



Denial of Disability Benefits

By

[Craig A.B. Ferris](#)

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This is a general overview of the subject matter and should not be relied upon as legal advice or opinion. For specific legal advice on the information provided and related topics, please contact the author or any member of the Pension and Employee Benefits Law Group.

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I. INTRODUCTION

Most lawyers are familiar with claims for coverage under disability insurance. However, most lawyers are not aware of the legal distinctions between a claim for disability benefits under a benefit trust and a claim for disability payments under a policy of insurance, distinctions that have been recognized by the courts in a number of cases.¹ These distinctions can be a mine-field for lawyers, trustees and plan administrators.

The purpose of this paper is to highlight the distinction between benefits provided under benefit trusts and claims made under disability insurance policies. While the substance of the claim is generally the same, the different legal nature of the benefits payable under a benefit trust will likely result in the claim being adjudicated and litigated in a different manner.

This paper will address four major legal issues. First, I will review the burden of proof required to prove disability. Second, I will review the case law relating to bad faith claims made where there is a denial of benefits. The paper will attempt to draw a clear line so that trustees and administrators can properly adjudicate claims without fear of exposure to additional liability based on their conduct. Third, I will look at the proper forum for the dispute. In certain circumstances where a disability benefit is mandated by a collective agreement, a dispute over the denial of disability benefits can be the subject of grievance arbitration as opposed to a legal proceeding in the courts. This paper will attempt to explain why. Finally, I will look at recent case law relating to aggravated and punitive damage awards.

II. THE CLAIM – PROOF OR LACK OF PROOF OF DISABILITY

In general, the onus is on the claimant to establish that he or she is disabled within the meaning of the plan or policy. This means that, in order to qualify for disability benefits, the claimant must provide proof that he or she is incapable of carrying out substantially “their own occupation” or “any occupation” depending on the wording of the benefit plan or policy of insurance in question.

Often the claim will be based on “self reporting”. This means that the claim will be based on the claimants own “subjective” evidence (e.g., “it hurts when I stand”) as opposed to objective medical

¹ *BC Life & Casualty v. Meek*, C981680 (BCSC) April 29, 1999; affirmed 2000 BCCA 215; *IWA-Forest Industry LTD Plan (Trustees of) v. Audia*, [1995] BCJ No. 437

evidence (e.g., a doctor's opinion that the claimant suffers from a specific condition). The legal question is whether the subjective evidence of the claimant is enough to prove disability? Most often it will not be.

A court is required to "objectively" determine whether there is substantial proof that the claimant, judged on a standard of reasonableness, is unable to physically performed the activities required to continue in his occupation or any occupation, as the case may be.²

In practical terms, this type of issue arises when a claimant provides self-reporting evidence of his or her disability. This is often coupled with a report or the clinical notes of a general practitioner who repeats the claimant's self-reporting complaints. The general practitioner will then use the self-reporting complaints as a means to justify that the claimant is "disabled". This issue becomes more complicated when there is no determined objective cause for the complaints (e.g., fibromyalgia).

The courts have generally held that subjective complaints are not sufficient to satisfy the onus on the claimant to prove disability. The court will engage in an objective test to determine whether a reasonable person, after reviewing the complaints along with all the other evidence, would find that the claimant to be totally disabled within the meaning of the benefit plan.

This is not a universal rule. The door has been opened to the court accepting the subjective complaints of the claimant as evidence of disability. In *Mathers v. Sun Life Assurance Co.* (1999) C.C.L.I. (3d) 151, the court held that, while the traditional test for proving disability is an objective one requiring proof of a total disability sufficient to satisfy the reasonable person (i.e. requiring objective medical evidence), there nonetheless may be situations where a judge could find that such a claim to be proven based on the claimant's own evidence alone. Some case law has followed this more subjective approach to proving disability.

