



Financial Services Commission of Ontario

DISPUTE RESOLUTION PRACTICE CODE

FOURTH EDITION

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As of April 1, 2016, the Licence Appeal Tribunal of the Safety, Licensing Appeals and Standards Tribunal Ontario (SLASTO) will assume all new applications for dispute resolution services.

Beginning April 1, 2016, FSCO no longer accepts applications for mediation, neutral evaluation and arbitration. This includes applications for arbitration where the Report of Mediator is issued before or after April 1, 2016.

FSCO will continue to be responsible for all files remaining open as of March 31, 2016, and the Dispute Resolution Practice Code will only apply to those files.

To get more information about accessing auto insurance dispute resolution services as of April 1, 2016, go to <http://www.slasto.gov.on.ca/en/AABS/Pages/default.aspx>

See Practice Code Archives for Earlier Editions



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PREAMBLE

INTRODUCTION

The **Dispute Resolution Practice Code ("Code")** is a user's guide to resolving disputes between consumers and insurers involving statutory accident benefits claims under the *Insurance Act* and the *Statutory Accident Benefits Schedule ("SABS")*.

The **Code** is published by the Dispute Resolution Group of the **Financial Services Commission of Ontario** ("FSCO" or the "Commission"). Although there have been previous editions of the Code, this edition is the first published by the Dispute Resolution Group as part of FSCO.

FSCO is responsible for regulating the insurance sector as well as other financial service sectors in Ontario, namely, pensions, credit unions and caisses populaires, cooperatives, mortgage brokers and the loan and trust sectors. It is an arm's-length agency of the Ministry of Finance. FSCO provides regulatory and direct services that protect the public interest and enhance public confidence in the regulated sectors.

FSCO was established on July 1, 1998, under the *Financial Services Commission of Ontario Act, 1997*. It amalgamated the operations of the former Ontario Insurance Commission, the Pension Commission of Ontario and the Deposit Institutions Division of the Ministry of Finance.

The **Code** creates rules for timely, cost-effective and fair dispute resolution services provided through FSCO's Dispute Resolution Group. The rules of procedure in this **Code** apply to new applications as well as cases already in progress. The rules have been made after extensive consultations with users of the dispute resolution system.

THE SERVICES OF THE DISPUTE RESOLUTION GROUP

The Dispute Resolution Group at the Commission provides mediation, neutral evaluation and arbitration services. There is also a process for appealing arbitration orders on a question of law, and a process for varying or revoking orders.

If consumers and insurers are unable to resolve disputes about statutory accident benefits, the first step in the dispute resolution process is mediation. Mediation of such disputes is mandatory in Ontario and must be conducted through the Commission before the dispute can proceed to arbitration or court. The insured person is charged no fee for mediation. However, each party must pay for its own expenses, which may include lawyer's fees, travelling expenses,

accounting services, and additional medical reports.

Mediation is an informal process in which a mediator helps parties involved in a dispute to clarify issues and find solutions that lead to a satisfactory outcome. The Mediation Unit of the Dispute Resolution Group has established a successful record in mediation, achieving full or partial success in over 75 percent of mediations. In December 1998, the Unit was awarded the prestigious Amethyst Award for outstanding achievement by the Ontario Public Service.

If the dispute remains unresolved after mediation at the Commission, the insured person has a number of choices. He or she can continue to negotiate directly with the insurance company. Alternatively, the insured person can opt for arbitration at the Commission, private arbitration, private neutral evaluation or a court action. Each option has its own rules, and the insured person may not be able to switch from one system to another. For example, once an action has been commenced in court, the insured person may not be able to switch to arbitration at the Commission, or vice versa.

ABOUT THIS CODE

This Code will help the parties move through the Commission's dispute resolution process. It explains what is required of everyone involved and sets out rules for such matters as the filing of documents, time limits and payment of fees and expenses. Of particular importance are the rights and responsibilities of insurers and claimants when dealing with statutory accident benefits claims. These rights and responsibilities are outlined in **Guidelines B 2-1** and **B 3-1**, which may be found in **Section B** of the **Code**.

It is important to note that the specific types of benefits, amounts, and eligibility requirements for benefits, will differ depending on when the motor vehicle accident took place.

If the accident occurred:	The applicable legislation is:
On or after September 1, 2010	<ul style="list-style-type: none">• <i>Insurance Act</i>, R.S.O. 1990, c.I.8, as amended, including amendments under Bill 16, <i>An Act to Implement 2010 Budget measures and to enact or amend various Acts</i>; and• <i>Statutory Accident Benefits Schedule-Effective September 1, 2010</i>, Ontario Regulation 34/10 [referred to generally as the New SABS]

<p>On or between November 1, 1996 and August 31, 2010</p>	<ul style="list-style-type: none"> • <i>Insurance Act</i>, R.S.O. 1990, c.I.8, as amended, including amendments under Bill 59, <i>the Automobile Insurance Rate Stability Act</i>, 1996, and Bill 198, <i>the Keeping the Promise for a Strong Economy Act (Budget Measures)</i>, 2002; and • <i>Statutory Accident Benefits Schedule — Accidents On or After November 1, 1996</i>, Ontario Regulation 403/96, as amended, including Ontario Regulation 35/10 setting out the transitional rules for accidents that occur before September 1, 2010 [referred to generally as the Old SABS].
<p>On or between January 1, 1994 and October 31, 1996</p>	<ul style="list-style-type: none"> • <i>Insurance Act</i>, R.S.O. 1990, c.I.8, as amended, including amendments under Bill 164, the <i>Insurance Statute Law Amendment Act</i>, 1993; and • <i>Statutory Accident Benefits Schedule — Accidents After December 31, 1993 and Before November 1, 1996</i>, Ontario Regulation 776/93, as amended [referred to generally as Bill 164 SABS].
<p>On or between June 22, 1990 and December 31, 1993</p>	<ul style="list-style-type: none"> • <i>Insurance Act</i>, R.S.O. 1980, c.218, as amended, including amendments under Bill 68, the <i>Insurance Statute Law Amendment Act</i>, 1990, consolidated by the <i>Insurance Act</i>, R.S.O. 1990, c.I.8, also known as the Ontario Motorist Protection Plan (“OMPP”); and • <i>Statutory Accident Benefits Schedule — Accidents Before January 1, 1994</i>, Ontario Regulation 672/90, as amended [referred to generally as Bill 68 SABS].

