Answer-to-Question-_1_

unlooked for mishap/ ordinary course of events/ fortuitous

moral certainty

1
A one person/party indemnifying another person/party for good consideration the loss or liability of the event the happening of which is uncertain This is also found in s1aa of the Insurance act.

B Insurance contracts are based on not wanting a risk to happen but if it does having protections against that risk. In a betting contract the bet is being made that the risk does come through. There is a policy against betting in insurance contracts.

2

good faith, insurable interest, subrogation, indemnification

3

The somersall v friedman case deals with subrogation and how an agreement can be made without the insurers consent for the loss of a subrogation claim. The majority dealt with how the rights of subrogation are not valuable. There is a heavy dissent. It is no longer good law due to the applicaiton of s546(6) which states that a settlement or release given before or afer an action is brought does not bar the rights of the insured or the insurer unless they have concurred in the settlement or release.
4

The essential terms of an insurance contract that must be agreed to are premiums, duration of coverage, coverage limits, subject matter, interests covered. Furthermore, under s516 there is a list of stuff that every policy must contain.

5

For the first application of 100,000 there is a possibility of an omission as regarding the whilistic healer and yoga for stress relief. AS stated in s652, every fact within the applicants knowledge that is material. To determine if this is material you have to apply the test from ontario metal. This is would a reasonable insurer deny coverage or increase the premiums. It is likely that getting stress relief is not material from yoga does not constitute a material fact however under insurance coverage it is very harsh as any material fact needs to be given.

Either way, 3 years after the policy began is past the 2 years incontestability period. Under s653(2) as long as there is no fraud a misrepresentation/omission of longer then 3 years cannot void the contract. In this way not disclosing yoga does not apply to void the first life insurance policy. This is found in the bureau v manufactureres life case.

This 2 year incontestability period beings again when a new policy begins or there is an increase in insurance. In this case sally increases the insurance to 200,000. Due to the fact that the incontestability period s653(2) begins again not disclosing the inhaled corticosteriods is a material fact that is not disclosed. This is shown because another insurance company denied coverage for the same issue. When she died 5 years later, this is past the incontestability clause however because there was fraud
the second contract can still be void. The fraud is found because she intentionally did not disclose information that she knew or ought to have known was material for the life insurance policy in order to get coverage.

In conclusion, Sally will be able to recover the 100,000 but not the increased premium of 200,000 due to fraud.

6

A

The amos test is:

purpose = is the car used in the ordinary way in which a car is used

causation = is there some nexus or causal relationship between the accident and the use/operation of the vehicle.

Dr Addict is attempting to claim indemnity for the officers injuries under his standard automobile policy. This means that Dr addict wants to apply his third party liability coverage against the claims of the officer. This differs from the normal approach because usually it is the individual who is injured trying to claim from either their own no fault system or their SEF 44 due to underinsured/unidentified tortfeasor.

Assuming that there is a stricter causation approach required for DR addict to apply his standard automobile insurance policy due to the fact that the loss or damage must arise out of the ownership, use or operation of the vehicle he is unable to apply the liability coverage. This is because for strict causation test there needs to be an unbroken link of causation between the accident and use operation of the vehicle. Dr. Addict's vehicle was used in an ordinary way in which is to say that
transportation always passes the purpose test. However the causation test is much harder to be found on the facts that there was no severance between the accident and use operation of the vehicle. Although Dr addict was attempting to evade police, he jumped out of the vehicle attacking the officer and this is how the officer sustained a significant injury. Due to this fact, there is a severance between the accident and the use and operation of the vehicle.

Side note, assuming that attacking the officer was an assault and found to contravene the criminal code this would not render a claim of indemnity unenforceable due to s533. If it was found that there was a causal connection between the accident and use/operation of the vehicle, the assault would not stop DR. Addict from being indemnified.

Conclusion is that Dr. addict will be unable to claim indemnity for the officer’s injuries due to the severance of causation between the accident and use/operation.

B

The fact scenario is similar to Martin v American assurance. Under an accident policy, an accident is an unlooked for mishap with a fortuitous and no expectation. What is important to decipher from the facts is whether or not Dr addict expected to die when he injected himself with the needle. Evidence that it was not suicide was that he was looking forward to going on vacation to Universal Studios. This is important to show that in fact it was an accident and not an intentional act by the DR. Secondly it is important to determine if he expected to die. It is unclear what his level of expertise was but being an addict and seemingly having previously injected himself it can be assumed that he has done this before, enjoyed doing it, and did not expect to die. Further just like the facts in Martin, he was
found with his trousers down and the needle nearby. This can be used as evidence to show that he was not expecting to die as he did not make proper preparations for death which would presumably be a note or pulling up his pants. His expectation most likely was to shoot up and then enjoy the chocolate high as he was a junky who just wanted his fix.

