Introduction

While bad faith claims tend to polarize parties and when brought, are often seen as a declaration of war, it is important to appreciate that the theoretical objective of the law in this area is essentially to set a standard of conduct to bring about fairness for both parties.

In the context of disability insurance claims, and speaking from the perspective of plaintiffs, fair treatment is particularly important because of the great vulnerability of insureds with legitimate disability claims.

Aggravated damages

While the topic assigned to this presentation is punitive damages, many disability insurance claims also advance a claim for aggravated damages/damages for mental distress. The following is a brief overview of the law relating to this head of damages.

The leading Canadian decision defining “aggravated damages” is Vorvis v. I.C.B.C. [1989] 1 S.C.R. 1085. McIntyre J. wrote:
“Aggravated damages will frequently cover conduct which could also be the subject of punitive damages, but the role of aggravated damages remains compensatory. The distinction is clearly set out in Waddams, *The Law of Damages* (2nd ed. 1983), at p. 562, para. 979, in these words:

….. aggravated damages describes an award that aims at compensation, but takes full account of the intangible injuries, such as distress and humiliation, that may have been caused by the defendant’s insulting behaviour.”

While the law is clear that aggravated damages are designed to compensate the plaintiff (as opposed to punishing a defendant), there is some disagreement as to what type of action of a defendant will attract an award of aggravated damages. Specifically, in *Fidler v. Sun Life Assurance Company of Canada* [2004] B.C.J. No. 982 (C.A.) which is under appeal to the Supreme Court of Canada, a major ground of appeal is whether the insured must show that the insurer has committed an independent actionable wrong.

In this regard, several legal authorities have argued that a distinction should be drawn between damages arising from the fact of a breach, and damages arising from the manner of breach. Although both types of damages are compensatory, the former often arise in actions where an intrinsic component of the contract is the provision of “peace of mind,” with damages being characterized as damages for mental distress. Damages which arise from the manner of breach are most often characterized as aggravated damages. Included in the latter category are wrongful dismissal actions: unlike insurance contracts which must be honoured after an insurance claim has been brought, the general rule in employment contracts is that either party is legally entitled to terminate the contract at any time.

The focus of this paper will be on the development of the law and legal principles applicable to “peace of mind” cases.

Historically, in breach of contract cases, courts have compensated aggrieved parties for economic losses flowing from breach of contract, but not for emotional suffering. This arbitrary limitation arose primarily from a “floodgates” argument.

Despite this general rule, the courts did carve out exceptions in certain cases, for example, where holiday plans were ruined. The law thus evolved to recognize that in certain classes of cases, where the object of the contract was to provide “peace of mind,” damages for mental distress


could be awarded.

The history of the “peace of mind” cases in Canada can be found in Vorvis, a wrongful dismissal action, in which McIntyre J. noted that the “peace of mind” cases “stand for the proposition that in some contracts the parties may well have contemplated at the time of the contract that a breach in certain circumstances would cause a plaintiff mental distress.” (p. 1102). He noted that “the power of the court to award damages upon that basis in an appropriate case was implicitly accepted” by the Ontario Court of Appeal in Brown v. Waterloo Regional Board of Commissioners of Police (1983), 43 O.R. (2d) 113 (Ont. C.A.). However, McIntyre J. determined that such a loss, which he described as aggravated damages, was not appropriate on the facts before him.

In Warrington v. Great-West Life Assurance Co. (1996) 24 B.C.L.R. (3d) 1, which involved breach of a disability insurance contract, the B.C. Court of Appeal held that aggravated damages may be awarded to the plaintiff where he/she has suffered “mental distress” as a consequence of that breach. The court referenced the observation of Pennell J. in Thompson v. Zurich Insurance Co. (1984), 7 D.L.R. (4th) 664 (Ont. H.C.) that “few contracts could affect one’s personal interests more than a contract for medical and rehabilitation benefits… The predominant, if not the sole object of the contract was to provide ease of mind to the insured that his medical accounts would be taken care of by timely payment during the period of rehabilitation.” The Court noted parallels with the disability policy before it, and concluded that a contract of disability insurance fell within the class of contracts which are designed specifically to provide “peace of mind” to one of the parties to the contract.

