Official Journal of the Ontario Insurance Adjusters Association • Vol. 89 • No. 1 • SEPTEMBER 2024

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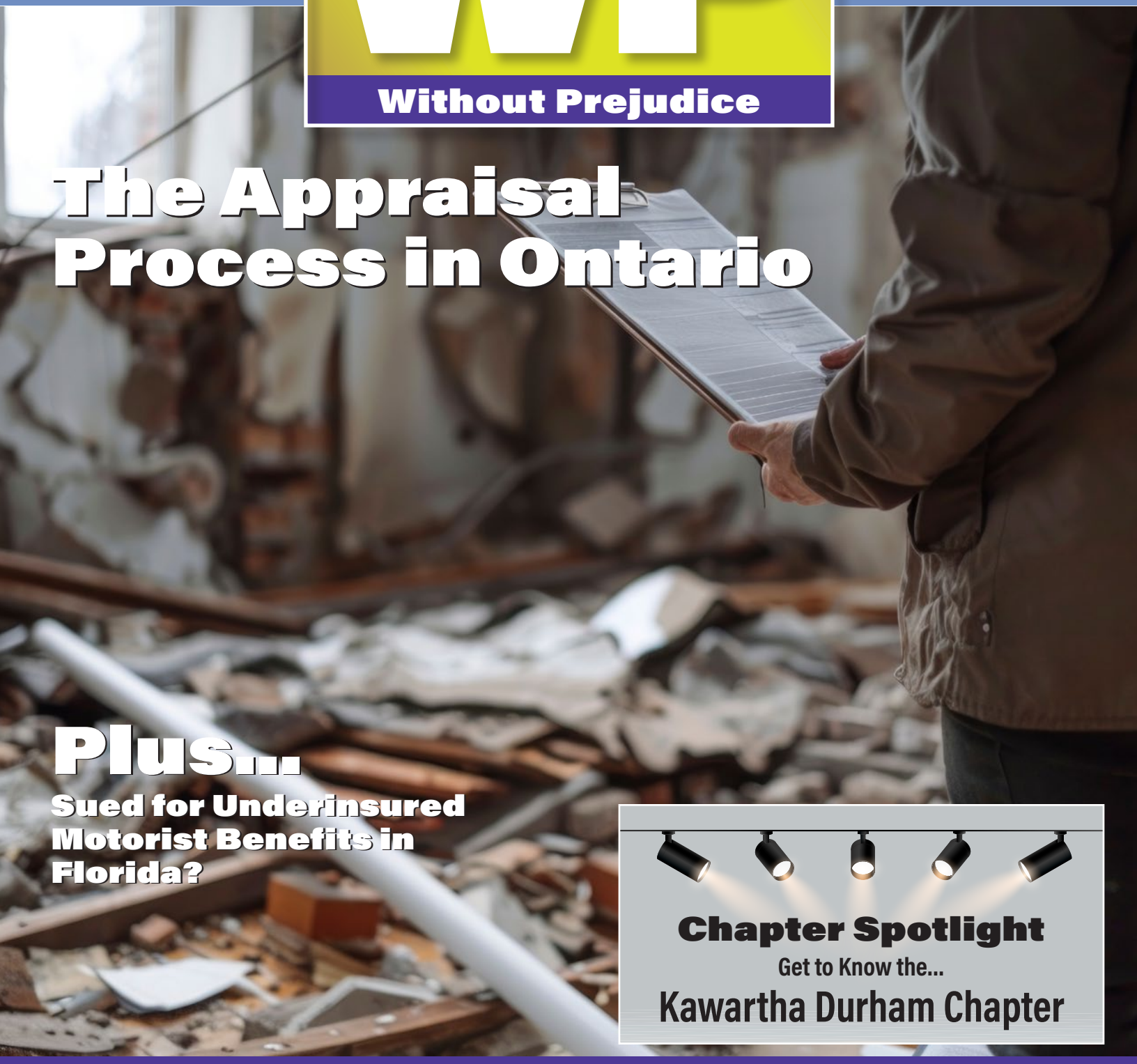

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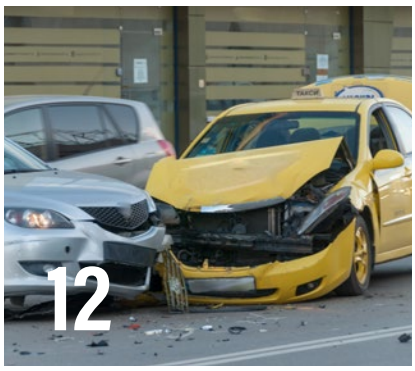

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President's Message

SHAWNA GILLEN, CFEI
President, CIP

When I think of September, I think of new beginnings. It is Back to School for the kids, and of course, the start of a new year for the Ontario Insurance Adjusters Association (OIAA). It is with much excitement and anticipation that I begin my tenure as the OIAA President for the 2024-2025 year. I am truly humbled to act as your President for this year.

This is my 10th year with the OIAA Provincial. I started in September 2015 as a Toronto Delegate. During my time as a Toronto Delegate, I acted as the Advertising Manager, Editor of the WP (Without Prejudice), and as the Chair of the Claims Conference. I have been working in the insurance industry since 2001 and have held numerous roles within claims including working as a Claims Examiner in Accidents Benefits, an Independent Adjuster handling all types of Auto claims, Claims Manager of Commercial Auto Claims, and Claims Manager of Accident & Health Claims. My current position is Compliance Manager (Claims) at Facility Association. I wish to thank my previous employer, AIG Insurance Company of Canada and my current employer, Facility Association for their encouragement and patience which has allowing me to volunteer with the OIAA for all these years.

I want to start out by thanking Kyle Case who last acted as the OIAA Past President in 2023-2024. Kyle volunteered with the OIAA both on the London Chapter and Provincial Chapter. Kyle's contribution and commitment to the OIAA has been dedicated and unwavering. Kyle will be very much missed and I would like to wish him the best in all his future endeavours! I look forward to seeing him at our Past President's Nights in the future!

I would also like to thank our outgoing President and now Past President, Terry Doherty for his contribution last year, and in the years prior, to both the Thousand Islands Chapter and Provincial Chapter. Terry introduced combining our Holiday Party and Past President's Night and moving the OIAA Claims Conference to April. Both of these changes received positive feedback from our membership and will be continued in the 2024-2025 year. Terry planned many events last year which took place around the province. This included a Wine Tasting event in Niagara, Hockey Night in Oshawa and a St. Patrick's event in Kingston. Terry introduced WP Radio several years ago and I am sure many of you have seen him with microphone in hand! Thank you for all of your hard work and contribution!

I would like to introduce the rest of the Senior Executive for the 2024-2025 year. Jennifer Brown is our First Vice President. Jen has been a dedicated member of the OIAA on both the Kitchener-Waterloo Chapter and Provincial Chapter for many years. Emily Feindel is our Second Vice President and acted as Toronto Delegate prior to her tenure on the Senior Executive. Carrie Keogh is our Treasurer and has

been the Chapter Delegate for Kitchener-Waterloo, as well as serving on the board with the Kitchener-Waterloo Chapter. Lastly, I would like to introduce, Christine Andrews who is our Secretary. Christine has previously acted as the Hamilton Chapter Delegate and has served on the Hamilton Chapter's board.

I am very excited for the coming year and to announce the OIAA's charity for the 2024-2025 year, Holland Bloorview Kids Rehabilitation Hospital. Holland Bloorview provides both inpatient and outpatient care for children with disabilities, children needing rehabilitation after illness or trauma, and children whose medical complexity requires a kind of care they cannot receive elsewhere.

Our first event is the September Kick Off taking place on Wednesday, September 25 at Junction Underground in Toronto. The event will feature a live karaoke band, Good Enough Live Karaoke (GELK). I hope whether you want to sing or watch your colleagues sing their hearts out that you will join us for what will be a fun-filled event. Tickets for the September Kick Off can be purchased on our website at www.oiaa.com. There are also sponsorship opportunities available.

Followed closely by our Holiday Party/Past President's Night taking place on Wednesday, December 4th. The location and theme are secret for now and to be revealed at the September Kick Off, and our website and social media following the Kick Off.

The Claims Conference will take place on Wednesday, April 2, 2025 at the Metro Convention Centre. Our last event of the 2024-2025 year, will be the Golf Tournament. Details to follow.

Again, I am looking forward to the 2024-2025 year and would welcome your comments and feedback. Please feel free to reach out to me at sgillen@facilityassociation.com.

