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Answer-to-Question-_1_

A.
1) the undertaking of one party (the insurer)
2) to indemnify the other party (the insured)
3) for an agreed upon consideration (doesn't have to be cash)
4) for the risk of an event; (the peril/loss that is insured against)
5) the occurrence of which is uncertain [uncertain as to IF it would happen, or WHEN it would happen (ie in case of life insurance)]

B.
- insurance contracts: pooling of funds to protect against chance of mishap/loss, the insured does not wish the insured-against event to happen, there must be an insurable interest

- Wagering contract: wish to gain through mere chance, there is no insurable interest, the party wishes the event to occur.

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--------------------------ANSWER-1-ABOVE-------------------------------
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--------------------DO-NOT-EDIT-THIS-DIVIDER-----------------------------
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--------------------------ANSWER-2-BELOW--------------------------------
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Answer-to-Question-_2_
1) insurable interest
2) utmost good faith
3) subrogation
4) indemnification
Somersall v Friedman decision does remain good law in Alberta. The majority stated the principles of subrogation, which are:

1) Purpose of subrogation is to preserve the principle of indemnification (the insured is not over or under-compensated), and to place liability on the party who is responsible;
2) at common law, the insurer's right of subrogation only arises where the insured has been completely indemnified for his/her losses; and
3) the insured is obliged to pursue any claims against third parties in good faith until the time when the insurer has the right to do so.

To the extent that the insurer can only pursue subrogation where the insured has been 100% indemnified for his losses, this has been changed by Alberta's Insurance Act. Pursuant to S546 (1) of the Insurance Act, an insurer that makes ANY payment or assumes liability for making any payment under a contract is subrogated to all rights of recovery of the insured against any person and may bring action in the name of the insured to enforce those rights. Pursuant to S546(2), when the net amount recovered by an action or settlement is (after deduction of costs of recovery) not sufficient to provide complete indemnity for the loss/damage suffered, the amount remaining is divided between the insurer and insured in proportion to the loss/damage that was borne by them.
tortfeasor who is an under-insured motorist, the insurer's right to subrogation may not be valuable, since the tortfeasor may be impecunious and exhausted its payment capacity. The dissent criticized this statement, emphasizing the importance of the insurer's right of subrogation.

Answer-to-Question-_4_
1) duration of coverage
2) insured-against risk
3) subject matter of insurance
4) amount of premiums
5) policy limits
6) deductibles

Answer-to-Question-_5_
Pursuant to S652 of the Insurance Act (Alberta), an applicant for
life insurance and a person whose life is to be insured must each disclose to the insurer in the application, on a medical examination, every fact within the applicant's or person's knowledge that is material to the insurance and is not disclosed by the other. A failure to disclose, or a misrepresentation of a fact renders the contract voidable by the insurer.

This section of the insurance contract does not require any element of intent in order for the insured to breach the duty of disclosure (uberrima fides, the insured's duty of disclosure). The insured must disclose every fact that he/she knows or ought to have known, regardless of whether they knew the fact was material.

Whether a fact is material is to be determined by the "reasonable insurer's test" - if the misrepresented/undisclosed facts were disclosed, would a reasonable insurer refused to insure against the risk, or have charged a higher premium?

For Sally's initial application for life insurance, all that she did not mention within her knowledge was her attendance at a wholistic healer/yogi for stress relief. It is unlikely that a reasonable insurer would find this fact material (causing it to deny coverage or to increase premiums).

Furthermore, the insurance policy has become incontestable and now falls under S653, since the insured died more than 2 years after the policy was in effect. Pursuant to S653, a failure to disclose, or misrepresentation of a fact required by S652 only makes the contract voidable where there was fraud.

In this case, the failure to disclose the wholistic healer/yogi was not fraudulent, since Sally did not consider that fact to be medical (in any event, it is not likely material). However, where Sally decided to increase her insurance to $200,00 and was asked
agaion about her medical history, she did not disclose her prescribed inhaled corticosteroids for her repeated lung infections. She did not do so because her mother had reported similar treatment to another insurer and had been denied coverage. In 35445 Alberta Ltd v TransAmerica Life Insurance Co. of Canada, the insured's life insurance was voided based on fraudulent misrepresentation after the life insurance has become incontestable. The fact that Sally was prescribed medications for repeated lung infections is likely considered a material fact by a reasonable insurer.

If the insurer can prove that the failure to disclose the medical condition was fraudulent, the insurer is able to void the whole contract under S653(2).

