DANCING WITH THE DEVIL

MANAGING DISABILITY INSURERS DURING THE LIFE OF A PERSONAL INJURY CLAIM

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INTRODUCTION

As personal injury lawyers our primary focus is on advancing our client's claim, with the expectation of achieving a fair result in the end. However, along the way, we often deal with a myriad of ancillary legal issues and difficulties confronting our clients. Although often not part of our retainer agreements, we will navigate such issues as rehabilitation benefits, employment situations such as dismissals, family law matters, WorkSafe issues, and the list goes on. Personal injury litigation is typically a fairly lengthy process and one of the most stressful difficulties confronting our clients is simple economic survival. For those who are unable to maintain employment as a result of injuries, coping with financial realities is often a daunting and stressful challenge. For those fortunate enough to have income replacement benefits of some kind, it can provide a significant source of comfort while they recover from injuries and go through the lengthy litigation process.

Unfortunately, even those who do have some form of income replacement benefits often find themselves in struggles with their income replacement provider. Their "peace of mind" becomes anything but, and they find themselves embroiled in disputes with their disability Insurer at the same time as trying to deal with their injuries and the stress of litigation.

There can be denials and delays in obtaining benefits or, as is often the case, benefits are terminated along the litigation process. When this occurs, our clients often turn to us for assistance.

In addition, almost all disability Insurers will have policy language that entitles the Insurer to be reimbursed from an at fault third party. Counsel often end up pursuing claims for past wage loss on behalf of both the Insurer who is seeking reimbursement, and the client who wasn't fully indemnified by the Insurer.

This paper will discuss managing disability insurance issues from the initial client meeting through to negotiating subrogated interests at settlement or judgment. Although the law relating to disability insurance and various issues arising will be discussed in a general way, the focus of this paper is more on the practical aspects of how to help your client obtain and maintain income replacement benefits and from a personal injury lawyer's perspective, how to negotiate with the Insurer over subrogation and reimbursement entitlement.

CLIENT INTERVIEW

The obvious first question to ask is if the client is aware if he or she has income replacement benefits. Typically if a client does, the most common form of benefit will be disability insurance covered through an employer's benefit plan or through a client purchasing disability insurance directly from a disability Insurer. If the client is fortunate enough to have income replacement benefits, then the following information should be requested from your client at the outset:

- Clarify who will be paying income replacement benefits and what benefits are available to your client;
- Request information from your client including your client's employment contract or employee handbook and a copy of the insurance policy or plan wordings themselves;
- Enquire if your client has applied for benefits and if so, whether any application forms have been filled out or whether any reimbursement agreements have been signed;
- Enquire if your client's general practitioner has been given any insurance forms to be filled out and if so, obtain your client GP contact information and arrange for a phone call particularly if the GP hasn't provided the form to the Insurer;
- If your client is aware, determine who has paid for the income replacement premiums, i.e. the employer, the employee or some combination thereof, or whether your client pays directly (this will have some implication for income tax purposes and net past wage loss claims);

- If applicable, enquire who the employer human resources person is who deals with disability forms or union representative;

- If a claim has been initiated, determine who the contact person is from the disability Insurer and a claim number;

- Advise your client about social media, and that Insurers, including disability Insurers, will sometimes engage private investigators.

REVIEWING APPLICATION FORM, POLICY WORDINGS AND REIMBURSEMENT AGREEMENTS

Application Forms

It is important to keep in mind that a disability Insurer or plan provider will keep a file which will likely be requested in the underlying litigation. It is good practice to assist a client in filling out any insurance related application form (including CPP, EI or Social Assistance) or at least review it before it is sent to the Insurer. It is important to ensure that the client lists all potential injuries because failure to do so at some point may indicate to defence counsel that they weren't complaining of that problem at the time of filling out the application which is usually shortly after the accident. In addition the particular language used on an application form can increase and maximize the chances of successfully obtaining coverage.

Medical Form

Almost invariably, a disability Insurer or plan provider will require a medical form be filled out by your client's physician that includes a provision setting out the expected return to work and the nature of injuries sustained in the accident.