Yours truly,
SHAWNA GILLEN, CIP
President
Facility Association
(437) 962-5820

OIAA - EXECUTIVE COUNCIL 2024 – 2025

SHAWNA GILLEN, *CIP*
President
Facility Association
(437) 962-5820
E-mail: sgillen@facilityassociation.com

JENNIFER BROWN, *FCIP*
First Vice-President
Echelon Insurance
416-427-1324
E-mail: jenniferbrownfcip@outlook.com

EMILY FEINDEL
Second Vice-President
AIG Insurance Company of Canada
(416) 596-3917
FAX : (855) 453-1063
E-mail: emily.feindel@aig.com

CHRISTINE ANDREWS, *CRM, FCIP*
Secretary
Sage Claims Solutions Inc.
(905) 389-4522
E-mail: Christine@sageclaims.ca

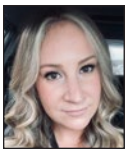
CARRIE KEOGH, *BA Hons.*
Treasurer
Co-Operators, Cambridge
Email: Carrie.anne.keogh@gmail.com

TERRY DOHERTY, *CFEI*
Past President
Aviva Canada Inc.
(613) 386-5513
FAX: 1-866-805-8585
E-mail: terry.doherty@aviva.com

SHERI TURNER
Georgian Bay Delegate
West Wawanosh Mutual Insurance Company
(800)265-5595 ext 883
Email sheri.turner@wwmic.com

Jeni Hamu, *B.Soc., CIP, CRM*
Hamilton Delegate
Travelers Canada
(289) 242-5297
E-mail: jhamu@travelers.com

Nadine Dionne, *BA, CIP*
Kawartha/Durham Delegate
ClaimsPro
(289) 387-0936
E-mail: Nadine.dionne@claimspro.ca



KAYLA HELMOND, *CIP*
Kitchener-Waterloo Delegate
Gore Mutual
1-844-974-4673 ext. 4240
FAX: 1-800-601-9773
E-mail: KHelmond@GoreMutual.ca

MICHELE FIELD, *FCIP*
London Delegate
Trillium Mutual Insurance Company
(519) 291-9300 ext. 5713
FAX: (519) 291-1800
E-mail:mfield@trilliummutual.com

ROB FIORIDO, *CIP*
Niagara Delegate
Portage Mutual Insurance
(289) 974-0211
FAX: (289) 937-4919
E-mail: rfiorido@portagemutual.com

MIKE BOTTAN, *CIP, CFEI*
Northern Delegate
Crawford and Company Canada Inc.
(705) 647-6781
FAX: (705) 647-6783
E-mail: Mike.bottan@crawco.ca

MARGARET MACKENZIE
Ottawa Delegate
Travelers Canada
(613) 780-6498
E-mail: MAMACKEN@travelers.com

ERIN SHEARD
Thousand Islands Delegate
Claims Pro
(613) 777-3811
E-mail: erin.sheard@claimspro.ca

CLAIRE RICHARDSON, *BA, CIP*
Thunder Bay Delegate
Sedgwick
(807) 345-7676 ext.1
E-mail: claire.richardson@sedgwick.com

NATALIE BARROW, *CIP*| Claims Adjuster
Toronto Delegate
Sedgwick Canada Inc
DIRECT 905.709.5072 | CELL 437.424.3471
E-mail: Natalie.Barrow@sedgwick.com

SHERRY DESAI, *CIP, CRM, ACS*
Toronto Delegate
AIG Insurance Company of Canada
(416) 646-3722
FAX : (855) 326-5546
E-mail: shery.desai@aig.com

ZOHAIR M. NASSUR, *BBA, AIII, CertCII, CertCILA, GIE*
Toronto Delegate
Sedgwick Canada Inc
(437) 286-1791
E-mail: zohair.nassur@sedgwick.com

JOEL BOBB, Claims Adjuster
Toronto Delegate
Axis Reinsurance Company
(416) 361-6663
M: (437) 216-1637
E-mail: joel.bobb@axiscapital.com

PETER REIDIGER, *CIP*
Windsor Delegate
ClaimsPro
(226) 782-1469
E-mail: peter.riediger@scm.ca

OIAA - EXECUTIVE COUNCIL COMMITTEES 2024 – 2025

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FOR THE MAGAZINE

JENNIFER BROWN
Managing Editor

NADINE DIONNE,
Associate Editor

JENI HAMU,
Associate Editor
Articles

NADINE DIONNE,
Advertising Manager

NATALIE BARROW
Articles

CONTRIBUTORS

Michael L. Forte
Michael L. Forte is a partner at the Tampa office of Rumberger, Kirk & Caldwell, P.A. He defends Canadian insureds and insurers in state and federal courts throughout Florida.

Daniel Strigberger
Daniel loves coverage. Want to know if the "your work" exclusion applies? Ask Dan. Want to know if a "house" is a "home"? Ask Dan. Want to know the best toppings to cover a pizza? Don't ask Dan: He can't eat gluten. But he does digest various insurance policy definitions, wordings, and exclusions without any heartburn.

Glenn Gibson
"Glenn has been actively involved across Canada in the appraisal / ADR process as both an appraiser and umpire for over 35-years. His white paper on this process has been cited several times in legal decisions."

Jodie Therrien
Jodie graduated from the University of Guelph with a Bachelor of Arts (Hons.) in Criminal Justice and Public Policy. She then obtained her Paralegal Diploma from Sheridan College. After practicing as a Paralegal, she obtained her Juris Doctor from the University of Windsor in 2019. Jodie was called to the Ontario bar in 2020. Prior to joining ZTGH, Jodie articled at a prominent full-service law firm. She then practiced at a Boutique Toronto Insurance Defence Firm, where she gained experience in tort and accident benefits claims. Jodie joined ZTGH in 2022. She has experience in the practice areas of: Health Law, Pollution, Class Actions, Product Liability, Property, Tort, Accident Benefits, Priority Disputes, and Fraudulent and Suspicious Claims As in life, Jodie employs a candid approach with her practice, and prides herself on her communication skills.

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OIAA

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GARDAWORLD

Sued for Underinsured Motorist Benefits in Florida?

Not So Fast.

By: Michael L. Forte, Esq. [1]

In Florida, plaintiffs frequently sue not just the other driver involved in a motor vehicle accident, but also their own insurer for underinsured motorist benefits. However, if your company does not write policies in Florida, Florida courts likely do not have jurisdiction over the UM claim, and the case should be dismissed. Two elements must be met for a Florida court to have jurisdiction over a Canadian insurance company: (1) either specific or general jurisdiction under Florida's "long arm" statute; and (2) sufficient minimum contacts with Florida under the U.S. Constitution.

Specific or General Jurisdiction under Florida's "Long Arm" Statute

Florida's long arm statute is found at Section 48.193. The statute lists nine activities that subject a defendant to specific jurisdiction of the Florida court system, when the activity gives rise to a cause of action:

1. Operating, conducting, engaging in, or carrying on a business or business venture in this state or having an office or agency in this state.
2. Committing a tortious act within this state.

3. Owning, using, possessing, or holding a mortgage or other lien on any real property within this state.
4. Contracting to insure a person, property, or risk located within this state at the time of contracting.
5. With respect to a proceeding for alimony, child support, or division of property in connection with an action to dissolve a marriage or with respect to an independent action for support of dependents, maintaining a matrimonial domicile in this state at the time of the commencement of this action or, if the defendant resided in this state preceding the commencement of the action, whether cohabiting during that time or not. This paragraph does not change the residency requirement for filing an action for dissolution of marriage
6. Causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, either:
   a. The defendant was engaged in solicitation or service activities within this state; or
   b. Products, materials, or things processed, serviced, or manufactured by the defendant anywhere were used or consumed within this state in the ordinary course of commerce, trade, or use.
7. Breaching a contract in this state by failing to perform acts required by the contract to be performed in this state.
8. With respect to a proceeding for paternity, engaging in the act of sexual intercourse within this state with respect to which a child may have been conceived.
9. Entering into a contract that complies with s. 685.102.

Florida Statutes Section 48.193(1)(a). See also Yager v. Convergence Aviation Ltd, 310 So. 3d 1276, 1279 (Fla. 5th DCA 2021).

Often, Canadian insurers do not engage in any of the above activities, and do not conduct business in Florida. Rather, they often are incorporated and have headquarters in a Canadian province; issue policies only to Canadian citizens; and use policy language specifying that any claims must be brought in the province where the policy was issued.

"General jurisdiction requires far more wide-ranging contacts with the forum state than specific jurisdiction, and it is thus more difficult to establish." Magwitch, LLC v. Pusser's West Indies Ltd., 200 So. 3d 216, 218 (Fla. 2d DCA 2016) (quotation omitted). For general jurisdiction, a plaintiff must show continuous, systematic, extensive and pervasive contacts between the defendant and Florida. Woodruff-Sawyer & Co. v. Ghilotti, 255 So. 3d 423, 429 (Fla. 3d DCA 2018). The plaintiff must show the defendant is "essentially at home in the forum state." Samsung SDI Co., Ltd. v. Fields, 346 So. 3d 1 02, 105 (Fla. 1st DCA 2022).