In other words, the normal standard for proof of disability claims requires some objective medical evidence; the claimant's own complaints are not sufficient to prove disability. Further, a general practitioner's report simply reciting the claimant's subjective complaints is not to be given any

² *Paul Revere Life Insurance Co. v. Sucharov*, [1983] 2 S.C.R. 541.

greater weight.³ However, subjective elements can be used to prove disability in some circumstances. This means that trustees and other cannot entirely reject the self-reporting complaints of a claimant when they are adjudicating disability claims.

From a practical perspective this means that those who adjudicate disability claims will face a more challenging task. It also means that there will likely be more appeals and challenges of adjudicators' determinations.

Benefit Trusts v. Disability Insurance

As noted above, the courts have distinguished between benefit trusts and disability insurance in claims where benefits have been denied. In *Nicholas v. Metropolitan Life Insurance Co. of Canada*, the court distinguished a disability insurance claim from the claim in that proceeding:

I have concluded that no action lies for breach of contract. I have not been provided with any authority which supports this argument. Ms. Nicholas did not have a contract with Met-Life or with the Trust. Her claim lies in her alternative position and that is a review of the decision of the Trustees (as delegated to Met-Life pursuant to the agreement), to disallow her long term disability benefits.

The scope of review is found in *Boe & Millar v. Alexander* (1987), 15 B.C.L.R. (2d) paragraph 106 C.A., where the Court of Appeal upheld a decision Mr. Justice Finch (as he then was): see [1985], 21 E.T.R., 249 (B.C.S.C.) In simple terms, a trustee must act reasonably. The court has jurisdiction to interfere with the decision of the trustee if the discretion was exercised improperly or unreasonably or not at all: see *Ashford v. Plumbing and Pipefitting Workers, Local 170, Pension Plan, (Trustees of)*, [1991] B.C.J. No. 2319 at p. 7.⁴

In this case, the claimant was diagnosed by a psychiatrist as “delusional” and approved for long-term disability benefits. She commenced a gradual return-to-work program and went back to work full-time. She left work again and was diagnosed with depression and chronic fatigue syndrome. The trustees' adjudicator denied the second long disability claim. The claimant appealed the trustee's decision to deny the benefits and that appeal was rejected. There were various medical reports filed

³ *Shewchuk v. London Life Insurance Company* (1996), 38 C.C.L.I. (2d) at p. 282.

⁴ *Nicholas v. Metropolitan Life Insurance Co. of Canada*, 2003 BCSC 506 at para. 6 and 7. [*Nicholas*]

and the trustees did not obtain an independent medical examination prior to dismissing the Appeal. The court found:

The standard of judicial review of the decision of Ms. Dubois [the adjudicator appointed by the trustees] is whether it was reasonable. I have reviewed all of the medical reports available to Ms. Dubois. After considering these reports and her evidence for the basis of rejecting the long-term disability benefit, I can come to no other conclusion that her decision was unreasonable.⁵

Another benefit trust case is *Recchia v. Co-Operators Life Insurance Co.*⁶ In this case the claimant was denied disability benefits. He failed to meet the limitation period file a legal challenge to the trustee's decision. He claimed directly against the trustees for negligent misrepresentation or, alternatively, for breach of fiduciary duty in failing to advise him of the limitation period. The plaintiff's argument was that the trustees had a fiduciary duty to act in his best interests and failed to do so by not providing information regarding limitation period. This claim was rejected:

While he did not say so expressly, it is clear from a reading of his reasons as a whole, in my view, that he had it in mind that the relevant limitation was contained in a public statute and, as well, that he had it in mind his findings that the appellant had consulted a lawyer before the limitation period expired and was relying on her family physician, who had also spoken to her about obtaining legal advice. Thus, unlike the situation that existed in *Froese*, the appellant could readily have learned of the limitation period had she set out to do so and she was not at the mercy of the respondents for that knowledge.⁷

As a result, while the claim was denied, the court did not reject the proposition that a fiduciary duty could arise between the trustees and a claimant in these circumstances. Rather, they dismissed the claim on the facts of the case. This means that this type of claim is potentially available against trustees when they deny disability benefits.

