimony of a reasonable insurer's actions, where there is no evidence to the contrary.

**Conclusion:**

Based on section 652 and Sally's failure to disclose her lung infections, the insurer has the ability to void the insurance contract (s. 653 (2)).
6. A.

**The Amos Test:**

The terms "arising out of use or operation" in the context of an insurance policy are defined based on the Two Part Amos Test, which as follows?

1. **Purpose:** Did the accident arising form ordinary uses to which automobiles are put (i.e. was the car used as a car?)
2. **Causation:** Is there a casual relationship or nexus between the appellants use/operation of the vehicle and the injuries sustained?

While the Amos test, was articulated in *Amos Insurance Corp*, that case dealt with a "no fault" insurance policy. Following Amos, the court articulated that a modified Amos test may need to be applied, depending on the wording of the policy (*CidDal v Vitlyngam*). In *Vitlingham*, the policy was one that included terms of "liability" and is similar to the one being dealt with here which requires "liability imposed by law." Thus, the modified Amos test should be applied to determine whether Dr. Addict will be able to claim indemnity.

**The modified Amos Test**

Under the modified Amos test, the first step remains unchanged however the major modification occurs under the "causation" step of the test. Under the modified Amos test, the focus is necessarily on the Tortfeasor's use/operation of their vehicle.
rather than the claimants (as is the case under the non modified test). Furthermore, the major change in analysis occurs under the causation part of the modified Amos. under the modified Amos test the court requires an unbroken causal connection between the injuries to the claimant and the tortfeasor's use/operation of the motor vehicle. This is a more stringent requirement than under the non modified Amos test.

Application of modified Amos to the facts:

1. **Purpose**: While the purpose test is typically easily resolved as it only requires that a vehicle be used for an ordinary "use" to which vehicles are typically put. Dr. Addict was using his vehicle to drive which is an ordinary use to which vehicles are put.

2. **Causation**: The requirement of an unbroken causal connection under the modified Amos test requires that a direct causal link be establish between Dr. Dudley's injuries and Dr. Addict's use of his car. To reiterate, the focus here is on the tortfeasor's use of the vehicle. An intervening event can sever the link of causation and the causation test will not be met (Lubermans v Herbison). Based on the facts here, there is a strong argument that the causal connection between Dr. Addict's use of the car and the injuries sustained by Dr. Dudley was severed when Dr. Dudley lunged out of the car. However, on the other hand, Dr. Dudley was described as using his vehicle as "rocket ship" which indicates that his vehicle may have been expressly implicated in his ability to lunge at Dr. Dudley rather than severing the causal link. Despite the merits to this argument, the stronger argument is likely that the direct causal connection between officer Dudely's injuries and Dr. Addict's use/operation of his automobile was severed by the fact Mr. Dudelys injuries were ultimately a direct result of Dr. Dudley's bodily contact with him, occurring outside
of the car.

B.

The main authority that Dr. Addict's beneficiaries can rely on to respond to this claim was established by the court in Martin v American International Assurance life Co. In Martin, the court dealt with similar facts where a Doctor who regularly administered himself with Demoral for pain, inadvertently overdosed, causing his death. In Martin, the insurance company argued that coverage should be denied under Mr. Martin's life insurance policy on the basis that Mr. Martin's death was not "accidental." The court rejected the insurer's claim and found that based on the court's interpretation of the term accident, Mr. Martin's death was in fact accidental. The definition of accident in Martin focused on the intention of party; asking whether or not he "intended" to die. The court found that despite intentional acts to inject himself with the demoral, Mr. Martin did not intend his death and therefore his death was "accidental."

Application of Martin:

Here, Dr. Addict's death may have been a result of the toxic amount of chocolate he injected but his intention to inject chocolate arose from his addiction. Martin establishes that intention to perform an act does not necessarily mean that there was intention in the result. Thus, based on Martin, there is a strong argument that Dr. Addict's death was accidental in the sense that he did not "intent" to die.
7.

A. The equitable doctrine of contribution requires insurers to contribute to coverage where the insurers cover the same:

1. Risk
2. Interest
3. Subject Matter
4. Insured

Where an insurer has paid an insured out under an insurance policy where there is overlapping coverage (re 4 factors above), then the equitable doctrine of contribution allows it to claim a portion of the loss from the other insurers.