Ideally, arrange a telephone call with your client's physician prior to the physician returning the form to the Insurer. Most physicians want to assist their clients but they may not be aware what is required to meet the definition of "total disability" in a disability

insurance context and are often, in my experience, overly optimistic about timeframes for recovery.

In the end, a little education for the general practitioner can go a long way in helping your client obtain coverage and to minimize any harm that can come in the underlying litigation. Most physicians are co-operative and appreciative but unfortunately it is not universal.

If your client's physician is generally unaware of what your client's job duties are, it is helpful to first educate yourself in terms of your client's job duties and then pass along that information to the physician so that he or she will be able to make a more informed opinion on whether your client is disabled from employment.

In terms of what to discuss with the physician, it is helpful to review the definition of total disability and to discuss whether the disability relates to the client's own occupation or any occupation. In addition, it is advantageous to have the physician emphasize any "objective" symptoms and to explain why simply relating a client's own subjective complaints can be problematic. When it comes to predicting the future, it is best to recommend the physician answer "unknown" if applicable, in terms of returning to work.

Reimbursement Agreements

Almost all income replacement policies or plans will have some provisions relating to reimbursement or subrogation from at fault third parties. Some policies themselves or employment agreements will require Insureds to enter into reimbursement agreements, some of which will stipulate and require an Insured to repay 100% of any income replacement or benefits paid. It is important at this stage to carefully review any such agreements as they may significantly impact your client when it comes to repayment of those benefits down the road. It is necessary to review the terms of the policy before your client signs any agreements to determine whether the reimbursement agreement is

fundamentally different than what is set out in the policy pertaining to subrogation or reimbursement.

To Sign Or Not To Sign

If the reimbursement agreement is significantly different or differs in any way from the Policy, it is arguably a modification to the original agreement. Most Insurers will require an agreement to be signed as a condition to the continuation of payment. Check to see if the policy itself addresses this "condition".

If there is a requirement in the employment contract, the employment agreement or the policy itself for a reimbursement agreement to be signed, your client will ultimately have to sign it. If a reimbursement agreement is required, then in my view it would be appropriate if there is a stipulation to repay 100% of any benefits paid to modify that agreement to include "subject to any deductions for:

(a) legal fees and costs reasonably incurred in pursuing any Insurer's subrogated interest;

(b) any income tax deductions applicable for past wage loss claims pursuant to legislation; and

(c) any reductions due to liability apportionment".

If there is no modification made to the Agreement, the Insurer or plan provider may be entitled to 100% reimbursement.

Review Policy Wordings and Agreements

The language contained in disability policies or plans differ significantly. As a result, it is necessary to review and familiarize yourself with the terms of any Policy or plan. Pay particular attention to any definition of "totally disability"; whether the policy covers own occupation or any occupation and timing of any changes in that regard; and any

reimbursement provision including third party claims and deductions from other sources such as CPP or EI.

Note that some Insurers have fairly onerous co-operation clauses that can be an unfortunate trap for the unwary. For example, there are some clauses that require an Insured to obtain the consent of an Insurer prior to settling any third party claim along with a penalty provision that if consent is not obtained then 100% of the benefits will have to be repaid. In addition, there are some terms that set out that if any steps are taken that prejudice the Insurer's right to reimbursement, all of the benefits owing will have to be repaid. It is therefore essential to review and familiarize yourself with all of the requirements and to discuss these with your client.

Once you know who the claims adjuster is, it is recommended you make a call to determine what updates are required and to ask that you be copied on all correspondence with your client and client's physician.

CPP BENEFITS

If you know or expect that your client's injuries will prevent him or her from working in any capacity for life, your client should be instructed to apply for CPP benefits. Why? CPP benefits are deducted from the amounts paid by the disability Insurer. (They are also deducted if they could have been claimed) CPP benefits are not deductible in the tort claim. At the end of the day, the CPP benefits will reduce the amount that the disability provider will be subrogated to. This will result in a greater percentage of the past wage loss flowing to your client rather than back to the disability Insurer.