A claim for disability benefits under a benefit trust, therefore, should be framed differently than a claim for benefits payable under a policy of insurance. Rather than claiming for breach of contract, a claim under a benefit trust should challenge the trustees' exercise of their discretion on the basis

⁵ *Nicholas* at para. 31.

⁶ *Recchia v. Co-Operators Life Insurance Co.*, 2003 BCCA 643 [*Recchia*].

⁷ *Recchia* at para. 13.

that the denial of disability benefits was unreasonable. This standard of reasonableness does not appear to have been applied to provide trustees with greater protection from the courts in their decisions to deny benefits; rather, it has opened up other types of claims, such as breach of fiduciary duty, against trustees in these circumstances.

III. THE PROPER FORUM FOR THE DISPUTE: THE COURTS OR GRIEVANCE ARBITRATION

This topic only applies to disability plans or insurance contracts that are the subject of a collective agreement.

Where the right to claim benefits under either a policy of insurance or a benefit trust arises from a collective agreement, a close reading of the terms of the collective agreement and the provisions of the *Labour Relations Code* is required. In general, if the language of the collective agreement suggests that the employer must pay for the benefits, there is a strong possibility that the claim will have to proceed through grievance arbitration. In that event, the eventual arbitration decision could only be challenged in the courts through a judicial review application. This type of review is limited, based on the privative clauses contained in the *Labour Relations Code*.

On the other hand, if the language of the collective agreement suggests that an employer bears no responsibility to pay the insurance benefits and it merely sets out the payment of premiums, or if no specific plan is referenced in the collective agreement at all, it is more likely that the claim can proceed in the courts.

A recent decision in British Columbia illustrates these principles. In *Paller v. Great-West Life Assurance Company and the Trustees of the Healthcare Benefit Trust*,⁸ two plaintiffs claimed long-term disability benefits. They argued that their benefits were wrongly terminated by the trustees and brought an action against the trustees and the adjudicator for reinstatement of benefits and related remedies. The Statement of Claim raised allegations of breach of fiduciary duty, breach of contract, negligence, and bad faith. The trustees brought an application to dismiss the claims on the basis that

⁸ *Paller v. Great-West Life Assurance Company and the Trustees of the Healthcare Benefit Trust*, 2003 B.C.S.C. 582 [*Paller*]

the court had no jurisdiction over the claim for long-term disability benefits. The application was granted.⁹ The court said:

Whether a disability insurance plan forms part of a collective agreement, such that disputes as to LTD Benefits are determined by the dispute resolution process under the agreement, is ultimately a question of the intention of the parties. Those intentions are discerned by examining the particular collective agreement, the benefit plan, and the applicable labour relations legislation.

The fundamental issue in jurisdictional challenges is the determination of the parties' intent with respect to their obligation and remedies, as derived from the language of the particular collective agreement and labour legislation. The courts will discern this intent from the based on the following principles:

- (b) The process for dispute resolution established by legislation and collective agreement;
- (c) The nature of the dispute and its relations to write an obligations created by the overall scheme of legislation and the collective agreement; and
- (d) The capacity of the scheme to effectively redress the issues.

In *Paller*, the court found that the Plaintiffs' claim was governed by the collective agreement. In doing so, the court considered the collective agreement and the benefit trust. The court found that the benefit trust was incorporated into the collective agreement, and the collective agreement provided a specific means for dealing with disputes over claims for LTD Benefits. The court concluded that the inter-relationship between the bargaining agent and the trustees did not support a finding that the trustees were strangers to the collective agreement. The Plan was found to be a vehicle created, controlled, and funded by the bargaining agent and its members for administrative convenience to carry out their obligations with respect to LTD benefits under the collective agreement.