The expectation test for accident is firstly a subjective test as to determine what the insured expectation was to death. Secondly, if there is not enough evidence to adduce either way then there can be applied an objective test to determine whether a reasonable person with similar expertise would have expected to die. The insurance company claims that he must have foreseen his death as a result of the toxic amount of the dosage. It seems clear on the facts however that DR addict was not expecting to die and all the evidence is similar to the martin case in which an expectation of death was not found.

Conclusion is that DR addict beneficiaries are able to raise a claim for coverage. Furthermore, an innocent beneficiary is able to collect even if there is criminal contravention of any criminal actions done by the insured. Whether or not being a chocolate addict is criminal is questionable as I do not know if this is a metaphor but s533 would apply if there was a further claim by the insurance company that doing drugs is in contravention of the act.

200,000 damages
equal sharing up to policy limit (lombard)
Home insurance limits of 100,000
Community league insurance of 500,000
A To apply contribution there must be several factors that are present that correspond to coverage under any insurance policy. These are same insured/assured, same risk/peril, same interest, same subject matter as applied in clark v fidelity. Under Lombard where there are 2 policies that cover the same insured, and the policy allow for primary coverage even when the coverage limits differ there should be equal sharing up to the coverage limits. In Lombard, even though one policy stated that they were excess and the other stated excess to the excess it did not matter because the courts found that they had to apply reasonable expectations and intentions of the parties. This is important because if the policies stood for being excess and excess to the excess there would be no primary coverage for the insured and this is patently unreasonable in the circumstances.

It is important to note that insured may have more then one policy that they may not even be aware of. This does not stop a contribution claim as seen in family v lombard, where the insured did not know she had the horse insurance policy until there was a claim made.

A contribution claim is not made like a subrogation claim where the insurer brings the claim in the shoes of the insured. INstead in a contribution claim, the insurer brings a claim on their own behalf in their own name against any other insurance companies who have accompanying policies that fall within the scope of coverage. THis again is determined by whether These are same insured/assured, same risk/peril, same interest, same subject matter as applied in clark v fidelity.

B

The fact scenario is very similar to family v lombard case. This is the case because there are 2 different policies that we are told the loss falls within the scope of coverage of both of the
policies. Also what is important is that the home insurance policy states that it is to be excess. While the community league policy states that it is excess over existing insurance whether insurance is primary, excess, or contingent. If this was the case and both policies are applied based on what is stated then there would be no primary coverage for the coach because one is excess to coverage and one is excess to the excess. As this is the case applying the ratio from family v lombard, there should be equal sharing up to the policy limits of both policies because this solves the problem of who is primary coverage. Under this analysis both home insurance and community league insurance can be held liable. Each is required to pay $100,000. If the damages were assessed at 300,000 (which they were not), home insurance would still only be liable up to the coverage limits while community league would be responsible for any difference in liability up to their policy limit of 500,000.

8
Debbie hits martin
1 year later, within limitation period

no default judgement, but notice was given to insurance company

A
i) debbie was intoxicated. As this was the cause, section B rights cannot be applied. This is found under section B (2bi exclusions) in the SEF 44 policy because no section B coverage is permitted when the person driving the car is driving impaired. In this way there is no coverage for section b no fault coverage.

ii) Debbie was intoxicated. Under section 3 exclusions for auto damage there is an exclusion for when the insured drives the automobile under the influence of liquor. In this way, there is no
coverage for auto damage.

iii) contributory negligence based on the actions of the driver and whether they were partially to blame. Most likely no because she ran a red light and there is no evidence of what the third party driver was doing at the time.

B

There is a reservation of rights letter that is possible. This is a unilateral letter sent by the insurer to the insured. This allows the insurer to deny coverage without the insured claiming waiver or estoppel. However a reservation of rights letter does not apply further rights to the contract so the insurer would be unable to bring a claim for recovery. They are however to investigate and respond to the claim while still holding the right to deny coverage.