Disability Insurance – An Overview[1]

Most policies provide coverage to Insureds who are deemed "totally disabled". This term is often defined but is sometimes not. Generally it means an Insured person is reasonably unable to work at either the person's own occupation or ultimately any occupation. The Supreme Court of Canada in *Paul Revere Life Insurance v. Sucharov* [1983] 2 S.C.R. 541 gave approval of the following definition from *Couch on Insurance* (1983) 2d (Rev. ed):

> The test of total disability is satisfied when the circumstances are such that a reasonable man would recognize that he should not engage in certain activity even though he literally is not physically unable to do so. In other words, total disability does not mean absolute physical inability to transact any kind of business pertaining to one's occupation, but rather that there is a total disability if the Insured's injuries are such that common care and prudence require him to desist from his business or occupation in order to effectuate a cure; hence, if the condition of the Insured is such that in order to effect a cure or prolongation of life, common care and prudence will require that he cease all work, he is totally disabled within the meaning of health or accident insurance policies.

What matters is that the Insured person is unable to perform substantially all of the duties of his or her occupation.

The Difference Between Short Term Benefits and Long Term Benefits

There are two main categories of disability typically within any policy. Short terms plans generally provide between 50% to 100% of a person's income up to a period of less than one year. The insurance company will usually require a medical report regarding disability (physical or mental), and an expected date of return before it will agree to pay benefits. The insurance company may require your client to see a medical examiner of its choice and the law supports the Insurer's right to an IME. It should be noted that

[1] *For a good, precise overview of legal principles, see the recent decision of Tanious v. The Empire Life Insurance Company 2016 BCSC 110*

short term disability benefits will usually start after a qualifying period of a few days but may start earlier.

With respect to long term disability, most insurance policies will include the words “total disability” to qualify for long term disability. Although each policy is often different, two categories of disability are usually contained within a long term disability policy, including:

- Any occupation - this means that a person is determined to be totally disabled if a medically determinable physical or mental impairment due to injury or illness prevents them from doing the regular duties of any occupation for which they are suited or may reasonably become suited to perform based on education, training and experience
- Own occupation – an employee is determined to be totally disabled if a medically determinable physical or mental impairment due to injury or illness prevents them from doing the regular duties of their occupation

Usually, Insurers will pay long term disability benefits for two years following an injury based on the own occupation standard. After this period, the Insurer will switch over to the any occupation standard requiring a demonstration that the person is unable to hold any occupation to which the person is reasonably suited.

Denials and Termination of Benefits

Although there may be many reasons for denial or termination of benefits, the majority of denials are based on an Insured person failing to provide adequate medical evidence that he or she is totally disabled within the meaning of the policy. Quite often, denials or terminations are made on the basis that there is “insufficient medical evidence” to substantiate that a person is totally disabled.

If your client’s benefits are denied or terminated it is usually because there is insufficient medical evidence to support a finding of total disability. This is particularly true in

“subjective” type of injuries such as soft-tissue, chronic pain, fibromyalgia, chronic fatigue or post-concussion syndrome.

If the Insurer sends a letter to your client terminating or denying because of insufficient medical evidence, then respond with a letter requesting the Insurer to provide a detailed written explanation for the basis upon which the Insurer concludes that there is insufficient medical evidence, particularly when evidence has been provided. If medical evidence has been made available, remind the Insurer of that evidence.

Sometimes the Insurer will refer to the advice they receive from their own “medical specialist or advisor”. If this is referred to, request the information that the “medical specialist” is relying on.

The next step is to contact your client’s treating physicians (whether GP or specialists) and ask for assistance in providing further medical evidence to substantiate that your client is totally disabled from carrying out his or her occupation or any occupation as the case may be. Again, it is critical to provide some explanation to the physician as to the meaning of total disability and what medical evidence is required to meet that test.

Once you have obtained the additional medical opinion evidence, provide a copy to the Insurer along with a brief letter setting out your client’s legal position and why your client should be entitled to coverage.

