Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A07-002110

BETWEEN:

DAOUD SEYED

Applicant

and

FEDERATION INSURANCE COMPANY OF CANADA

Insurer

REASONS FOR DECISION

Before: Richard Feldman

Heard: March 23, 24 and 25, 2009 at the office of FSCO in Toronto, Ontario

Appearances: Michelle Whiteman, student-at-law, for Mr. Seyed

Nicholaus de Koning, counsel, for Federation Insurance Company of Canada

Issues:

The Applicant, Daoud Seyed, claims that he was injured in a motor vehicle accident on February 12, 2006. He applied for and received various statutory accident benefits from Federation Insurance Company of Canada ("Federation"), payable under the *Schedule*.[1] Disputes arose between the parties concerning the Applicant's entitlement to certain accident benefits. The parties were unable to resolve their disputes through mediation and Mr. Seyed applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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[1] *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996,* Ontario Regulation 403/96, as amended.

The issues in this hearing are:

1. Pursuant to sections 4 and 5 of the *Schedule*, is Mr. Seyed entitled to receive a weekly income replacement benefit at the rate of $400.00 per week from August 9, 2006 to date and ongoing?

2. Pursuant to section 14 of the *Schedule*, is Mr. Seyed entitled to receive a medical benefit for the outstanding cost ($2,490.62) of treatment he received up to February 27, 2009 at St. Clair West Rehabilitation Centre?

3. Pursuant to section 16 of the *Schedule*, is Mr. Seyed entitled to attendant care benefits at the monthly rate of $498.77, less any amounts paid by the Insurer on account of this benefit, for services provided by Alia Safi from February 20, 2007 to February 12, 2008?

4. Pursuant to section 22 of the *Schedule*, is Mr. Seyed entitled to payments for housekeeping and home maintenance at the weekly rate of $100.00, for services provided by Alia Safi from February 13, 2006 through February 12, 2008?

5. Pursuant to section 24 of the Schedule, is Mr. Seyed entitled to the following:

   a. $1,484.00, representing the cost of an orthopaedic assessment proposed by Assessment Direct in a Form OCF-22 dated October 12, 2006; and

   b. $1,500.00, representing the cost of a neurological assessment by Dr. Rehan Dost of Assessment Direct, dated February 6, 2007?

6. Is the Applicant entitled to interest for the overdue payment of benefits pursuant to section 46(2) of the *Schedule*?

7. Is either party liable to pay the other's expenses in respect of the arbitration under section 282(11) of the *Insurance Act*?

Result:

1. This application is dismissed.

2. The decision on expenses is reserved, to be resolved in accordance with Rules 75 through 79 of the *Dispute Resolution Practice Code*.

EVIDENCE AND ANALYSIS:

Brief History

Mr. Seyed moved to Canada in 1984. He holds a Bachelor of Science degree from the University of Devry. He is an educated and articulate man who is proficient in the English language and who has worked for many years in Canada and the United States in computer science. He and his spouse[2], Alia Safi, have three children together who, as of the date of the hearing, were aged 16, 14 and 8.

From August 1999 through August 2002, Mr. Seyed was working in Missouri. From about September 2002 through September 2005, he was living with his spouse and children in an apartment on Lawrence Avenue West in Toronto. In October 2005, Mr. Seyed started a new job with Radiant Systems Inc. as a computer analyst for Caterpillar in East Peoria, Illinois. Commencing January 23, 2006, Mr. Seyed started working as a computer systems analyst (database administrator) with VNU near Chicago, Illinois. While Mr. Seyed was pursuing his career in Illinois, Ms. Safi and their children continued to reside in the apartment in Toronto.

On Sunday, February 12, 2006, the 2000 Toyota Camry owned and operated by Mr. Seyed was struck by another vehicle on the front, passenger-side (above the front wheel) in a "T-bone" type collision. The accident occurred in Niles, Illinois. The police attended the scene of the accident. According to the police report, Mr. Seyed denied that he was injured and declined any medical attention. Mr. Seyed returned to work the next day (Monday, February 13, 2006) and continued

[2]Mr. Seyed testified that he and Ms. Safi are not legally married but he often refers to her as his wife.

to work thereafter without absence. In May 2006, for the first time, Mr. Seyed sought medical attention for back pain and pain in his left shoulder (radiating down his left arm). By mid-May 2006, Mr. Seyed was approved for short-term disability leave from work. At that point, Mr. Seyed returned to live with his spouse and children in Toronto. He has remained in Toronto with his family since then. The short-term disability benefits were continued by the collateral insurer up to August 9, 2006.