As a class of insurance contract, a disability insurance contract has unique characteristics which place it within the four corners of the “peace of mind” contracts. The Court in Warrington described a disability insurance contract thus:

“The long-term policy stated that income benefits were payable monthly in arrears. It is not difficult to imagine that the receipt of bi-weekly or monthly payments upon becoming disabled would be of critical importance to most insureds, who may be expected to have pressing monthly expenses related to themselves, their families and their property that cannot be paid if their wages are stopped.” (para. 21)

On the issue of whether damages for mental distress should be dependent on any additional wrong committed by the insurer, Newbury, J.A. in Warrington wrote:

“… logically, Mr. Warrington’s mental distress did not result from Great-West’s motive of bad faith (or breach of a duty of good faith) or mental state or motives in refusing Mr. Warrington’s claim. It resulted from the delay itself. The effect on him would have been the same whether the insurer had been well-motivated, reasonable, unreasonable, or even malicious in that delay. Thus in my view it was erroneous to find that an
independent tort had been proven that resulted in injury in the form of mental distress to Mr. Warrington.” (p. 31, paras. e, f)

In Whiten, supra, this Court confirmed that insurance contracts are purchased by the public for “peace of mind. Binnie J. wrote:

“Insurance contracts, as Pilot’s self-description shows, are sold by the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim.” (para. 129)

In Fidler v. Sun Life, the trial judge and the Court of Appeal proceeded on the basis that the disability insurance contract in question was a “peace of mind” contract. Sun Life agreed. Mr. Justice Finch C.J.B.C. wrote:

“The general principle in contract law is that damages will not be awarded for mental distress that results from the breach of a contract. However, there is an exception to this general principle for “peace of mind” contracts where the very purpose of the contract is to secure the peace of mind of the insured. The parties agree that the insurance contract at issue is a “peace of mind” contract.” It created an expectation of benefits and freedom from financial distress in the event Ms. Fidler experienced a long-term disability.”


In recent years, legal critics have challenged the arbitrariness of distinguishing between economic and non-economic damages, on the basis that where a significant element of a contract is the provision of a nontangible benefit, it is wrong for courts to deny compensation on breach of the contract1.

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The current academic debate concerning “peace of mind” cases is whether it is best to carve out exceptions to the general rule, allowing damages for mental distress on the basis of special categories of contracts, or whether it is preferable to try to fit the existing exceptions within the foreseeability principles in Hadley v. Baxendale (1854), 9 Ex. 341, 156 E.R. 145. The imposition of an additional requirement on the insured of proving a requisite mental element on the part of the party in breach in order to be compensated for one’s losses extends far beyond the traditional elements of contract. With regard to such arbitrary restrictions, critics have commented on the “conceptual incongruity of asking a plaintiff to show more than just that mental distress damages were a reasonably foreseeable consequence of breach”: see O’Byrne, “Damages for Mental Distress” at p. 25.

In England, the House of Lords recently broadened the test for recovery of non-economic damages in Farley v. Skinner, [2002] 2 A.C. 732. Lord Steyn made the following comment:

“for Lord Mustill, at p. 360, the principle of pacta sunt servanda would be eroded if the law did not take account of the fact that the consumer often demands specifications which, although not of economic value, have value to him. This is sometimes called the “consumer surplus”: see Harris, Ogus and Phillips, “Contract Remedies and the Consumer Surplus” (1979) 95 LQR 581. Lord Mustill rejected the idea that “the promisor can please himself whether or not to comply with the wishes of the promise which, as embodied in the contract, formed part of the consideration for the price.” (para. 21)

In Fidler, the plaintiff has argued that as society has become more complex, the law has increasingly recognized a need in certain areas of contract law to hold parties more accountable for honouring their obligations under the contract. This has been particularly apparent in insurance law, where insurers are increasingly held to a duty of good faith to pay legitimate claims. There has also been a development towards allowing concurrent liability in tort and contract, such that aggrieved parties may sue in negligence for poor performance of a contract. These principles, together with an increased appreciation of the realities of emotional suffering, converge to support the need to recognize damages for mental distress in contexts where social policy supports the need to fulfill contractual obligations4.

With specific reference to disability insurance cases, the plaintiff’s argument in Fidler is that these cases, perhaps more than any other, deserve recognition as “peace of mind” contracts where breach of the contract alone will trigger damages for mental distress.

