CITATION: Zefferino v. Meloche Monnex Insurance, 2012 ONSC 154
COURT FILE NO.: 06-23974
DATE: 2012-01-09

SUPERIOR COURT OF JUSTICE - ONTARIO

RE: Nicola Zefferino, Plaintiff

AND:

Meloche Monnex Insurance Company, Defendant

BEFORE: R.B. Reid, J.

COUNSEL: L. Ferro, Counsel, for the Plaintiff

R. D. Rollo, Counsel, for the Defendant

HEARD: September 28 and 29, 2011

ENDORSEMENT

[1] The plaintiff brings this motion for summary judgment pursuant to Rule 20 of the Rules of Civil Procedure[i]. The claim is based on the alleged negligence of the defendant insurance broker in failing to properly offer optional income replacement benefit coverage to the plaintiff as part of a policy of automobile insurance. The defendant did not contest the appropriateness of the summary judgment procedure and requests that the claim be dismissed.

[2] For the reasons set out below, the claim is dismissed.

Background facts:

[3] The action arises out of a motor vehicle accident on May 27, 2005 in which the plaintiff suffered personal injuries such that he can no longer be gainfully employed.

[4] The plaintiff was the named insured under an automobile insurance policy sold by the defendant.

[5] The policy began in September 2003 and was renewed in 2004. In February 2004, the vehicle which was involved in the 2005 collision was substituted for a prior vehicle.

[6] Under the standard policy terms, the plaintiff was entitled to receive and did receive the statutory minimum income replacement benefit of $400 per week as a result of his income loss following the accident.

[7] The plaintiff alleges that the defendants failed to offer optional income replacement benefits which, if they had been offered, the plaintiff would have purchased. As a result of that failure on the part of the defendants, the plaintiff alleges he was under-insured. His income at the time of the accident would have qualified him for income replacement benefits of $1000 per week.

[8] When the subject policy of insurance was sold in 2003, the defendant was in the business of selling insurance by telephone to customers within certain groups or organizations. In this case Sabina Zefferino, the spouse of the plaintiff, was an employee of the TD bank which qualified her to purchase insurance from the defendant.

[9] All the defendant's salespeople are licensed to sell insurance by the Registered Insurance Broker of Ontario. As such, they have training in the requirements of the Insurance Act.

[10] The structure of the defendant's business model is dissimilar from traditional insurance brokers in that the defendant offered its services by telephone through employees in a call center rather than on a face-to-face basis with customers.

[11] The plaintiff and Mrs. Zefferino had dealings with four other insurance companies between 1993 and the commencement of the relationship with the defendant in 2003. The choice by the plaintiff and his spouse to deal with the defendant was made based on its very competitive pricing.

[12] In order to confirm the proper handling of files and perhaps in order to enhance efficiency, the defendant's sales representatives work off a standard script in their conversations with potential customers and record information as it is provided to them. Copies of the computerized records of the defendant were produced. Those records confirmed telephone contacts by both the plaintiff and his spouse relating to the new policy in 2003, the vehicle change and the renewal in 2004.

[13] The records indicate that optional benefits were refused in each of two telephone conversations between the defendant's representative and Sabina Zefferino on September 2, 2003. On the first of those calls, the notation reads: "No need". Similarly in a conversation with the plaintiff on the same date, it is noted that he was offered and declined optional accident benefits coverage as well as other modifications to the basic insurance contract terms. On February 4, 2004, the defendant's records indicate a call from Sabina Zefferino to change vehicles under the policy with the note: "Discussed coverages. Clt. chose to keep cov same".

[14] Upon the acceptance of the contract by the defendant, and on each change, the plaintiff was sent a certificate of automobile insurance which, on its face under the heading "Insurance Coverages" showed various "optional increased accident benefits" all of which (including income replacement) were listed as "not purchased".