1) didn't mention her wholistic healer/yogi for stress relief b/c she didn't consider that medical

2) 3 years later, applied to increase her insurance - asked about medical history - did not disclose that she had been prescribed inhaled corticosteroids for repeated lung infections

3) 5 years later, died in car accident

--- ANSWER-5-ABOVE ---

--- DO-NOT-EDIT-THIS-DIVIDER ---

--- ANSWER-6-BELOW ---

Answer-to-Question-_6_
A. 

PUsuant to the Amos Test (Amos v Insurance Corp of BC), the test for "use and operation" of vehicle is as follows:
1) the loss/injury must result from a common and well-known activity that vehicles are put to use; and
2) there must be SOME nexus between the loss/damage/injury and the use of the vehicle. (ie the vehicle must be more than the mere site of the injury)

However, the Amos test was in respect to a section B claim (claim by injured party against its own insurer), pursuant to Citadel General Assurance vs Vytlingam, the Amos test is not the proper test for determining liability coverage. In Vytlingam, the SCC refined the Amos test to the follows:
1) the vehicle was used for a common and well-known purpose that vehicles are normally intended for (transportation usually satisfies this test); and
2) the claim must arise from an unbroken chain of causation from the use and operation of the vehicle. (there must be no intervening act between the loss/injury and the use of the vehicle, the defendant must be at fault as a motorist, and the vehicle constitutes part of the tort).

- in this case, the standard automobile insurance insuring Dr. Addict's vehicle is analogous to the liability insurance mentioned in Vytlingam (and subsequent cases like Lumbermens Mutual Casualty v Herbison). The modified Amos test as employed by Vytlingam should be employed. In this case, Dr. Addict's vehicle was used for a common and well-known purpose - ie transportation. The first part of the test is satisfied. However, there are many intervening acts that severed the chain of causation between the use of vehicle and Officer Dudley's injuries - he lunged out of his vehicle at Officer Dudley, ended up on the concrete road - these acts severed the chain of
causation (intervened with the motoring). Hence, Dr. Addict will not likely be able to claim indemnification for Officer Dudley's injuries under his standard automobile policy.

B.

Dr. Addict's beneficiaries should respond to the denial by arguing the case "Martin v American International Assurance Life Co."

In that case, the deceased insured was a doctor with addiction problems. He injected himself with medication (for his pain), and suffered an overdose and was found dead the next morning. His life insurance policy insured against "accidental" death. His insurer denied coverage on the grounds that his death was due to an intentional act and hence not classified as "accidental".

In that case, the court refused to interpret "accidental" as excluding death that was caused by an deliberative act. The court applied a contextual objective test as follows:

1) did the insured subjectively expect to die;
   - assessment of whether the insured thought death was a likely consequence of his intentional actions
   - external evidence should be taken into account, such as the insured's words/actions the day before his death, the arrangement of his body when he was found dead.
   - in that case, the court found that the deceased was happy and planning for his future immediately prior to his death, which did not support the position that he expected to die.
   - In this case, Dr. Addict was found dead with a happy but surprised expression on his face. Furthermore, he was looking forward to going to the Harry Potter ride at Universal Studios Florida. These facts support the argument that he did not expect to die from his actions.
2) in the event the insured's subjective intentions cannot be ascertained, would a reasonable person in the shoes of the insured expect to die by the same actions - it is arguable that a reasonable person would not have expected to have died by injecting themselves with pure chocolate, as it is not a poisonous drug etc.

In Nelson v Industrial alliance Pacific Life, the court set out principles distilled from case law regarding the interpretation of "accident"
1) antecedent mishap is external to the insured
2) antecedent mishap causes peculiar response particular to the insured
3) the insured miscalculated the risk of a deliberative action

In this case, although it would be hard to argue that the insured's death resulted directly from bodily injury effected solely through external/violent means, it is arguable that he miscalculated the risk of his deliberative actions.

A.

Contribution is an equitable doctrine, which provides relief to the indemnifier where others have undertaken to indemnify the same risks (Cameco Corp v Insurance Co)
It provides that where there are multiple insurers insuring the same insureds and the same risks, they will each contribute to indemnifying the loss.

This promotes the principle of indemnification - where the insured cannot have double recovery or profit from occurrence of risk through their insurers.

In Clarke v Fidelity-Phoenix, the court listed the following conditions that must exist in order for right to contribution to arise - the insurers must be insuring against:
1) the same risk
2) for the same insured
3) for the same insurable interest
4) for the same subject matter.