PROOF OF DISABILITY

The onus is on the Insured to establish disability within the meaning of the disability or plan. Medical proof must be provided to establish that a person is entitled to benefits and is unable to carry out their own occupation or any occupation.

In cases involving “any occupation” once a plaintiff establishes a prima facie case they are disabled, the onus shifts to the Insurer to establish the Insured is or may reasonably be suited for some occupation.

In general, the more “objective” the medical evidence provided, the more convincing it will be to an Insurer or Court. Although Courts have allowed claims based purely on subjective complaints, they generally engage in a more objective test to determine if a reasonable person, after reviewing all of the evidence, would find a person to be totally disabled.

In the decision of *Mathers v. Sun Life Assurance of Canada* 1999 BCCA 292 Mr. Justice Finch made the following comment on the appropriate test to be used:

> “While it is possible that a judge could find such a claim to be proven on the plaintiff’s own evidence alone, it is clear in my view that the test is not entirely subjective. *Sucherov* establishes that proof of total disability must be sufficient to satisfy the reasonable man, the traditional objective test. For that reason, acceptance by the trial judge of objective medical evidence of total disability usually would be required”.

This case if often used by Insurers to argue that objective medical evidence is required and it is insufficient to rely on the Plaintiff’s own evidence or a physician who relies purely on the Plaintiff’s subjective complaints. It is fair to say that in general, proof of total disability should ideally have some objective medical evidence other than your client’s own subjective complaints. However, it is also clear that in some circumstances subjective elements alone can be used to prove disability to satisfy the reasonable person test. A good example of a claim that was ultimately accepted based primarily on subjective complaints is the decision of *Eddie v. Unum Life Insurance Company of Canada* 1999 BCCA 507. Madam Justice Prowse for the majority stated:

> “Thus, while the medical evidence called on behalf of Ms. Eddie in support of her claim that she was disabled from working was largely dependent on her subject description of her symptoms and their effect upon her, there was evidence from others verifying the apparent effect of her condition on

> her day to day living and her ability to work. The credibility of these witnesses was not challenged, nor was it suggested to Ms. Eddie that she was faking or malingering in order to establish disability benefits or for any other reason".

In addition, the Court in that case concluded that there was no reason in law why the decision in *Maslen v. Rubenstein* 83 BCLR 2nd 131 BCCA was inappropriate in the disability context. In *Maslen* the Court stated that in the context of injuries such as psychological conditions or chronic pain syndrome, there must be evidence of a convincing nature to overcome the probability the pain will continue, in the absence of objective symptoms **but the plaintiff's own evidence if consistent with the surrounding circumstances would nevertheless suffice for that purpose.**

Causation

Questions regarding multiple or coterminous causes of loss are resolved on the determination of proximate cause. Proximity is determined by looking at factors to determine which of the causes is the dominant, effective or operative cause. Where there are two competing causes that contribute to an injury or loss, the "but for" test is used to determine which is the proximate cause.

If there are two competing causes, one of which is covered, and one excluded there needs to be clear policy language that the injury, loss or sickness will be excluded. Otherwise, a court will resolve any ambiguity in favour of the Insured.

ACTION AGAINST INSURER OR BENEFIT PROVIDER

If an Insurer still maintains a denial after exhausting any applicable appeal processes you may be left with no alternative other than to commence an action against the Insurer or plan provider as the case may be.

Breach of Contract or Breach of Duty

Lawyers should be aware that there is a distinction between claims under a policy of insurance as opposed to a benefit trust. Claims made under a policy of insurance will be brought against an Insurer for breach of contract. A claim for benefits under a benefit trust should be brought and framed differently than a breach of contract claim. Rather than claiming for breach of contract, a claim under a benefit trust should challenge a trustee's exercise of their discretion on the basis that a denial of disability benefits was unreasonable. [2]

Proper Forum

If insurance arises from a collective bargaining agreement, it is essential to review the agreement to determine whether or not the claim can be made in the Supreme Court or whether the claim will necessarily have to proceed through an arbitration.