Contribution is an important doctrine with respect to insurance contracts as it

1. Upholds the principle of indemnity so that an insured cannot collect try to recover full indemnity from multiple insurers
2. It promotes fairness so that each insurer is responsible to pay for the risk it has agreed to assume

B. Here, both Home Insurance and Community League purport to be "excess coverage" In fact community purports to be "excess to the excess." Similar facts were at issue in Family Insurance v Lombard. There, the court found that despite both insurance policies purporting to be excess coverage (and one excess to the excess), they were both liable to cover the insureds loss. The courts conclusion was based on the fact that the intention of both parties to remain as excess insurance were irreconcilable and would ultimately leave the insured without coverage. Based on the irreconcilable nature of the parties intention, the court
thus found that they were liable based on "an equal sharing approach" so that each party was liable up to the lower policy limits, with the remainder being borne by the insurer with the higher limits.

8.

i. Yes, Protect insurance may deny Debbie coverage under section B based on breach of the policy for driving while intoxicated.

ii. Yes, Protect may also deny Debbie coverage for her auto damage (under section c) based on breach of the policy for driving while intoxicated.

iii. No, Protect insurance cannot deny liability coverage (section A) because driving while intoxicated is not a breach of Section A.

B. Protect has three options to preserve their right to deny coverage while continuing to defend the claim. These are; a reservation of rights letter, a non waiver agreement, and third party by order.

1. Reservation of Rights Letter- A reservation of Rights letter is a unilateral notice given by the insured to the insurer that by defending a claim it is not waiving its rights to later deny coverage. The reservation of rights letter essentially protects the insurer from the insured later claiming waiver or estoppel based on the fact that the insurer has defended them in the action.
2. Non Waiver Agreement: The purpose of the non waiver agreement is two fold. Firstly, it protects the insurer against any claims of waiver or estoppel by the insured, where the insurer defends the actions. Secondly, it establishes the right of the insurer to bring an action against the insured for any amounts that it has paid out by virtue of settlement or judgement that it would not otherwise be liable to pay. The second point is essentially what differentiates the non waiver agreement from the reservation of rights letter.

3. Third Party By order: The insurer can be added as a third party to the litigation according to section 579 (14) of the insurance act. However, the essential prerequisite to be added as third party by order is that the insured must first deny coverage.

Recommendation: Out of the three options discussed, the insurer's best course of action would be to enter into a non waiver agreement with insured as this will not only protect htem against any claims of waiver or estoppel but also preserve their righ to "claim over" from the insured. If the insurer wishes to do so they must however ensure that the rights set out in the non waiver agreement are clearly articulated and that they are properly communicated to the insured.

C. i) An insured does in fact have a duty to cooperate with the insurer and a breach of such a duty can give the insurer the righ to deny coverage. However, the case law on point indicates that a breach of the duty to cooperate must be a serious breach in order to be found as a breach of the contract (Thorsen v Merritt). In Thorsen, similar facts were involved, where the
insured moved away and the insurer was unable to contact them. The court found that this was not a breach of the duty to cooperate.

ii) Once it denies coverage to Debbie driver, Protect may still defend the tort claim by virtue of s. 579 (13); being added as a third party by order. Upon denying coverage and denying liability, the insurer must be a third party by order to the litigation upon application to the court.

D. The defences that can be raised by the insurer in right of creditors actions are limited by virtue of s. 579 (4). The limited availability of defences however, apply for the first 200,000 of the claim. For any amount above the 200,000 threshold, the insurer may avail itself of any defence that it is entitled to set up against the insured [s. 579 (10)].

up to 200,000

For any claims up to the first 200,000 the insureds defences are limited to defences such as whether; the insured is not the insured (other technical matters) and the major one being issues of coverage. Furthermore, the insured cannot argue that the policy is not a motor vehicle policy. The defences at this stage are extremely limited and the insurer is precluded even from raising misrepresentation as to ownership.

Post 200,000

For any amounts greater than 200,000 the insurer can raise any defences that it is entitled to set up against the insured. At
this stage, can raise claims such as Martin's failure to cooperate. Furthermore, they wish to raise a defense based on Debbie's failure to give "prompt" notice as required by virtue of section 556 stat condition 3(1)(a).

E. While, the insurer is entitled to raise any defenses it has against an insured against a third party creditor, for any claims above 200,000, the corally is that insured is entitled to raise relief from forfeiture in response.