Plaintiffs sometimes argue that a policy affording coverage in Florida subjects the Canadian insurer to general jurisdiction, but this argument is contrary to Florida law. "The mere risk of loss in a forum, even if foreseeable, is not sufficient to subject a foreign defendant to personal jurisdiction." Hassneh Ins. Co. of Israel, Ltd. v. Plastigonen Techs., Inc., 623 So. 2d 1223, 1225 (Fla. 3d DCA 1993). See also Georgia Insurs. Insolvency Pool v. Brewer, 602 So. 2d 1264, 1267 (Fla. 1992) ("Obligations arising from incidents occurring in another state alone does not result in personal jurisdiction."); Blumberg v. Steve

Weiss & Co., 922 So. 2d 361, 364 (Fla. 3d DCA 2006) ("it is not, however, enough [for jurisdiction] that the actions of a defendant committed outside of Florida ultimately have consequences in Florida.").

In Meyer v. Auto Club Insurance Association, 492 So. 2d 1314 (Fla. 1986), a Michigan insurance company issued an automobile policy to a Michigan resident. The policy covered motor vehicle accidents occurring in any of the 50 states. The insured subsequently was involved in a motor vehicle accident in Florida, and then moved to Florida. He filed suit against the insurance company in a Florida court, seeking medical and lost wage benefits under the policy. The trial court denied the insurance company's motion to dismiss for lack of person jurisdiction under Florida's long arm statute. The appellate court reversed, concluding that Florida courts did not have personal jurisdiction.

At the Florida Supreme Court, the plaintiff insured argued "that issuance of the policy with this territorial coverage brings respondent within the purview of section 48.193(1)(d), as the risk insured against under his policy included the possibility of an accident occurring within any of the states, including Florida." Meyer, 492 So. 2d at 1315. The Court rejected the idea that the insurance company subjected itself to Florida jurisdiction simply by way of covering a loss that occurred in Florida:

At the time this contract was entered into, both parties were located in Michigan, not Florida. The property covered under the policy and the risk insured against were likewise in Michigan, not Florida. These facts clearly negate the applicability of section 48.193(1)(d).

Meyer, 492 So. 2d at 1316. See also Level 8 Mgt., Inc. v. Wildflower Legacy and Wealth Planning, LLC, --So. 3d --, No. 2D2023-2070 (Fla. 2d DCA July 17, 2024); Travel Insur. Facilities, PLC v. Naples Community Hosp., Inc., 367 So. 3d 611, 617 (Fla. 6th DCA 2023) (finding no jurisdiction over a British insurer whose insured was injured in Florida); Strickland Insur. Group v. Shewmake, 642 So. 2d 1159, 1161 (Fla. 5th DCA 1994) ("The policy of insurance can not be read so broadly as to allow the insurer to be sued wherever the insured is involved in an accident, even though the contract of insurance applies to accident and losses which occur in any of the 50 states, Puerto Rico or Canada.").

Sufficient Minimum Contacts with Florida under the U.S. Constitution

Overlaying Florida's long arm statute is the Due Process Clause of the Fourteenth Amendment, found in the U.S. Constitution. Federal due process requires sufficient minimum contacts between the defendant and the forum state, so as to comply with traditional notions of fair play and substantial justice. See Venetian Salami Co. v. Parthenais, 554 So. 2d 499, 501 (Fla. 1989). Because most Canadian insurers have no pertinent contacts with Florida at all, it cannot have the sufficient minimum contacts required by the U.S. Constitution. E.g. Blumberg v. Steve Weiss & Co., 922 So. 2d 361, 365 (Fla. 3d DCA 2006) ("In World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286, 297, 100 S.Ct. 559, 62 L.Ed.2d 490 (1980), the United States Supreme Court held that, in order for a state to exercise jurisdiction in satisfaction of the fourteenth amendment's due process requirements, the defendant's conduct and connection with the forum state must be such that it 'should reasonably anticipate being haled into court there.'").

Conclusion

For the above reasons, a UM claim filed in Florida against a Canadian insurer should be dismissed at the start of the case. See also Gadea, 949 So. 2d 1143, 1149 (Fla. 3d DCA 2007) ("[T]he long-arm statute must be strictly construed, and any doubts about applicability of the statute [must be] resolved in favor of the defendant and against a conclusion that personal jurisdiction exists.").

Michael L. Forte

Michael L. Forte is a partner at the Tampa office of Rumberger, Kirk & Caldwell, P.A. He defends Canadian insureds and insurers in state and federal courts throughout Florida.

Priority Disputes 101:
The Final Frontier

By: Daniel Strigberger

The final article looks at the arbitration and appeal process. As bonus, we also look at another interesting notice provision in O Reg 283/95.

Section 7: Initiating Arbitration

Section 7 of O Reg 283/95 deals with priority disputes that cannot be resolved:

(1) If the insurers cannot agree as to who is required to pay benefits, the dispute shall be resolved through an arbitration under the Arbitration Act, 1991 initiated by the insurer paying benefits under section 2 or 2.1 or any other insurer against whom the obligation to pay benefits is claimed.

(2) If an insured person was entitled to receive a notice under section 4, has given a notice of objection under section 5 and disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the Arbitration Act, 1991 initiated by the insured person.

(3) The arbitration may be initiated by an insurer or by the insured person no later than one year after the day the insurer paying benefits first gives notice under section 3.

(4) Despite subsection (3), the arbitration may be initiated by the Fund at any time before or after the expiry of the time limit set out in subsection (3) if the Fund is paying benefits in respect of an accident that occurred on or after September 1, 2010.

(5) No insured person is entitled to initiate or participate as a party to an arbitration under this section if the insurer paying benefits is the Fund.

(6) If the dispute relates to an accident that occurred on or after September 1, 2010, the failure of an insurer other than the Fund to comply with section 2.1 or 3.1 may be the subject of a special award made by the arbitrator.[1]

Where the insurers cannot agree on priority, the dispute must be resolved in a private arbitration under the Arbitration Act, 1991.[2] This means that neither the courts nor the Licence Appeal Tribunal have jurisdiction to hear priority disputes at first instance.

Section 7(1) stipulates that the arbitration can be initiated by the insurer paying benefits or the insurer(s) that are responding to a priority dispute claim. But I have never seen an arbitration initiated by a responding insurer.

Pursuant to section 7(3), arbitration must be initiated no later than one year after the insurer paying benefits gave a priority dispute notice under section 3, or the claim will be statute-barred.[3] Once the insurer paying benefits gives its section 3 notice, a new one-year limitation period to initiate arbitration starts to tick.

Unlike section 3, there are no saving provisions under section 7, if the one-year limitation is missed. Therefore, insurers must make sure they initiate arbitration properly, pursuant to section 23 of the Arbitration Act, 1991:

Commencement of arbitration

23(1) An arbitration may be commenced in any way recognized by law, including the following:

1. A party to an arbitration agreement serves on the other parties notice to appoint or to participate in the appointment of an arbitrator under the agreement.
2. If the arbitration agreement gives a person who is not a party power to appoint an arbitrator, one party serves notice to exercise that power on the person and serves a copy of the notice on the other parties.
3. A party serves on the other parties a notice demanding arbitration under the agreement.

In practice, we usually initiate arbitration by serving an arbitration notice of some kind to the other insurer(s). There is no standard or prescribed form or pleading for the notice. Some are called Notice to Participate and Demand for Arbitration, or Notice Demanding Arbitration, or Notice to Submit to Arbitration. Whatever the form is named, it should at the very least identify the parties to the arbitration and disclose what the dispute is about. A letter to the same effect is likely satisfactory too.[4] However, to initiate arbitration an insurer must be clear and unequivocal that it is in fact initiating arbitration. A letter saying "we will be initiating arbitration" is not good enough.[5]

Section 8: Procedure for Arbitrations

When the Regulation was amended effective September 1, 2010, section 8 was expanded somewhat to deal with some annoying issues that plagued many priority dispute arbitrations, namely, delay:

8(1) Except as provided in this Regulation, the Arbitration Act, 1991 applies to an arbitration under this Regulation.

(2) The following rules apply with respect to an arbitration of a dispute relating to an accident that occurs on or after September 1, 2010:

1. If an insurer to whom a notice to initiate arbitration is delivered does not respond to the notice within 30 days, the insurer is deemed to have accepted the jurisdiction of the arbitrator proposed in the notice.
2. A pre-arbitration hearing must be scheduled and take place no later than 120 days after the appointment of the arbitrator.
3. Subject to paragraph 4, once a date for the arbitration is scheduled, the arbitration must be conducted on that day.
4. The arbitrator may grant an adjournment on such terms as the arbitrator considers appropriate, but only if there is cogent and compelling evidence of the reasons why the hearing cannot proceed on the scheduled day.
5. Unless consented to by all parties, the hearing of the arbitration must be completed within two years after the commencement of the arbitration.