When a disability insurer breaches the contract, the long-term nature of the parties’ relationship has significant implications for the “peace of mind” of the insured5. The following characteristics, many unique to disability insurance claims, explain the extent to which a breach of contract alone can adversely impact disability insureds:

a) when benefits are improperly denied or terminated, the insured’s financial security, both short-term and long-term, is lost. Most long-term disability insurance contracts provide for the payment of disability benefits to age 65. Upon breach, the insured is forced to address the financial consequences of the breach, which may be felt immediately (in the inability to meet ordinary living expenses), and/or long term (the insured may exhaust his/her savings and face financial hardship many years later). Where insureds have been supporting a family, the financial and emotional repercussions of non-payment are even more serious. Moreover, because of their long-term health problems, insureds have no options to replace lost financial security;

b) persons who need disability insurance are exceptionally vulnerable. Unlike most other insurance contracts, the insured’s vulnerability is not only economic but also involves a seriously compromised state of health. By definition, the insured is too ill, mentally, psychologically, and/or physically, to work. Illness alone can often wreak havoc on personal relationships. The increased stress of being denied disability benefits often exacerbates the insured’s health. In addition, the insurer’s decision to terminate or refuse benefits may compromise or delay the insured’s rehabilitation and recovery;

c) because benefits are payable on a monthly basis, issues of entitlement and the consequences of non-payment can arise during any given month, and can recur repeatedly;

d) the relationship between the insured and the insurer in a disability claim cannot be ended once it has soured. It is comparable to a marriage with no provision for a divorce: for as long as the insured remains disabled from working, he/she is compelled to live in a state of financial dependency on the insurer;

5 See also Monks v. ING Insurance Co. of Canada [2005] O.J. No. 2526, awarding $50,000 in aggravated damages.
e) disability benefits are often tied to other incidents of employment such continued contributions to the employee’s pension plan and continuation of extended health benefit coverage. Therefore the implications to the insured of being denied disability benefits can significantly exceed the loss of benefits themselves. These ancillary arrangements are generally known to the disability insurer; and

f) once the insured becomes unable to work and files a disability claim, he must continue to deal with the specific insurer under the contract. Unlike many other breach of contract cases where the aggrieved party can negotiate alternative contracts and thereby mitigate one’s losses, a disabled insured has no means (other than efforts to recover) to mitigate his losses.

The greater the financial dependency on the insurer, the greater the power imbalance and the greater the insured’s state of vulnerability. The longer benefits are withheld, the greater the insured’s mental and financial distress. Over time, injustices (or perceived injustices) such as delays in the payment of benefits, repeated demands for additional medical documentation in the context of a chronic condition, (the insurer often requires the insured to furnish costly medical reports) and/or the pressures of undergoing repeated or invasive surveillance will cause insureds to react with a growing sense of anger, frustration, and desperation. The above consequences of the insurer’s breach, often cumulative, can be devastating to the insured, yet they can all occur solely as a result of the insurer’s breach of contract, without the insurer committing an additional independent actionable wrong.

At the present time, damages for mental distress in disability insurance cases, where awarded, tend to range from $5,000 to $20,000. The highest award ($35,000) was recently made by Morrison, J. in Asselstine v. Manufacturers Life Insurance Co., [2003] B.C.J. No. 1692 and affirmed by the Court of Appeal 2005 BCCA 292.

Punitive damages in *Fidler v. Sun Life*

**Factual background**

Because punitive damages are in large measure fact-driven, the history of Ms. Fidler’s claim is set out in some detail below.

In 1990, while working at the Royal Bank, Connie Fidler became ill with an acute urinary infection leading to acute pyelonephritis for which she was hospitalized July 2-5, 1990 and given IV antibiotics. After the infection cleared, Ms. Fidler suffered from debilitating fatigue, which was diagnosed as post-infectious chronic fatigue syndrome. Her application for long-term disability insurance was initially denied.
Ms. Fidler pursued an appeal. By then, she had been assessed by five doctors including 4 specialists. There was general medical agreement that Ms. Fidler had chronic fatigue syndrome, a diagnosis of exclusion and one for which there is no proven effective therapy. On March 21, 1991, Sun Life approved Ms. Fidler’s claim and arranged to enforce CPP offset provisions.