Pursuant to S544(1) [applies to general insurance], the default in Alberta for contribution is "rateable contributions" - if on the happening of loss or damage, there is more than 1 contract in force covering the loss/damage, the insurers under the respective contracts are each liable to the insured for their rateable proportion of the loss, unless it is otherwise expressly agreed in writing between the insurers".

B.
Home Insurance Co. and Community League Co. both ought to be held liable to Cora Coach under their respective policies. This is due to the decision in Family Insurance v Lombard Canada Ltd.

In the Lombard case, a similar set of circumstances occurred. One insurance policy purported to be excess insurance, while the other insurance policy purported to be "excess to excess". In this case, the Home Insurance Co's policy states that it will be considered excess, and the insurance company is not liable for
any loss or claim until other insurance is used up. On the other hand, Community League Co states that its policy is excess over other existing insurance, whether the other insurance is primary or excess (hence, excess to excess).

In Lombard, the court stated that the interpretation of the insurance policies depend on the intentions of the parties to the contract (hence, the intention of each insurance company vis-a-vis the insured). In the face of irreconcilable intentions, the court will apply the most fair and equitable solution. In that case, the court treated the conflicting clauses (excess vs. excess to excess) as mutually repugnant and inoperative, since if they do apply, the insured would be left without primary coverage.

In this case, the circumstances are analogous. The liability claim against the insured fell within the scope of coverage of both policies, yet both allege that they are not primary coverage, and Cora Coach would be left without primary coverage. Hence, the conflicting intentions should be treated as mutually inoperative.

In the Lombard case, the court chose to treat each policy as independently liable to the insured. However, in this case, given that the claim against the insured was settled outside the policy limits of one of the policies (Home Insurance Co), and given S544(1) of Alberta's Insurance Act, the 2 insurance policies should be held liable to Cora Coach by way of rateable contributions.

Home Insurance Co: $100,000.00/$600,000.00 X $200,000.00
Community League Insurance Company: $500,000.00/$600,000.00 X $200,000.00

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Answer-to-Question--8--
A  i) Section B is Accident Benefits - including medical, loss of employment wages, death benefits etc. Protect Insurance does have basis to deny Debbie coverage with respect to Section B coverage, since Section B of Alberta's standard motor insurance coverage has exclusion clause with respect to driving while impaired.

   (2)(b)(i): The insurer shall not be liable for bodily injury sustained by any person who is convicted of an offence under section 253(b) of the Criminal Code (driving with more than 80 milligrams of alcohol in 100 mililitres of blood) or under section 253 (a) (driving while ability to drive impaired by alcohol or drug) occuring at time of the accident.

ii) Her auto damage: insurance company does have basis to deny Debbie coverage with respect to her auto damage, since impaired driving is also excluded in Section C Loss of or Damage to Insured Automobile.

iii) Liability coverage with respect to claim of Martin Motorist - claim of Martin Motorist would fall under the Debbie's Section A Liability Insurance. Protect Insurance would not be able to deny Debbie coverage due to her IMPAIRED DRIVING, since impaired driving is not excluded from Section A benefits. Furthermore, pursuant to S533(2) of Alberta's Insurance Act, a contravention of any criminal or other law in Alberta or elsewhere does not render unenforceable a claim for indemnity under a contract of insurance except when the contravention is committed by the insured with the intent to bring about damage, or unless
otherwise provided by contract.

- Although the insurance company cannot raise impaired driving as a basis to deny Debbie coverage, it can raise can raise breach of duty to provide notice of loss. Debbie did not notify her insurance company upon the accident where she hit a third party. Unless otherwise provided by contract, the duty to notify the insurer of loss is triggered by where a reasonable person, in the shoes of the insured, would have thought that a loss has occurred. In this case, hitting running a red light and hitting someone would most likely trigger knowledge of loss in reasonable person and trigger the duty to notify. Furthermore, the insurance company can raise the failure to provide proof of loss, as Debbie did not provide third party claim to the insurance company "immediately" or at all.

B. It is important for the insurer to be able to defend the claims against the insured by third party plaintiff, without compromising its ability to deny coverage to the insured at a later time in the event they find and can prove a breach by the insured (since the insurer will be liable to third party judgments against the insured if the third party brings action pursuant to S579).

The insurer can protect its interests by either a reservation of rights letter or a non-waiver agreement.

A reservation of rights letter is a unilateral statement of the state of affairs by the insurer. It usually sets out something to the effect of "we will investigate and defend the claim against you, but in doing so, we reserve the right to deny you coverage subsequently".