The determination of jurisdiction ultimately comes down to the intent of the parties. The intent of the parties is determined by examining the particular collective agreement and if applicable, labour relations legislation.

Punitive or Aggravated Damages?

The law with respect to punitive damages in a disability insurance context was clarified by the Supreme Court of Canada in *Fidler v. Sun Life Assurance Co. of Canada* 2006 SCC 30. In this decision, punitive damages were described as follows:

[2] *For a good analysis of the difference between claims brought against disability Insurers versus claims brought under a benefit trust, see Craig Ferris' "Denial and Disability Benefits" February, 2007 prepared for the Pacific Business and Law institute.*

> "While compensatory damages are awarded primarily for compensating the plaintiff for pecuniary and non-pecuniary losses suffered as a result of a defendants' conduct, punitive damages are designed to address the process of retribution, deterrence and denunciation.
>
> 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…

The Supreme Court of Canada set out that an Insurer who denies benefits should do so based on a reasonable interpretation of the policy and should operate under a duty of fairness in making that determination. An adjudicator for an Insurer can be wrong as long as the adjudicator acted fairly in the process.

In upholding a trial judge's award of punitive damage, the B.C. Court of Appeal in *Asselstine v. Manufacturers Life Insurance Co.* 2005 BCCA 292 agreed with the trial judge's comments that insurance companies cannot disregard compelling medical evidence while placing undue emphasis on evidence that only supported a denial.

If there is evidence that an Insurer ignores the medical evidence that is provided on behalf of your client, or selectively chooses the medical evidence that only supports the position of denial, then a claim for punitive damages and aggravated damages would be warranted. Insurers have a duty of good faith and fairness to their Insureds and are not to undertake an adversarial position when contemplating coverage. It has been my experience that serving a Notice of Civil Claim in circumstances where there is a real possibility of a claim for punitive damages will result in an Insurer taking a sober second look at its decision which can often lead to reinstatement of benefits for your client.

DEDUCTIBILITY AND SUBROGATION

We are all familiar with the general rule that in a tort claim you cannot recover twice (double recovery) for the same claim. There are a few exceptions to this general rule and one of those is the private insurance exception.

In order to qualify for this exception, the plaintiff must show that the benefits received were "in the nature of insurance" and that the plaintiff received some type of consideration for that benefit.

If the benefits did not fall within this exception, the income received will be deducted from the tort claim. In the case of disability insurance, this is relatively rare.

Disability Insurer's Right of Recovery

It is rare that an Insurer does not address the right of reimbursement in the policy or plan or through a reimbursement agreement. The courts have made it clear that the common law right to subrogation can be modified via contractual provision.

If subrogation or reimbursement is addressed in the contract, the proper analysis is to look at the contractual terms to determine the parties' rights. This can have a significant impact on reimbursement. This is because in common law, an Insurer is not entitled to subrogate until the Insured is made whole. Where there is a clear right of contractual reimbursement, the payor is entitled to recover the benefits paid on the basis of the contractual provisions regardless of whether the plaintiff has been made whole or not. In the absence of clear contractual provisions, common law rights of subrogation will apply.

Absent contractual provisions, if it is established that the policy is a contract of indemnity, the Insurer will not be entitled to subrogate until the Insured has been fully indemnified (a contract of indemnity is when an Insurer binds itself to pay money to an Insured upon proof of an uncertain event and as a result the Insured has suffered a loss).

The reality is in the disability context, Insurers have been rewriting their policy wordings in order to enhance their subrogation or reimbursement rights. It is rare, unless you are dealing with old policy wordings, that there is nothing in the contract that specifies the relationship between the parties with respect to reimbursement or subrogation.

However, it should be kept in mind when you review the policy wording that ambiguous language will be construed against the Insurer who writes language in favour of the Insureds so a careful reading of the contractual provisions are necessary.