Around the time of his return to Toronto, the Applicant retained the legal services of Gary Mazin and, through Mr. Mazin, filed an Application for Accident Benefits with Federation on July 21, 2006. At that time, with the assistance of his counsel, Mr. Seyed elected to claim caregiver benefits and sought Federation's approval for various proposed assessments. What followed was a long and complex series of claims by Mr. Seyed, some of which were approved and some of which were denied. Some of the benefits that were denied now form the basis of this arbitration. What lies at the heart of the current disputes between the parties, however, are the numerous and significant inconsistencies that have arisen in the information that has been provided to Federation and to others by the Applicant and those acting on his behalf.

Credibility is Key

In many cases that come before the Financial Services Commission for arbitration, the alleged impairments of which the applicant complains are related to "soft tissue injuries". There is often little "objective" evidence of such injuries. In such cases, the treating practitioners, medical assessors and arbitrators at the Commission must assess the reliability of the applicant's subjective reports of (amongst other things): (1) the amount of pain he or she is experiencing; (2) the degree to which that pain limits his or her ability to function; and (3) the amount of relief provided by various forms of treatment. Causation may also be an issue, especially if there is a substantial delay between the date of the accident and the date upon which the Applicant first seeks medical attention and/or if there is a history of similar complaints prior to the motor vehicle accident in question. In such cases, the credibility of the applicant is key. This is just such a case. For the reasons that follow, I find that Mr. Seyed has little, if any, credibility. There

are simply too many suspicious circumstances, omissions and deliberate misrepresentations to give any weight to the testimony of Mr. Seyed, his spouse or anyone who relied upon their word.

Past Medical History

Mr. Seyed has not been consistent in what he has disclosed concerning his past medical history. He told most doctors who have seen him since the accident that he has no (relevant) medical history. When he saw Dr. Baghar Oustwani (physician) in Illinois on May 8, 2006, Mr. Seyed indicated that he had had similar back and shoulder pain on two occasions in the previous four years. He told Dr. S.G. Esmail (neurologist) that his pain pre-dated the accident but had gotten worse since the accident. At the hearing, Mr. Seyed testified that he had no health issues prior to the accident in February 2006. These various statements cannot easily be reconciled and they raise concerns both about Mr. Seyed's credibility and the issue of causation.

Delay in Seeking Medical Attention and in Attributing the Complaints to the Accident

According to the police accident report (Ex. 3, Tab 3), there were no injuries suffered by anyone involved in this accident. The report further discloses that emergency medical services (EMS) did not attend the scene and Mr. Seyed declined medical attention.

Around the date of the accident, the Applicant contacted Federation and reported the accident. According to the business records of the Insurer relating to this telephone conversation (Ex. 3, Tab 21), Mr. Seyed advised that his sister and her three children had been passengers in his vehicle and that neither he nor any of them had been injured in the accident. When testifying before me, Mr. Seyed did not mention that there were occupants in his vehicle other than himself. He also did not produce any of them as witnesses at the hearing.

On August 16, 2006, Mr. Seyed made a statutory declaration (Ex. 1, Tab 1, pp. 17-19). It was prepared by Mr. Seyed's legal representative. In this declaration, Mr. Seyed states that, as a result of the collision, he lost consciousness for about 10 minutes and that he sustained injuries to his back and neck.

When describing the accident during his testimony before me, Mr. Seyed also stated that he had lost consciousness and that, upon regaining consciousness, he immediately noticed pain in his neck and head and felt nauseous. He testified that, from the time of the accident onwards, he constantly suffered from neck pain, which triggered severe headaches and felt a "stabbing pain" in his left arm, with numbness and tingling in the extremities of that arm. Mr. Seyed testified that he handled the constant pain by taking over-the-counter medication until he could not bear it any longer and then went to see Dr. Oustwani on May 8, 2006.