A similar decision was made in *Ali v. Manufacturers Life Insurance Co.*¹⁰ The court affirmed the decision of the trial judge that an action should be dismissed for lack of jurisdiction as the dispute was within the exclusive jurisdiction of the Labour Relations Board. The facts were unusual. The

⁹ *Paller* at para. 8

¹⁰ *Ali v. Manufacturers Life Insurance Co.*, 2005 B.C.C.A. 294 [*Ali*].

claimant had brought a grievance arbitration and had been awarded a benefit. However, Manulife, the adjudicator under a group policy, argued that it was not bound by the award under the collective agreement and refused to reinstate disability benefits. The claimant then sued Manulife. Manulife applied to dismiss the claim on the basis that it was subject to arbitration, even though Manulife was not a party to the arbitration agreement. Manulife was successful.

The court decided as follows:

The Appellant contends that she has a claim for LTD Benefits under the Manulife policy and ancillary damages against the Respondents independently of the arbitration process under the collective agreement. In my view, that fails to recognize that the terms of the collective agreement and the addendum impose the responsibility for payment of benefits under the Plan on the employer. The Appellant grieved her claim to benefits under the collective agreement against her employer. That grievance and the employer's agreement to summary arbitration by the CRC accords with an intention to incorporate the Plan into the collective agreement and to resolve disputes as to benefit entitlement through grievance and arbitration procedures under the collective agreement, in accordance with s. 12 of the addendum. The Appellant proved her disability before the CRC.

The result is that the process of the collective agreement precludes any claim by the appellant against the insurer, as held in similar circumstances by Sinclair Prowse J. in *Graham v. Great-West Life Assurance Co...* The court presumably would have jurisdiction over any claim by St. Jude's to indemnity from Manulife under the policy but no such claim for indemnity is advanced in this litigation.¹¹

This means that even the fact that the insurer refuses to pay a claim which had been effectively grieved and found to be valid did not give rise to a claim in the courts on behalf of the disabled employee against the insurance company. The court determined that the claimant should have been paid directly by the employer after the successful grievance arbitration decision. It was up to the employer to then claim indemnity against Manulife under the group insurance policy. This claim could be brought in the courts and was not subject to grievance arbitration.

¹¹*Ali* at para. 10.

The fact that the insurer or adjudicator in a disability of trust is not a proper party to the grievance arbitration has also been reinforced by the decision in *Hospital Employees Union v. Children and Women's Health Centre*.¹²

What does this mean for trustees and adjudicators of LTD claims? First, it means that the issue of jurisdiction must be considered if your plan or insurance policy arises from a collective agreement. Based on the principles set out above, it may be that the claim is more properly framed as a grievance arbitration, as opposed to a court proceeding. There are disadvantages and advantages to each process. The arbitration will be quicker and less expensive, but it will also be less thorough than a court proceeding. In grievance arbitration, there will be little, if any, discovery, and the ability to cross-examine witnesses will be limited. Grievance arbitration trades completeness for expediency. In any case, this is not a choice that a trustee or adjudicator is permitted to make. If a dispute was intended to be decided by grievance arbitration, the courts will not hear it and defer to that process.

IV. GOOD FAITH, BAD FAITH: WHERE IS THE LINE?

Claims for bad faith continue to multiply. Indeed, it seems that any claim based on a denial of disability benefits is invariably brought with an additional allegation that the denial was made in bad faith. While the overwhelming majority of bad faith claims fail, they do add cost, time, and increase the risk profile for defendants.

Successful bad faith claims result in damages payable over and above the amount of disability benefits payable. Accordingly, they become an additional expense over and above the cost of disability benefits. The amount of these awards, as discussed below, can be significant. Accordingly, it is important for trustees and adjudicators to conduct themselves so as not to attract these types of awards.