These rules DO NOT apply if the accident occurred on or **before** June 21, 1990.

If any provision of the **Code** is found to be contrary to the *Insurance Act* or any other law, then that law will prevail.

HOW THIS CODE IS ORGANIZED

The **Code** has been divided into 7 sections.

Section A, the Rules of Procedure, consists of General Rules for Dispute Resolution at the Commission: Mediation, Arbitration, Neutral Evaluation, Appeal of an Arbitration Order, Variation or Revocation of an Order, as well as General Procedures for Hearings.

Section B contains **Guidelines** issued by the Superintendent of the Financial Services Commission of Ontario (FSCO) and the former Commissioner of the Ontario Insurance Commission on the interpretation and operation of the SABS.1

Section C contains **Practice Notes**, which are issued by the Dispute Resolution Group to explain key elements of the dispute resolution process.

Section D sets out the applicable **fees and assessments** during the process.

Sections E and F contain the **regulations on settlements and expenses**, respectively.

Section G has copies of all the required **forms**.

For general information on mediation, neutral evaluation, arbitration, appeal, and variation/revocation, see "**Some Answers to Frequently Asked Questions [FAQS] by Claimants**", which may be found in this **Introduction** section.

*This section includes guidelines issued by the FSCO's predecessor, the Ontario Insurance Commission, as well as FSCO, and may make reference to the Ontario Insurance Commission and/or the Commissioner. Where reference is made to the Ontario Insurance Commission and/or Commissioner, these should be read as FSCO and/or Superintendent.

SOME ANSWERS TO FREQUENTLY ASKED QUESTIONS [FAQS] BY CLAIMANTS

What disputes can be brought to the Dispute Resolution Group at the Commission?

Our services help resolve disputes about whether or not you qualify for benefits under the *Statutory Accident Benefits Schedule (SABS)*, and how much those benefits should be. You may use the services of the Dispute Resolution Group if an accident benefit has been claimed from your insurance company, and denied. The SABS deal only with injuries arising out of motor vehicle accidents that occurred on or after June 22, 1990.

We do not handle disputes between two or more insurers over which insurer is responsible for the payment of statutory accident benefits. These disputes must be referred to private arbitration under the *Arbitration Act*, 1991.

How do I start the dispute resolution process?

The first step is **mediation**. You must send a completed **Application for Mediation (FORM A)** to the Dispute Resolution Group. (See **Part 2** of the **Rules – Mediation**.)

MEDIATION

What is mediation?

Mediation is an informal process in which a neutral third party (the mediator) helps the parties resolve the issues in dispute. Mediators work with the parties to find acceptable solutions. They help clarify the issues and explore options that can lead to a satisfactory outcome. Mediators don't take sides and they don't have the power to impose decisions. Our statistics indicate that most disputes are settled at mediation.

How much will it cost?

There is no cost to the insured person for mediation. However, you must pay for your own expenses, such as lawyer's fees, travelling expenses, accounting services, and additional medical reports.

In what languages are mediation services provided?

Mediation services are available in both English and French. French language services are provided at the request of the applicant. Interpretation services in other languages must be arranged by the party requiring them. The party arranging the service must pay the cost.

Do I need a lawyer?

Although a lawyer is not required in mediation, many people feel more comfortable having a lawyer help them with the process.

Should I be there?

Yes. Mediation can be conducted either in person or on the telephone (usually by conference call). You have a responsibility to personally participate in the mediation process, even if you have a representative. If for some extraordinary reason you cannot participate, your representative must have full authority to enter into an agreement or settlement at mediation on your behalf. If your representative does not have this authority, your mediation may be delayed.

How long will it take?

The Insurance Act states that all mediations must be concluded within **60 days**. In some cases this limit can be extended on written consent of all the parties.

What documents will I need?

You should try to provide copies of the best available documentation about your case.

For medical disputes, this can include such things as doctor's reports, hospital reports, and physiotherapy reports. If your dispute is about the amount of your income, such things as tax returns, financial statements and bank records can be helpful. See **Practice Note 4** "Exchange of Documents" under **Section C** of the **Code**.

Each party may ask the other for relevant documentation. If you fail to produce requested documents that the mediator considers necessary for settlement discussions, this will be noted in the mediator's report.

What if my dispute is not resolved in mediation?

If some issues remain unresolved at the end of the mediation, you have a number of choices. You may continue to negotiate with your insurance company directly. Alternatively, you can opt for arbitration at FSCO, private arbitration, neutral evaluation or court action.

NEUTRAL EVALUATION

What is neutral evaluation?

Neutral evaluation is a process where a neutral third party (the neutral evaluator) provides the parties with an assessment of the issues in dispute, as well as an opinion on the likely results if the dispute were to proceed to arbitration at FSCO or to court. This assessment is intended to help the parties settle their dispute at an early stage.

How do I obtain neutral evaluation?

Neutral evaluation is offered either privately or as part of the arbitration process at FSCO. You and your insurer may agree to refer your dispute to a private (non-FSCO) neutral evaluator. The mediator may also make a referral to private neutral evaluation. See **Practice Note 5** "Mediator Referral to Private Neutral Evaluation" under **Section C** of the **Code**. Upon the written request of the parties, the Director of Arbitrations will appoint a person selected by the parties to conduct a private neutral evaluation.

If you want neutral evaluation at FSCO, you must file for arbitration and both parties must agree to neutral evaluation. See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" under **Section C** of the **Code**.

Private evaluators set their own rates. FSCO is not responsible for the costs of private neutral evaluation and the terms of payment and cost must be negotiated between the parties and the selected evaluator.

Although there is no additional charge to the insured person for neutral evaluation conducted at FSCO, the insured person must pay the **\$100** filing fee for arbitration.

What if my dispute is not resolved through neutral evaluation?

If you participated in private neutral evaluation, and the **Report of the Neutral Evaluator** has been issued, you may choose arbitration at FSCO, private arbitration under the *Arbitration Act*, or court. If you completed neutral evaluation at FSCO, and all the issues did not settle, your file will normally be fast-tracked directly to an arbitration hearing, without the necessity of a pre-hearing discussion.

ARBITRATION AT FSCO'S DISPUTE RESOLUTION GROUP

What is arbitration?