A review of the records of Dr. Oustwani reveals that Mr. Seyed told him during this first examination (May 8, 2006) that he had been suffering from pain for about two weeks and makes no mention whatsoever of having been involved in a motor vehicle accident three months earlier. Mr. Seyed does tell Dr. Oustwani, however, that he had suffered from two previous episodes of similar pain in the past four years. Similarly, there is no mention of the accident when Mr. Seyed sees Dr. Oustwani on May 11 and May 15, 2006. Not surprisingly, Dr. Oustwani makes no mention of a motor vehicle accident when he completed a disability certificate for Mr. Seyed on May 15, 2006 (so that Mr. Seyed could obtain short-term disability payments).

Mr. Seyed then returned to Toronto and saw his family physician, Dr. Shahnavaz Lakhani, on May 18, 2006. A review of Dr. Lakhani's records from the summer of 2006, discloses no mention by the Applicant of his having been involved in a motor vehicle accident.

The first mention of an accident anywhere in the medical records appears to be in a report by Marshall Ross (from North-West Chiropractic & Rehabilitation Centre) to the Applicant's collateral insurer, signed on June 9, 2006 (Ex. 2, Tab 4, pp. 35-36), almost four months after the accident and approximately one month after the Applicant stopped working. Marshall Ross provides a diagnosis of "cervical radiculitis secondary to MVA".

At the hearing before me, Mr. Seyed's explanation for the substantial delay in seeking medical intervention was that he was concerned about the cost. I do not find this explanation to be credible as Mr. Seyed admitted having substantial funds available to him at that time as well as having access to health benefits through his employment that not only could but, in fact, did

cover the cost of visits to Dr. Oustwani and of obtaining an MRI and x-ray of his back and neck in May 2006.

The fact that the police records made at the time of the accident indicate that no one suffered any injuries, combined with a substantial delay in seeking medical attention or telling a medical professional about the accident, is another reason to question both the credibility of the Applicant and whether the Applicant's alleged impairments, even if he were to be believed, have resulted from the accident of February 12, 2006.

Details Concerning the Living Arrangements of the Applicant Before and After the Accident

Having reviewed the documents filed and having heard the testimony of the Applicant, I am satisfied that the Applicant has deliberately misled the Insurer and others as to his living arrangements.

From 1998 through 2007, the Applicant advised Revenue Canada in his income tax returns that he is single and resides at an address in Scarborough, Ontario. At the same time, Mr. Seyed was reporting to the U.S. government that he was married and had three children and, in his U.S. tax returns, was claiming his wife and children as dependents. He was also advising his employers in the U.S. that he was married.

The Applicant's spouse and children were receiving welfare while he was earning an annual income of up to, and sometimes more than, (U.S.) $50,000.00. It was suggested to the Applicant by counsel for Federation (during cross-examination) that his likely motivation for misrepresenting both his residential address and family status to the Canadian government was to ensure Ms. Safi's continued receipt of welfare funds. While Mr. Seyed did not exactly admit this, he did not strenuously deny this allegation either.

Mr. Seyed testified that for the past ten years, except for the times he has been living and working in the U.S., his home has been in Toronto in an apartment at the Lawrence Avenue West address. He has been living there with his spouse and children.[3] When the Applicant first obtained automobile insurance from Federation in 2002, it was the Lawrence Avenue West address that was provided by the Applicant as his home address. In August 2004, still using this address, the Applicant added his wife to the policy as a driver.

In October 2004, however, the Applicant advised the Insurer that his address had changed to an address in Cambridge, Ontario. In March 2005, the Applicant advised the Insurer that he had moved to a different address in Cambridge, Ontario. In November 2005, the Applicant, still using an address in Cambridge, Ontario, added the 2000 Toyota Camry to the policy.

When it suits his purposes, however, Mr. Seyed uses his true address. For instance, in March 2005, when he wished to receive employment insurance benefits, he provided the government with his address on Lawrence Avenue West in Toronto.