In disability insurance contracts, the insurer is always held to a standard of good faith. This means that the conduct of an insurer will be looked at to determine whether the insurer acted fairly and

¹² *Hospital Employees Union v. Children and Women's Health Centre*, 2000 B.C.A.A. 170.

promptly in adjudicating a claim. In the benefit trust context, the scope of a bad faith claim is easier to define. A trustee owes a fiduciary duty to the Plan and its members. Any conduct that would seem to be unfair and unresponsive in dealing with a legitimate disability claim could be considered a breach of that fiduciary duty or, at the very least, a breach of a duty of good faith. One author described the insurer's duty as follows:

[T]here are common elements to the duty of good faith found in all of these types of policies. The central theme of which is that the insurer must not use its superior power and the insured's vulnerability to coerce an unfair, unjust settlement.¹³

The allegations made in one recent case are illustrative of the types of allegations which a claim for bad faith:

As an adjunct to the claim under the Policy the Plaintiff also asserts a bad faith claim against Crown. The Plaintiff supports this claim with allegations that Crown, through its employees who handled the claim, demonstrated "gross indifference in failing to adequately investigate and evaluate the claim," by failing to observe their own procedures and protocols with regard to proper handling of claims, by failing to follow up with the various doctors whose names were provided by the Plaintiff in his proof of loss material, by turning a deaf ear to Canadian Pacific's intervention on behalf of its former employee, by rejecting an "offer of cooperation" made by the Plaintiff and generally, by failing to demonstrate the utmost good faith which the law requires of both an insured and an insurer in their dealings with one another under a contract of insurance.¹⁴

While the types of allegations that will fall within an allegation of bad faith can all be categorized as "unfair" conduct, the exact the nature of allegations vary. The most common allegations include dismissing medical reports which are favourable to the insured, misleading the insured, terminating or denying benefits without advising the insured, misrepresenting the terms of the Plan, and not adequately reviewing the medical information submitted.

All of this does not mean that an adjudicator is not allowed to investigate the claim properly and to issue a proper denial. Provided an adjudicator acts in a timely manner, in accordance with normal policies and procedures, reviews all of the data and makes a knowledgeable assessment of it, and

¹³ Spurgeon, A. "Post – *Whiten vs. Pilot*", *Bad Faith Seminar*, Trial Lawyers Association of British Columbia, Seminar, June 7, 2002 at p.21

¹⁴ *Foster v. Crown Life Insurance Co.*, 2003 ABQB. 548 at para. 41 [*Foster*]

properly communicates with the claimant, there is no reason that a denial of disability benefits need give rise to an additional claim based on bad faith.

In *Foster vs. Crown Life Insurance*, the allegation of bad faith was rejected by the court:¹⁵

In the *Non-Marine Underwriters of Lloyd's* case referred to in paragraph 43 above, the discussion of bad faith includes the observation that the court must look at the conduct of the insurer “in light of the circumstances as they then existed” to assist in determining whether bad faith has been shown in any particular case. The circumstances of this case were that the claim was received some 21 years after the event and there was no medical opinion submitted with it to justify or explain the delay. In my view, while the Plaintiff properly questions why there was no follow up with the doctors mentioned in the proof of loss material it is at least as proper, and probably more so, to question why, in light of the elapsed time, and in light of the evidence which showed that the Plaintiff had worked at a number of jobs subsequent to his termination at Canadian Pacific, there was no clear and unambiguous medical opinion to deal with the substantial delay and to explain why the filing was being made “as soon as was reasonably possible”.

Other examples of bad faith type claims give indications of the conduct expected from adjudicators. In *Asselstine v. Manufacturers Life Insurance Company*,¹⁶ the claimant was suffering from multiple sclerosis and was denied benefits. A bad faith claim was successful. The insurer failed to follow the proper definition of disability in the policy, incorrectly rejected medical evidence and made numerous other errors in the adjudication process. In *Clarfield v. Crown Life Insurance Company*,¹⁷ the court found that the insurer had a policy of refusing certain types of claims. This policy justified an award of bad faith damages.

From these cases, it becomes clear the type of conduct which is required to protect yourself from bad faith claims:

- First, if a plan has a standard policy for the adjudication of claims, then adjudicators should follow it. Any deviation from the policy or standard procedures can be seen as evidence of bad faith.

