



# Accident Benefit REPORTER

## Celebrating Leadership In Litigation For 70 Years

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**T**homson, Rogers turns 70 this year. As we celebrate this important milestone, I want to briefly share some of our firm history with you.

In 1936, when founding partner Edson Haines started a litigation firm in Toronto, work was just being completed on the Hoover Dam in Nevada and King Edward VIII abdicated his throne in England to marry Mrs. Simpson. The practice of personal injury law was in its infancy. Edson was later joined by his brother Douglas and, together they formed a partnership known as Haines & Haines. Initially the firm practiced both plaintiffs' work on behalf of injured persons and their families, as well as defence work on behalf of insurers.

The firm expanded again when the Second World War ended. B. J. Thomson, Phil Benson and L. R. Freeman joined the Haines brothers. Shortly thereafter Kenneth Howie and William Rogers came on board and the firm became known as Haines, Thomson, Rogers, Benson & Howie.

Ken Howie, now counsel to the firm, revolutionized the way lawyers practiced personal injury law and trained many of the lawyers with our firm today.

The firm continued to grow in size throughout the 1950s and 60s. By 1972, 54 lawyers practiced in what was then a full service law firm and one of the largest in Canada.

Accomplished litigators such as Douglas Goudie, Ralph Howie, Keith Gibson and our current senior partner, Lawrence Mandel, honed their skills trying personal injury claims before the courts.

Our founding partner, Edson Haines, took an appointment to the Ontario Supreme Court. Many of our other partners followed Edson Haines to the bench, as Judges in what is now known as the Ontario Superior Court. We have been honoured by the appointment of, amongst others, James Farley, Lloyd Brennan, Keith Gibson, Tamarin Dunnet and Patrick Moore.

In 1966, the firm shortened its sometimes cumbersome name to Thomson, Rogers and it has been known by that name ever since. Then, in the early 1970s, the firm changed its focus away from the full-service concept towards specialization in advocacy.

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Publication  
Volume 7 Issue 1  
Summer 2006  
ISSN 1481 0239



Today, we continue the tradition started by Edson Haines in 1936. Our lawyers represent injured persons and their families. From humble beginnings, the firm has evolved into the largest personal injury law firm in Ontario and a leader, as well, in family law litigation, commercial litigation and land use advocacy.

With the assistance of our loyal and supportive staff, we intend to continue this tradition for the next 70 years and beyond, with one simple goal: to secure the best interests of our clients, honourably and vigorously.



*Alan Farrer, Managing Partner*

*Alan Farrer  
Managing Partner*

## Changes to the Unfair and Deceptive Acts and Practices Regulation

Section 439 of the Insurance Act prohibits unfair or deceptive acts or practices. The Act provides significant financial penalties for those who permit or commit an unfair or deceptive act or practice. The Unfair or Deceptive Acts or Practices regulation which came into effect in the year 2000 has been amended by Ontario Regulation 547/05. The effect of the amendments are to significantly increase the definition of what constitutes an unfair or deceptive act or practice. A number of these newly defined unfair or deceptive acts or practices become effective March 1st, 2006.

The conduct of adjusters and service providers will face increased scrutiny as a result of these new definitions.

The relevant changes as they impact upon adjusters who are faced with the responsibility to agree or dispute Treatment Plans or other rehabilitation interventions are as follows:

1. "For the purposes of the definition of 'unfair or deceptive act or practice' in section 438 of the Insurance Act, each of the following actions is prescribed as an unfair or deceptive act or practice:...

"9. Any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims."

"13. Any examination or purported examination under oath that does not comply with the requirements under the Act or the regulations".