Arbitration is a decision making process, similar to court. The advantages of arbitration over the court process are that it is quicker, less expensive and less formal. The arbitrator will listen to the witnesses called by each side, review all the evidence filed at the hearing and make an order that is binding on both sides.

Who can apply for arbitration?

Only the insured person may apply for arbitration; the insurance company does not have this right. You may not apply for arbitration unless you have first gone to mediation with your dispute.

How do I apply for arbitration?

You must complete an **Application for Arbitration (FORM C)** and send it to the Dispute Resolution Group, together with your **\$100** filing fee.

Over and above the **\$100** filing fee, you will also be responsible for your own expenses, such as witness fees, travelling and legal expenses, accounting services, additional medical reports and experts' fees. An arbitrator may award the expenses of a proceeding to either the insured person or the insurer. In awarding expenses to either party, the arbitrator will consider the factors described in **Rules 75 and 76** and under the **Expense Regulation** found in **Section F** of the **Code**.

In some cases the insured person may recover some or all of the expenses of the arbitration from the insurer, if the arbitrator so orders. Expenses awarded by the arbitrator are recoverable only up to the maximums set out in this **Code** under **Rule 78** and under **Section F** Schedule to the Expense Regulation. Legal fees are only recoverable at the rates set out in this **Code** under **Rule 78**. If your lawyer or agent charges more than these rates, you will be responsible to pay your lawyer directly for any additional amount.

In certain cases, the arbitrator may award the insurance company a portion of its expenses which the insured person will be responsible for paying. See **Rule 75** and the **Expense Regulation** found in **Section F** of the **Code**.

As well, if the arbitrator concludes that your claim was frivolous, fraudulent, vexatious or an abuse of process you may be ordered to pay an additional amount up to the amount of the assessment the insurance company has paid. See **Fees and Assessments** found in **Section D** of the **Code**.

In what languages are arbitration services provided?

Arbitration hearings may be held in English or French. French language services are provided at the request of the applicant. Interpretation services in other languages may also be provided by the Dispute Resolution Group, as requested by the applicant and required by the arbitrator. The

Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

Do I need a lawyer?

A lawyer is not required for arbitration, but many people are represented. Insurance companies are nearly always represented by lawyers at arbitration. You are encouraged to at least consult a lawyer.

What documents are required?

As in mediation, you should have independent documentation about your claim. You and the insurance company should have already exchanged the relevant documents prior to attending a pre-hearing conference. These documents must ultimately be provided to the arbitrator at the pre-hearing and hearing. If necessary, an arbitrator at the pre-hearing may order the production of other important documents. It is in the best interests of both parties to comply with an order for production in a timely manner. See **Practice Note 4** "Exchange of Documents", under **Section C** of the **Code**.

Should I be present at the arbitration hearing?

Yes. Arbitration hearings are usually held in person at FSCO's offices in Toronto or at locations throughout Ontario. Sometimes the parties can agree to waive an oral hearing and the arbitrator's decision will be based on the documents and written submissions filed.

How long will the arbitration hearing take?

The length of the arbitration process will vary depending on the nature and complexity of the case. The average length of an oral hearing at the Dispute Resolution Group is between two and three days.

APPEAL, VARIATION/REVOCAION

What should I do if I think the arbitrator's decision is wrong?

If you think that an arbitrator's decision is wrong, two possible procedures are available. First, you can **appeal** the decision, but only where the arbitrator made an error of law. You will not be allowed to appeal simply because you think the arbitrator should have accepted your evidence

instead of the other party's.

A **Notice of Appeal (FORM I)** must be filed within **30 days** of the date of the arbitration decision. The filing fee is **\$250**. Appeals are decided by the Director of Arbitrations or a delegate (Director's Delegate).

The second option is an **Application for Variation/Revocation (FORM L)**. This process is appropriate where the insured person's situation has changed since the arbitration hearing, where new evidence has become available that was not available for the arbitration hearing, or where there is some clear error in the arbitration decision. The filing fee for an **Application for Variation/Revocation** is **\$250**.

How do I find a lawyer?

The Law Society of Upper Canada offers a lawyer referral service. For more information, phone 1-900-565-4577 (\$6.00 fee is charged), and check the Law Society's website at: www.lsuc.on.ca, and choose option "Public Legal Information".

USER ADVISORY GROUPS TO THE DISPUTE RESOLUTION GROUP

The Dispute Resolution Group is fortunate to have two user advisory groups who meet with members of the Dispute Resolution Group's senior management at regularly scheduled meetings throughout the year. The Bar-Dispute Resolution Group Forum ("Counsel Forum") is comprised of lawyers and other representatives who regularly appear on behalf of claimants or insurers within the dispute resolution system. The other group, Companies Forum, is comprised of ADR representatives and claims people from most of the major automobile insurers in Ontario. The members of Companies Forum regularly handle disputed accident benefit claims within our system.

These user groups meet regularly and provide valuable insight and suggestions to the Dispute Resolution Group to ensure that it continues to provide just, flexible, cost effective and efficient dispute resolution services. Further information concerning meeting dates and the minutes of these two advisory groups is available through the FSCO website at www.fSCO.gov.on.ca

GENERAL INFORMATION CONCERNING THE TIME LINES FOR THE SERVICES OF THE DISPUTE RESOLUTION GROUP

1. An insured person or an insurer may apply for mediation of a dispute about an insured person's entitlement to accident benefits where a claim has been denied by the insurer or the time period for the insurer to respond to the claim has elapsed (**Rule 12.1**).
2. An **Application for Mediation** in **FORM A** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed (**Rule 11**).
- e3. An **Application for Mediation** in **FORM A**, completed in accordance with the requirements of **Rule 12.2**, will be
 3. An **Application for Mediation** in **FORM A**, completed in accordance with the requirements of **Rule 12.2**, will be registered and assigned to a mediator within 3 weeks of its receipt.
 4. Mediation will be concluded within **60 days** of the registration of the completed **Application for Mediation** (**Rule 19**).
 5. A **Report of Mediator** (**Rule 22**) will be issued within **7 business days** of the conclusion of mediation.
 6. An **Application for Arbitration** in **FORM C** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay an amount claimed. However, an insured person may file a completed **Application for Arbitration** within **90 days** after the mediator reports to the parties in the **Report of Mediator** (**Rule 11**).
 7. An **Application for Arbitration** in **FORM C** will be registered and assigned to an arbitration case administrator within **5 business days** of receipt of an **Application** completed in accordance with **Rule 25.1**.
 8. Dates for holding an arbitration pre-hearing discussion (**Rule 33**) will be available to the parties within **6 to 8 weeks** from the registration of a completed **Application for Arbitration**.
 9. Dates for holding an oral arbitration hearing will be available to the parties within **4 to 6 months** from the conclusion of the pre-hearing discussion.
 10. An oral arbitration hearing is generally concluded within **3 days**.