- a reservation of rights letter works to the effect of preventing the insured from raising arguments of estoppel or waiver against the insurer, but does NOT create substantive legal
rights which the insurer does not have. In the event the insurer settles a claim with the third party plaintiff in defending the tort action against the insured, the insurer cannot rely on the reservation of rights letter to claim repayment by the insured in the event it proves that the insured has breached the contract. — it is the weaker method to protect the insurer's rights

A non-waiver agreement is a mutual acknowledgement and agreement to the insurer's rights. It serves 2 purposes:
1) preserves the right of the insurer to continue to investigate, negotiate and defend against tort claims against the insured, while reserving the right of the insurer to deny coverage to the insured in the event it proves breach by the insured subsequently.

2) it gives the insurer the right to claim money back from the insured where it has reached settlement with the third party plaintiff (without judgment pursuant to S579(13)).

I would recommend the non-waiver agreement because it is the stronger method to protect the insurer's interests.

It must be noted that for a non-waiver agreement to be effective, 3 conditions must be met:

1) the rights reserved by the non-waiver agreement must be clearly set out. Any ambiguities will be strictly interpreted against the insurer

2) the non-waiver agreement will not be enforced where there is misrepresentation of the terms/consequences of the agreement by the insurer, or a misunderstanding by the insured; and

3) the non-waiver agreement cannot be relied on ONCE the insurer
has denied coverage.

C i) Protect can claim that Debbie has breached the duty to co-operate. However, courts will generally not let the insurer not provide coverage due to this breach unless the breach of duty to co-operate was malicious or in bad faith. IN Trosen v Merit Insurance, where the insured moved and didn't notify the insurer, and the insurer (and the lawyer it hired to defend the insured's claim) could not find the insured to sign affidavits etc, the court held that this failure to notify the insurer was due to ignorance rather than bad faith, hence the insurer was still liable in duty to defend and indemnify.
   - question is whether her moving was due to bad faith/malice.

ii) the Insurer can defend tort claim of Martin Motorist by applicable to the court to be made a third party by Order. This is done under S579(14), (15) and (16). Once the insurer is made third party by order, it is essentially placed in the same position as the defendant insured.

D. For the first $200,000.00, it is a statutory minimum mandated by the Traffic Safety Act. For this amount, the insurer cannot raise any breaches of contract or misrepresentations against the Judgement Creditor that it could have raised against the insured (pursuant ot S579 (4) and (5)). Furthermore, it cannot claim that the insurance policy was void ab initio due to any action by the insured (such as breach of contract). Within the first $200,000.00, the insurer may only raise arguments as to coverage or the judgment itself (ie there was no judgment, the judgment has been satisfied). In this case, there are no available arguments in coverage or judgment.

Beyond the first $200,000 (in this case $150,000), the insurer can raise any defenses it had against its insured other than
those set out in Statutory Condition 2 in S556 (pursuant to S579(11)). The insurer will not be able to raise the defence of prohibited uses (such as unlicensed driver), which does not apply in this case. Furthermore, the insurer will not be able to raise the defence of impaired driving, since that is not excluded from Section A Liability Insurance. However, the insurer is able to raise breach of duty to notify insurer of loss and breach of duty to provide proof of loss against the $150,000 claim.

E. If Protect Insurance is able to raise elements of the breach to duty to notify of loss and breach of duty to provide proof of loss, Martin can raise any defenses that the insured would have been able to raise against the insurer (Markus v Western Union Insurance). In this case, Martin may be able to raise the defense of relief from forfeiture. In considering whether such defence would be successful, the following will be considered:

1) source of court's power to grant relief from forfeiture
   - S520 gives court power to grant specific relief from forfeiture.
   - S10 of Judicature Act gives court power to grant general relief from forfeiture

2) Particular insurance claim applicable to
   - S520 is in respect of general insurance claims, excluding life insurance, injury/illness insurance, hail insurance
   - S10 Judicature Act is applicable to the ones excluded by S520

3) particular tests for relief
   1) Specific Relief:
      1) breach must be imperfect compliance or incomplete compliance rather than non-compliance
      2) there must not be substantial prejudice to the
insurer

3) it would be unfair/inequitale to require strict compliance from the insured

2) general relief
   1) insured must have acted reasonably
   2) gravity of breach
   3) weighing of value between benefit by granting relief vs. detriment/harm by allowing breach

- in this case, the insurance is auto insurance and not falling under the general provision, the breach should be classified as non-compliance rather than imperfect/incomplete compliance (Williams v York Fire) since there has been no notification or proof of loss provided at all (as opposed to untimely/not within specified time). When Specific Relief from forfeiture cannot be applied, General Relief from forfeiture can still be considered, as it has less stringent requirements. In this case, the relief may be granted IF the insured had acted reasonably, the breach was not grave in nature and weighing value in favor of insured.