¹⁵ Supra, at para. 45

¹⁶ [2003] B.C.J. No. 1692

¹⁷ [2000]O.J. No. 960

- Second, if you are relying on medical opinion evidence in your denial, the medical evidence should be disclosed to the claimant along with an explanation as to why any particular medical evidence has been preferred over medical evidence submitted by the claimant. A failure to disclose or to explain why a claim is being denied, can be seen as evidence as to bad faith.
- Finally, any policy which creates a predisposition to denying a claim based on circumstances of other cases can be seen as evidence of bias and will raise the risk of a successful claim of bad faith.

Once litigation has commenced it is important to remember that both the adjudicator's file and all clinical and medical records will be disclosed. Any written comments made which suggest that the adjudicator has a bias against, poor opinion of or a suspicion that the claimant is a malinger, other than on a sound basis, can be seen as evidence of bad faith. All written and verbal communication should be made with the expectation that it may be reviewed by the claimant or his or her lawyer at a later time.

While the nature of allegations of bad faith continue to grow and the number of claims continue to rise, if adjudicators act appropriately and follow specified procedures, the risk of a bad faith claim can be substantially diminished.

V. AGGRAVATED AND PUNITIVE DAMAGE AWARDS

Aggravated and punitive damages are a fixture in any claim for long-term disability benefits. The two types of damages are distinct and can be awarded either independently or in addition to one another.

Over the past few years, the law in this area has been substantially clarified by three decisions, the most important of which is *Fidler v. Sun Life Assurance Co. of Canada*.¹⁸ Also of interest are the

¹⁸ *Fidler v. Sun Life Assurance Co. of Canada*, 2006 SCC 30 [Fidler].

decisions in *Asselstine v. Manufacturer's Life Insurance Co.*¹⁹ and *Gerber v. Telus Corporation and the Trustees of the Telus Corporation Disability Income Plan*.²⁰

Aggravated Damages

Aggravated damages are awarded because of the effect of the conduct of the party denying the benefits on the insured or claimant. No “independent wrong” is necessary in order for an award of aggravated damages. The award is made for loss of “peace of mind” and provides compensation for disappointment, distress, upset and frustration. In *Fidler*, the Supreme Court of Canada concluded:

We conclude that damages for mental distress for breach of contract may, in appropriate cases, be awarded as an application of the principle in *Hadley v. Baxendale*: see *Vornis*. The court should ask “what did the contract promise?” and provide compensation for those promises. The aim of compensatory damages is to restore the wronged party to the position he or she would have been in had the contract not been broken. As the Privy Council stated in *Wertheim v. Chicoutimi Pulp Co.*, [1911] A.C. 301, at p. 307: “the party complaining should, so far as it can be done by money, be placed in the same position as he would have been in if the contract had been performed”. The measure of these damages is, of course, subject to remoteness principles. There is no reason why this should not include damages for mental distress, where such damages were in the reasonable contemplation of the parties at the time the contract was made. This conclusion follows from the basic principle of compensatory contractual damages: that the parties are to be restored to the position they contracted for, whether tangible or intangible. The law’s task is simply to provide the benefits contracted for, whatever their nature, if they were in the reasonable contemplation of the parties.

It does not follow, however, that all mental distress associated with a breach of contract is compensable. In normal commercial contracts, the likelihood of a breach of contract causing mental distress is not ordinarily within the reasonable contemplation of the parties. It is not unusual that a breach of contract will leave the wronged party feeling frustrated or angry. The law does not award damages for such incidental frustration. The matter is otherwise, however, when the parties enter into a contract, an object of which is to secure a particular psychological benefit. In such a case, damages arising from such mental distress should in principle be recoverable where they are established on the evidence and shown to have been within the reasonable contemplation of the parties at the time the contract was made. The

¹⁹ *Asselstine v. Manufacturer's Life Insurance Co.*, 2005 BCCA 292 [*Asselstine*].