(3) The decision of an arbitrator made under this Regulation must be made public.

(4) If the decision relates to an accident that occurred on or after September 1, 2010, the decision must be made public,

a. by the insurer that the arbitrator finds to be liable to pay the benefits; and

b. in a manner and form specified by the Chief Executive Officer.1

The first delay tactic (intentionally or not) that responding insurers would use is that they would simply ignore an arbitration notice. To get the matter rolling, the applicant insurer would be forced to apply to the Superior Court for an Order appointing an arbitrator, pursuant to section 10 of the Arbitration Act, 1991. Paragraph 1 under section 8(2) of the Regulation addresses this issue by requiring the respondent insurer to respond to the arbitration notice within 30 days, failing which the insurer is deemed to accept the jurisdiction of the arbitrator proposed in the notice. This provision works well — if the insurer initiating arbitration remembers to propose an arbitrator in their arbitration notice.

Paragraphs 2 to 5 under section 8(2) also seek to accelerate priority dispute arbitrations. Arbitrators have held that the timelines in section 8(2) of the Regulation are directory and permissive, rather than mandatory.[6] In other words, it would be rare for a priority dispute to be dismissed simply because the first pre-hearing wasn't conducted within 120 days of the arbitrator's appointment, or the main hearing wasn't completed within two years.

Section 9: Costs of Arbitration

Section 9 of the Regulation deals with arbitration costs:

9(1) Unless otherwise ordered by the arbitrator or agreed to by all the parties before the commencement of the arbitration, the costs of the arbitration for all parties, including the cost of the arbitrator, shall be paid by the unsuccessful parties to the arbitration.

(2) The costs referred to in subsection (1) shall be assessed in accordance with section 56 of the Arbitration Act, 1991.

In practice, the parties will usually include costs provisions in an Arbitration Agreement.

Section 10: Tiered Notices

In SABS Priority Disputes 101: Notice in 90, I discussed the 90-day limitation period in section 3 of O Reg 283/95:

(1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

Does an insurer giving notice under section 3 need to give a priority dispute notice to any and every insurer that might have priority for the claim? To answer this question, it is necessary to look at the interplay between sections 3 and 10 of the Regulation. Section 10 states:

(1) If an insurer who receives notice under section 3 disputes its obligation to pay benefits on the basis that other insurers, excluding the insurer giving notice, have equal or higher priority under section 268 of the Act, it shall give notice to the other insurers.

(2) This Regulation applies to the other insurers given notice in the same way that it applies to the original insurer given notice under section 3.

(3) The dispute among the insurers shall be resolved in one arbitration.

Section 10 of the Regulation allows an insurer that received a priority dispute notice to bring other insurers into the dispute. Pursuant to section 10(1), an insurer given notice under section 3 cannot dispute priority on the basis that another insurer has priority over it. For example, if Insurer A (first tier insurer) sends Insurer B (second tier insurer) a priority dispute notice, Insurer B cannot dispute priority on the basis that Insurer C (third tier insurer) has priority over it. If Insurer B wishes to defend on that basis, it must send Insurer C a priority dispute notice.

In Co-operators v. Ontario[7], Co-operators (first tier insurer) gave the Fund (second tier insurer) a priority dispute notice within the 90-day notice window. The Fund refused to accept priority, in part on the basis that Co-operators had failed to give a section 3 notice to another insurer (TTC Insurance). The Fund argued TTC Insurance would have had priority over the Fund. (As an aside, during the 90-day notice window it wasn't very clear as to whether a TTC vehicle was involved in the incident.) Co-operators argued that it discharged its obligations under section 3 by giving a bona fidenotice to the Fund under section 3[8], and if the Fund wanted to "point the finger" at TTC Insurance it could have given that insurer a priority

dispute notice under section 10.

The arbitrator and appeal judge rejected the Fund's argument, finding that Co-operators discharged its obligations under section 3 by giving notice to the Fund. Arbitrator Novick wrote:

Mr. Strigberger contends that an insurer should be found to have complied with section 3 as long as it provides timely notice to an insurer who it claims is in higher priority to it. He submits that it is essentially a subjective exercise, and that if with the benefit of hindsight other insurers are later found to be in priority, there should be no penalty to the first insurer for not having provided notice to every last possible priority insurer. I agree with that submission. The words "who it claims" in section 3 modify the requirement imposed on first insurers, and cannot be ignored. In keeping with the rules of statutory and regulatory interpretation, each word in a provision must be assumed to have a purpose and contribute to its overall meaning. If the drafters of the regulation had intended to impose the obligation on a first insurer to provide notice to every potential insurer that could be in priority, those words would not have been included. The fact that they appear in the provision in my view must mean that a first insurer has some discretion in this regard.[9]

Arbitrator Novick applied the same reasoning five years later in Co-operators v. Intact and Northbridge.[10] In this decision, the claimant applied to Co-operators (first tier insurer) for benefits under his spouse's policy[11]. Co-operators investigated priority and identified that he was also a named insured under a policy with Intact. Co-operators gave Intact (second tier insurer) a priority dispute notice. Meanwhile, further investigations revealed that the claimant might have been an occupant of a company vehicle and likely had regular use of the company vehicle at the time of the accident. However, Co-operators erroneously identified the insurer of the vehicle as Economical and sent that insurer a priority dispute notice within the 90-day window. At some point after giving Economical notice, and after the 90th day had passed, Co-operators discovered that the insurer of the company vehicle was Northbridge. Intact then sent a section 10 notice to Northbridge (third tier insurer).

Northbridge disputed Co-operators's claim, arguing that Co-operators was required to give Northbridge a priority dispute notice under section 3. Part of Northbridge's argument was that Co-operators's priority dispute notice to Intact was invalid because there was no way Intact could be higher in priority to Co-operators (a point Co-operators disputed as well).

Referring to her earlier decision in Co-operators v. Ontario, the arbitrator found for Co-operators:

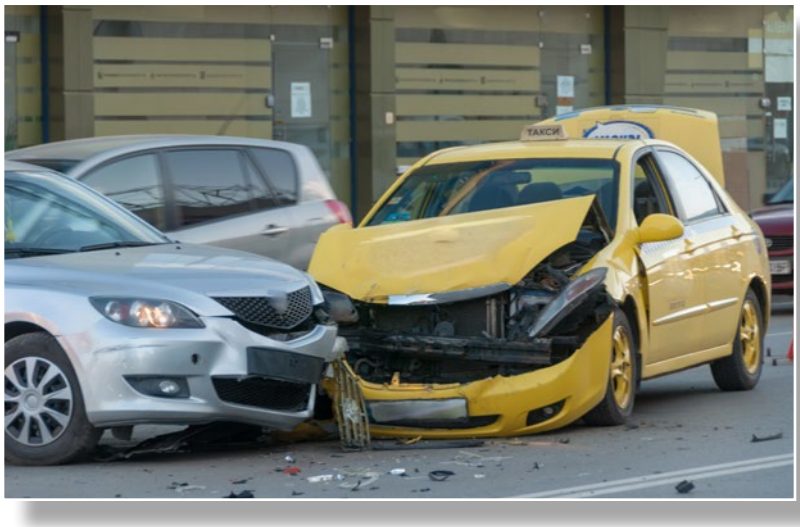
I find that the same reasoning applies in this case. I appreciate counsel for Northbridge's contention that it seems unfair to allow Intact to essentially "save" Co-operators by indirectly doing what Co-operators had failed to do directly. However, when the priority scheme set out in the regulation is considered as a whole, I find that this is permitted. A priority investigation is often like chasing a moving target. As Ms. Darke's evidence revealed, inquiries directed at potential priority insurers can be frustrated, and information is revealed slowly and in a piecemeal fashion. That reality must be balanced against the public policy concern of ensuring that individuals who are in need of benefits receive them on a timely basis.

The regulation addresses this balance by requiring a first insurer to provide notice to insurers who it claims are in higher priority to pay within ninety days of receiving an application for benefits. It then permits those insurers, who have the benefit of more time and a singular focus, to bring in other insurers that they feel are in equal or higher priority. Section 10 clearly spells out that once added, all parties must participate in one arbitration process.