5...each of the following actions, if done on or after March 1st, 2006, is prescribed as an unfair or deceptive act or practice in relation to a claim for statutory accident benefits... (the Schedule):





David MacDonald  
Partner

- “1. The failure or the refusal of an insurer without reasonable cause to pay a claim for goods or services or for the cost of an assessment within the time prescribed for payment in the Schedule.”
- “2. The determination by an insurer that a person is not entitled to a statutory accident benefit, or that a person does not have a catastrophic impairment if,
  - i. the insurer makes the determination before obtaining a report of an examination in respect of the person under section 42 of the Schedule, and
  - ii. the Schedule does not authorize the insurer to make the determination without having obtained the report.”
- “3. The making of a statement by or on behalf of an insurer for the purposes of an adjustment or settlement of a claim if the insurer knows or ought to know, that the statement misrepresents or unfairly presents the findings or conclusions of a person who conducted an examination under section 42 of the Schedule.”
- “4. A requirement by an insurer that an insured person attend for an examination under section 42 of the Schedule conducted by a person whom the insurer knows or ought to know is not reasonably qualified by training or experience to conduct the examination.”
- “5. A requirement by an insurer that an insured person attend for an examination under section 42 of the Schedule that the insurer knows or ought to know is not reasonably required for the purposes authorized under the Schedule.”
- “6. The failure of an insurer to obtain the written and signed consent of an insured person in the approved form before a pre-claim examination under section 32.1 of the Schedule is conducted in respect of the insured person.”

By virtue of these new definitions, if an adjuster receives a Treatment Plan from a treating or proposed treating Health Care Professional and denies that Treatment Plan without a section 42 examination to indicate that the treatment is unreasonable, that adjuster has committed an unfair or deceptive act or practice under section 438 of the Insurance Act. (Section 5 . 2. of O. Reg.547/05)

If the adjuster receives a Treatment Plan, refers the Treatment Plan for consideration by a section 42 insurer examiner and the insurer examiner indicates that the treatment is reasonable, the adjuster may have committed an unfair or deceptive act or practice in unreasonably delaying or resisting the fair adjustment of the claim. (Section 1. 9. of O. Reg. 547/05)

If an adjuster receives a Treatment Plan and, after arranging a section 42 examination, denies the Treatment Plan in accordance with the findings of the section 42 examiner, treatment is delayed until the person’s lawyer obtains an arbitration decision confirming the reasonableness of the Treatment Plan. As the Treatment Plan has been found reasonable, the insurer may have committed an unfair or deceptive act or practice. (Section 1. 9. of O. Reg 547/05).

If an adjuster receives a submission of expenses by an insured or a request from a treatment provider to pay for the cost of an assessment, and fails to pay that amount within the time prescribed for payment by the SABS, if the expense is payable, the adjuster has committed an unfair or deceptive act or practice. (Section 5. 1. of O. Reg 547/05).

If a Section 42 examiner completes a Form 1 in a manner not in accordance with the requirements of the Form 1, the occupational therapist and the adjuster/insurer relying upon the Form 1, may have committed an unfair act or practice, (Section 1.9. and 1. 13 of O. Reg 547/05)

#### **PENALTIES:**

Section 439 of the Insurance Act states:

“Prohibition - no person shall engage in any unfair or deceptive act or practice”.

The Superintendent of Insurance has powers to examine and investigate, in order to determine whether a person has been, or is, engaged in any unfair or deceptive act or practice, pursuant to Section 440.

After investigating, the Superintendent shall report if an unfair or deceptive act or practice has occurred and can order the person to stop the unfair act or practice. The Superintendent also has the power to order the person to cease in engaging in the business of insurance or any aspect of the business of insurance. As well, the Superintendent may order the person to perform the acts that are necessary to remedy the situation.

Under section 447 (2) every person is guilty of an offence who contravenes this Act or the regulations. Section 447 (3) prescribes a penalty on conviction of an offence under the Act. On a first conviction the person convicted is liable to a fine of not more than \$100,000.00 and on each subsequent conviction to a fine of not more than \$200,000.00.

Further, every director, officer and chief agent, of a corporation, who caused or permitted an offence or failed to take reasonable care to prevent the corporation from committing an offence, is liable on first conviction to a fine of not more than \$100,000.00, and on each subsequent conviction, a fine of not more than \$200,000.00, whether or not the corporation has been prosecuted for or convicted of the offence. Where a person is convicted of an offence under the Act, the court making the conviction may, in addition to any other penalty, order the person convicted to make compensation or restitution in relation to the offence.

