Case summary of Varriano v. Allstate Insurance Company of Canada

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In *Varriano v. Allstate Insurance Company of Canada*, the Ontario Court of Appeal (ONCA) commented on whether an insurer has to provide a medical reason when denying benefits pursuant to s. 37(4) of the *Statutory Accident Benefits Schedule* (SABS).

Background

Mr. Varriano was injured in a motor vehicle accident on September 30, 2015, and received Income Replacement Benefits (IRBs) from his insurer, Allstate, for approximately two months, until they notified him that his IRBs would stop, effective December 2, 2015, because he had returned to full-time work.

Mr. Varriano filed an application before the Licence Appeal Tribunal (LAT) disputing the decision to terminate his benefits. Allstate took the position that Mr. Varriano's application was time-barred, given that it had been filed more than two years after the December 30, 2015 Benefits Letter. The LAT agreed with Allstate on an initial hearing and on a reconsideration hearing.

The Divisional Court overturned the decision of the LAT, finding that Mr. Varriano's application was not time-barred because Allstate's Benefits Letter did not meet the legislative requirements under s. 37(4) of the Statutory Accident Benefits Schedule – *Effective September 1, 2010, O. Reg. 34/10* (the SABS). It found that s. 37(4) required Allstate to provide medical reasons in the Benefits Letter for the stoppage of benefits, because a plain reading of s. 37(4) supported the interpretation of the word "and" in the phrase "medical and any other reasons" bore a conjunctive meaning.

Allstate appealed this decision and the Court of Appeal who allowed Allstate's appeal. It found that the Divisional Court's interpretation was incorrect, and that Allstate's Benefit Letter complied with the legislative requirements.

The decision: Insurers do not always have to provide a medical reason when denying benefits under the SABS

Section 37(2) of the SABS allows insurers to discontinue an insured's benefits for specified reasons, including the fact that the insured person has returned to their pre-accident employment. In exercising that power, pursuant to s. 37(4), the insurer is required to provide notice to the insured containing the reasons for their decision.

The Court of Appeal noted two key errors in the Divisional Court's interpretation of s. 37(4). First, the Divisional Court improperly applied the modern principle of statutory interpretation and in so doing failed to acknowledge that the grammatical and ordinary usage of the word "and" can include both the joint sense and the several sense. In this case, it was clear that the ordinary meaning of the word "and" was intended in its several sense. The Court of Appeal read s. 37(2) in conjunction with 37(4), which states that the insurer may rely on "any one or more grounds set out in [s. 37(2)]. Therefore, by explicitly including those words, s. 37(4) recognizes that an insurer may rely on a single non-medical reason for termination of benefits, even though the insured may be otherwise medically entitled to the benefit.

Second, it wrongly concluded that s. 37(4) was an insurance coverage provision that had to be interpreted broadly. The Court of Appeal noted that the provision in question is not a coverage provision, as it does not determine whether a person is entitled to coverage under the SABS. The correct interpretation had to accord with the purposes of the SABS, *i.e.*, the "timely submission and resolution of claims and the purpose of the provision itself, which is to permit the insured to decide whether or not to challenge the denial of benefits."

Key takeaways

The decision helps provide clarity on the requirements for insurers under section 37(2) and 37(4) of the SABS and unequivocally rejects the lower court's proposition that insurers must provide a medical reason when denying benefits. When faced with such a question, the answer is a clear no.

If you have any further questions about similar issues, please reach out to the key contacts below.

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