On April 4, 1991, CPP approved Ms. Fidler’s application for benefits retroactive to October, 1990. As time passed, Ms. Fidler was also diagnosed with fibromyalgia and it became increasingly clear that her disabilities were long term. Ms. Fidler continued to receive CPP disability benefits through to the date of trial.

On June 5, 1991, Sun Life referred Ms. Fidler’s claim to its rehabilitation department. Over the next several months, Ms. Fidler explored whether she could work from her home to prepare for a potential return to work. She purchased a computer and attempted to take a computer course, but was too ill to continue. Sun Life made no referral to its rehabilitation department in 1994. It initiated a referral September, 1995, but did not follow through on the referral. Sun Life made no referrals to its rehabilitation department after 1996.

Over the period March, 1991 to May 12, 1997, Sun Life availed itself of several methods to assess Ms. Fidler’s disability claims. Sun Life initiated requests for, and adjudicated Ms. Fidler’s claim on the basis of, supplementary medical reports from Ms. Fidler’s treating doctors, disability questionnaires to the doctors, supplementary statements, claimant interview reports, questionnaires and consults of treating doctors, telephone interviews, background investigation checks, disability assessments, and internal medical opinions.

At certain stages, Sun Life unilaterally ceased paying benefits. For example, on September 29, 1992, Sun Life terminated Ms. Fidler’s benefits effective January, 1993, (the change of definition date from “own occupation” to “any occupation”). The medical evidence at the time was that Ms. Fidler was not able to work at any occupation. Ms. Fidler then obtained updated reports from her treating specialist. Sun Life still withheld benefits. The termination of benefits was causing Ms. Fidler severe financial stress. A further report dated January 20, 1993 was sent, and Sun Life changed its mind and reinstated benefits. A similar episode recurred in 1994.

In December, 1995, Sun Life requested Ms. Fidler to complete a Lifestyle Questionnaire. She did so on January 3, 1996, and the questionnaire was forwarded to Sun Life together with a notation that Ms. Fidler’s husband was recently killed in an accident while working in Japan. In July, Sun Life requested Ms. Fidler to complete a Supplementary Statement, which she did on August 5, 1996. In that statement, Ms. Fidler described the following problems: “chronic pain, unable to sleep, weak physically, irritable bowel & stomach, eyes sensitive to light, headaches, no concentration, short term memory very poor, chronically tired”. Ms. Fidler wrote “I feel I am doing well to take care of myself and my daily business – ie paying bills, shopping, etc. and as this seems like a full time effort for me I cannot imagine trying to hold a job.” At the same
time, Sun Life commissioned surveillance, which was done in August and September, 1996, with a report released to Sun Life dated September 28, 1996.

The trial judge observed that the tapes showed Ms. Fidler “carrying out a number of what can be described as errands or personal business activities.”

Sun Life reported in an internal memorandum dated December 16, 1996 that the claimant was active for “5 FULL DAYS!” In fact, Ms. Fidler was observed shopping for only two consecutive days. At trial, the representative of Sun Life, Mr. Craig, admitted that this description of the surveillance was an exaggeration.

By letter dated May 12, 1997, Sun Life wrote to Ms. Fidler advising that it had terminated benefits effective April 30th, 1997 on the basis of a non-medical investigation.

In response, Ms. Fidler wrote a series of letters and made several phone calls trying to clarify the basis for Sun Life’s decision. She requested production of the surveillance videotapes. However, the 1996 and 1998 tapes were not released until February, 2002, and the 2001 tape was not released until a week before trial.

Internal memos disclose that Sun Life was aware that its decision to terminate benefits was mishandled and that it lacked medical evidence to support its position. An internal memo dated June 17, 1997 stated:

“The long delays between the time of the surveillance and advice of termination would not be in our favour if this case went to court. The best way to have handled this case would have been to arrange for an IME before declining or at leaving (sic) have an MC (medical consultant) review file and provide his comments.”

In addition, and contrary to what it told Ms. Fidler, Sun Life had not conducted a “thorough review” of Ms. Fidler’s claim prior to terminating her benefits. This is evident from a Sun Life memo by the Principle Claims Administrator in Montreal dated March 18, 1998, which noted:

“The claimant’s condition has not changed according to the medical reports on file and our decision was based solely on the results of the investigation.”