Persons who wish to report an unfair or deceptive act or practice may do so by writing to the Registrar of Unfair and Deceptive Acts and Practices at the Financial Services Commission of Ontario to the attention of Sirak Sahle, Registrar,  
5160 Yonge Street, P.O. Box 85, Toronto,  
Ontario, M2N 6L9 or by telephone  
(direct) 416-590-7058,  
fax 416-590-8480.

*David F. MacDonald, Partner*



# Key Changes to the Statutory Accident Benefits Schedule

On March 1, 2006 Ontario Regulation 546/05 made under the Insurance Act, came into force. This Regulation dramatically changed the procedure governing motor vehicle accident claims in Ontario.

Included in this edition of the Accident Benefit Reporter are excerpts of a chart prepared by Leonard Kunka, (a partner at Thomson, Rogers specializing in personal injury cases), which highlights the most important changes arising from Ontario Regulation 546/05.

For a complete chart of changes to the legislation please visit our web site at:  
[http://www.thomsonrogers.com/post\\_DAC\\_system\\_chart.pdf](http://www.thomsonrogers.com/post_DAC_system_chart.pdf)



Leonard Kunka  
Partner

## Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System) Effective March 1, 2006

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
INSURER EXAMINATIONS s. 42		<ul style="list-style-type: none"> <li>Insurer only needs to give 5 days notice of a proposed exam (notice can be verbal if followed by a letter confirming it)</li> <li>Insurer's can do as many IE's as they wish except in PAF cases</li> <li>PAF examinations and CAT determination based on GCS of 9 or less must be paper review only</li> <li>Insurer has to make "Reasonable Efforts" to schedule an IE for a time and location convenient to the insurer-within 30 km of insured's house unless they live outside a geographical region defined in the legislation</li> </ul>	<ul style="list-style-type: none"> <li>This is a very short window of notice for an examination</li> <li>Expanded right of insurer to do examinations</li> <li>The 30 km restriction says nothing about IE doctors traveling to do the examination, and therefore there is no practical restriction on the insurer's ability to conduct IE's with whomever they wish</li> </ul>
DUTY TO PROVIDE MEDICAL INFORMATION TO IE ASSESSOR s. 42(10)		S. 42(10) REQUIRES THE INSURED to provide to the IE assessor within 5 business days of the notice of the appointment "all reasonably available information and documents that are relevant or necessary for a review of the insured person's medical condition", and if an attendance is required at the IE, the insured "shall submit to all physical, psychological, and functional examinations requested by the person or persons conducting the examination"	<ul style="list-style-type: none"> <li>This requirement is unduly harsh on injured parties. There is virtually no way an insured will be able to obtain the necessary medical information and test results (most often in the hands of 3rd parties) within this short time period</li> <li>What is relevant and necessary information for the IE assessor is unclear and subject to dispute</li> <li>"all reasonably available information and documents that are relevant or necessary for a review of the insured person's medical condition" should be interpreted to mean only that documentation which the insured has in their possession at the time the s. 42 IE is requested</li> </ul>