²⁰ *Gerber v. Telus Corporation and the Trustees of the Telus Corporation Disability Income Plan*, 2004 ABCA 118 [*Gerber*].

basic principles of contract damages do not cease to operate merely because what is promised is an intangible, like mental security.²¹

In the context of insurance contracts, this means that aggravated damages will be available for mental distress. The evidence to support claims for aggravated damages is generally available in the form of advertising, plan booklets and descriptions which allow a court to conclude that claimants are being promised peace of mind should they suffer a medical disability.

A similar approach to that of *Fidler* was taken by the BC Court of Appeal in *Asselstine*.

The decision in *Fidler* is limited to damages for breach of contract. A claim for benefits under a benefit trust is not a claim for breach of contract. The *Gerber* case is instructive because it deals with a benefit plan. The court awarded aggravated damages even though the benefit plan was not a contract. Rather, the court found that it was part of the contract of employment and as such could provide the basis for an aggravated damage award. The court wrote:

[W]hile it is a benefit of the employment contract, its proper characterization is as a contract of insurance. This being so, we are of the view that it is, in nature and substance, a “peace of mind” contract.²²

This decision must be contrasted with *Nicholas v. Metropolitan Life Insurance Company*. In that case, the trial judge wrote, “I have not been provided any authority for awarding aggravated damages arising from a claim for long-term disability from a trust.”²³

Accordingly, there appear to be conflicting decisions concerning whether aggravated damages are available against trustees of benefit trusts. However, given the direction of the law as pointed out in *Fidler*, it appears likely that aggravated damage principles could be applied to a breach of duty of good faith or breach of fiduciary duty claim against trustees, if they acted in a bad faith in their adjudication of a disability claim. Accordingly, aggravated damages may be available against both insurance contracts and against benefit trusts.

²¹ *Fidler* at paras. 44-45

²² *Gerber* at para. 4.

²³ *Nicholas* at para. 52.

Punitive Damages

Punitive damages are not intended to compensate a loss, but are awarded for the purposes of punishing wrongful conduct. In *Fidler*, the Supreme Court of Canada described punitive damages as follows:

While compensatory damages are awarded primarily for the purpose of compensating a plaintiff for pecuniary and non-pecuniary losses suffered as a result of a defendant's conduct, punitive damages are designed to address the process of retribution, deterrence and denunciation: *Whiten v. Pilot Insurance Co.*, [2002 SCC 18].

By their nature, contract breaches will sometimes give rise to censure. But to attract punitive damages, the impugned conduct must depart markedly from ordinary standards of decency – the exceptional case that can be described as malicious, oppressive or high-handed and that offends the court's sense of decency: *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130 (S.C.C.) at para. 196; *Whiten*, at para. 36. The misconduct must be of a nature as to take beyond the usual opprobrium that surrounds breaking a contract. As stated in *Whiten*, at para. 36, “punitive damages straddle the frontier between civil law (compensation) and criminal law (punishment)”. Criminal law and quasi-criminal regulatory schemes are recognized as the primary vehicles for punishment. It is important that punitive damages be resorted to only in exceptional cases, and with restraint.²⁴

In *Fidler*, the Court agreed that an insurer that denies benefits should do so based on a reasonable interpretation of the policy and that the insurer was under a duty of fairness in making that determination. The duty of fairness does not require the insurer or adjudicator to be correct, but merely to have acted *fairly* in the process. The simple fact that a claim that was denied by an insurer eventually succeeds in a court is not evidence of itself as bad faith.²⁵

In *Fidler*, the trial judges had determined that no punitive damages should be awarded. The British Columbia Court of Appeal overturned this decision and awarded punitive damages. The Supreme Court of Canada reinstated the trial judges finding that there was no conduct justifying punitive damages. The trial judge found that the insurer's denial of benefits was the product of a real, albeit incorrect doubt as to whether Mr. Fidler was incapable of performing any work as was required under the policy. The Supreme Court of Canada stated that “the question is whether the denial was

²⁴ *Fidler*, supra, at para. 61-62

²⁵ *Whiten v. Pilot Insurance Co.*, 2002 SCC 18 at para. 29.