In January, 1998 Ms. Fidler forwarded a letter from her family doctor, Dr. Wilkinson, which confirmed that she was unable to work, suggested that Sun Life schedule an Independent Medical Assessment (“IME”) and assist with a graduated exercise program and cognitive therapy. In response, Sun Life prepared a memo which stated: “An IME is essential if we wish to maintain our denial successfully in the event of litigation.” Sun Life did not reinstate benefits, nor did it refer Ms. Fidler’s claim to its rehabilitation department, nor did it take any steps to schedule an IME until September, 1998.
Once Sun Life finally scheduled an IME, Ms. Fidler immediately attended in the hope that this would resolve any outstanding questions. At the same time, Sun Life conducted further surveillance of Ms. Fidler. The doctor chosen by Sun Life, Dr. Wade, a rheumatologist, forwarded a lengthy report to Sun Life advising that Ms. Fidler’s “number one complaint is that of pain” and that she also complained of poor sleep, fatigue, irritable bowel, and headaches. Sun Life had provided Dr. Wade with Ms. Fidler’s Lifestyle Questionnaire and the 1996 surveillance which he did not consider significant. In his conclusions, Dr. Wade recommended a graduated rehabilitation program, medication and counseling. He wrote:

“It would be my opinion that Connie Fidler is increasingly able to consider returning to work on a graduated basis. Prior to this being successful, she should embark upon a graduated training program to improve her level of physical fitness.”

Instead of making a referral to its rehabilitation department and reinstating benefits pending Ms. Fidler’s hoped for recovery, Sun Life forwarded Dr. Wade’s report to its Medical Consultant ("MC"). The MC did not conduct a physical examination of Ms. Fidler. In a 2 page handwritten note, the MC concluded that Ms. Fidler was not disabled from working. Sun Life then considered how to justify ignoring Dr. Wade’s report in the following internal memo generated by someone in its Disability Management Unit:

“When an examining doctor makes recommendations, we look bad if we do not follow through with recommendations as we are asking for his opinion. I would recommend that you stress that result of IME & medical do not support T.D.A.O. (total disability any occupation), however, as a good will gesture we would pay 3 months of benefits to assist with her back to work efforts and also stress that file will be closed with this handling...”

Upon hearing that her file would be closed, Ms. Fidler retained a lawyer and a letter was sent returning Sun Life’s cheque. In January, 2000, Ms. Fidler underwent a functional capacity evaluation requested by Sun Life, traveling from Oliver to Coquitlam, to be assessed by an OT chosen by Sun Life. By the end of the FCE, Ms. Fidler was in tears. The evaluator, Ms. Fast, concluded:

“Ms. Fidler would be considered currently to have limitations with respect to receptionist duties due to her slow speed of movement, particularly with regard to her keyboarding ability. Below average short term memory function might also limit her ability to successfully perform such job duties. Her overall tolerance to activity is limited such that I would consider her incapable of more than half-time employment at a sedentary level currently, although I would expect this could be increased on a gradual basis.

After October, 2000, and well into the trial, Ms. Fidler was without legal representation. Ms. Fidler explained that in order to retain counsel, she would have to withdraw a portion of her RRSP’s, something she was reluctant to do.
In September, 2001, Ms. Fidler underwent a second IME with Dr. Wade, who noted she had experienced “further significant stress related to the status of her disability” and again made suggestions concerning her rehabilitation. Again, Sun Life took no steps to reinstate benefits or assist in rehabilitation.

Sun Life examined Ms. Fidler for discovery in March and October, 2001. Sun Life made no offer to reinstate benefits following these examinations for discovery. Also in October, 2001, Sun Life conducted a further 9 days’ of surveillance.

One week before trial, following a brief examination for discovery, Sun Life offered to pay all of Ms. Fidler’s outstanding benefits and to reinstate benefits.

The trial proceeded on the assessment of damages for mental distress and punitive damages only.

At trial, Sun Life’s representative, Mr. Craig, testified that his decision to reinstate benefits was based on his belief, arising from an examination for discovery held a week before trial, that Ms. Fidler would be successful at trial. However, on cross-examination, Mr. Craig was unable to explain how the April 2002 discovery caused him to reinstate benefits and why the decision to reinstate had not been made earlier.