REIMBURSEMENT OF PAST AND FUTURE WAGE LOSS

The calculation for the amount of benefits paid up to trial or settlement is a relatively straight forward matter. However, in British Columbia, because a plaintiff is only entitled to make a net of tax past wage loss claim, an analysis needs to be made as to whether your client has paid taxes on the benefits they have received or not. In British Columbia, although decisions are somewhat inconsistent, the majority view is that if a plaintiff has already paid taxes on disability benefits they have received, the net tax applications should not apply to those sums. Thus in Hill v. Murray, 2014 BCSC the Judge stated:

> "Counsel never addressed whether the Court should deduct income tax from the subrogated claim of $7,328. In final submissions, however the plaintiff sought the full amount and the defendant applied the tax rate… Although there is some authority for the Defendant's position in this Court (see Redi) for example, the bulk of authority supports the Plaintiff's position (See Ho v.Dosanjh, 2010 BCSC 844 and Gormick v. Amenta 2013 BCSC 1998. Therefore, I find Ms. Hill is entitled to the full amount of the subrogated claim."

In order to determine whether your clients have paid taxes for disability benefits received, obviously their income tax returns are the starting place. The determination of whether a person is taxed on disability benefits depends on who pays the premiums.

If the employer pays the premiums the benefits are taxed at source. If any portion is paid by the employee or person, then that portion or all of it will not be taxed.

When negotiating a settlement with ICBC or in terms of presenting a past wage loss claim at trial, counsel should consider the following factors:

(a) What portion of the past wage loss claim was paid by insurance benefits – i.e. 50 – 100%?

(b) In terms of the past wage loss that was covered by income replacement benefits, what portion of premiums were paid by employer and what portion were paid by the plaintiff? Any portion that was paid by the employer will have been taxed at source (as of 2015) and no further deductions for tax pursuant to legislation should be made.

(c) Any disability payments that were taxed should not be subjected to a further income tax deduction and full recovery of that amount should be sought.

Keep in mind that failing to engage in this process may have consequences to you as counsel and to your client if failing to do so results in a diminished amount of the subrogated interest of the disability Insurer.

LOSS OF EARNING CAPACITY

Unlike past wage loss claims, it is far more difficult for Insurers to seek reimbursement of future losses paid to a plaintiff. The reasons for this are twofold: first, the determination of future losses are fraught with uncertainty; and second, the entitlement to loss of earning capacity is not a wage loss replacement but the loss of a capital asset.

For example, in *Budnark v. Sun Life Assurance Co. of Canada* [1994] BCJ No. 1960, the judge held the following with respect to the future loss of income award:

> "…the tort award for future loss of income cannot be used by a disability Insurer as the basis on which to call upon a beneficiary to account. This is because it ordinarily will never be known how the award will compare with the actual future loss. I see no way in which, in any point in time, it can be said that the moment has arrived in which the Insurers right of subrogation may be determined.
>
> The possible exception I see to this is where a tort award for future loss of income is premised upon complete future unemployability so that the award is calculated to compensate the plaintiff for all of the income he or she would have earned up to the termination date of the benefits under the disability policy."

Similarly, in *Kobzey v. Sun Life Assurance Co. of Canada* [2001] BCJ No. 1840, the court dealt with the disability Insurer's reimbursement claim for future earnings. In the case, the disabled claimant settled her tort claim and the settlement value for both past income and future loss of earning capacity was approximately $200,000.00. The Court of Appeal, overturned the trial decision and commented that:

> "For the future component, there is an inherent difficulty in relating subrogation to loss of future earning capacity. Entitlement under this head is not wage replacement in the ordinary sense but compensation for loss of an asset…"

NEGOTIATING SUBROGATION AMOUNTS WITH INSURER

In the writer's experience, Insurers are happy to receive any amounts that have been paid out and are relatively amenable to negotiation. However, over the years, it appears that Insurers are becoming more sophisticated and are enforcing their subrogation rights with a much greater scrutiny than in the past. Nevertheless, most Insurers will entertain some degree of negotiation and deductions from the amount of benefits paid out to your client. Factors to consider in negotiating amounts include:

(a) Legal fees – most Insurers will agree for a deduction of legal fees for the amount set out in your contingency fee agreement plus applicable taxes. Note, however, some Insurers now are setting out in their Reimbursement Agreements with the Insured, the

maximum amount of legal fees they will entertain (which is almost invariably less than the contingency fee amount). In the writer's experience, even with the contractual amounts set out between Insured and Insurer, they will nevertheless still entertain negotiations over legal fees. (To avoid any such disputes at the end of the claim, it would be preferable to engage the disability Insurer setting out the terms of that engagement from the outset).