[15] Following the legislative change in November 2003 that made the offer of optional income replacement benefits mandatory, subsequent renewals and modifications of the policy were accompanied by a sheet providing a brief explanation of the insurance outlined in the certificate and including the following as to accident benefits:

> Your insurance company is obligated to explain details of accident benefits coverage to you. Provides [*sic*] benefits that you and other insured persons are entitled to receive if injured or killed in an automobile accident. These benefits include: income replacement for persons who have lost income; payments to non-earners who suffer complete inability to carry on a normal life; payment of care expenses to persons who cannot continue to act as a primary caregiver for a member of their household; payment of medical, rehabilitation and attendant care expenses; payment of certain other expenses; payment of funeral expenses and

> payments to survivors of a person who was killed. You may also purchase the optional benefits to increase the basic level of benefits provided in the policy. The optional benefits your insurance company must offer are: increased income replacement; increased caregiver and dependent care; increased medical, rehabilitation and attendant care; increased death and funeral; and an indexation benefit.

[16] It is undisputed that the defendant's representatives did not engage either the plaintiff or his spouse in detailed discussion of the income replacement benefits or the potential for securing optional benefit coverage. There was no discussion of the plaintiff's income nor were there examples given of the levels of income that would support the optional benefit coverage. The defendant did not quote the additional cost of optional benefits at any level.

[17] In his examination for discovery, the plaintiff indicated that neither he nor his spouse had any knowledge of income replacement benefits.

[18] Sabina Zefferino did not testify or provide affidavit evidence.

Statutory provisions:

[19] The requirement to provide optional benefits is set out in Part VIII of the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*[ii] ("*SABS*"). Section 27(1) states as follows:

> Every insurer shall offer the following optional benefits:
>
> 1. An optional income replacement benefit that fixes the amount referred to in subparagraph ii of paragraph 2 of subsection 7(1) at $600, $800 or $1000, as selected by the named insured under the policy, for the purpose of determining the weekly amount of an income replacement benefit.

Section 27(1) goes on to deal with other optional benefits that are not relevant to this case.

Section 27(2) provides that the optional benefits referred to in subsection (1) are applicable only to listed individuals including the spouse of the named insured.

Issues:

[20] To establish a successful claim in negligence, the following questions must be answered:

(a) Did the defendant owe the plaintiff a duty of care in the sale of an automobile insurance policy?

(b) Did the defendant breach the applicable standard of care by failing to properly offer optional income replacement benefits to the plaintiff?

(c) Would the plaintiff likely have purchased the optional benefits if they were properly offered and if so, what amount of benefits would likely have been purchased?

Issue (a): Did the defendant owe the plaintiff a duty of care?

[21] In the body of case law that has developed since the House of Lords' 1963 decision in *Hedley Byrne & Co. v. Heller Partners Ltd.*[iii], there has been a clear recognition that a duty of care can be owed by insurance agents who are in the business of providing insurance information and advice to customers. In *Fletcher v. Manitoba Public Insurance Co.*[iv], the Supreme Court of Canada determined that the sale of automobile insurance is a business in the course of which information is routinely provided to prospective customers with the expectation that they will rely on it and they do in fact reasonably rely on it. The court found that the providers of such information owe a duty of care to their customers if: "(i) such customers rely on the information, (ii) their reliance is reasonable, and (iii) [the provider] knew or ought to have known that they would rely on the information".

[22] Although the *Fletcher* case involved a government-owned insurer, I see no distinction between such a party and the defendant in this case on the issue of duty of care. It is reasonable to expect that the plaintiff and his spouse relied on the expertise of the defendant's employees to advise about available coverage. That reliance was reasonable

given the greater familiarity with the provisions of the Insurance Act on the part of the salespeople for the defendant who were required to be licensed and knowledgeable, as compared with the plaintiff and his spouse who had no such specific knowledge. As in *Fletcher*, it is obvious in this case that the defendant knew or ought to have known that purchasers of insurance constitute a class of persons that may reasonably be expected to rely on the information communicated to them by its employees.

[23] As result, I find that the defendant did owe the plaintiff a duty of care.

Issue (b): Did the defendant breach its duty of care?

[24] To determine whether there was a breach of the duty of care requires an analysis of whether or not the defendant's conduct fell below the required standard of care required of a seller of insurance. The onus is on the plaintiff to establish on the balance of probabilities the breach by the defendant of the standard of care.

[25] The plaintiff relied on the mandatory nature of the requirement to offer optional benefits. It further relied on the apparent consumer protection purpose of the mandatory offer. To the extent that the defendant failed to satisfy its statutory requirements, the plaintiff argued that there was a breach of the standard of care.