At no time prior to the accident did Mr. Seyed ever advise Federation that he was living and working in the U.S. Even after the accident, he maintained that he was living in Cambridge Ontario. In January 2007, when the Insurer was trying to schedule a medical examination of the Applicant (but was trying to do so in the Cambridge area), Mr. Seyed's lawyer wrote a letter on his behalf (Ex. 1, Tab 6, p. 89) advising that Mr. Seyed "currently lives in Toronto for treatment and will not be back to the home in Cambridge for the next couple of months."

The evidence before me clearly shows that, from 2002 to the present, Mr. Seyed has not lived in Cambridge (although his brother does) but apparently he saw some advantage in deliberately misleading the Insurer as to his actual place of residence.

The numerous addresses provided by the Applicant to the U.S. federal government, the Illinois Department of Transportation, his employers, his collateral insurer, his automobile insurer (Federation), the Canadian government and to me (by way of his testimony at the hearing) leaves

[3]They have lived in first one and then another unit within the same apartment building.

me with great doubt as to exactly where and with whom the Applicant was living at the time of the accident.

Contradictory Evidence re Services Required and Services Provided

Initially, the Applicant elected to claim caregiver benefits. In order to qualify for such benefits, he would have had, at the time of the accident, to have been the primary caregiver to his children and to have been residing with them. At the time of the accident, Mr. Seyed was living in Illinois and his children were living in Toronto with their mother, who was a full-time homemaker and caregiver to them. Nevertheless, the Applicant advanced this claim and doggedly pursued it (with the assistance of Mr. Mazin) and continued to submit invoices for caregiver services allegedly incurred by the Applicant until this claim was finally withdrawn by him in January 2007 (Ex. 1, Tab 6, p. 116).

According to the invoices filed for caregiver services, Suhail Idris provided caregiver services (at the rate of $350 per week) in Illinois from February 13, 2006 until May 7, 2006 and then the Applicant's brother, Nimat Seyed, allegedly provided these services (at the same rate) in Toronto from May 8, 2006 through December 31, 2006. Ms. Safi testified that Mr. Idris never cared for her children and that the children resided with her in Toronto during the period that Mr. Idris allegedly was caring for them in Illinois. She also confirmed that Nimat Seyed did very little to care for her children after the Applicant returned to live with her and the children in May 2006.

With respect to the period from February 13, 2006 through May 7, 2006, the Applicant also admitted that his children were not cared for by Mr. Idris. He claimed that this was merely a misunderstanding and thought that the invoices were for the services of Mr. Idris in caring for him (i.e., Mr. Seyed) during this period.[4] This explanation is ludicrous for two reasons. First, I do not accept that Mr. Seyed confused caregiver and attendant care benefits. The caregiver invoices claim that the services allegedly provided by Mr. Idris included: feeding, tutoring and taking [him] for walks.

[4]He claimed that he confused the forms for caregiver services and attendant care.

When this was pointed out to Ms. Seyed at the hearing, he had to admit that Mr. Idris did not help him with feeding or with homework or with taking him for walks. Secondly, for the same period (February 13, 2006 through May 7, 2006), the Applicant submitted invoices to the Insurer in which it was alleged that Ms. Safi was providing him with attendant care services. If I accepted that the Applicant was honestly confused as to the nature of the forms he was submitting, then I would be forced to conclude that he was claiming compensation for duplicate services by different people during the same periods of time.

By making and maintaining claims that are clearly devoid of merit, an applicant runs the risk of undermining his credibility. In this case, Mr. Seyed pursued a caregiver claim where he was not the primary caregiver and his children were not living with him and they were not even living in the same country. Although it was not necessary for me to adjudicate the Applicant's entitlement to caregiver benefits since that claim had been withdrawn by the time this case came to hearing, I nevertheless find that the Applicant's conduct in advancing this claim and in submitting falsified invoices goes to the issue of his credibility. Similarly, the Applicant also submitted invoices for attendant care that were far in excess of the Applicant's needs (as assessed by his own occupational therapist). He also claimed both attendant care and housekeeping benefits beyond the two-year period immediately following the accident despite the fact that, in order to qualify for such benefits, he would have to be found to have suffered a catastrophic impairment and there is no allegation or evidence to support such a finding.