(b) Costs - there may be some pro rata sharing of costs associated with pursuing the claim. This could include medical reports, economist reports and various other fees associated with pursuing the claim. If the Defendant Insurer pays for all of these, then it should be a wash. As we know, ICBC doesn't always pay for all of the costs and sometimes there is a discount for liability or formal offers to settle.

(c) Net past wage loss – most Insurers, will agree to a discount on the basis that past wage loss claims in British Columbia are net of taxes and most wage loss claims are presented to ICBC on a gross past wage loss claim with a deduction for taxes. However, again, disability Insurers are becoming more aware of the fact that some benefits have already been taxed and therefore no deduction should be given. The writer is aware of at least one interesting argument made by a disability Insurer that for those portions that were not taxed, because they are non-taxable to the recipient, no tax should be taken off by ICBC.

(d) Liability – most Insurers are amenable to discounts on the basis of contributory negligence or liability risks.

(e) Inadequate limits – again, most Insurers are amenable to discounts if your client has to discount his or her claim because of either inadequate limits or competing claims that diminish the overall amount of insurance available. Most insurance policies are silent with respect to inadequate limits. However, some Insurers will argue that the Insurer and Insured should share that loss on some pro-rata basis. The Supreme Court of Canada, however, concluded that the Insurer's position is secondary to the position of the Insured on the basis of subrogation law. (Ledingham v. Ontario (Hospital Services Commission [1975] 1 S.C.R. 332)

(f) Discounted claims – Insurers will also appreciate that there may be discounted claims because of things such as mitigation and will entertain a deduction if appropriate. Generally, if your client accepts a discounted amount for past wage loss, based on risk, it is

appropriate to ask the disability Insurer for a commensurate discount.

Most policy wordings will seek reimbursement of past or future income. If there is a dispute over future earnings, review the policy wordings and remind the Insurer that what is being replaced in the future is not income, but loss of a capital asset. In addition, one of the problems with "future" subrogation, is the fact that an Insurer can still terminate future benefits at any time. There is inherent uncertainty in future earning claims.

It is always preferable to try to deal with the reimbursement issues prior to finalizing any settlement. If this is not possible, you can structure any deal in the tort action so that settlement is conditional on the disability Insurer agreeing to the terms. Many Insurers will have provisions setting out that the Insurer must agree in advance of any settlement. Failure to seek that agreement could have significant implications.

CONCLUSION

There are many issues that can arise when dealing with disability Insurers and plan providers. If the situation appears complex, and this is not a familiar area of law, there are lawyers who specialize in this area. For example, if your client has pre-existing injuries, or has a subsequent non-tortious medical event, entitlement to coverage and also whether the Insurer has a right to be fully reimbursed can become quite complex both medically and legally. Subrogation is usually limited to the "same disability". If the benefits are being paid through a benefit trust, there will be a number of legal differences in pursing these types of claims as opposed to benefits being paid through disability insurance.

If your client is fortunate enough to have income replacement benefits of some kind, in all likelihood, your client is going to need some help. For a number of reasons, it is in your interest as counsel to become fully engaged in this process. We all know how stressed our clients become because of financial pressures. As counsel, we want to

do everything we can to minimize that stress. In addition, it is often the case that your client's physician will not be aware of the policy requirements. My experience is that good physicians want to help and are appreciative of our help in what is required of them.

Lastly, as counsel we will necessarily have to engage in negotiations with the disability Insurer at the ultimate conclusion of the matter. Understanding what the requirements are from the outset will minimize problems at end and will make negotiations with the Insurer that much easier. In addition, you will be in a better position to be able to inform your client of what to expect prior to settlement in terms of what the net result will be to him or her.