I find that if the drafters of Regulation 283/95 had intended that the first insurer only be permitted to provide notice to an insurer on a higher priority "rung", they would have used clear words to convey that message. In my view, a close reading of section 3 and section 10 do not lead to that conclusion. Instead, these provisions acknowledge the reality that determining priority may take a few steps. Section 3 is designed to "get the party started". Section 10 allows that once the fun begins, others may join in and it does not really matter who arrived with whom, and at what time.[12]

This decision was upheld on appeal.[13]

Arbitrator Bialkowski had an opportunity to deal with a similar issue in Scottish & York v. Belair[14] in the context of a productions motion. In that case, the claimant was an occupant of a taxi involved in an accident. She applied for benefits to S&Y (first tier insurer), which insured the other vehicle involved in the accident. Investigations revealed that the owner of the taxi was insured with Belair, so S&Y gave Belair (second tier insurer) a priority dispute notice under section 3 of the Regulation. Arbitration proceedings began. During the course of the arbitration, Belair's lawyer advised that Belair did not insure taxis and did not insure the vehicle that was involved in the accident. Further investigations by S&Y's lawyer confirmed that the taxi was actually insured with Zurich. Belair (not S&Y) then served Zurich (third tier insurer) with a priority dispute notice under section 10 of the Regulation and an arbitration notice.



Zurich disputed the notice it received from Belair, arguing that the section 3 notice that S&Y had given Belair was "invalid". Like Northbridge's argument in Co-operators, the gist of Zurich's argument was that there was no chance that Belair would ever have priority over this claim, and it was actually S&Y who had conducted the investigations to identify Zurich. It argued that S&Y's reliance on Belair's section 10 notice was a "clear attempt to circumvent the 90 day notice rule which applies to S&Y, as the s. 10 notice will not protect or benefit Belair in any way". Zurich sought production of all communications between the lawyers for the two other insurance companies before the section 10 notice was given.

Arbitrator Bialkowski followed Co-operators and rejected Zurich's submissions. He found there was no basis for a finding that a section 3 notice can only be valid if given to an insurer standing higher in priority. Accordingly, the productions Zurich sought were irrelevant to the issue in the case.

In short, the case law is pretty clear that the insurer giving notice under section 3 (first tier insurer) can rely on any section 10 notices that a second tier insurer gives to a third tier insurer. The result is that the first tier insurer can piggyback on the section 10 notice and pursue priority directly against the third tier insurer.

Finally, the 90-day notice limitation under section 3 does not apply to a notice given under section 10. Insurers trying to read in a 90-day time limit into section 10 have been unsuccessful. In Wawanesa v. Peel Mutual[15], the third tier insurer argued that the second tier insurer had 90 days from the date it received the section 3 priority dispute notice to give a notice under section 10. The arbitrator rejected that argument:

> To apply the Notice rule to the second tier insurer vis-à-vis a third tier insurer does not fit within the provisions of the regulation. The second tier insurer is necessarily not the "first insurer", nor is it the insurer paying benefits under section 2. The second tier insurer is not entitled to be in receipt of a completed (or any) application from the SABS claimant. The second tier insurer does not enjoy the benefit of SABS sections 31 and 32 that allow the SABS insurer to obtain information from the claimant that might assist in identifying higher ranking insurers that should be shouldering the burden of payment.

While meeting the 90 day deadline might be challenging for the first tier insurer, that standard of response seems completely unsuitable when cast over an insurer that lacks the most basic access to information that might be critical to impleading the ultimately responsible insurer. I don't overlook the provisions of section 6 of the regulation in this regard, but note the lack of any compliance parameters that might give hope for a prompt and fulsome response to inquiries made by an insurer that is not administering the claim. At best section 6 is a poor tool if it is to be

used to ferret out priority information in a short time frame.

I conclude that blindly applying the section 3 procedural provisions to second tier insurer actions is not consistent with the wording of the regulation, and is insensitive to the context. To apply the section 3 provisions to second tier insurers would give rise to an injustice, ultimately resulting in the payment of benefits by the wrong insurer. The regulation is designed to facilitate a process that will lead to the cost of a claim being visited upon the correct insurer, without burdening the insured person with prosecution of priority dispute issues. It would be abhorrent to interpret the regulation in a manner which has the opposite result unless that outcome is required by the clear and specific language of the regulation. The language of the regulation does not have that clarity.[16]

Accordingly, there is no prescribed time limit for a second tier insurer to give a third tier insurer a priority dispute notice under section 10 of the Regulation. Ideally, this notice should be given while the one-year limitation period to initiate arbitration is still open.

The Final Frontier

Once the arbitrator releases their decision, section 47 of the Arbitration Act, 1991 prescribes a 30-day deadline to appeal:

Time limit

47 (1) An appeal of an award or an application to set aside an award shall be commenced within thirty days after the appellant or applicant receives the award, correction, explanation, change or statement of reasons on which the appeal or application is based.

The parties' Arbitration Agreement will also usually contain a clause stipulating the same deadline to start an appeal.

Appeals are made to a single judge of the Superior Court. By default, section 45(1) of the Arbitration Act, 1991 limits all appeals to questions of law. If the default provision applies, a party cannot appeal any issues involving questions of fact or mixed fact and law. Further, section 45(1) requires a party to seek leave (get the court's permission) to appeal before they can proceed with the appeal:

Appeal on question of law

45 (1) If the arbitration agreement does not deal with appeals on questions of law, a party may appeal an award to the court on a question of law with leave, which the court shall grant only if it is satisfied that,

(a) the importance to the parties of the matters at stake in the arbitration justifies an appeal; and

(b) determination of the question of law at issue will significantly affect the rights of the parties. 1991, c. 17, s. 45 (1).

Idem

(2) If the arbitration agreement so provides, a party may appeal an award to the court on a question of law. 1991, c. 17, s. 45 (2).

However, insurers are free to add a provision in their Arbitration Agreements that allows them to appeal any questions of fact or mixed fact and law:

Appeal on question of fact or mixed fact and law

45 (3) If the arbitration agreement so provides, a party may appeal an award to the court on a question of fact or on a question of mixed fact and law.

Preserving appeal rights is the most important task when formulating an Arbitration Agreement. Rarely do insurers wish to limit their appeal rights to questions of law only, and having to first seek leave to appeal a decision comes with its own unnecessary risks. Therefore, we always make sure our Arbitration Agreements contain a provision that allows a party to appeal the arbitrator's decision, without leave, on questions of mixed fact and law. I have never agreed to a right to appeal on questions of law only or questions of fact.

Once the Superior Court decides the appeal, the unsuccessful party could try to get leave to appeal the decision to the Court of Appeal. If the Court of Appeal denies leave, the dispute ends according to the Superior Court's appeal decision. If the Court of Appeal grants leave, the appellant would then file a Notice of Appeal and the matter would be heard before three Court of Appeal judges.

After the Court of Appeal's decision is released, a party can try to appeal to the Supreme Court of

Canada, with leave. It is very difficult to get leave to the Supreme Court of Canada in a priority dispute between two Ontario insurance companies. Accordingly, it is much better to win at the Court of Appeal!

[1] Disputes Between Insurers, O Reg 283/95, s 7, https://canlii.ca/t/rvj#sec7

[2] Arbitration Act, 1991, SO 1991, c 17, https://canlii.ca/t/52wr5

[3] Aviva Insurance Co. of Canada v. Pafco Insurance Co., 2018 CarswellOnt 884 (Arbitrator G. Jones).

[4] Gore Mutual Insurance Co. v. Markel Insurance Co., [1999] O.J. No. 2688, [1999] I.L.R. I-3740 (Ont. S.C.J.).

[5] State Farm Mutual Insurance Co. v. Echelon General Insurance Co., 2008 CarswellOnt 11430 (Arbitrator S. Novick)

[6] Economical Mutual Insurance Co. and Unifund Assurance Co., 2017 CarswellOnt 15486, 72 C.C.L.I. (5th) 254 at para. 23 (Arbitrator K. Bialkowski); Pafco Insurance Co. and Wawanesa Mutual Insurance Co., 2016 CarswellOnt 21858 at para. 23 (Arbitrator S. Novick).

[7] Co-operators' General Insurance Co. v. Ontario (Minister of Finance), 2013 CarswellOnt 16186 (Arbitrator S. Novick), affd Co-operators General Insurance Company v. Ontario (Minister of Finance), 2014 ONSC 515 (CanLII), https://canlii.ca/t/g32v4, leave to appeal refused 2014 CarswellOnt 19331 (Ont. C.A.).

[8] The subject accident happened before September 1, 2010, so section 3.1 of O Reg. 283/95 did not apply.

[9] Co-operators' General Insurance Co. v. Ontario (Minister of Finance), 2013 CarswellOnt 16186 at para. 25 (Arbitrator S. Novick).

[10] Co-operators General Insurance Co. v. Intact Insurance Co. and Northbridge General Insurance Corp., 2018 CarswellOnt 877 at paras. 58-60 (Arbitrator S. Novick).

[11] The claimant's spouse applied on his behalf under her own policy because he was incapacitated in hospital. At an examination under oath, she said that she had completely forgotten that her husband had his own policy with Intact.