11. An arbitration order from an oral hearing will be issued within **60 to 85 days** from the conclusion of the oral hearing.
12. A written arbitration hearing is generally concluded within a **60 day** period (**Rule 38**).
13. An arbitration order from a written hearing will be issued on the later of:
 - (a) **60 days** after the last day on which the insured person is entitled to file a **Reply by the Applicant for Arbitration**;
 - (b) **30 days** after the last day on which the parties are required to file additional materials or written submissions (**Rule 38**).
14. A **Notice of Appeal** in **FORM I** on a question of law, must be filed within **30 days** of the date of the arbitration order being appealed (**Rule 52**).
15. A decision in the appeal will be issued within **60 to 85 days** from the conclusion of the oral or written appeal hearing.
16. A request for an **Assessment of Expenses** must be made within **30 days** from the date the order of the arbitrator was issued (**Rule 79**).
17. An order on an **Assessment of Expenses** will be issued within **60 to 85 days** from the conclusion of the oral or written hearing on expenses.

HOW DO I GET INFORMATION?

More detailed information is available through the Dispute Resolution Group's recorded telephone information service at (416) 250-6714 or toll free at 1-800-517-2332 or FSCO's website at www.fSCO.gov.on.ca

SECTION A – RULES OF PROCEDURE

PART 1 – GENERAL RULES FOR DISPUTE RESOLUTION

1. **INTERPRETATION**

1.1 These Rules will be broadly interpreted to produce the most just, quickest and least expensive resolution of the dispute.

1.2 Where something is not specifically provided for in these Rules, the practice may be decided by referring to similar Rules in this **Code**.

1.3 A defect in form or other technical breach will not make a proceeding invalid.

1.4 These Rules are made by the Director under the authority of section 21 of the *Insurance Act* and section 25.1 of the *Statutory Powers Procedure Act*.

1.5 Subject to the requirements of the *Insurance Act* and the *Statutory Powers Procedure Act*, the Director may make changes to these Rules at any time, if he or she considers it appropriate.

1.6 (a) These Rules apply effective May 31, 2001, to all applications for dispute resolution, whenever commenced.

(b) Despite Rule 1.6(a), these Rules do not apply to an arbitration proceeding in which a pre-hearing was held prior to May 31, 2001, unless the parties agree or an arbitrator orders that they apply.

2. **GUIDELINES**

2.1 The Superintendent of Financial Services, and previously the Commissioner of Insurance, may publish guidelines on the interpretation and operation of the *Statutory Accident Benefits Schedule*. Guidelines are found in **Section B** of the **Code**.

2.2 These guidelines shall be considered when interpreting the *Statutory Accident Benefits Schedule*.

3. **PRACTICE NOTES**

3.1 The Dispute Resolution Group may issue Practice Notes about policies and administrative procedures. Practice Notes are found in **Section C** of the **Code**.

3.2 Practice Notes

are designed to guide users in the dispute resolution process at the Commission. However, they are not binding and do not affect the duty of the adjudicator to make decisions based on the circumstances and merits of each case.

4. **DEFINITIONS**

4.1 In these Rules:

"**accident benefits**" means benefits under the *Statutory Accident Benefits Schedule*;

"**adjudicator**" means the Director or person appointed by the Director under the *Insurance Act* and these Rules to conduct a proceeding requiring the exercise of a statutory power of decision;

"**appeal**" means an appeal in accordance with section 283 of the *Insurance Act*;

"**arbitration**" means an arbitration in accordance with section 282 of the *Insurance Act*;

"**arbitrator**" means an arbitrator appointed by the Director under section 282 of the *Insurance Act*;

"**Commission**" means the Financial Services Commission of Ontario;

"**Director**" means the Director of Arbitrations appointed under section 6 of the *Insurance Act* or an employee of the Commission to whom the Director has delegated his or her powers or duties;

"**Dispute Resolution Group**" means the Dispute Resolution Services Branch of the Commission and includes any person carrying out any function of the Dispute Resolution Services Branch by direct or delegated authority or by appointment or by designation;

"**document**" includes written documents, forms, reports, charts, films, photographs, transcripts, videotapes, audio tapes, business and computer files;

"**electronic hearing**" means a hearing held by conference telephone, or some other form of electronic technology allowing persons to hear one another;

"**file**" means to file with the Dispute Resolution Group;

"**hearing**" means the opportunity to state one's case before an adjudicator in the context of an oral, written or electronic hearing;

"**mediation meeting**" means a scheduled meeting at which the parties and their representatives attend before a mediator in person, by telephone conference or other forms of electronic technology allowing persons to hear one another;

"**mediator**" means a mediator appointed by the Director under section 280 of the *Insurance Act*;

"**neutral evaluation**" means an evaluation under section 280.1 of the Insurance Act of the probable outcome of a proceeding in court or arbitration;

"**neutral evaluator**" means a person appointed by the Director under section 280.1 of the *Insurance Act*;

"**oral hearing**" means a hearing at which the parties attend in person before an adjudicator;

"**private arbitration**" means an arbitration under the *Arbitration Act*, 1991;

"**private neutral evaluator**" means a person who has been appointed by the Director under section 280.1 of the Insurance Act to perform a neutral evaluation of the probable outcome of a dispute, other than a person appointed to perform the evaluation at the Dispute Resolution Group under **Rule 44** of the **Code**;

"**proceeding**" means a matter requiring the exercise of a statutory power of decision;

"**serve**" means the delivery of a document to a person as permitted by these Rules;

"**Statutory Accident Benefits Schedule**" means any of the following:

- (a) the Statutory Accident Benefits Schedule - Effective September 1, 2010;
- (b) the Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996;
- (c) the Statutory Accident Benefits Schedule - Accidents after December 31, 1993 and Before November 1, 1996; or
- (d) the Statutory Accident Benefits Schedule - Accidents Before January 1, 1994.