With respect to attendant care services, Ms. Safi allegedly provided services worth between $1,200 and $1,800 each month from February 13, 2006 onwards. Ms. Safi gave a statement to the Insurer (in January 2007) that in February 2006 she left the children with her mother here in Toronto and went to Illinois to look after her husband. In her testimony before me, Ms. Safi admitted that she did not go to stay with the Applicant and that she provided no attendant care services to him prior to his return to Toronto in May 2006. While I accept that her testimony before me on this point was accurate (she did not provide attendant care services to the Applicant in Illinois), she failed to provide any credible explanation for her previous conduct in signing false invoices and making a false statement to the Insurer.

Similarly, Mr. Seyed failed to provide any reasonable explanation for his submitting numerous invoices that were false and misleading.

Again, all of this severely undermines the credibility of the Applicant.

Nature and timing of "re-election"

Mr. Seyed attended an examination under oath on January 10, 2007. At this examination, he finally admitted that, at the time of the accident, he was not the primary caregiver to the children. Consequently, he withdrew his claim for caregiver benefits. On June 11, 2007, approximately 17 months after the accident, 11 months after he stopped receiving income (or income replacement from the collateral insurer) and about six months after he withdrew his claim for caregiver benefits, the Applicant purported to "re-elect" and claim income replacement benefits. Assuming that he is entitled to make such a "re-election", the way in which this claim was advanced only served to add to the Insurer's suspicions in this case and, in all of the circumstances, I think the Insurer's suspicions were warranted.

Exaggeration of Symptoms

As previously indicated, in cases such as this, the credibility of the applicant is of paramount importance. Medical assessors and treating practitioners rely upon the accuracy of the history provided by the applicant, his complaints and reports of the relief provided by various types of treatment. If the applicant withholds important information, exaggerates or otherwise misleads the medical professionals, then their opinions can be given little, if any, weight.

In this case, there is some objective evidence that Mr. Seyed suffers from degenerative disc disease with possible nerve impingement. These conditions, however, may well pre-date the motor vehicle accident or be unrelated to it. Even if the Applicant could prove that the accident caused or exacerbated these problems, the relatively mild condition noted on the x-rays and MRI's would not automatically entitle the Applicant to accident benefits. The real question is the extent to which any noted condition impairs the Applicant's function. This is determined largely

based upon the Applicant's subjective reports of functional limitations, typically related to complaints of pain. If Mr. Seyed lacks credibility, this throws into doubt the opinion of any medical professional who relied largely or entirely upon his word.

There is evidence that Mr. Seyed has exaggerated his symptoms. He has shown up for appointments wearing a neck brace (cervical collar) and/or knee brace and/or wrist brace and/or using a cane even though his occupational therapist has repeatedly recommended against the use of such devices. Dr. Jonathan E. Siegal (psychologist) found evidence of significant symptom magnification and exaggeration (as demonstrated by the results of the Victoria Symptom Validity Test); in fact, the Applicant's score on this test was such that Dr. Siegel concluded that Mr. Seyed had to be making a concerted effort to give the wrong answers (Ex. 6, Tab 23, p. 11). Leslee Wilkinson (registered therapist) found that the symptoms displayed by Mr. Seyed were disproportionate to the diagnoses noted in the latest disability certificate and that his poor functional performance could only be explained by self-limiting behaviour (Ex. 6, Tab 31). Dr. Mah (chiropractor) reported inconsistencies and evidence of pain amplification and found that the clinical examination of Mr. Seyed could not corroborate his reported symptoms. (Ex. 12)

Summary

While the Applicant *may* have suffered some problems with his back, neck and left arm as well as some psychological problems, his application cannot succeed without *credible* evidence as to (amongst other things):

- his condition at the time of the accident;
- his living arrangements at the time of the accident;
- the types of activities in which he was engaged at the time of the accident;
- his condition in the three-month period immediately following the accident and before seeking any medical treatment;

- the cause of any impairments from which he has suffered post-accident
- his functional limitations (if any);
- the caregiver, housekeeping and attendant care services actually provided to the Applicant (if any); and
- the benefit the Applicant derived from various forms of treatment.