[12] Co-operators General Insurance Co. v. Intact Insurance Co. and Northbridge General Insurance Corp., 2018 CarswellOnt 877 at paras. 58-60 (Arbitrator S. Novick).

[13] Co-operators General Insurance Company v. Ontario (Minister of Finance), 2014 ONSC 515 (CanLII), https://canlii.ca/t/g32v4, leave to appeal refused 2014 CarswellOnt 19331 (Ont. C.A.)

[14] Scottish & York Insurance Co. v. Belair Direct Insurance Co., 2019 CarswellOnt 16065 (Arbitrator K. Bialkowski).

[15] Wawanesa Mutual Insurance Co. v. Peel Mutual Insurance Co., 2011 CarswellOnt 19009 (Arbitrator L. Samis).

[16] Wawanesa Mutual Insurance Co. v. Peel Mutual Insurance Co., 2011 CarswellOnt 19009 (Arbitrator L. Samis) at paras. 18-20.

Daniel Strigberger

Daniel loves coverage. Want to know if the "your work" exclusion applies? Ask Dan. Want to know if a "house" is a "home"? Ask Dan. Want to know the best toppings to cover a pizza? Don't ask Dan: He can't eat gluten. But he does digest various insurance policy definitions, wordings, and exclusions without any heartburn.

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Chapter Spotlight

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KAWARTHA DURHAM CHAPTER

President's Message

With summer 2024 almost in the books, WOW is all I can say – time flies when you're having fun!

The Kawartha Durham Chapter of the OIAA is pleased to announce new and exciting happenings as our chapter and board grows. I was privileged and honored to be elected President of the chapter in June 2024. We have a great new executive team and awesome social directors volunteering countless hours for our events.

The Kawartha Durham Chapter encompasses a wide area stretching east from Pickering, northeast to Peterborough and northwest to Lindsay, Fenelon Falls, Bobcaygeon and surrounding area. I feel truly blessed to live on Cameron Lake in the village of Fenelon Falls. Our chapter's activities and fun casual sprit reflects the beautiful area contained within our chapter boundaries.

Our Annual Education Day in May 2024 at Deer Creek conference center, featuring our guest speaker Jason Frost and team from Rogers Partners was a great success. Same can be said for our annual golf tournament at Wolfrun Golf Club in June. I was so proud of all the hard work done by the committee and a special thanks to all the corporate sponsors, who are such an intricate part of making our events the success they are.

Our chapter charity for 2023/2024 is Soper Creek Wildlife Rescue. Through 50/50 draws and prize tables, we were able to raise much needed funds for this worthy cause. We met two furry friends at the golf tourney: a rescue skunk (Smelvin) and baby possum (Winky). These two very cute critters stole the show, were very social and everyone loved the photo ops! Thanks to all who brough donations for the wildlife rescue.

Stay tuned as we have more exciting events planned for the remainder the year, and into 2025, including a Wine and Paint night, Christmas Bells & Bowling, and our annual Hockey night featuring the rivals, Peterborough Pete's vs Oshawa Generals in January.

If anyone would like more information about upcoming events, joining our chapter or sponsorship information please reach out to me directly at alicia.hughes@qbe.com, or visit our web site at www.oiaakawarthadurham.com.

Cheers to all!

Alicia Hughes

President/Treasurer

Kawartha /Durham OIAA

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DO YOU HAVE A CHILD OR GRANDCHILD ENROLLING OR ENROLLED IN POST-SECONDARY EDUCATION FOR 2024/2025?

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Selection is based on financial need, contribution to school, community life and/or other meaningful pursuits, major accomplishments and strong indication of academic promise. Eligible applicants will be a child or grandchild of an active OIAA member, who has been a member in good standing for a year and is a current member in good standing for 2024-2025.

Previously successful award recipients are welcome to apply again with a new Essay.

The deadline to apply is November 8, 2024 at 5:00 pm.

Visit our website www.oiaa.com for further details.

The Appraisal Process in Ontario

By: Glenn Gibson

In the past three-years there has been a flurry of activity on the Appraisal process in the Ontario Superior Courts of Justice in both the Divisional Court and the Court of Appeal. These decisions are all very instructive and provide guidance on the process. And they comment on the authority of the umpire to lead the process and reach a majority decision on the "amount of loss". This paper reviews three very important decisions...

INTACT INSURANCE CO. V. LAPORTE (C.O.B. WARRIOR GEAR) 2024 ONCA 454, ONTARIO COURT OF APPEAL, JUNE 10, 2024

Initial Appeal to Ontario Divisional Court:

An appraisal award was appealed to the Ontario Divisional Court. The hearing took place on March 9, 2023. A split decision was issued quickly on March 31, 2023. The Divisional Court found the appraisal panel's majority decision in determining the actual cash value of a building loss to be unreasonable. They overruled the method and outcome of the award.

Subsequent Appeal to Ontario Court of Appeal:

The Divisional Court's decision was appealed to the Ontario Court of Appeal. The fact it was a split decision may have impacted their decision to hear this appeal. It is rare to see a Divisional Court decision go upward one further step. The hearing was on May 2, 2024. A unanimous decision was issued on June 10, 2024. The Ontario Court of Appeal overruled the Divisional Court's decision.

The decision of our top court in Ontario (ONCA) included several noteworthy points:

1. There were several different methods put forward in the appraisal process to determine the actual cash value (ACV) of a building loss. The insurer preferred the Market Value Approach whereas

the insured felt that the Formula Approach (Replacement Cost less Depreciation) was the appropriate valuation method to be used in determining ACV. As the hearing unfolded, the insurer amended their number to using a third method- the Income Approach. The eventual gap between the parties was about $700,000.

2. The umpire was able to get some movement from both parties as they collaborated to try and reach a majority decision. Eventually, the umpire asked both appraisers to reconsider their positions and submit to the umpire their best and final position. He indicated he would then choose one number from the two options put forward. They did so and the insured put forward a compromise valuation of about $1.1 million. The insurer re-evaluated their position and proposed a figure of $390,000. This still left a wide gap between the appraisers' positions. The umpire considered all the evidence he heard and agreed with the insured appraiser's valuation of $1.1 million.

The insurer was not happy with the award, and they appealed to the Ontario Divisional Court. The three judges of this court, in a split vote of 2-1, ruled in favor of the insurer and quashed the ACV figure that the umpire and appraiser for the insured had agreed upon. A key argument in the insurers appeal was that the appraisal award raised a moral hazard as this permitted the insured to be over-compensated for the loss. They felt the umpire lacked the evidence to establish an ACV that was more than the market value of the building. Did this represent an inappropriate windfall to the insured?

The standard of review for the Divisional Court included looking at the reasonableness of the outcome. Was it contrary to the principle of indemnity? Did the insured unfairly profit from their loss?

The Divisional Court opined that, "There was no evidence before the Umpire to justify the significant deviation from the indemnity principle." And they noted that no reasons were given to justify the umpires upward swing in his valuation numbers. The Divisional Court quashed the award and awarded $16,000 in costs to the insurer.

The Ontario Court of Appeal decided to hear an appeal launched by the insurer over what they felt was an unjust award. They heard arguments on June 10, 2024, and wasted no time in releasing a

unanimous decision on June 28, 2024. Justice David Paciocco wrote the decision which was agreed upon by Justices Nordheimer J.A. and Monahan J.A. They reversed the decision. Why? In part,

1. They noted...

"S. 128 [of the Insurance Act of Ontario] does not call for a scientific identification of value but provides instead for an easy, expeditious, collaborative, and pragmatic dispute resolution mechanism. After his proposed ACV was rejected today empire chose to select from the two proposed awards, as he was entitled to do. This was a permissible tactic designed to encourage the parties to be reasonable. In this context, it was not arbitrary for him to accept what he considered to be the most suitable of the two offerings, even though the precise quantum he offered differs from his proposal or may resist precise, objective validation. Courts reviewing appraisals may under section 128 cannot insist on precise quantification without destroying the pragmatic dispute settlement role that the process plays."

2. The Court of Appeal also said...

"[a]ppraisal is not a science. It is an art that operates based on best estimates of myriad factors, which is precisely why appraisers are given discretion to consider context and to drop on their expertise. The majority did not defer to the empire when it should have done so."

The umpire's award was deemed to be "[r]easonable and warrants deference." Costs were awarded to the insured against the insurer for $18,000.

ARVANITOPOULOS ET AL V. WAWANESA, 2024 ONSC 3718 ONTARIO SUPERIOR COURT, DIVISIONAL COURT, JUNE 28, 2024

This insured has had a variety of issues that went before the courts at different times during this appraisal process. This decision of the Ontario Divisional Court was heard on June 10, 2024, and Justice F.L. Myers wrote the unanimous 17-page judgment that was released on June 28, 2024.