In assessing whether a party will be entitled to relief from forfeiture it must be asked 1) Is relief from forfeiture available and 2) is it fair to apply it.

Step 1: Is RFF available?

1. Courts power to grant it- The court has the power to grant relief from forfeiture by virtue of s. 520 of the Insurance Act and by virtue of section 10 of the judicature act.

2. Nature of the insured breach- Both RFF under s. 10 and s. 520 only apply to imperfect compliance but they do not apply to non-compliance. Here the Debbie'ss failure to provide prompt notice is likely considered imperfect complaince.

3. Type of Insurance: RFF under Section 520 does not apply to accident, sickness or life insurance. However, S. 10 does apply to the aforementioned categories. Since we are dealing with accident insurance, Debbie driver will have to rely on relief from forfeiture via s. 10 of the JA, as section 520 is inapplicable.
Step 2: Is it fair to apply it?

The short rule in determining whether it is fair to apply relief from forfeiture asks whether it would be more fair to excuse the insured from a technical breach than to deny them coverage.

Specifically the test asks whether

1. Were the insured’s actions reasonable
2. What was the object of the breach
3. was the insurer unduly prejudiced

The focus on reasonableness in step one of the test under RFF under s. 10 is more stringent than that under s. 520 as it is a more judgmental test assessing the reasonableness of the insured’s actions.

Conclusion: While Martin is able to raise relief from forfeiture under s. 10 in response to the defence raised by the insured for Debbie’s failure to provide prompt notice, this will be a difficult argument to make. Essentially, Martin will have to show that Debbies failure to provide notice was reasonable and the insurer was not unduly prejudiced by the claim. The question here is ultimately of fairness and this will likely be a hard argument for Martin to make.

9. The General principles for Contractual Interpretation as evinced from the case law prior to Progressive Homes are as follows. I will provide a brief outline of such principles prior to discussing them in the context of Progressive Homes.

Step 1: Intentions– Ascertain the intentions of the parties from a reading of the contract, as a whole, and give effect to those
intentions.

Give words their plain and ordinary meaning provided it accords with the intention of the parties.

Where, words are capable of two or more meanings give effect to the one that reasonably reflects the intention of the parties.

Step 2: Ambiguity: If the intentions of the parties remain ambiguous and unresolved then apply the doctrine ofcontra proferentum to interpret the term in favor of the insured.

Interpret exclusion clauses narrowly and coverage broadly.

Give effect to the reasonable expectations of the parties.

In doing so avoid any interpretation that would create a windfall to the insurer and an unexpected gain to the insured.

Relevance of Progressive Homes:

Prior to Progressive homes, it was well established that an insurer would not have a duty to defend an insured, under a CGL policy, for claims arising from defective workmanship. However, Progressive changed this based on its broad of terms in the policy and narrow interpretation of exclusion clauses. While Progressive dealt explicitly with the "duty to defend," its interpretation of the terms in the policies will likely have implication for analyses of coverage in cases to follow.

In Progressive the term accident was "interpreted" broadly to include negligence and the term property damage was interpreted
"broadly' so as not to be limited to third party property damage. Finally the "work performed" exclusion clause in progressive was interpreted narrowly so that despite preceding costs for repairing defective work, the policy would apply to damage flowing from the defective work.

Finally in considering the work performed exclusion clause and the accompanying subcontractor exclusion, the court assessed the varying versions of the clause and looked at the changes made to them. In doing so the court considered the intentions of the parties.

Post Progressive:

To reiterate, while Progressive dealt directly with the duty to defend, its emphasis on a broad reading of coverage clauses and narrow reading of exclusion clauses, is pertinent with respect to coverage. While the duty to defend is necessarily broader than the duty to indemnify, both are derived from the courts interpretation of contractual terms. The interpretation in progressive was undoubtedly favorable to the insured's. The court in Progressive emphasized the interpretation of exclusion clauses narrowly and coverage provisions broadly; which is a corollary of the contra preforentum rule (discussed above). The framework for interpretation in progressive can be taken as indication to insurer that if the wishes to exclude coverage for in its policies they must be explicit in doing so or they may find themselves liable for coverage of areas which they previously might have taken for granted would not apply. Finally, Progressive indicated how slight changes in wording will be taken into consideration in the courts interpretation of the contract thus reflecting a general principle of interpretation to interpret the contract as a whole (contextual approach) to ascertain the
intention of the parties.