For all of the reasons given above, I find that I cannot rely upon the word of the Applicant unless it is supported and corroborated by more credible evidence. The opinions of the medical experts upon whom the Applicant has relied are of no value because they assumed that he was being truthful with them and I have found that such an assumption is unwarranted in this case. It is clear that the Applicant, his spouse, his brother and others have misrepresented what services, if any, were provided to the Applicant. He has shown a willingness to lie when it suits him. There are so many problems with the credibility of the Applicant and his evidence that, on this basis alone, I find that this application ought to be dismissed.

There were, however, some additional arguments advanced by the parties with which I will deal briefly below.

Other Issues

Material Misrepresentation

Pursuant to s. 30(2) of the *Schedule*, the insurer is not required to pay an income replacement benefit or a housekeeping and home maintenance benefit in respect of a person who has made, or who knows of "a material misrepresentation that induced the insurer to enter into the contract of automobile insurance or who intentionally failed to notify the insurer of a change in the risk material to the contract."

In this case, it is uncontroverted (see Ex. 11) that the Applicant never advised the Insurer or its agents that he was residing and working in Illinois at any point prior to the accident on February 12, 2006. It is also uncontroverted that the Insurer considers the Applicant's residing in Illinois to be a "material change in risk" and that, had Federation been advised of the truth, it would have cancelled the policy as Federation is not licensed to issue policies of automobile insurance in Illinois and it does not have statistical data to evaluate the risk, or calculate premiums, associated with an insured person residing and working in Illinois.

Given the Applicant's history of misrepresenting his actual place of residence to the Insurer (both before and after the accident), I infer that his failure to notify the Insurer that he had moved to Illinois was deliberate. Therefore, in addition to the other reasons previously given, I find that the Insurer is also not required to pay any income replacement or housekeeping benefits to the Applicant pursuant to s. 30(2) of the *Schedule*.

Unreported Income

Section 64.1(1) of the *Schedule* provides as follows:

> If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident that occurs after April 14, 2004 shall be determined for the purposes of this Regulation without reference to any income the person has failed to report contrary to that Act or legislation.

The Insurer contends that, pursuant to s. 64.1(1) of the *Schedule*, since the Applicant did not report his U.S. income in his Canadian income tax returns, his pre-accident income should be determined based solely on the income that was reported to Revenue Canada. The evidence demonstrates, however, that Mr. Seyed did report his U.S. income in his U.S. tax returns and I am not satisfied that I have sufficient information before me to conclude that s. 64.1(1) of the *Schedule* is applicable to this case. In any event, given my findings with respect to the credibility of the Applicant and his ineligibility for income replacement benefits as a result of s. 30(2) of the *Schedule*, I find that this is a moot point.

Cost of Assessments

Pursuant to section 24 of the *Schedule*, Mr. Seyed claimed the following:

a. $1,484.00, representing the cost of an orthopaedic assessment proposed by Assessment Direct in a Form OCF-22 dated October 12, 2006; and

b. $1,500.00, representing the cost of a neurological assessment by Dr. Rehan Dost of Assessment Direct, dated February 6, 2007.

With respect to the proposed orthopaedic assessment, the Form OCF-22 was signed by a chiropractor (M. Shteynberg) who would not be performing the assessment and who was not entitled to make the statements required by s. 38.2(2) of the *Schedule*. As a result, this form was invalid (as was pointed out by the Insurer at the time) and Federation was entitled to treat it as a nullity and refuse to pay for the proposed orthopaedic assessment.

With respect to the neurological assessment, it is undisputed that the Applicant failed to comply with the provisions of s. 24(1.1) of the *Schedule* (i.e., failed to seek the Insurer's approval before incurring this expense). The Applicant did not attempt to demonstrate that there were circumstances that would permit an exception under s. 24(1.2) of the *Schedule*.

Thus, had I not disposed of the application on the basis of the Applicant's lack of credibility, his claim for the cost of these assessments would have been dismissed in any event for the reasons set out above.

Cost of Treatment

The Applicant's representatives continued to amend this part of the claim right up to and including the last day of the hearing. The Applicant alleged that, as of February 27, 2009, there was an outstanding account in the amount of $2,490.62 for treatment he received at St. Clair West Rehabilitation Centre. The Applicant, however, failed to produce an account from this

facility up to February 27, 2009 to verify the outstanding amount, show how it was calculated, provide details of the treatment provided and demonstrate to which treatment plans (if any) the outstanding balance relates. The Applicant also did not call a witness from St. Clair West Rehabilitation Centre.