This case dates back 9-years to February 2015. A fire caused substantial damage to a dwelling. Repairs were started but things went off the rails rather quickly. It wasn't until the fall of 2022 that the parties agreed to participate in the appraisal process. This eventually led to an appraisal award. It was that award that was put forward in this appeal to the Divisional Court.

The timing of this appeal was interesting. It was heard on the same day that the Ontario Court of Appeal was releasing their unanimous decision on Intact v LaPorte (ONCA 454). And they were very much alive to the guidance from their upper court including this commentary in their decision:

> *"A s(ection) 128 settlement process is meant to be an easy, expeditious, collaborative, and cost-effective way of settling disputes about appraisals: Desjardins General Insurance Company Group v. Campbell, 2022 ONCA 128, 467. D.L.R, (4th) 480, at para 36. It begins with each party appointing an appraiser of their own. If the appraisers cannot resolve the matter between them, an umpire whom they have appointed will determine the matter".*

A few things stand out in reviewing the reasons which resulted in an appraisal panel's decision being upheld:

1. Both appraisers had submitted extensive briefs.
2. The appraisal hearing took place over six-days and after multiple years of starting and stopping. The insurer had to go to court twice to gain access to the house to do a reinspection.
3. The umpire has a right and an obligation to *"[e]nsure that all appraisal participants behave with respect and decorum befitting a legal proceeding—especially one that is supposed to embody a collaborative process."* This commentary flowed from an allegation that the appraiser for the insurer was making threats and misbehavior against a witness during the hearing.
4. Was the result of the process reasonable and fair? Was the final decision of the process logical?
5. Case law provides that umpires are NOT required to provide reasons for their majority decisions. *"The decisions are not necessarily judicial in nature. They involve expertise, judgment and compromise. However, they remain subject to judicial review. In the absence of reasons, the court will consider the evidentiary record and*

relevant circumstances to try and understand the decision maker's reasoning process."

6. Despite the allegations against one appraiser both appraisers knew the issues and they both had the opportunity to present their evidence. It was noted that the appraiser for the insured was a very experienced appraiser. He was not prevented from asking questions or leading evidence from the insured and/or witnesses.
7. An allegation was made about delays in the deliverance of the insurer's brief. The court said, *"I see no issue of fairness in the delay of the delivery of the insurer's brief while the applicants took their strategic steps. Those who play by the procedural sword cannot complain when the thrusts and parries of their strategic fencing caused delays that could have been readily avoided by cooperation."*
8. The umpire *"[c]ontrolled the scope of oral testimony volunteered by an expert witness. He did not impair the applicant's entitlement to know or make their case."*
9. *"It is not the courts task to determine whether the hearing was conducted perfectly like a trial in cord brackets (assuming a perfect trial exists) or as a perfect appraisal hearing. The issue is whether the applicants were unfairly limited or precluded from participating in the appraisal process."*
10. At the end of the day, the appeal court decided the insured's appraiser had a *"[f]ull and fair opportunity to know the case they had to meet and to participate in it fully."*
11. It was found the umpire's behavior was not biased against the insured's appraiser.

"[t]he umpire's control of the oral hearing was within the scope of his discretion. Limiting the participation of parties and witnesses and requiring the parties' cases be run by their appointed representatives- the two appraisers- is not a sign of bias. Neither is admonishing a witness to keep his testimony within the bounds of relevancy.

12. In this case, the umpire went alone to inspect damaged personal property as both appraisers declined an invitation to do so. This was NOT deemed to be an error by the umpire. The insured had argued that by going alone the umpire put himself forward as a fact witness. The Divisional Court turned aside that argument.
13. With respect to the appraisal award agreement the Divisional Court was clear that it was not their role to *"reweigh the evidence".*

Summary

This was a 9-year journey to get this matter to this conclusion with the insured now being required to pay $28,400 in costs to the insurer.

ARVANITOPOULOS ET AL V. WAWANESA, 2024 ONSC 3718 ONTARIO SUPERIOR COURT, DIVISIONAL COURT, JUNE 28, 2024

A fire destroyed a cottage property on January 20, 2022. An agreement could not be reached on the amount of loss and the insurer elected Appraisal to

resolve the differences.

In 2019, when the insured bought the cottage, the insurer used a firm to calculate the building replacement cost. This firm established a square footage of 1,341 sq. ft. This seemed to be the basis for establishing a building policy limit. At the appraisal hearing, the appraiser for the insurer introduced evidence that the square footage was 1,140 sq. ft. This was based on a physical measurement of the fire damaged site.

The appraisal heard arguments on each side's views on the replacement cost. The umpire eventually sided with the position of the insurer and a majority decision was released. It was that decision that was subject to appeal in the Divisional Court.

In the appeal, the insured's lawyer argued that the insurer relied on their own estimator to set the original building value. They argued this was the basis for setting the premium, but the appeal court did not prefer the evidence submitted on this point.

The appeal court noted that there were no reasons provided on how the umpire reached a decision to align with the insurer's number. And they noted there was NO requirement for reasons to be given. They once again noted, "[a]ppraisal awards should generally be afforded great deference".

The appeal court found the decision was reasonable. They provided their own weight to the evidence of an estimator who did physical measurements at the site.

They awarded $9,000 in costs against the insured on this appeal.

Some thoughts?

The appraisal or alternative dispute resolution provisions have been a part of our Statutory Conditions in insurance property contracts for many decades. Across Canada, there have been some legislative changes in recent years, but the process itself has remained relatively uniform.

It is intended to provide a simple, cost-effective, and efficient solution when there is a dispute regarding the quantification of a policyholder's loss. The process can be dynamic. In recent years, several decisions—primarily in Ontario—have seen courts provide instructions on how the process should work and what the authority and role of an umpire should be. The message is clear: any appraisal award will be granted significant deference by the courts.

These recent decisions by the Ontario Court of Appeal and the Ontario Divisional Court are crucial as they provide specific and clear guidance on how they see this process working. When it works correctly, it can and does achieve its intended goals.

Glenn Gibson | ICD.D CIP FCLA CFE
The GTG Group
"Glenn has been actively involved across Canada in the appraisal / ADR process as both an appraiser and umpire for over 35-years. His white paper on this process has been cited several times in legal decisions."

Similarity Does Not Equate To Commonality

When Considering Whether To Certify A Class Action: Pugliese v. Chartwell, 2024 ONSC 1135 (CanLII)

By: Jodie Therrien

The COVID-19 pandemic presented challenges for every aspect of our daily lives. Front-line health-care employees, and those in the Long-Term Care Sector, bore the brunt of the negative effects of waves of mass COVID-19 infections that began in Ontario in early 2020. However, in Pugliese v. Chartwell, 2024 ONSC 1135 (CanLII), Justice E.M. Morgan made it clear that similarity is not commonality when a class certification motion is brought before the court.

BACKGROUND

This decision arose from a Certification Motion which proposed the certification of eight class actions against various long term care home operators for their alleged systemic failure in protecting residents, family and visitors from COVID-19. Six of the actions pertained to privately owned corporate groups, each of which owned and/or managed a chain of Long-Term Care (LTC) homes. The other two actions pertained to municipally owned homes (McVeigh v. Toronto) and to some 34 independently owned homes (McDermott v. ATK). The criteria for certification under section 5(1) of the Class Proceedings Act ("CPA") are well known and must be met in order to certify a class action in Ontario. Under the CPA:

5 (1) The court shall, subject to subsection (6) and to section 5.1, certify a class proceeding on a motion under section 2, 3 or 4 if,

(a) the pleadings or the notice of application discloses

a cause of action;

(b) there is an identifiable class of two or more persons that would be represented by the representative plaintiff or defendant;

(c) the claims or defences of the class members raise common issues;

(d) a class proceeding would be the preferable procedure for the resolution of the common issues; and

(e) there is a representative plaintiff or defendant who,

i. would fairly and adequately represent the interests of the class,

ii. has produced a plan for the proceeding that sets out a workable method of advancing the proceeding on behalf of the class and of notifying class members of the proceeding, and

iii. does not have, on the common issues for the class, an interest in conflict with the interests of other class members.

The Defendants argued that the Plaintiffs failed to fulfill the CPA criteria, and therefore the class actions could not be certified.

CERTIFICATION MOTION DECISION

Justice E.M. Morgan certified six of the proposed class actions against the privately owned corporate groups, with the exception of the independent owners/licensees within those actions. In McDermott v. ATK, the independent homes argued that the Plaintiffs failed to fulfill the CPA criteria in its entirety. Justice E.M. Morgan determined that ultimately, in this action, two fundamental problems stood in the way of granting certification.

