CITATION: Goorbarry v. Bank of Nova Scotia, 2011 ONCA 793
DATE: 20111216
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COURT OF APPEAL FOR ONTARIO

Feldman, Sharpe and Epstein JJ.A.

BETWEEN:

Camille Goorbarry

Plaintiff (Appellant)

and

The Bank of Nova Scotia, Operating as Scotiabank

Defendant (Respondent)

William G. Scott, for the appellant

William M. LeMay and Kathryn J. Bird, for the respondent

Heard: November 25, 2011

On appeal from the judgment of Justice P. Theodore Matlow of the Superior Court of Ontario dated April 26, 2011.

Feldman J.A:

[1] The appellant commenced her action for long term disability benefits in December 2006. On a motion for summary judgment, the action was dismissed because it was

commenced beyond the limitation prescribed by her Employee Benefit Plan.[1] The "Claims" provision of the Plan reads as follows:

> Initial proof of the individual's disability must be given to the Head Office of the Administrator in writing within 90 days from the date on which the individual has been continuously disabled for 26 weeks. The Administrator may demand proof of the continuance of his disability at any time thereafter when and so often as it may reasonably require. If proof of the continuance of the individual's disability is not so furnished at any time, he will be deemed to have ceased to be disabled immediately prior to the date as of which such demand was made.
>
> The Planholder shall have the right and opportunity to have a physician designated by it examine any person in respect of whom a claim is being made when and so often as it may reasonably require.
>
> No action or proceeding against the Planholder in respect of a claim under this plan shall be commenced within 60 days of the date on which proof of the claim is filed with the Administrator, nor after 2 years from the date of the happening of *the covered event*. [Emphasis added.]

[2] The phrase "the covered event" is not defined anywhere in the Plan.

[3] The appellant suffered two accidents, one at work in June 1993, and a car accident in May 1994. The appellant applied for and received short term disability benefits for 26 weeks, then she applied for long term disability benefits. That application was denied by letter dated June 23, 1995 from Canada Life, the Plan administrator. The same letter

[1] Under the former *Limitations Act* R.S.O. 1990 c. L.15, no section prohibited parties from agreeing to a limitation other than the statutory limitation. Under the *Limitations Act 2002* S.O. 2002, c. 24 Schedule B, s. 22, private agreements cannot supercede the Act, subject to a number of exceptions, one of which in s. 22(2) allows a limitation under the new Act to be varied or excluded by an agreement made before January 1, 2004. In his article, "Developing a New Uniform Limitations Act: A Survey of Canada's Emerging Limitations Regimes" in Jacob Ziegel, Wayne Gray, Brian Bucknall et al. eds., *The New Ontario Limitations Regime* (Toronto: Ontario Bar Association, 2005) 165, author John Lee states at p. 183 that under the former Act, it was accepted that parties could make their own limitation agreement because the Act was silent on the issue.

advised her of the appeal process. The appellant appealed but her appeal was denied. The respondent's records show a letter dated July 31, 1995 from Canada Life, explaining that the medical opinion the appellant provided was unsupported by any objective tests or other support to substantiate her claim. As a result, her appeal was denied and her claim remained terminated as of July 31, 1995. According to the appellant's Statement of Claim, she received a letter from Canada Life terminating her benefits effective November 21, 1995. Although this letter is not in the record on the appeal, its existence seems to be acknowledged by the respondent and by the motion judge.

[4] Although no action was started until 2006, 11 years after the claim was denied, the appellant submits that the claim is not barred for two reasons. The first is that because there is no definition of "the covered event" in the Plan document, there is an ambiguity in that document which must be read *contra proferentem* against the insurer. The result is that there is no identifiable starting point for the limitation period and therefore the claim is not out of time.

[5] The second argument is that case law has established that long term benefits that are payable monthly are governed by a rolling limitation period that runs for two years from each month that no payment was made. The result is that although the claim cannot go back to 1995, it was commenced in time in respect of the payment for November 2004 and for all following payments as long as the disability continues.