Dr. Larry Frydman, (chiropractor) testified at the hearing on behalf of the Applicant. Dr. Frydman's testimony on the reasonableness of ongoing chiropractic treatment was equivocal at best. The most he would say in favour of the treatment in dispute is something to the effect that if the patient reports that the treatment is helping, it is reasonable. In my view, that is far too simplistic an approach but even if I were to adopt Dr. Frydman's view, this is still based upon the assumption that the patient is telling the truth (both about his symptoms and the degree of relief provided by the treatment in question); such an assumption is not warranted in this case.

Attendant Care

The evidence shows that the Insurer paid attendant care in accordance with the Form 1's it received. The Applicant claimed amounts for attendant care that were far in excess of the amounts recommended by the occupational therapist who assessed his attendant care needs. In the circumstances, this part of the Applicant's claim was also doomed to failure.

Technical Breaches by the Insurer

On behalf of the Applicant, Ms. Whiteman asks that I ignore the Applicant's conduct and focus on the conduct of the Insurer. For instance, the Applicant takes the position that once he "re-elected" and claimed income replacement benefits ("IRBs"), there was no clear and unequivocal denial of this benefit by the Insurer.

With respect to the IRB claim, the timing is a bit complicated.

The first Disability Certificate (Form OCF-3) for the Applicant came from Dr. Bradley Sugar (chiropractor) on July 5, 2006. Dr. Sugar concluded that the Applicant qualified for IRBs and indicated that caregiver benefits were "N/A" (not applicable). Nevertheless, on July 21, 2006, the Applicant chose to claim caregiver benefits instead of IRBs.

The next Disability Certificate was provided by Dr. George Otto (physician) on October 13, 2006. Dr. Otto described the injuries as "lumbosacral strain, cervical spine strain and bilateral leg contusion". He indicated that the first post-accident examination of the Applicant was August 3, 2006 (2006/08/03) and that the onset of disability (inability to work, amongst other things) was May 10, 2006 (2006/05/10). At the time this Disability Certificate was produced, however, the Applicant was still claiming caregiver benefits rather than IRBs.

In January 2007, the Applicant withdrew his claim for caregiver benefits.

In June 2007, the Applicant purported to elect to claim IRBs. From June 2007 onwards, the Insurer began to investigate the IRB claim being advanced by the Applicant. In September 2007, the Applicant commenced an Application for Arbitration but did not include, in that Application, a claim for IRBs.

In December 2007, Dr. Otto provided another Disability Certificate. In this Disabilty Certificate, Dr. Otto asserts that the first post-accident examination was March 8, 2006 (2006/03/08). This Disability Certificate is ambiguous. Under the benefit category "Income Replacement Benefits", when asked if the Applicant was substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident, Dr. Otto ticked off "No" but next to that Dr. Otto wrote: "He is unable to work due to injuries listed above" (for an anticipated duration of 9-12 weeks). He also states that the onset of disability (inability to work, amongst other things) was February 12, 2006. Obviously there are some interesting differences between the two Disability Certificates from Dr. Otto but he was not called as a witness and I am left with the discrepancies and ambiguities contained in these documents.

In January 2008, although there had not been a formal denial of the Applicant's IRB claim, Mr. Mazin requested that this issue be added to the Application for Arbitration that had already been filed. On consent, this issue (i.e. the IRB claim) was first mediated and then added to this arbitration proceeding.

The Applicant argues that Federation failed to follow the correct procedures in the handling of the IRB claim and submits that, following the reasoning of *Kong and Personal Insurance Company of Canada*[5], Federation should be ordered to pay the benefits claimed on that basis alone (i.e., regardless of the merits of the claim).

I reject this argument for several reasons.