At trial, Ms. Fidler testified that Sun Life’s lack of cooperation and the difficulties she experienced as a result of Sun Life’s 5 year refusal to pay benefits had been extremely upsetting to her. The trial judge found that Ms. Fidler’s own doctors consistently confirmed Ms. Fidler’s total disability and that Ms. Fidler would likely have been successful at trial on the issue of whether she was totally disabled.

**Trial decision**

Following a trial (which was broken up because Ms. Fidler was too ill to continue) Ralph J. awarded Ms. Fidler $20,000 in damages for mental distress and dismissed the claim for punitive damages.

**Court of Appeal decision**

Sun Life appealed the award of $20,000 for damages for mental distress on the basis that there was little or no evidence Ms. Fidler had suffered financial stress as a result of the five year withholding of benefits (Ms. Fidler’s husband had been killed and she had been paid out a life insurance policy).
Ms. Fidler cross-appealed the dismissal of her claim for punitive damages.

On appeal, all justices upheld the award for $20,000.00. With respect to the claim for punitive damages, Chief Justice Finch and Prowse J.A. overruled the trial judge’s decision and awarded Ms. Fidler $100,000. Ryan J.A. in dissent would have dismissed Ms. Fidler’s cross-appeal.

**Supreme Court of Canada**

The SCC granted Sun Life leave to appeal both awards. The appeal was argued before the full nine member panel on December 6, 2005. The Supreme Court’s decision has not yet been released.

**Legal principles governing award of punitive damages**

The leading decision on punitive damages is the Supreme Court of Canada decision *Whiten v. Pilot Insurance Company* (2002), 209 D.L.R. (4th) 257, which held that the general objectives of punitive damages are punishment (in the sense of retribution), deterrence and denunciation. The Court confirmed that an insurer’s breach of its contractual duty of good faith is independent of and in addition to the breach of its contractual duty to pay the loss and therefore constitutes an “actionable wrong” within the *Vorvis* rule (para. 79). Damages are to be awarded only where there has been “high-handed, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from ordinary standards of decent behaviour” and where awarded, damages must be assessed in an amount reasonably proportionate to the harm caused, the degree of the misconduct, the relative vulnerability of the plaintiff and any advantage or profit gained by the defendant. Punitive damages are only awarded where compensatory damages are insufficient to accomplish the above objectives, and then only in an amount necessary to rationally accomplish their purpose. (para. 94)

**Trial decision**

In dismissing the plaintiff’s claim for punitive damages in *Fidler*, the trial judge noted that all of Ms. Fidler’s doctors considered her incapable of work, and that Sun Life had conducted extensive surveillance which was invasive of Ms. Fidler’s privacy, but held that the conduct was not so egregious as to meet a threshold of bad faith. The trial judge ruled that the subjective nature of Ms. Fidler’s illness essentially absolved Sun Life of any finding of wrongdoing, “despite strong medical evidence that she continued to be disabled.”
There is no reference in the trial judgment to the standard of conduct to which a disability insurer should be held. The trial judge did not appear to consider several key aspects of Sun Life’s conduct relevant to a claim for punitive damages, including the fact that Sun Life terminated benefits without a medical basis to do so, the many avenues open to Sun Life to adjudicate Ms. Fidler’s claim which were not used after breach, Sun Life’s failure to provide Ms. Fidler with evidence justifying its decision to terminate benefits, its failure to investigate in a timely manner and reinstate benefits on the basis of additional evidence, and its failure to address rehabilitation and disability issues raised in the IME reports. Nor did the trial judge scrutinize the circumstances under which Sun Life agreed to reinstate Ms. Fidler’s benefits. In fact, the trial judge would not admit key evidence (the transcript of Ms. Fidler’s examination for discovery held one week before trial, and the document Mr. Craig prepared summarizing his decision to reinstate benefits) which would have shed considerable light on Sun Life’s motives for reinstating benefits just before trial.

**Court of Appeal decision**

The starting point for the Court of Appeal in examining the conduct of an insurer was an appreciation that, due to the vast power imbalance between the insurer and the insured, an insurer is held to a standard of “utmost good faith”.