[6] In my view, neither argument has merit.

[7] When the Claims section is read as a whole and in context, the intent and meaning of the term “covered event” as well as the intent and meaning of the two year limitation period are clear.

[8] Although there is no specific definition of “the covered event” in the Plan document, the meaning flows from these three paragraphs of the Claims section. The first paragraph describes the time criteria and method for launching a claim and for maintaining the claim. The second gives the plan holder the right to require a medical examination and the third contains the limitation period for commencing an action on a claim under the Plan.

[9] From these three paragraphs, it is apparent that “the covered event” defines the factual elements that must be in place before a claimant can commence an action. There are two possible “covered events”. The first is the date when the person provides initial proof of disability following 26 weeks of being continuously disabled. If no payment is made, the person has two years to commence an action. The second covered event occurs when the person is deemed to have ceased to be disabled as of the date prior to the date when demand was made for proof of continuing disability and proof was not furnished. Again, the person has two years following that date to commence an action.

[10] In this case, the appellant’s claim is that she became disabled in accordance with the Plan for the purpose of entitlement to long term disability benefits when she made a claim after being continuously disabled for 26 weeks in 1994. From the record before this

court, although her claim was denied, it appears that she was paid benefits up to either the end of July 1995 or mid-November of that year. It is unclear whether these were short term or long term disability benefits. Alternatively, when she appealed the denial of her claim, she provided some medical evidence but it was rejected as insufficient, resulting in her being deemed no longer disabled. Again, this occurred either in July or November of 1995. Therefore, one or both of the covered events occurred in 1995 and the appellant had two years thereafter to commence her action, unless the rolling limitation period case law applies.

[11] I now turn to that argument. It is based on the decision of this court in *Wilson's Truck Lines Ltd. v. Pilot Insurance Co.* (1996), 31 O.R. (3d) 127 (C.A.); (1997), 33 O.R. (3d) 37 (C.A.). The claim in that case was for accident benefits payable under the *Insurance Act*, R.S.O. 1980, c. 218, Schedule "C", (3), para. 7, subsection (c), which contained the limitation period of one year "from the date on which the cause of action arose." The court adopted the definition of "cause of action" previously given by Morden J.A. in *July v. Neal* (1986), 57 O.R. (2d) 129 (C.A.), at p. 137, adopting the words of Lord Diplock in *Letang v. Cooper*, [1965] 1 Q.B. 232 at 242-43: "a factual situation the existence of which entitles one person to obtain from the court a remedy against another person."

[12] Applying that definition, the court rejected the argument that the cause of action did not arise until there was a definite denial of a claim by the insurer. Rather, the right to sue arises when the claimant has a right to what is being claimed, which in that case

was 31 days after the claim was filed with the insurer. (para. 38) Importantly, the court added at para. 58 that if the claimant was actually entitled to the benefits claimed, then his right to sue for them accrued every 30 days thereafter and lasted for one year each time. This is referred to as a rolling limitation period.

[13] In order for the rolling limitation period to apply in the context of the limitation contained in the respondent's Benefit Plan, the "covered event" would have to occur every month, just as the cause of action accrued every month in the *Wilson's Truck* case. However, on the specific wording of this Plan, the "covered event" does not reoccur. As I explained above, there are two covered events that are described within the Claims section of the Plan. The first occurs when the person first qualifies for long-term disability benefits, and the second, when the person is deemed no longer to be disabled because they have not provided satisfactory proof of continuing disability. Unlike in *Wilson's Truck*, each of these events happens only once, not every month on an ongoing basis.

[14] I agree with the motion judge that the action must be dismissed as it was brought beyond the period set out in the Benefit Plan.

[15] I would therefore dismiss the appeal with costs to the respondent fixed at $7,500 inclusive of disbursements and H.S.T.

Signed: "K. Feldman J.A."
"I agree Robert J. Sharpe J.A."
"I agree G. J. Epstein J.A."

RELEASED: "KF" DECEMBER 16, 2011