First, it is not clear to me that, in all the circumstances of this case, Mr. Seyed was entitled to make the purported "re-election" from caregiver to income replacement benefits in June 2007. The Applicant relies upon *RBC General Insurance Company and Antony*[6] for the proposition that an applicant can change his or her initial election. In that case, on appeal, it was found that the original election was invalid. Thus, it was not actually considered to be a "re-election". Nevertheless, the Director's Delegate went on to suggest that a re-election might be permitted where there is a reasonable explanation for the delay which would necessarily involve a consideration of a number of factors including: how much time passed between the initial election and the purported re-election, the reasons for the delay, the insured person's reason for seeking to re-elect, the effect of re-election on the amount and duration of benefits and whether re-election would prejudice the insurer's ability to investigate and assess the claim.

In the case before me, Mr. Seyed purported to re-elect almost one-and-a-half years after the accident. No explanation has been given for the delay in the purported re-election but it is clear to me that Mr. Seyed only withdrew his caregiver claim when, at his examination under oath, he was forced to admit facts that demonstrated that there was no valid basis for his original claim for caregiver benefits. There was no suggestion that his original election was invalid; Mr. Seyed

[5](FSCO P06-00007, July 2, 2008), Appeal

[6](FSCO P03-00023, July 22, 2004), Appeal

is an educated man who has no difficulty understanding English and who had the assistance of experienced counsel at the time he elected to claim caregiver benefits. There is also no explanation for the six month delay between the withdrawal of the claim for caregiver benefits and the purported re-election and claim for IRBs. Since this claim came in so late in the history of this case, Federation needed time in which to gather information and decide how it would respond. It appears to me that Federation was acting in good faith by considering Mr. Seyed's request to re-elect and in investigating the merits of his claim rather than summarily rejecting it.

Second, I would limit the *Kong* decision to the facts of that case. In *Kong*, one of the issues (at a motion for interim benefits) was the manner in which the insurer terminated payment of income replacement benefits at a time when, under the *Schedule* as it was then, an applicant had the right, prior to termination, to have his/her entitlement to IRBs assessed at a Designated Assessment Centre ("DAC") and to have the insurer continue paying the IRBs pending the outcome of the DAC assessment. In *Kong*, as a result of the insurer's failure to follow the correct procedures as they existed at that time (i.e., by failing to specify a termination date in the notice of stoppage and by failing to inform the applicant of his right to a DAC assessment), the notice of stoppage was considered a nullity and the insurer was ordered to continue paying IRBs until the insurer complied with requirements of s. 37 of the *Schedule*. At the hearing of the merits of the case, the arbitrator found that Ms. Kong's impairments were not such that she qualified for IRBs but the arbitrator declined to order repayment of amounts that had been paid by the insurer prior to its compliance with s. 37. Subsequently, the *Schedule* was amended and DAC's were eliminated. In the case before me, based upon the date that Mr. Seyed first advanced a claim for IRBs, he no longer had a right under the *Schedule* to a DAC assessment. There is no evidence that Mr. Seyed was prejudiced by not receiving a Form OCF-9 denying his claim to income replacement benefits. There is no issue before me of repayment to Federation of benefits paid to Mr. Seyed. The facts of the present case are distinguishable from those in *Kong*.

Third, as I pointed out in *Galati and Aviva Canada Inc.*[7], there are other remedies for breaches by insurers other than providing a windfall to a person who may not otherwise be entitled to the benefits in question.

Fourth, in my view, it is tantamount to an abuse of process for a person who has deliberately and repeatedly attempted to mislead the Insurer to attempt to gain an advantage by relying upon some technical deficiency in the Insurer's handling of the file.

Conclusion

For all of the foregoing reasons, this application shall be dismissed.

EXPENSES:

The parties made no submissions on expenses. If they are unable to resolve this issue, either party may make an appointment for me to determine the matter in accordance with Rules 75 through 79 of the *Dispute Resolution Practice Code*.

Richard Feldman Arbitrator	June 8, 2009 Date

[7](FSCO A04-001256, August 19, 2005)

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A07-002110

BETWEEN:

DAOUD SEYED

Applicant

and

FEDERATION INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. This Application is dismissed.

2. The decision on expenses is reserved, to be resolved in accordance with Rules 75 through 79 of the *Dispute Resolution Practice Code*.

Richard Feldman
Arbitrator

June 8, 2009
Date