"written hearing" means a hearing held by means of the exchange and filing of documents, whether in written form or by electronic means.

5. **DISPUTE RESOLUTION SERVICES AND DOCUMENTS**

5.1 A person has the right to communicate with the Dispute Resolution Group in French and to receive services in French, as provided in the *French Language Services Act*.

5.2 French language services in mediation, arbitration, neutral evaluation, variation/revocation and appeal are provided at the request of the insured person.

5.3 In mediation, interpretation services in languages other than French and English must be arranged by the party requiring them. The party arranging the interpretation service must pay the cost.

5.4 In arbitration, variation/revocation and appeal hearings, interpretation services in languages other than French and English will be arranged by the Dispute Resolution Group where requested by the insured person and required by the adjudicator. The Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

5.5 Where interpretation services are provided at a hearing, an interpreter must make an oath or affirm that he or she will truly and faithfully translate the evidence.

5.6 The Dispute Resolution Group may issue letters of direction, notices and other documents signed by the Director.

5.7 Where these Rules require the delivery of a document by the Dispute Resolution Group, delivery will be deemed to have occurred where:

(a) one of the methods of delivery permitted under **Rule 7** is used; and

(b) the document is sent to the last known address of the party, contained in the records of the Dispute Resolution Group.

5.8 If so required by the Dispute Resolution Group, the parties to a mediation, arbitration or appeal shall make use of an electronic scheduling system provided by the Dispute Resolution Group for the purposes of scheduling any hearing, conference, pre-hearing discussion or other meeting referred to in this Code.

6. **FILING**

6.1 Where these Rules require a document to be filed:

- (a) the document must be delivered to the Dispute Resolution Group;
- (b) one of the methods of delivery permitted under **Rule 7** must be used; and
- (c) the time frames set out in **Rule 7** apply

7. **SERVICE OF DOCUMENTS**

7.1 A document must be served by one of the following methods:

- (a) personal delivery;
- (b) regular, registered, or certified mail;
- (c) courier service, including Priority Courier;
- (d) facsimile;
- (e) document exchange on a person who participates in an exchange service;
- (f) e-mail; or
- (g) any other manner specified by the Director.

7.2 A document that is served by facsimile must include a cover page indicating:

- (a) the name, address, telephone number, and (if any) the e mail address (if any) of the sender;
- (b) the name of the individual to be served;
- (c) the date and time the document is being sent;
- (d) the total number of pages being sent including the cover page; and

(e) the name and telephone number and (if any) the e-mail address of an individual to contact in the event of a problem.

7.3 The e-mail message to which a document served by e-mail is attached must include:

- (a) the name, address, telephone number and e-mail address of the sender;
- (b) the name of the person to be served;
- (c) the date and time the document is being sent;
- (d) the name and telephone number of an individual to contact in the event of a problem with the transmission.

7.4 Service by a party or delivery by the Dispute Resolution Group will be considered to take place within the time frames set out below:

- (a) if a document is served by personal delivery, service takes place on the day delivery is made;
- (b) if a document is served by regular, registered, or certified mail, service takes place on the fifth day after the date the post office stamps the mailed document;
- (c) if a document is served by courier service, including Priority Courier, service takes place on the earlier of receipt, or on the second day after the document is given to the courier;
- (d) if a document is served by facsimile or e-mail, service takes place on the day that the document is sent;
- (e) if the document is served by means of a document exchange on a person who participates in an exchange service, service takes place one day after the deposit, if the document is date-stamped in the presence of the person depositing the document;
- (f) if a document is served by any other means specified by the Director, service takes place within the time specified by the Director.

8. CALCULATION OF TIME

8.1 To calculate time under these Rules or an order:

- (a) where there is a reference to a number of days between two events, they will be counted by excluding the day on which the first event happens and including the day on which the second event happens;

(b) where the time for doing an act under these Rules ends on a Saturday, Sunday, or a statutory holiday, the act may be done on the next day that is not a Saturday, Sunday, or a statutory holiday; and

(c) filing or service of a document **after 4:45 p.m.** or on a Saturday, Sunday or a statutory holiday will be considered to be made on the next day that is not a Saturday, Sunday, or a statutory holiday.

9. REPRESENTATION

9.1 A party may represent him or herself or may appoint another person to represent him or herself.

(a) Only individuals who are licensed to provide legal services or who are exempt from licensing requirements under the by-laws of the Law Society of Upper Canada can represent parties in the dispute resolution process.

Licensed paralegals are not permitted to represent applicants who are seeking a catastrophic impairment designation. However, lawyers handling claims that involve catastrophic impairment are permitted by the Law Society of Upper Canada to delegate the mediation of subsidiary issues to licensed paralegals employed by their firm. (updated — December 2009)

(b) A party must provide the Dispute Resolution Group with his or her own name, address, telephone number and (if any) e-mail address, and if represented, the name, address, telephone number and e-mail address of their representative.

(c) Parties and their representatives must provide the Dispute Resolution Group with written notice of any change of their address, telephone number and e-mail address. The Dispute Resolution Group is entitled to rely upon the last known addresses, telephone numbers and e-mail addresses contained in its records.

9.2 Subject to **subsection 9.3**, a party who appoints a representative must provide full authorization to the representative to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute. The Dispute Resolution Group may require written confirmation from the party that a representative has this authority.

9.3 Where an insurer's representative has limited authority to enter into an agreement or settlement, an officer of the company with the requisite authority must attend or be available by telephone for the duration of the mediation, settlement discussion or other proceeding.

9.4 A mediator, neutral evaluator or adjudicator, as the case may be, may adjourn a mediation, neutral evaluation or proceeding, on such terms as he or she considers just, if a party is not present and their representative does not have the requisite authority outlined in subsections 9.2 and 9.3.

9.5 A party who changes his or her representative must promptly notify the former representative, the other parties and the Dispute Resolution Group, in writing, of the name, address, telephone number and e-mail address of the new representative. The new representative must also confirm his or her appointment in writing. The Dispute Resolution Group is entitled to rely on the last written notification concerning a party's representative contained in its files.

9.6 A party who is represented and wishes to act on his or her own behalf, must notify the representative, the other parties and the Dispute Resolution Group, in writing, of the decision to act on his or her own behalf.