Non waiver agreement is a bilateral agreement between the insurer and the insured. As long as it is properly understood and signed with no misrepresentation as to what it stands for the insurer is able to deny coverage and claim against the insured for recovery. This is the best way in which the insurer can respond to the claim while still holding rights to deny coverage and gives the right to claim recovery against the insured. This is the method best adapted to preserve rights to deny coverage as it still gives the insurer the opportunity to recover the insured.

If the insurer does decide to deny coverage under the contract, the insurer can be made a third party in the action. In this way, the insurer is able to defend the claim without defending the insured. There are statutory rules set out in s579 14 and 15 that regulate what exactly is expected and what the insurer as a third party in action is able to do including contest the liability of the insured, contest the amount of the claim, and disclosure of records and cross examination.
C

i) This brings up the issue of duty to cooperate. There must be material and substantial breach of this duty along with intent evidenced by the insured before duty to cooperate can be breached. As shown by thorsen v merit, leaving the country was not in bad faith and not intentional so duty to cooperate was not breached. On the facts there is no evidence that debbie intentionally is not responding to the insurance company so there will be no breach of the duty to cooperate. IF later it is found there is intent by debbie to escape any claim, there is breach of duty and the insurer would have grounds to deny coverage. Until more evidence is present, there is no breach.

ii) after denying coverage the insurer can protect the tort claim by being made a third party by order under s579(14 and 15). Under these provisions the insurer can defend the claim without defending the insured. Under s579(15) there are provisions for what the insured can apply as defence to the tort claim.

D

Under s579, with a judgement, a judgement creditor can bring a claim against the insurer to pay the judgement. Due to s579(4 and 5) there is a severe limitation for any defences that the insurer can bring. The only defences an insurer can bring for a judgement amount under 200,000 are not the right insured, not the right insurance company (these first 2 are brought when the policy was cancelled prior to the loss), there is no judgement (not applicable), the judgement has been fulfilled (not applicable), and the loss does not fit under coverage (winch case). There is no facts given in this case that allude to any of these possible defences applying to debbie. However under s579(11) defences are applicable for coverage over the statutory minimum of 200,000. As
this is the case, any defence can be applied against the third party claimant that would be applicable to the insured for breach of the contract.

The insurer can raise the claim that there was no valid proof of loss or notice of loss given to the insurer. This is found in s556 sc 3 and 4 depending on whether the loss and damage was to the person or to the automobile. 1 year after the accident with no notice of loss or proof of loss is in breach as the notice must be given promptly and the proof of loss for damage to person must be given immediately and for damage to automobile within 90 days. As this is the case, this defence can be applied to the loss over 200,000.

The insurer can also raise the claim that there was a breach in the duty to disclose as there was a material change in the risk after the car accident. The change in the risk is material to the contract and within the insured knowledge. The fact that the accident is material is knowledge that is necessary just that the accident happened as determined by Thompson v allianz. Applying the ontario metal material risk analysis, an insurance company would definitely either find premiums would increase or coverage would be denied. Not disclosing the accident is a material change in risk and can be applied to the loss over 200,000.

E

Martin can make the argument that there should be Relief from forfeiture applying to the defences. AS shown in Williams v York Fire the test for specific relief from forfeiture is prejudice to insurance company and fairness in the situation. Under s520 relief from forfeiture (RFF) applies when there has been an imperfect compliance with respect to the loss. However no proof of loss and no notice of loss does not constitute imperfect compliance. As this is the case although it is a tenable argument
it will fail under the specific RFF s520 in the IA. Martin could also claim a RFF claim under the general RFF under s10 of the judicature act martin needs to show that the complaiant acted resaonbly in the circumstances, gravity of the breach, and benefit of the insured versus prejudice to the insurance company. Under both specific and general, the third party steps into the shoes of the insured and argues RFF however in this case the insured did not reasonably by not giving a proof of loss or proof of notice or disclosing the accident and furthermore did not conduct imperfect compliance by not doing anything. As this is the case neither general or specific RFF can be applied by martin.

If however, proof of loss or proof of notice was given but in a way that breached the statutory conditions under s556(sc3 and 4) imperfect compliance could be found and RFF would be a possiblity.