It is very important in this field to note the extent of the vulnerability of insureds with legitimate claims. Many suffer from debilitating illnesses which are difficult to prove. These include mental and emotional disabilities, depression, headaches, fatigue (for example, with MS), memory and concentration problems, and pain. Insureds who are too ill to work may have difficulties understanding what can be done to challenge the insurer’s decision to terminate benefits and taking the necessary steps to pursue their remedies. Insureds who have no savings and face financial crisis as a result of the termination of benefits will likely not be able to afford legal representation if the retainer is based on hourly rates, and, given the small amount of monthly benefits payable in many cases, insureds may not find lawyers willing to act for them on a contingency fee basis. Nor can insureds often afford to pay for additional medical reports necessary to prove their ongoing disability.

For all of the above reasons, it is critically important that insurers be held to a standard of conduct that will provide insureds with a fair adjudication of their claims, without the need to pursue litigation.
In *Fidler*, the plaintiff argued that, based on an extrapolation from judicial decisions in other insurance cases⁶, disability insurers should:

i. *only* terminate benefits if there is credible medical evidence that the insured is able to work. (It is useful to note the line of cases that states that where an insured is receiving benefits, the onus should shift to the insurer to prove the insured is capable of suitable work)⁷;

ii. upon terminating benefits, provide the insured with a full explanation of its decision, including any evidence it relies on in support of its decision, so that the insured has a full opportunity to respond;

iii. exercise its investigation rights under the policy (including IME’s) in a timely manner. This obligation would apply throughout the currency of the policy;

iv. consider all additional information carefully and immediately reinstate benefits if the additional information supports ongoing disability;

v. if there are medical or other ambiguities, the insurer should make reasonable efforts to clarify the ambiguities, keeping the insured informed of its enquiries;

vi. if the evidence is that the insured requires rehabilitation support before he/she is able to engage in work, benefits should continue until the insured is in fact able to work. If the insurer elects to pursue rehabilitation efforts, this should be done in consultation with the insured’s medical doctors; and

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vii. if the insurer elects to conduct surveillance, it was submitted that surveillance should be reasonable and subject to medical review. Surveillance videos should not be taken of third parties (for example, the insured’s family members), and should be limited to the minimum necessary to establish the insured’s level of functioning. All surveillance tapes should be disclosed to the insured as soon as reasonably possible.

Some of these arguments were accepted by the Court of Appeal, others (specifically the limitations of surveillance) were not. All of them are being advanced before the Supreme Court of Canada.

A key issue at trial and on appeal was whether Sun Life’s refusal to pay benefits should be excused because Ms. Fidler’s illness could not be verified by objective tests. It was submitted that elements of ambiguity or uncertainty or conflict concerning the nature and extent of an insured’s disability will exist in most cases and that the logical extension of this argument was that an insurer would never be exposed to a punitive damages award where an insured suffers a “subjective” illness.

The nature of insurance claims, and particularly disability claims, is such that insurers are far better equipped to clarify ambiguities than insureds, who are disabled, unfamiliar with the adjudication process, may not understand their own limitations (particularly in cases of mental disability), and will not often know the nature and type of evidence reasonably necessary to establish disability.

The reasons of the Chief Justice recognize that insureds who become disabled because of illnesses which are difficult to assess stand in need of disability benefits as much as those with obvious physical disabilities. How the insurer investigates a given claim may depend on the circumstances of the case, but an insurer’s accountability for paying benefits should not be lowered because of the nature of the disability. Finch C.J.B.C. held that where disabilities are difficult to assess, it becomes that much more important for insurers to proceed “openly, fairly and cautiously.”

The Chief Justice noted that Sun Life had not accurately described the surveillance video and had not provided Ms. Fidler with a fair and reasonable opportunity to challenge its decision to terminate her benefits and observed that after breach, Sun Life’s focus was on defending the claim, rather than on fairly adjudicating it. Finch C.J.B.C. concluded that the most probable motive for Sun Life’s decision to reinstate benefits one week prior to trial was an awareness just before trial that Ms. Fidler had decided not to back down.

The plaintiff argued that there was a need for deterrence, and that if punitive damages were not awarded as a deterrence for Sun Life’s conduct, the lesson would be that insurers can terminate
benefits in cases such this with impunity, knowing that if insureds persist in their claim, they can make amends without penalty at the doorstep of trial. The corollary would be that insureds who are disabled from working and entitled to benefits will be forced to press their claims through a difficult and oppressive litigation process because nothing short of that (and possibly not even trial) will create sufficient financial risk to an insurer to pressure it to pay benefits that are due and owing.