[26] In order to reach a conclusion about whether the defendant breached its mandatory obligation to properly offer optional benefits, it is necessary to consider the meaning and nature of that obligation. If an offer in the form of a simple solicitation of interest is all that is required, there would be no breach of the defendant's obligation in this case. If however, a more purposive approach to the legislation is applied, the defendant may need to take a more detailed history and then ensure that the customer understands the optional coverage, its cost, whether it might apply in the customer's particular circumstances and what the consequences could be for failure to secure the additional coverage. In effect, the question boils down to whether or not the defendant must offer the optional coverage in such a way that the customer can make a fully informed decision about what to purchase.

[27] As noted, the obligation to offer the optional coverage is mandatory, and is part of a statutory scheme under which automobile insurance is required for all vehicle owners. Insurers must offer their products and services in compliance with the *Insurance Act*[v] and its Regulations.

[28] The *Insurance Act* and *SABS* establish minimum basic levels of coverage that apply to each policy, subject to the purchase of optional higher coverage levels. Although the pricing of the mandatory policy is left with the insurers, it is reasonable to assume that the setting of minimum statutory provisions was arrived at by balancing the need for an adequate universal standard of coverage against cost. To make the mandatory offer of optional coverages meaningful, consumers must be given an understandable alternative which would allow them to measure the need for more coverage against risk and cost. Otherwise, there would be no purpose behind that mandatory language. The plaintiff argued, and I agree, that there is a consumer protection purpose behind the need to offer the optional coverages. As stated by Gonthier J. in *Smith v. Co-operators General Insurance Co.*[vi], "There is no dispute that one of the main objectives of insurance law is consumer protection, particularly in the field of automobile and home insurance." Although some people will want basic coverage only and therefore seek it out at the lowest possible cost, others on reflection may choose to pay more for the greater peace of mind that comes from a higher level of protection. While more common variables may be the potential for increased liability coverage and lower deductable and collision coverage, optional income replacement benefits are in the same category. The fact that they are less well known may increase the insurer's practical obligation to explain their existence and the details of the optional coverage.

[29] The defendant argued that the conduct of its representatives in offering the optional benefits without detailed inquiry into the customers' circumstances and without providing a quote as to additional costs that might be involved was consistent with the industry-standard. This evidence was provided by the defendant's own witnesses. No independent expert evidence was called on the subject by either party.

[30] Customary behavior is relevant to the issue and is some evidence of compliance with the standard of care but is not conclusive. Put another way, general non-compliance with a statutory requirement does not mean that the non-compliance is acceptable or, in the context of this litigation, sufficient to establish a lower standard than the *SABS* may require.

[31] The evidence of the defendant was to the effect that optional benefit coverage is always offered but that a quote as to the cost of the coverage is provided only if the customer shows an interest in purchasing the additional benefits. The defendant's representatives do not inquire about the personal financial circumstances or level of income of the customer. This is on the basis that, while such information might be relevant to the individual's need for coverage, the defendant considers that to do so would be contrary to the provisions of Regulation 664 of the *Insurance Act*[vii] which prohibits an insurer from deciding whether to issue, renew or terminate any contract based on improper criteria.

[32] In my view, it is entirely feasible for a seller of insurance products to explain the nature of the optional income replacement benefits as applicable to the particular customer without securing information that might taint the insurer's decision whether or not to offer coverage. For example, a customer could be told that unless there was income over certain thresholds, the various levels of optional coverage might not be payable even if purchased. The evidence of the defendant was that the cost of the optional coverages was pre-set, so that it would not have been difficult to apprise any customer of the potential charge for coverage at various levels. The customer could even be provided with hypothetical loss scenarios and asked to draw his or her own conclusion about whether the income replacement benefits would be adequate. The defendant's standard practices and instructions to its representatives did not require those sorts of discussion.

[33] I consider that there was a failure on the part of the defendant in this case and in accordance with its standard practice to "offer" the option benefit coverage in any meaningful way. As such, the offer that was made, which was more in the nature of a mention accompanied by a solicitation of interest, did not comply with the statutory mandate contained in the *SABS*.

[34] As to the defendant's argument that its practice was in accordance with industry standards, I acknowledge that there is no evidence to the contrary. However I consider that the failure to properly offer the optional benefit coverage, effectively negating any requirement to ensure that customers can make an informed decision on the subject, is a breach of the standard of care applicable to the defendant in the circumstances. I am not persuaded that the evidence of common practice in the industry offered by the defendant through its own representatives is sufficiently persuasive to establish a standard of care under which the offer of optional benefits could be made in a less meaningful way.