First, and with respect to the "nexus" problem, in considering the negligence cause of action, the Plaintiffs placed considerable emphasis on the top-down nature of the corporate Defendants' responsibilities. In that regard, to make out a claim in negligence, Plaintiffs require Defendants, and vice versa. The thirty-four distinct, legally unrelated Defendant corporations were sued in respect of the LTC homes that each of them separately owned and operated. As the Defendants argued, the relationship of the Defendants to one another was non-existent. There

was no top-down theory to this action, the Defendants did not have any hierarchical structure between them, nor were they a single enterprise acting in unison. In the absence of collective or top-down acts making disparate defendants a single enterprise, there was no lis between the parties. Whatever the acts of each Defendant might be, there could not be systemic negligence.

Second, the Plaintiffs failed to fulfill the well known "Ragoonanan principle" , established in Ragoonanan Estate v. Imperial Tobacco Canada Ltd. (2000), 2000 CanLII 22719 (ON SC), which simply put, dictated that there must be a representative plaintiff with a claim against each defendant. The Ragoonanan principle applies to the cause of action criterion in section 5(1)(a) of the CPA as well as to the representative Plaintiff issue in section 5(1) (e) of the CPA. As Justice E.M. Morgan outlined, one cannot have a class action without a representative plaintiff, and one cannot sustain an action at all without a named plaintiff. The independent homes argued that absent a representative Plaintiff, the Ragoonanan principle was not fulfilled. There were only six representative Plaintiffs related to six of the Defendants. In the absence of a representative Plaintiff with a claim against each Defendant, there was no cause of action against that Defendant and the claims could not be maintained.

The result was that neither of McDermott v. ATK nor McVeigh v. Toronto were certified as a class action, and the motion as against the Defendants in those two actions was dismissed.

Jodie Therrien
Author, and Counsel for the Defendant in McDermott v. ATK
416-777-5203
jtherrien@ztgh.com

Jodie graduated from the University of Guelph with a Bachelor of Arts (Hons.) in Criminal Justice and Public Policy. She then obtained her Paralegal Diploma from Sheridan College. After practicing as a Paralegal, she obtained her Juris Doctor from the University of Windsor in 2019. Jodie was called to the Ontario bar in 2020. Prior to joining ZTGH, Jodie articled at a prominent full-service law firm. She then practiced at a Boutique Toronto Insurance Defence Firm, where she gained experience in tort and accident benefits claims. Jodie joined ZTGH in 2022. She has experience in the practice areas of: Health Law, Pollution, Class Actions, Product Liability, Property, Tort, Accident Benefits, Priority Disputes, and Fraudulent and Suspicious Claims As in life, Jodie employs a candid approach with her practice, and prides herself on her communication skills. While she is detail-oriented, and strives to achieve early resolution, she has valuable experience representing clients before various Courts and Tribunals. At the University of Windsor, Jodie secured a coveted Criminal Law Clerkship with the Ontario Court of Justice. While articling, she worked on several class action lawsuits, and produced arguments with regard to pure economic loss and reputation harm, that were heard before the Supreme Court of Canada in 1688782 Ontario Inc. v. Maple Leaf Foods Inc.

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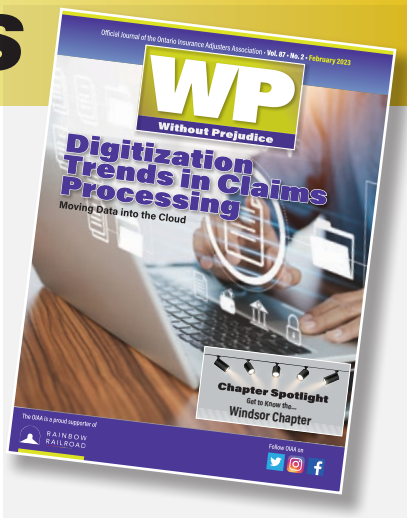

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September 19 ..... **Kitchener Waterloo - Kick Off Event @ Schooner St. Brewery**

September 20 ..... **Niagara Golf Tournament co-hosted with NSIBA (Niagara South Insurance Brokers Association) @ Whisky Run in Port Colborne, ON.**

OCTOBER 2024

October 1 ..... **London: Kick off Event – LCA's Derby Days & Past President's Night @ Top of the Fair – 900 King Street, London, Ontario**
More info @ https://londonclaimsassociation.com/events/

October 17 ..... **Kitchener Waterloo - Octoberfest Corporate Night**

October 19 ..... **Kawaratha Durham – Wine and Paint night**

NOVEMBER 2024

November 20 ..... **Kawaratha Durham - Bells and Ball Christmas Charity Bowling Night**

November 21 ..... **London Holiday Party – Best Western Plus Lamplighter Inn & Conference Centre**

November 28 ..... **Kitchener Waterloo - Biomechanics of Collision**

November 29 from 11:30am - 4:00pm ..... **Thunder Bay Holiday Party**

November 29 ..... **Georgian Bay - Christmas Party**

November 30 (tentative) ..... **London: Toy and Food Drive**

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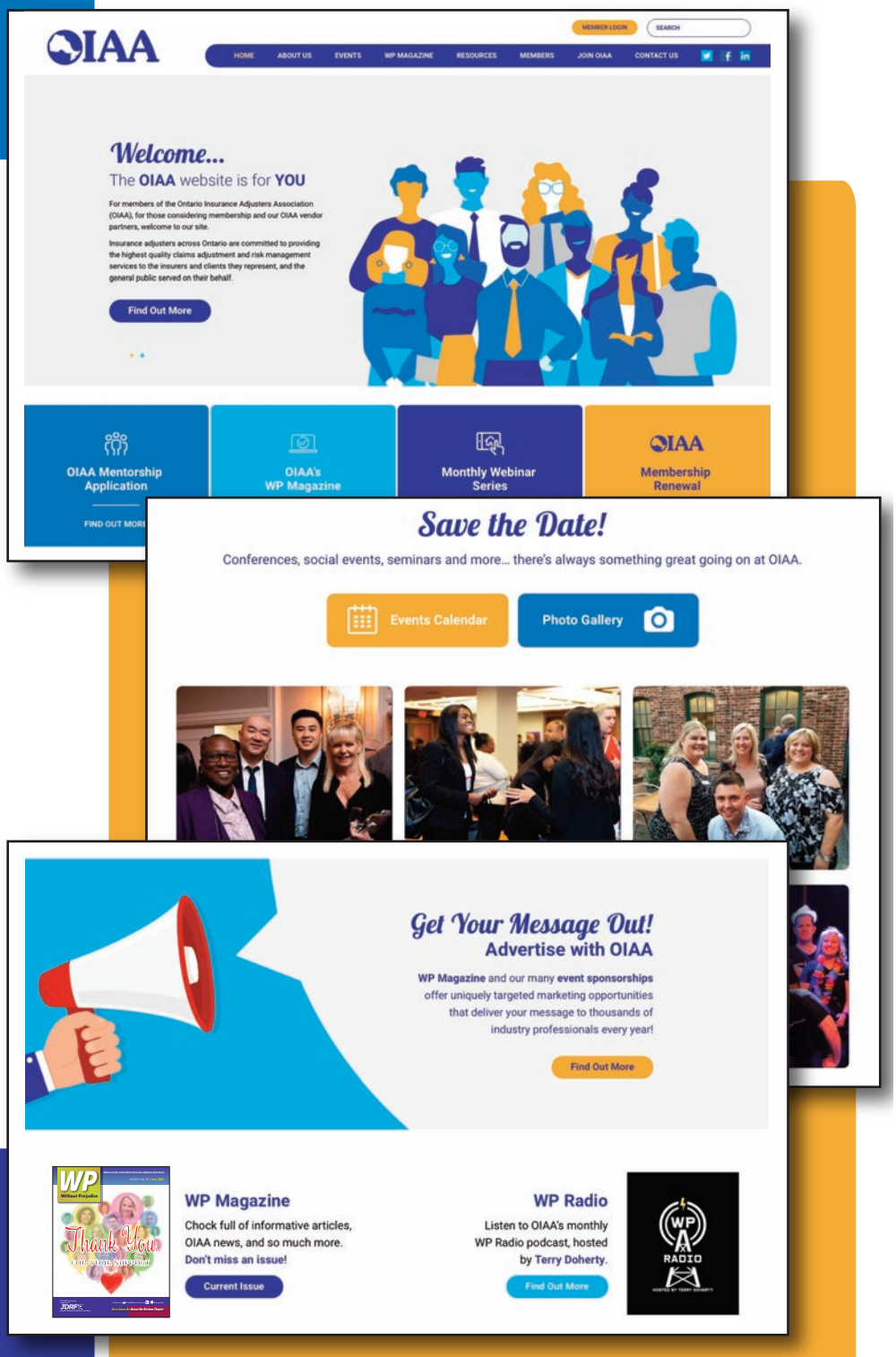

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