Progressive Homes is a case under duty to defend. The duty to defend is principal within the duties of the insurer. The test for duty to defend is laid out in scollera, where the true nature of the claim must be determined by applying the test 1) are the claims plead properly 2) are there any derivative claims 3) are the non derivative claims falling wihtin coverage. Important to understand is that for duty to defend to apply there must only be a mere possiblity of coverage.
More importantly however is the application of the interpretive principles that go along with the progressive homes case. This interpretive principles apply to any insurance contract and must be applied evenly and properly in order to get at the reasonable intention of the parties while navigating through any potential ambiguity. There must also be no windfall applied to the insurer and no double coverage applied to the insured, in other words full indemnity.

Intention
1) plain word meaning
2) when there are 2 possible options, determine the more reasonable of the 2 to give effect to the intention of the parties
3) read the contract as a whole, as every provision as a smaller piece of the entire contract

ambiguity
1) contra proferndum, meaning that when there is ambiguity to solve it in favor of the insured
2) coverage clauses must be interpreted broadly
3) exclusion clauses must be interpreted narrowly
4) give reasonable expectation to both parties

In the actual claim the onus is on the insured to show that there is coverage allowed under the policy. Then the onus switches to the insurer to show that exclusions apply in order to deny coverage. Finally, the insured has the onuse to show that exceptions apply to the exclusions.

IN Lombard, a claim was brought for third party liability coverage for a building company who constructed buildings which were leaking. The pleadings were based in negligence and in issues of defect workmanship. What needs to be remembered is that in
finding coverage, there was only a standard of mere possibility due to the fact that the issue was whether there was a duty to defend.

First off there was a discussion as to whether there was property damage found. There was a broad reading of the term property damage. Property damage was found to include damage that resulted from the construction being built as reading the whole policy, included this definition because there would be no reason to have the workmanship exclusions if it did not apply.

Next was a determination of the term accident. There was a plain ordinary application of the word accident along with the definition from the gibbens case as unlooked for mishap or fortuitous event. An accident was found to include the workmanship due to the fact that in the pleadings there was no intention to build a faulty building.

Finally exclusion clauses were read in a way that found that none of the property damage fell within the exclusions allowing there to be a duty to defend. In order for the onus of the insurance company to be properly "beaten" the exclusion has to be clear and unambiguous and apply to the facts on the case. In none of the three reiterations of the exclusions in the policy did the facts fall within the exclusions. As this is the case, a proper application is that coverage is provided. Furthermore, in this case the exclusion clauses are read very narrowly in order to find that the building does in fact have coverage under the policy.

IN the Durham district school case, these interpretive policies are applied to determine whether or not there would be coverage when the son burned down a school. This is applicable because the provisions of the contract included any insured who acted intentionally or criminally or did nothing to stop the risk. The
son intentionally burned down the building. But the claims also found that the parents were negligent in the way they handled their son. The determination by the court applied contra proferendum due to the ambiguity of whether the negligent applied as negligence by itself or if there had to be criminal negligence. Applying contra proferendum, the court determined that there would be coverage as the provision was not clear as to whether there should be a separation. Because there were two possibilities in how the courts could apply the provision, they were able to properly assess the ambiguous provision in a way that would benefit the insured.

IN the Lewis v Economical case, there was an issue when an insured hit their head on a pipe protruding from a parked car. The benefits would only be covered if the insured was struck by the car. Applying a plain word meaning to struck or hit, they found that the car did not have to be moving to "strike" the insured. Insurance companies for the most part will apply beneficial rulings for the insured in cases where there is ambiguity due to the fact that there is a power imbalance between an insurance company and the insured. Furthermore, this comes up because the insurance company drafts these policies and any ambiguity must be found against the drafter. This not only is an example of plain ordinary wording but also a valid demonstration of how coverage clauses are to be read broadly in order to properly apply the reasonable expectations of the party.

IN the Family v Lombard case, the courts apply in a sense the reasonable expectations of the parties and gives effect to the full intention of the parties. Generally, both policies were to be used as primary coverage unless there was excess and then provisions for excess were given. Because of this, without the courts intervention the insured would not have any primary coverage so the court applied reasonable expectations of the parties and found that each insurance company owed an equal share
up to the policy limits.

In the Jesuit case, there were incredibly sympathetic circumstances however it shows that even though there is a power imbalance between the insured and insurer, there will not always be a way in which the court can benefit the insured. Furthermore, in Wong estate v liberty mutual, when there is an unambiguous provision in a contract, the court must apply it properly so criminal negligent was found to be excluded from the policy. The exclusion was clear and unambiguous and therefore had to be given proper straightforward application.