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Effective March 1, 2006**

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>TIME PERIODS FOR DELIVERY OF IE REPORTS</p> <p>s. 42(10) s. 42(11)</p>		<ul style="list-style-type: none"> <li>• The IE assessor need not provide a report until s. 42(10) has been complied with</li> <li>• Where no examination of insured required:               <ul style="list-style-type: none"> <li>-exam completed and report delivered within 10 days if exam relates to a person with a CAT injury, and in all other cases within 5 days</li> </ul> </li> <li>• If a physical examination is required, the exam must take place within 30 days of compliance with s. 42(10) for CAT injuries and the report is to be delivered 10 days after the examination</li> <li>• For Non-CAT injuries, the assessment is within 10 days after compliance with s. 42(10) and the report is to be delivered 10 days after the exam</li> <li>• The Insurer can withhold conducting the examination until s. 42(10) has been complied with, see s. 42(12)</li> <li>• Each of the benefit sections permit withholding of benefits if the insured does not comply with s. 42(10) without explanation</li> </ul>	<ul style="list-style-type: none"> <li>• This will lead to potentially long delays in the IE being conducted, and delays in the insured receiving benefits</li> </ul>
<p>EXAMINATION COSTS REPLY REPORTS: COSTS PAID FOR RESPONDING TO AN IE REPORT</p> <p>s. 42.1</p>	<ul style="list-style-type: none"> <li>• No such provision existed</li> </ul>	<p>The insurer must pay the reasonable fees charged by a health care professional for responding to the insurer's IE (s.42) report, if:</p> <p>The examination and responding report is limited to those parts of the s.42 IE the insured person disagrees with, and that are relevant to the denial of the claim</p> <ul style="list-style-type: none"> <li>• If the assessment is for a catastrophic determination, or if the insured person is already designated CAT, the responding report must be sent to insurer within 80 business days, otherwise 40 business days</li> </ul>	<ul style="list-style-type: none"> <li>• This is allegedly the section that expands the right of the insured person to have a treating provider respond to the insurer's IE. The amounts payable by the insurer may be inadequate in many situations. There is no limit on the amount the insurance company can pay their expert. The fees that are allowed include transportation, examination and reporting</li> <li>• Practically speaking the insured will not be able to get more than one responding report for the maximum of \$900. Many specialists will not even respond for that amount</li> </ul>

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Effective March 1, 2006**

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>EXAMINATION COSTS</p> <p>REPLY REPORTS: COSTS PAID FOR RESPONDING TO AN IE REPORT</p> <p>s. 42.1</p> <p><i>Cont'd</i></p>		<ul style="list-style-type: none"> <li>• Where the insurer's s.42 IE is a paper review and the IE doctor is a member of the same health profession as the original provider, the assessment and report is limited to matters relating to the s.42 IE</li> <li>• If the reply assessment and/or report is prepared by a GP or some other health care provider, the amount payable by the insurer is limited to \$775. If a physician specialist does the assessment and report, \$900 is the maximum charge</li> <li>• There is no monetary limit on responding reports if the insured person is CAT</li> <li>• The responding report to be from the same person who completed the original form unless the IE assessor was from a different health professional or different specialty or the IE was multi-disciplinary</li> <li>• The responding review is limited to a review of the same s. 42(10) material the IE assessor reviewed;             <ul style="list-style-type: none"> <li>a) where the IE examiner and the responding person are of the same qualifications, or</li> <li>b) where the original IE exam was limited to a review of only the s.42(10) material, or</li> <li>c) where the assessment relates to a claim for med/rehab benefits and an assessment or exam of the insured with respect to the same accident has been conducted within the previous 12 months</li> </ul> </li> <li>• The responding report does not oblige the IE doctor to comply with its findings – s. 42.1(10)</li> <li>• The report is only to be used “for the purposes of assisting in the resolution of a dispute in accordance with sections 280 – 283 of the Act.</li> </ul>	<p>Secondly, where multiple reports are necessary, the \$900 limit still applies. The insured is therefore at the mercy of the insurer who can conduct unlimited IE's with no cost restrictions</p> <ul style="list-style-type: none"> <li>• The old legislation matched examinations by type of practitioner. However, in the new legislation, the \$900 maximum cost restriction on responding reports, will limit the insured's ability to respond. The practical effect is that the insured may be limited to one responding report, even where the IE is a multi-disciplinary report of several medical practitioners</li> <li>• The extensive powers given to the insurer under s. 42 allow insurers to examine an injured party as often as they wish, with as many IE doctors as they wish, with no financial constraints on their ability to conduct these examinations. Contrast this to the highly constrained and financially restricted ability of the insured to respond to the IE reports</li> <li>• The effect of these changes is to create a very complex piece of legislation for the insured to navigate through. Often the insured will not be able to afford a lawyer to assist them in navigating through these rules and tight time periods, and the insured will therefore be at the mercy of the insurer, which has virtually limitless ability to assess the insured</li> <li>• The changes to the legislation are a major movement away from the principal under the previous legislation that an injured party's treatment should be governed by their treating medical practitioners</li> </ul>

## Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System) Effective March 1, 2006

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>CONSULTATION BY AN IE DOCTOR WITH A TREATING HEALTH PROVIDER</p> <p>s. 24.1(1)1 s. 24.1(1)2 s. 24.1(1)3</p>	<ul style="list-style-type: none"> <li>No such provision existed</li> </ul>	<ul style="list-style-type: none"> <li>The insurer must pay the reasonable fees charged by a member of a health profession for consulting with a person who is conducting an examination of the insured person under section 42 (IE), if the conditions of 24.1 (1) are satisfied</li> </ul> <p>Conditions:</p> <ol style="list-style-type: none"> <li>1) Consultation is with the medical practitioner who prepared the disability certificate or treatment plan or Form 1</li> <li>2) The treating medical Practitioner has to agree to the consultation</li> <li>3) Fees cannot exceed the charge for a 30 minute telephone consultation</li> </ol>	<ul style="list-style-type: none"> <li>This allows a 30-minute consultation between the insurer's doctor and one of the injured party's care providers who has prepared the disability certificate, the treatment plan, the assessment of attendant care needs or the catastrophic application</li> <li>It is difficult to see how the insured will benefit from allowing the insurer's doctor to consult with treating health care professionals</li> </ul> <p><b>Note:</b> <i>The treating medical practitioner should ensure they have the consent of their patient to speak to IE doctor.</i></p>
<p>FAILURE TO NOTIFY WITHIN 7 DAYS</p> <p>s. 32(6)</p>	<ul style="list-style-type: none"> <li>Insurer could delay benefits for 45 days after receiving application s. 32(6)</li> </ul>	<ul style="list-style-type: none"> <li>Insurer can delay benefits for the LATER of 45 days after receiving application or 10 business days after the day the person complies with ANY request made by the insurer under s. 33 for information</li> </ul>	<ul style="list-style-type: none"> <li>Harsher penalty to the insured for failing to give notice within an already very short notice period</li> </ul>
<p>PRE-CLAIM EXAMINATION</p> <p>s. 32.1</p>	<ul style="list-style-type: none"> <li>No such provision existed</li> </ul>	<ul style="list-style-type: none"> <li>Allows insurer to request an examination of the insured by one or more health professionals of the insurer's choice while insured is still in hospital or long-term care facility or within 3 days of discharge</li> <li>Exam at insurer's expense</li> <li>Insured must consent to exam</li> <li>Can occur only if no application for benefits has been made</li> <li>Any refusal to consent to this examination cannot affect the rights of the insured to benefits</li> <li>Insurer cannot rely on report to deny a benefit claimed later</li> </ul>	<ul style="list-style-type: none"> <li>The pre-claim exam is purely an expansion of the insurer's right to examine the injured party</li> <li>There is no obligation on insurer to follow any of the recommendations made as a result of a pre-claim exam</li> <li><b>INSURED SHOULD NOT CONSENT TO THIS EXAMINATION</b></li> </ul>

**Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System)  
Effective March 1, 2006**

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
PRE-CLAIM EXAMINATION s. 32.1 <i>Cont'd</i>		<ul style="list-style-type: none"> <li>Report from pre-claim exam to be delivered within 5 days to insurer, insured and insured's health practitioner</li> </ul>	
SPECIFIED BENEFITS IRB, NON-EARNER, CAREGIVER, HOUSEKEEPING & HOME MAINTENANCE s. 35	<ul style="list-style-type: none"> <li>Each of these benefits had their own section</li> </ul>	<p>s. 35 now lumps these benefits into one section and requires that the</p> <ul style="list-style-type: none"> <li>Insured "shall" submit a completed disability certificate (not older than 10 days) with the application for any specified benefit</li> <li>Within 10 business days the insurer must:               <ol style="list-style-type: none"> <li>pay the benefit;</li> <li>send a request to the insured for information under s. 33; or</li> <li>request an IE under s. 42</li> </ol> </li> </ul> <p>If IE is requested then the IE procedure and time limits under s. 42 kick in</p>	<ul style="list-style-type: none"> <li>Even if insurer requests information under s. 33, they can request an IE after receiving that information</li> <li>No obligation on insurer to pay specified benefits while waiting for disability certificate or if insured does not attend IE</li> <li>Many built-in ways the insurer can avoid paying the specified benefit by the combination of s. 33 and s. 42 if the insured does not supply all the information required under those sections and within the tight time limits of those sections</li> <li>Could result in long delays before specified benefits are paid</li> <li>Only penalty for insurer not supplying IE within time periods specified in s. 42 is that insurer has to pay the benefit from 15 days after the IE up to the date the report is delivered</li> <li>Insurer has to pay back withheld benefits if the insured person provides a reasonable explanation for not attending IE, if the insurer determines that the insured person is entitled to the specified benefit</li> </ul>
DETERMINATION OF CONTINUING ENTITLEMENT TO SPECIFIED BENEFITS s. 37	<ul style="list-style-type: none"> <li>s. 37 previously outlined procedure for refusal or stoppage of IRB, Caregiver or Non-Earner Benefit</li> </ul>	<ul style="list-style-type: none"> <li>New section outlines procedure for "Determination of Continuing Entitlement to Specified Benefits"</li> <li>Insurer shall request a new disability certificate to determine if benefit is still payable or request insured to attend an IE</li> <li>Insured has 15 days to supply disability certificate</li> </ul>	<ul style="list-style-type: none"> <li>If insured does not submit new disability certificate within 15 days, insurer does not have to pay benefits from the 15th day after the insurer's request up to the time the insured complies. This is very difficult when treating healthcare providers who author disability certificates are busy and appointments are difficult to secure</li> </ul>

**Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System)  
Effective March 1, 2006**

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>DETERMINATION OF CONTINUING ENTITLEMENT TO SPECIFIED BENEFITS</p> <p>s. 37</p> <p><i>Cont'd</i></p>		<ul style="list-style-type: none"> <li>• Insurer to continue paying benefit unless the insured fails to submit the new disability certificate, or the insurer receives IE and decides to terminate the benefit (no matter what IE report says), or the insured fails to attend IE, or fails to supply necessary information to IE doctors, or other enumerated reasons</li> <li>• If insured fails to supply information to IE doctor or fails to attend IE and later complies, insurer to repay withheld benefits, if insured provides reasonable explanation within 10 days</li> <li>• If insurer wishes to terminate a benefit after IE, it must keep paying until IE report and explanation of the denial has been given to insured</li> </ul>	<ul style="list-style-type: none"> <li>• Unlike the DAC system, there is no obligation on the insurer to pay the benefit even if the IE supports the payment of the benefit</li> </ul>
<p>MEDICAL &amp; REHABILITATION BENEFITS</p> <p>s. 38</p>	<ul style="list-style-type: none"> <li>• Application for assessment to determine medical and rehabilitation benefit entitlement</li> </ul>	<ul style="list-style-type: none"> <li>• Applications for Assessment are submitted with the treatment plan for all med/rehab expenses that are not PAF</li> <li>• Insurer not required to pay for med/rehab benefit without application for the benefit, except for ambulance and emergency goods &amp; services within first 5 days of accident</li> <li>• Application for med/rehab benefit must include: signature of insured unless waived by insurer; treatment plan; statement by a health practitioner approving the treatment plan and stating that expenses are reasonable and necessary and not PAF; contents of treatment plan outlined in s.38(3)</li> <li>• Within 10 days after receipt of application, insurer shall give one of the following notices to the insured: disclosing any insurer's conflict of interest; outline of goods/services insurer agrees to pay; outline of goods/services</li> </ul>	<ul style="list-style-type: none"> <li>• Social workers are now included in list of health care professionals who can complete a Treatment Plan</li> </ul>

**Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System)  
Effective March 1, 2006**

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>MEDICAL &amp; REHABILITATION BENEFITS</p> <p>s. 38</p> <p><i>Cont'd</i></p>		<p>insurer does not agree to pay and request s. 42 IE; advising that a good/service falls under PAF guidelines and s. 42 IE is required to determine same</p> <ul style="list-style-type: none"> <li>• Insurer to pay for the goods/services under treatment plan from 11th day after receipt of the application up to date of notice</li> </ul>	
<p>ATTENDANT CARE BENEFITS</p> <p>s. 39</p>	<ul style="list-style-type: none"> <li>• 14 days after receiving application insurer must pay or demand Form 1</li> <li>• Where insurer challenges Form 1, a DAC must occur</li> <li>• Insurer required to pay attendant care benefits pending DAC</li> </ul>	<ul style="list-style-type: none"> <li>• Form 1 with new rates has been created</li> <li>• Insured submits an Assessment of Attendant Care Needs from a health professional authorized to treat the impairment</li> <li>• Within 10 days insurer must pay attendant care or request s.42 IE</li> <li>• Insurer must pay attendant care expenses pending IE, but only where an assessment of attendant care needs has been submitted</li> <li>• Insurer may demand repeated attendant care assessments by requesting a new assessment of attendant care needs form, which insured must supply within 10 days of request and further IE if requested</li> <li>• After 104 weeks, insurer can only request one s. 42 IE per year</li> </ul>	<ul style="list-style-type: none"> <li>• Dramatic increase in the insurer's rights to challenge attendant care expenses</li> <li>• Tight time frames for insured to respond to request for further assessment of attendant care needs</li> <li>• The effect of expanded rights of insurer's under s. 39 together with the limited ability of insured's to respond to IEs in s. 42 is a huge benefit to insurers to attack and deny attendant care expenses</li> <li>• The harsh timelines of s. 42 requiring an insured to produce documentation to the IE assessor operates as a further penalty to the insured. It will be difficult for the insured to obtain necessary medical information within the short time periods outlined in s. 42. This can lead to suspension of necessary attendant care benefits to an insured until documentation can be produced</li> </ul>

## Comparison of Old Legislation (DAC System) to New Legislation (Post-DAC System) Effective March 1, 2006

Benefit & Section Number	Old Legislation (DAC System)	New Legislation (Post-DAC System)	Comment
<p>DETERMINATION OF CATASTROPHIC IMPAIRMENT</p> <p>s. 40</p>	<ul style="list-style-type: none"> <li>• Insurer must give notice within 30 days of receipt of application denying or accepting the impairment is CAT. Insurer or insured could request DAC. DAC determination binding</li> </ul>	<ul style="list-style-type: none"> <li>• Insurer must give notice within 30 days of receipt of Application accepting the impairment as CAT or requesting s. 42 IE</li> <li>• If insured was receiving attendant care benefits before the application is made, and if application is within first 104 weeks, the insurer must continue to pay attendant care benefits until determination is made</li> <li>• Insurer must provide report of IE within 5 days of the examination</li> <li>• Insured has the obligation to provide all necessary medical information under s. 42(10)</li> <li>• Same rules apply to the insured and the insurer for failure to comply with s. 42 requirements for medical information-s. 40(7) or for delivery of report</li> </ul>	<ul style="list-style-type: none"> <li>• The only penalty to insurer for not supplying report within 5 days of examination is to require insurer to pay benefits from 15 days after IE doctor receives necessary medical information or 15 days after an examination, until the report is delivered</li> <li>• There is no longer any binding CAT determination short of Arbitration decision or Judicial decision</li> </ul>

*The material in this newsletter is provided for the information of our readers and is not intended nor should it be considered legal advice. For additional copies or information about "Accident Benefit Reporter", please contact Thomson, Rogers.*