9.7 A representative who seeks to withdraw from a proceeding must:

(a) provide a written request for withdrawal, with reasons, to the Dispute Resolution Group and all parties to the proceeding;

(b) provide the last known address, telephone number and (if any) e-mail address of the represented party.

9.8 Where the party represented provides written consent to the representative's request for withdrawal, the Registrar or an adjudicator shall permit the representative's withdrawal. Otherwise, an adjudicator may permit the representative to withdraw, subject to such terms as the adjudicator considers just.

9.9 An adjudicator may exclude from a proceeding anyone, other than a duly qualified barrister and solicitor, appearing as a representative or agent on behalf of a party, or as an advisor to a witness, if the adjudicator finds that such person is not competent to properly represent or to advise the party or witness or does not understand and comply with these Rules and the duties and responsibilities of a representative, agent or advisor.

10. ***PARTY UNDER DISABILITY***

10.1 Subject to **Rule 10.2**, a party to a mediation, settlement discussion, neutral evaluation or proceeding is presumed to have the mental capacity to manage his or her property, appoint and instruct a representative, and conduct his or her own case.

10.2 A minor, or a person who has been declared mentally incapable, within the meaning of **Sections 6 or 45** of the *Substitute Decisions Act, 1992, (SDA)* must commence a mediation or other proceeding through:

(a) the Public Guardian and Trustee or a Court appointed guardian of property under the provisions of the *SDA*; or

(b) an attorney under a valid continuing power of attorney that gives the attorney authority over all the property of the party; or

(c) in the case of a minor,

(i) a parent with whom the minor resides;

(ii) a person with lawful custody of the minor;

(iii) a court appointed guardian of the minor's property under the provisions of the *Children's Law Reform Act*; or,

(iv) the Children's Lawyer, in the event there is no person available under subparagraphs (i), (ii), (iii) or if there is a conflict of interest between the minor and such person.

10.3 Where an adult party has not been declared mentally incapable under the provisions of the *SDA*, but exhibits signs of mental difficulty during the course of a mediation, settlement discussion, neutral evaluation or proceeding, either party may request a hearing on a preliminary issue, or the Dispute Resolution Group may direct a hearing on a preliminary issue to determine whether:

(a) the party has the mental capacity to proceed in the dispute resolution process;

(b) there is an attorney with a valid continuing power of attorney over the party's property; or

(c) there is a person such as a spouse, same sex partner, near relative, close friend or a professional such as a doctor, lawyer or business entity, such as a trust company, who has made or intends to make arrangements for the appointment of a guardian over the party's property under the provisions of the *SDA*.

10.4 Parties shall be given written notice of the hearing on a preliminary issue to inquire into a party's mental capacity to proceed in the dispute resolution process.

10.5 Where an adjudicator is not satisfied that a party has the mental capacity to proceed in the dispute resolution process, and there is no attorney or person such as described in **Rule 10.3(b) and (c)**, the adjudicator may appoint a spouse, same sex partner or near relative of the party to act on the party's behalf if that person, in the adjudicator's opinion, is suitable, willing and able to proceed in the dispute resolution process and to receive and administer statutory accident benefits on behalf of the party who has exhibited signs of mental difficulty. The adjudicator may place such conditions or restrictions upon appointments pursuant to this section, as the adjudicator considers reasonable and necessary to protect the interests of the person exhibiting mental difficulty, the other parties to the proceeding and the dispute resolution process.

10.6 Where there is no person such as described in **Rules 10.2, 10.3 or 10.5** available to act, the adjudicator may notify the Public Guardian and Trustee to request that appropriate steps be taken pursuant to the provisions of the *SDA*.

10.7 The representative of a person under a disability under **Rule 10.2** or the representative of a party who has been found to lack the mental capacity to proceed in the dispute resolution process under **Rule 10.5**, shall comply with the approval of settlement requirements of Rule 7.08 of the *Rules of Civil Procedure*.

11. **TIME LIMITS FOR MEDIATION, NEUTRAL EVALUATION OR ARBITRATION**

11.1 An application for mediation, neutral evaluation or arbitration must be filed no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed.

11.2 Despite **Rule 11.1**, an insured person may file a completed **Application for Arbitration** within **90 days** after the mediator reports to the parties in the **Report of Mediator** or within **30 days** after the neutral evaluator, appointed by the Director, reports to the parties in the **Report of Neutral Evaluator**, whichever is later.

11.3 The limitation period is not extended by the issuance of an amendment to a **Report of Mediator** under **Rule 23**.

SECTION A – RULES OF PROCEDURE

PART 2 – MEDIATION

12. APPLICATION FOR MEDIATION

12.1 An insured person or an insurer may apply for mediation of any dispute about an insured person's entitlement to accident benefits or the amount of those benefits where a claim has been denied or the prescribed time period for the insurer to respond to the claim has elapsed.

12.2 A party who applies for mediation must file, in duplicate, a completed **Application for Mediation** in **Form A**, which includes:

- (a) a description of each issue in dispute;
- (b) a list of available documents to which the applicant intends to refer in the mediation;
- (c) a list of existing documents that the applicant wishes to obtain from other sources, including the other party, which are required for the purpose of discussing settlement of the dispute;
- (d) if the applicant is the insurer, the name, address, telephone number, facsimile number and e-mail address of its company representative; and
- (e) if the applicant is the insured person:
 - (i) the name, address, telephone number, and (if any) the e-mail address of the insured person; and
 - (ii) the name, address, telephone number, facsimile number and e-mail address of the insured person's representative (if any).

If available, the applicant should file a copy of the insurer's written explanation of denial or the **Explanation of Benefits Payable by Insurance company** form.

For additional guidance on the exchange of documents between the parties, see **Practice Note 4** found in **Section C** of the **Code**.

12.3 If it appears that an **Application for Mediation** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the *Act* and its Regulations, or is frivolous, vexatious or an abuse of process, the Dispute Resolution Group will:

- (a) deliver written notice of the jurisdictional concerns or deficiencies in the **Application** to the applicant and his or her representative; and
- (b) hold the **Application** in abeyance for **20 days** from the delivery of the notice

12.4 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 12.3(b)**, the Dispute Resolution Group may reject the **Application**.

12.5 A party may not reapply for mediation of any dispute that has been mediated and, according to the Report of Mediator, the dispute was not resolved.

