



# ACCESS TO JUSTICE

LEGAL ISSUES FOR THE INJURED AND PEOPLE WITH DISABILITIES

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## DISABILITY INSURANCE

### “TOTAL” AND “PARTIAL” DISABILITY

No one likes to think they will ever become too disabled to work. But just in case, many people have disability insurance, either through a group plan at work or an individual plan purchased separately. These disability insurance policies generally state that an insured will be entitled to benefits if he or she is “totally disabled.”

Totally? What if the disabled person can still perform specific functions (e.g. answering the telephone, walking short distances) but the cumulative demands of the job are too much? Are they totally disabled?

In the leading Supreme Court of Canada decision, Sucharov v. Paul Revere, the court held that a broker who was able to perform isolated tasks but experienced panic attacks when he tried to run his business was totally disabled under the terms of the policy. At least during the time it took him to get better.

Time periods can be important. Many policies

initially consider a person totally disabled if he or she is unable to perform the material tasks of his/her job -- “own occupation.” After some period of time (often 24 months), the person is only considered totally disabled if he/she is unable to work at any occupation for which he/she is reasonably suited as a result of his/her education, training and/or experience -- “any occupation.”

However, even in the “any occupation” period, the courts may consider the insured totally disabled if the other occupations do not offer the opportunity to generate roughly equivalent incomes as the insured’s old job. In some policies, this is made explicit by adding a clause that renders the insured ineligible for disability benefits if he or she earns more than a certain percent of their indexed pre-disability income.

*Partial disability* - Some policies provide coverage in the event of partial disability. Almost invariably, however, the insured must first be found to be totally disabled for a period of time before the partial disability clause can potentially apply.

### OTHER ISSUES

**A**lternative coverage - Most policies require an insured to apply for CPP disability benefits or other coverage. Then the disability benefits are reduced by the amount those other coverages could provide, as long as the insurance company can prove that the insured was eligible for the other coverage.

*Rehabilitation* - Insurers often put rehabilitation provisions in their policies. These may require the insured to undergo assessments by doctors hired by the insurance company and participate in a rehabilitation plan approved by the insurance company. If the insured can’t or won’t participate, his/her benefits may be terminated.

This is a problem if the insured’s treating physicians disagree with the approved rehabilitation plan (classic example: where the insured has chronic fatigue syndrome). What to do?

Most doctors who conduct assessments for insurance companies are careful to state their assessment doesn’t create a doctor/patient relationship with the insured. In the absence of the fiduciary duties arising from a doctor/patient relationship, it is reasonable to argue that the insured ought to be able to follow his treating physicians’ advice and still receive benefits.

*Misrepresentation* - The law requires that a person who applies for disability insurance be scrupulously honest in filling out the application. The person’s answers, after all, let the underwriters assess the risk of insuring the person and decide to (1) exclude coverage for admitted health problems, (2) increase the premiums charged, or (3) refuse to insure the person altogether.

If a policy is issued and the person later applies for benefits, the insurance company may check that the insured didn’t misrepresent any fact(s) in the application which would have caused the insurance company to treat the insured’s policy differently.

If they find a misrepresentation, the insurance company may be entitled to treat the policy as void *ab initio* (from the beginning).

Countering that, the insured may argue that the application form’s questions were too vague to elicit the proper information. Furthermore, if the policy was in effect for more than two years and the insured had faithfully paid premiums for the duration of the policy, the insurance company may be bound unless it proves both a fraudulent *and* a material misrepresentation. In other words, if the error or omission was inadvertent or minor, the policy would be treated as valid. The courts have historically strained to find ways to uphold long-term contracts.

### MENTAL DISTRESS

**A** disability insurance contract is one of the few contracts which people enter into in order to ensure their peace of mind. The insured person agrees to pay hard-earned after-tax money in exchange for a promise of financial protection in the event he/she loses the ability to work. Because of this unique aspect to disability insurance, the B.C. Court of Appeal decided that if

- an insurance company fails to pay benefits
- when the person is genuinely disabled from working
- and the person suffers mental distress as a consequence of the insurance company’s refusal to pay benefits

the insurance company is liable to pay damages for mental distress in addition to paying any regular benefits owed. In B.C. these mental distress damages have ranged from \$7,500 to \$35,000. (Sun Life Assurance is challenging this approach to damages for mental distress in the Supreme Court of Canada.)

*Caselaw often broadens coverage beyond a literal interpretation of the insurance document.*

**T**he “fine print” in insurance contracts can be important and difficult to interpret. And because all disability policies are worded differently, legal decisions interpreting one policy cannot be applied indiscriminately to a different policy.

Nonetheless, caselaw often broadens coverage beyond a literal interpretation of the insurance document. Therefore, before accepting a denial of benefits (particularly where the disability will likely be long-term and the benefits substantial), an insured should always thoroughly examine the facts in light of relevant legal principles. Many insurance applications that are initially denied may be approved or successfully litigated with sound argument.