a result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claim's process.”²⁶

In *Asselstine*, the British Columbia Court of Appeal upheld the trial judge's award of punitive damages in the amount of \$150,000.00. The trial judge wrote:

[T]he defendants, and insurance companies generally, cannot expect to be able to disregard compelling medical and other information while placing undue emphasis on evidence aligned only with their interests; and rely on a report based on flawed premises generated and selectively disclosed by them, meanwhile steadfastly maintaining an unsupportable position and be seen as balancing fairly the interests of both the insured and the insurer. I award punitive damages here as a reminder that it is not in the economic interest of the insurer to engage in similar conduct in future similar situations.²⁷

At the end of the day, punitive damages will only be awarded in rare and exceptional cases. Trustees, adjudicators and administrators need to ensure that their suspicions do not cause them to mislead the claimant, to selectively disclose evidence in their possession, or to fail to objectively consider evidence presented to them in the course of a claim. If those making a decision on benefits follow a proper process, a court is unlikely to award punitive damages.

In recent years, the amount of punitive damages awards has risen and is now significant. As noted above, in *Asselstine*, the award was \$150,000.00. In *Clarfield v. Crown Life Insurance Company*, the award was \$200,000.00.²⁸

Other examples of punitive and aggravated damage awards are as follows:

The Leblanc v. London Life Insurance Co., [1999] O.J. No. 3199 - \$10,000.00

Deborah Eddie v. UNUM Life Insurance Co. of Canada, 1999 BCAA 507 - \$15,000.00

Cross v. Canada Life Insurance Co., 2002 16 C.C.E.L. (3d) 310 - \$18,000.00

Fowler v. Maritime Life Insurance Co., [2002] N.J. No. 217 - \$75,000.00

Gerber v. Telus Corp., 2003 ABQB 453 - \$20,000.00

²⁶ *Fidler* at para. 71

²⁷ *Asselstine v. Manufacturers Life Insurance Co.*, 2003 BCSC 1119 at para. 213; aff'd 2005 BCCA 292

²⁸ *Clarfield v. Crown Life Insurance Company* (2000), 50 O.R. (3d) 696 (Sup. Ct.).

Aggravated and punitive damages serve as a reminder to all involved in adjudicating claims to act thoughtfully and reasonably in making their decisions. As the Supreme Court of Canada has said, it is not required that adjudicators get every claim right, it is only required that he or she act fairly and reasonably in each instance.

VI. CONCLUSION

Challenges to denials of disability benefits are on the rise. One need only check the yellow pages, the newspapers, and other forms of advertising to find counsel who are more than willing to take disability claims on a contingency fee basis. Lawyers often advertise and give free seminars to individuals who believe they have wrongly been denied disability benefits. This is a big industry and it is getting bigger.

In light of this, there is a large economic incentive for plaintiff's counsel to bring claims for bad faith, seeking punitive and aggravated damages. The effect of such a claim may increase their client's recovery and their fees. This means that the process for adjudication of claims must be completed more carefully than ever.

With adequate planning, training and administration, there is no reason why claims for aggravated and punitive damages should be awarded. The law allows adjudicators to adequately weed out ineligible claims without the threat of heightened liability.

Vancouver

1600 Cathedral Place
925 West Georgia Street
Vancouver, British Columbia
Canada V6C 3L2
Telephone 604.685.3456
Facsimile 604.669.1620

Calgary

3700, 205-5th Avenue SW
Bow Valley Square 2
Calgary, Alberta
Canada T2P 2V7
Telephone 403.269.6900
Facsimile 403.269.9494

Yellowknife

P.O. Box 818
200, 4915 – 48 Street
YK Centre East
Yellowknife, Northwest Territories
Canada X1A 2N6
Telephone 867.669.5500
Toll Free 1.888.465.7608
Facsimile 867.920.2206

genmail@lawsonlundell.com
www.lawsonlundell.com