13. **APPOINTMENT OF A MEDIATOR**

13.1 On receipt of a completed **Application for Mediation**:

- (a) the Dispute Resolution Group will deliver a copy of the completed Application and a **Response to the Application for Mediation** in **FORM B** to the other party; and
- (b) a mediator will be appointed promptly.

14. **RESPONSE TO APPLICATION FOR MEDIATION**

14.1 The party responding to the **Application for Mediation** must, within **10 days** of receiving the **Application**, file a completed **Response to an Application for Mediation** in **FORM B**, which must include:

- (a) a response to each issue raised in the **Application**;
- (b) details of any additional issues which are to be mediated;
- (c) If the respondent is the insurer, a copy of the insurer's written explanation of denial or **Explanation of Benefits Payable by Insurance Company** form if it was not included in the application;

- (d) a list of available documents to which the responding party intends to refer in the mediation;
- (e) a list of existing documents that the responding party wishes to obtain from other sources, including the other party, which are required for the purpose of discussing settlement of the dispute; and
- (f) if the responding party is represented, the name, address, telephone number, facsimile number and e-mail address of the representative.

14.2 The Dispute Resolution Group may reject an incomplete **Response** which may result in delay or a failed mediation.

14.3 The responding party must deliver the completed **Response** to every other party in the dispute.

15. **COMBINING APPLICATIONS AND ADDING NEW ISSUES**

15.1 Where two or more **Applications for Mediation** have been filed involving the same parties or the same accident, the Dispute Resolution Group may:

- (a) combine the **Applications**;
- (b) schedule any mediation meetings to take place one immediately after the other; or
- (c) on the consent of all parties, conduct any mediation meetings with all parties present.

15.2 Where either party wishes to add an additional issue to a mediation, they must provide a written request identifying the new issue to the mediator and the other party at least **10 days** prior to the scheduled date of the mediation meeting. Thereafter, issues may be added on the consent of all parties.

16. **THE MEDIATION PROCESS**

16.1 The Dispute Resolution Group shall notify the parties when the dispute is ready to be scheduled for mediation and assigned to a mediator.

16.2 The Dispute Resolution Group may also notify the parties that they are to endeavour to agree, within **20 days** of the date of the notice, to a date and time for the mediation that is no later than **60 days** after the date of the notice and for which the Dispute Resolution Group confirms a mediator is available.

16.3 If the parties do not notify the Dispute Resolution Group, within the **20-day** time period provided for in a notice delivered under Rule 16.2, that they have agreed to a date and time for the mediation in accordance with that Rule, the Dispute Resolution Group may proceed to schedule a date and time for the mediation without the agreement of the parties, and such date and time shall be binding on the parties unless the Dispute Resolution Group or the mediator permit otherwise.

16.4 At least **10 days** before the scheduled mediation meeting, the parties shall exchange with the other parties and provide the appointed mediator with the key documents required to discuss the settlement of any issue in dispute.

See **Practice Note 4** "Exchange of Documents" found in **Section C** of the **Code**.

16.5 Mediation may be conducted in person, by telephone, or by any other means that the mediator considers appropriate.

16.6 The mediator will look into all the issues in dispute which are identified on the **Application for Mediation** or the **Response to an Application for Mediation** or by written request under Rule 15.2 and will help the parties settle as many of the issues as possible.

17. ***PARTICIPATION IN MEDIATION***

17.1 Parties to the mediation and their representatives (if any) must participate in good faith in the mediation process and provide all relevant documents within the time frames set out in these Rules.

17.2 The appointment of a representative does not relieve any party of the obligation to participate in the mediation, in person, by telephone or other electronic technologies, and to provide instructions to any representative in respect of any issue in dispute or settlement offers made.

17.3 Where a party does not comply with **Rules 17.1** and **17.2** the mediator may:

- a) adjourn the mediation on such terms as he or she considers appropriate; or
- b) report to the parties that mediation did not take place.

18. **CONFIDENTIALITY DURING MEDIATION**

18.1 All statements and offers to settle made during mediation, except those contained in the **Report of Mediator**, are deemed to be made for the purpose of settlement and shall not prejudice any position that the parties take in any subsequent arbitration or court proceeding.

18.2 A mediator shall not be required to testify or produce his or her notes or other documents in a civil proceeding or in a proceeding before any board or tribunal respecting a mediation or respecting information obtained in the discharge of the mediator's duties under these Rules.

18.3 Where a party to a mediation provides information to the mediator in confidence, the mediator will not disclose the information without the permission of the party, unless required by law to do so.

18.4 If a party provides documents to a mediator in confidence, the mediator will return the documents to the party and the documents will not form part of the mediation file.

18.5 The Dispute Resolution Group will not provide any part of the mediation file to a neutral evaluator or adjudicator, except the **Report of Mediator**.

19. **TIME LIMITS FOR MEDIATION**

19.1 Subject to **Rule 19.2**, mediation must be concluded within **60 days** of the filing of an **Application for Mediation**, completed in accordance with the requirements of **Rule 12**.

19.2 Subject to **Rule 21.1(a)** the parties may agree to extend the **60 day** time limit for mediation.

19.3 Where the parties have agreed to extend the time limit, they must:

- (a) consult with the mediator; and
- (b) provide the mediator with written confirmation of the dates agreed upon for the extension

20. **SETTLEMENT OF AN ISSUE**

20.1 Where the parties settle an issue on their own during the mediation process, they will advise the mediator of the terms of their settlement.

20.2 A settlement is subject to legal requirements, as applicable, including restrictions on settlements within one year of the date of the accident and completion of the appropriate Settlement Disclosure Notice.

See the **Settlement Regulation** found in **Section E** of the **Code**.

21. **FAILURE OF MEDIATION**

21.1 Mediation has failed on an issue when:

- (a) the mediator is of the opinion that mediation will fail and notifies the parties; or
- (b) the time limit for mediation, including any extension, has expired and no settlement has been reached.

21.2 If mediation fails on any of the issues in dispute, the insurer will provide the mediator with its last offer in respect of such issue or issues.

21.3 No party may bring a proceeding in any court, refer the issues in dispute to an arbitrator, or agree to submit an issue to private arbitration unless mediation was sought and has failed.