The Court of Appeal accepted that without an award of punitive damages, Sun Life would experience no meaningful adverse consequence for its actions and awarded damages roughly equivalent to double the total amount of benefits which Sun Life withheld over the five year period leading up to trial.

Other cases across Canada

In Ontario, the issue of whether to make a special award under section 282(10) of The Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996, Ontario Regulation 403/96, as amended was reviewed in Thangarasa v. Gore Mutual Insurance Co. [2005] O.F.S.C.D. No. 106. The analysis of the Arbitrator, J. Wilson, combines principles related to both damages for mental distress/aggravated damages and punitive damages. He noted that the purpose of s. 282(10) was to “punish insurers that unreasonably fail to pay accident benefits promptly, as required by the SABS, and to deter that company and others from acting similarly in the future. The size of the special award should be aimed at that purpose.”

Arbitrator Wilson then listed the following factors as relevant to a special award:

“To paragraph, the award should be proportionate to: (i) the blameworthiness of the insurer’s conduct; (ii) the vulnerability of the insured person; (iii) the harm or potential harm directed at the insured person (iv) the need for deterrence (v) the advantage wrongfully gained by the insurer from the misconduct; and (vi) should take into account any other penalties or sanctions that have been or likely will be imposed on the insurer due to its misconduct.” (para. 20)

At para. 21 of his decision, he then noted:

“While this analysis appears to focus particularly on the “bad faith” aspect of a special award, there are other important considerations that enter into the crafting of a special award. It should be remembered that the legislature has specifically mandated a wider and less focused mandate for special awards than bad faith alone. In fact, the conduct of the insurer may be a lesser consideration than the effect on the insured of the withdrawal of benefits provided only that the pre-condition that “an insurer has unreasonably withheld or delayed payments” has been met.”
Arbitrator Wilson then noted that Gore Mutual and its employees “inexplicably ignored consistent, credible evidence that would support Mr. Thangarasa’s ongoing disability in favour of lesser evidence that would support termination of benefits” and raised the doctrine of willful blindness, which he was described as follows:

“…willful blindness arises where a person who has become aware of the need for some inquiry declines to make the inquiry because he does not wish to know the truth. He would prefer to remain ignorant….” (para. 38)

Arbitrator Wilson addressed the insurer’s argument that it reasonably relied on a DAC report as follows:

“…there is some logic to assuming that an insurer should not be found to be acting unreasonably if what it is doing is in accordance with the conclusions of the DAC assessors and their report. A DAC report, however official, is just that – a report. Its conclusions are not interim orders shielding parties from all and any claims of interest, nor, indeed, claims for special awards.” (para. 46)

As a result of finding that there was unreasonableness and willful blindness on the part of Gore Mutual, Arbitrator Wilson granted a special award of $39,295 in relation to a finding of entitlement of weekly income replacement benefits of $64,177 (which were found to have been owing from February 5, 2001 to April 1, 2005).

Lastly, in *Insurance Corp. of British Columbia v. Hosseini* [2006] B.C.J. No. 6, the BC Court of Appeal allowed the appeal of an individual who caused an accident while uninsured. While two of the justices based their decision on the failure of ICBC to meet the requirements under the *Insurance (Motor Vehicle) Act* to bring an action against an insured in breach, the third judge, Mr. Justice Thackray, held that the Insurance Corporation of British Columbia (ICBC) was estopped from claiming indemnity from Mr. Hosseini for the amount it had paid the victim of the accident because it had breached its duty of good faith toward Mr. Hosseini by failing to notify him about the details of ICBC’s settlement with the victim and by then denying him a driver’s licence for the following 6 years pending “repayment” of the amount of the settlement.

**Conclusion**

The final word on the standard of insurer conduct in disability insurance cases remains to be determined by the Supreme Court of Canada. In the meantime, however, our Court of Appeal has recognized the imbalance of power between insurers and insureds, the vulnerability the insureds, and the need for insurers to proceed openly and cautiously in order to ensure that insureds are treated fairly and reasonably throughout the adjudication process.