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-------------ANSWER-8-ABOVE-----------------------------
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-------DO-NOT-EDIT-THIS-DIVIDER-----------------------------
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-------------ANSWER-9-BELOW-----------------------------
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Answer-to-Question-_9_

The general framework of analysis of insurance coverage is as follows (from SCC case Consolidated Bathurst)
1) Interpret the insurance contract by giving effect to the
reasonable intention of the parties at the time of contract formation
   a) where terms are defined in the policy, give effect to that meaning;
   b) where terms are not defined in the policy, to give effect to plain and ordinary meaning;
   c) where applying plain and ordinary meaning, more than 1 interpretation can apply, go with the interpretation that best promotes the reasonable intentions of the parties

2) where there are ambiguities, apply the following:
   a) contra preferendum: apply ambiguities against the insurer (except to statutory conditions or manuscript contracts)
   b) inclusion clauses should be construed widely, and exclusion clauses construed narrowly
   c) give effect to reasonable expectations of the parties
   d) avoid windfall to the insurer and unanticipated benefit to the insured
   e) give effect to the context of the case
   f) pay attention to jurisprudence and to give consistent interpretation to similar contracts in order to promote predictability and certainty (Progressive Homes)

In Progressive Homes, the court used the principles of interpreting insurance contracts in the context of the insurance company's duty to defend, it stated that
1) court should give effect to the plain and ordinary meaning of the terms and consider the whole contract; and
2) in the event of ambiguities, the exclusion clause should be interpreted narrowly;
3) the court should give consistent interpretation to similar insurance policies to promote certainty and predictability

Furthermore, the duty to defend arises on the "pleadings test" - the duty to defend arises where the alleged facts in pleadings
raise the mere possibility that the claim falls within the insurance coverage. The true nature of the pleading is NOT dependent on the wording chosen by the plaintiff - rather, the court must look at the true underlying nature of the defendant insured's actions that gave rise to the action.

In the end, the court found that "faulty workship" causing defects do fall within the defintion of "accidents/occurrences" in the insurance policy, and the duty to defend did arise.

The case Durham District School Board further clarified the principles set out in Progressive Homes. In that case, the insurance company had an exclusion clause for "criminal, intentional acts and failures to act". The plaintiff brought 2 claims, one against the insurer's son for intentionally causing fire, and the second against the insured for negligently failing to supervise. In this case, the court had to determine whether the claim against the insured fell within the exclusion clause (hence no duty to defend). The court listed the following principles:

1) Ordinary principles of contract interpretation
   - the ordinary principles of contract interpretation apply to insurance contracts.
   - the court should give effect to the reasoable intentions of the parties
   - where there are ambiguities, exclusion clauses should be construed narrowly

2) The true nature of the claim
   - court must ascertain the true nature of the claim againt the insured based on the underlying actions of the insured that gave rise to the claim

3) Derivative action
   - where there are multiple claims brought, one of which fell within insurance company's exclusion clause, the court must
determine whether the claims that on their face do not fall within the exclusion clause are derivative of the claims that are excluded from the policy.

- to determine whether a claim is derivative of another, court must consider whether the underlying factors behind the actions are sufficiently disparate to render the claims unrelated.

The general principles of analysis of insurance coverage was applied in a number of cases. For instance, in Jesuit Fathers of Upper Canada vs Guardian Insurance Company of Canada, and Brissette Estate v Estbury Life Insurance, the court emphasized the importance of giving effect to the reasonable intentions of the parties at the time the contract is formed, based on plain reading of the contract. Where the intentions are clearly ascertainable, the court should NOT move on to the second stage of analysis for resolving ambiguities, even where there may be public policy benefits for doing so.

In Engle Estate v Aviva Insurance Co., the court interpreted the parties' reasonable intentions by first looking at the terms/wording in the clause in question, then looking at the whole contract to determine meanings of particular phrases/words.

It was repeatedly emphasized that the second stage of analysis (resolving ambiguities) is unnecessary where the intentions of the parties can be determined at the first stage, by plain reading of the insurance contract.