Issue (c): Would the plaintiff likely have purchased optional benefits if properly offered, and if so, in what amount?

[35] In his examination for discovery, the plaintiff indicated that he would have purchased optional benefit coverage if he had understood the offer made by the defendant's representatives. This evidence is clearly self-serving, and provided after-the-fact of the accident.

[36] The parties agreed that at the date the policy was purchased, the plaintiff had an income that would have supported optional benefit coverage in the amount of $600 per week, and that prior to the accident, his weekly net income would have made him eligible for optional income replacement benefits at the level of $1,000 per week.

[37] Following the accident, Sabina Zefferino applied for and received optional income replacement benefit coverage at the level of $600 per week. She was advised that the new coverage would not apply to the plaintiff's pre-existing situation.

[38] As noted above, the plaintiff and his spouse purchased insurance from four other insurance companies during the ten years before relationship with the defendant began. There is no evidence that anything other than basic coverage was secured on any of those prior occasions.

[39] The choice of securing insurance through the defendant was based on price.

[40] The defendant's notes of communications with the plaintiff's spouse indicate that the optional coverage was declined because there was no need. Even assuming as I have done that the standard of care required a more fulsome explanation of the optional coverage by the defendant, there is no hint of any interest on the part of the plaintiff and his spouse in coverage greater than the statutory minimum in any area.

[41] The plaintiff chose not to call direct evidence from his spouse. Sabina Zefferino was the person by virtue of whose employment the insurance offered by the defendant was available. She herself contacted the defendant on several locations in relation to the policy initiation and renewals. At his examination for discovery, the plaintiff testified to his understanding of his wife's involvement with the insurance purchase. She was the main contact with the defendant and the plaintiff recalled no direct contact himself. On the critical subject of what coverage would have been purchased if it had been properly offered, there is therefore no information from the plaintiff's spouse even though it could be highly relevant. The defendant asks that an adverse inference be drawn against the plaintiff pursuant to the provisions of Rule 20.02(1) in that she has personal knowledge of contested facts but did not provide evidence. I am prepared to draw such an adverse inference as to her understanding of the optional benefits and her choice to decline them, in support of the defendant's position that there is no convincing evidence of the plaintiff's intention to purchase optional coverage.

[42] As a result, I consider that the plaintiff's evidence that he would have secured additional income replacement benefit coverage had he understood what was being offered not to be credible. Not only is it clearly self-serving, but it is not consistent with the plaintiff's and his spouse's previous actions. No evidence was provided by Mrs. Zefferino, even though it may well have been relevant. In my view, the plaintiff (or his spouse) chose to purchase the least expensive form of insurance available. He cannot now change that bargain. As such, he fails in the third issue necessary to establish a successful claim in negligence in that he has not shown on a balance of probabilities the necessary causal connection between the defendant's breach of duty and his loss.

[43] Given my conclusion, it is not necessary to determine the level of optional coverage that would have been purchased.

Conclusion and Costs:

[44] This was an appropriate case for a motion for summary judgement. The plaintiff is required to put his best foot forward. In my view, there is no need for a trial to fully appreciate the issues and the evidence that pertains to those issues. There is no genuine issue requiring a trial. Both counsel made cogent and comprehensive submissions.

[45] Because of the plaintiff's failure on the third issue, the action is dismissed.

[46] If the parties are unable to resolve the issue of costs consensually, I am prepared to receive written submissions according to the following timetable: the defendants are to provide to the plaintiff a bill of costs together with brief written submissions within two weeks of this date. The plaintiff is then to provide to the defendant his submissions within a further two weeks. The submissions of the plaintiff and the defendant are then to be filed with the court together with any reply submissions by the defendant by no later than five weeks from this date.

Reid J.

Date: January 9, 2012

[i] R.R.O. 1990, Reg. 194
[ii] O. Reg. 403/96
[iii] [1964] A.C. 465 (H.L.)
[iv] 1990 CanLII 59 (S.C.C.) at page 11
[v] R.S.O. 1990, c I.8
[vi] [2002] 2 S.C.R. 129 at par. 11
[vii] R.R.O. 1990, Reg. 664