22. **REPORT OF MEDIATOR**

22.1 The mediator will record the following in the **Report of Mediator**:

- (a) the mediator's description of the issues that were in dispute;
- (b) if any of the issues were resolved, the terms of any settlement;
- (c) the insurer's last offer in respect of any issue that remains in dispute;
- (d) any steps the parties agree to take to help them settle any issue that remains in dispute;

(e) a list of documents requested by the parties that have not been produced and that, in the opinion of the mediator, were required for the purpose of discussing settlement of any issue that remains in dispute; and

(f) the mediator's recommendation whether issues that remain in dispute should be referred to neutral evaluation.

22.2 The Dispute Resolution Group will deliver a copy of the **Report of Mediator** to the parties, to a person appointed by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

23. AMENDMENT OF MEDIATOR'S REPORT

23.1 If a party believes that the **Report of Mediator** is not accurate, the party must notify the mediator and the other parties in writing, with reasons, within **10 days** of receiving the **Report**.

23.2 After considering the reasons and the comments of the parties, the mediator may issue an amendment to the **Report of Mediator**, if the mediator considers it appropriate.

23.3 The Dispute Resolution Group will deliver a copy of the amendment to the **Report of Mediator** to the parties, to the person approved by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

24. REFERRAL TO NEUTRAL EVALUATION

24.1 If mediation fails on any of the issues in dispute, the parties jointly or the mediator who conducted the mediation may, for the purpose of assisting in the resolution of the issues in dispute, refer the issues in dispute to a person appointed by the Director for an evaluation of the probable outcome of a proceeding in court or arbitration.

24.2 Where the mediator or the parties jointly refer the issues in dispute to neutral evaluation, the parties shall either:

(a) jointly retain a private neutral evaluator appointed by the Director; or

See **Practice Note 5** "Mediator Referral to Private Neutral Evaluation" under **Section C** of the **Code**.

(b) If an **Application for Arbitration** in **Form C** is filed, jointly request neutral evaluation at the Commission in accordance with the Rules under **PART 3, ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION**.

See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission" under **Section SC** of the **Code**.

24.3 The Director will promptly appoint a person to conduct a private neutral evaluation under **Rule 24.2(a)** upon receipt in writing of:

(a) the name, address, telephone number and e-mail address of the person who has been jointly retained by the parties;

(b) confirmation from the person jointly retained that he or she has agreed to perform the neutral evaluation at the parties' expense and in accordance with the requirements of the Insurance Act; and

(c) confirmation of the applicable mediation file number

24.4 Where the issues in dispute are referred to neutral evaluation, no party may proceed to court or arbitration unless the report of the person who performed the neutral evaluation has been given to the parties.

SECTION A – RULES OF PROCEDURE

PART 3 – ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION

25. APPLICATION FOR ARBITRATION

25.1 An insured person applying for arbitration (the "applicant") must file a completed **Application for Arbitration** in **FORM C**, which includes:

- (a) a description of each issue to be arbitrated, provided the issues were submitted to mediation and failed;
- (b) an explanation why any document identified in the Report of Mediator as having been requested by the insurer, has not been provided to the insurer;
- (c) a list of other key documents in the applicant's possession to which he or she intends to refer in the arbitration;
- (d) a list of key documents the applicant intends to obtain from other sources, including those the applicant requests from the insurer, such as surveillance evidence;
- (e) payment of the application filing fee set out in **Section D** of the **Code**;
- (f) An indication whether the applicant prefers an oral, electronic or written hearing;
- (g) the name, address, telephone number, and (if any) the e-mail address of the applicant; and
- (h) the name, address, telephone number, facsimile number and e-mail address of the applicant's representative (if any).

25.2 The applicant must also:

- (a) file a copy of the **Report of Mediator** related to the issues to be arbitrated; and
- (b) where an evaluation by a private neutral evaluator has occurred, file the **Report of the Neutral Evaluator** or confirmation that the parties have received a copy of it.

25.3 The insured person may request neutral evaluation at the Commission in the ***Application for Arbitration***, unless an evaluation by a private neutral evaluator has occurred. Neutral evaluation at the Commission will be conducted according to **Rules 44** and following:

See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" under **Section C** of the **Code**.

25.4 If it appears that an ***Application for Arbitration*** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the Insurance Act and its Regulations, or is frivolous, vexatious or an abuse of process, the Dispute Resolution Group will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the applicant and his or her representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

25.5 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 25.4(b)**, an arbitrator may reject the ***Application***.

25.6 The Dispute Resolution Group will deliver a copy of the completed ***Application for Arbitration*** to the other parties.

26. OPTIONS AVAILABLE TO AN INSURER, INCLUDING NEUTRAL EVALUATION AT THE COMMISSION

26.1 Within **20 days** of receipt by the insurer of the ***Application for Arbitration***, the insurer must respond in **one** of the following ways:

(a) serve and file a ***Response by Insurer*** in **FORM E**, completed in accordance with **Rule 27**, together with a **Statement of Service** in **FORM F**; or

(b) if the insured person has requested neutral evaluation at the Commission, the insurer must file an ***Agreement to Neutral Evaluation***, in **FORM D**, by facsimile transmission; or

(c) unless a private neutral evaluation has occurred, the insurer may request neutral evaluation at the Commission by obtaining the written consent of the applicant, and filing an ***Agreement to Neutral Evaluation*** in **FORM D**, by facsimile transmission.

26.2 Where the parties jointly choose Neutral Evaluation at the Commission, it shall be conducted according to **Rules 44** and following.

27. **RESPONSE BY INSURER**

27.1 Where parties do not jointly choose neutral evaluation, the **Response by Insurer** in **FORM E** must include:

- (a) a response to each issue raised in the **Application for Arbitration**;
- (b) a description of any additional issues that the insurer wishes to have arbitrated, provided the issues were submitted to mediation and failed;
- (c) an explanation why any document identified in the **Report of Mediator** as having been requested by the applicant, has not been provided to the applicant;
- (d) a list of other key documents in the insurer's possession to which it intends to refer in the arbitration, including surveillance evidence;
- (e) a list of key documents the insurer intends to obtain from other sources, including those the insurer requests from the applicant;
- (f) an indication whether the insurer prefers an oral, electronic or written hearing; and
- (g) the name, address, telephone number, facsimile number and e-mail address of the insurer's representative.

27.2 If it appears that a **Response by Insurer** is incomplete or exceeds the jurisdiction of the dispute resolution process under the *Insurance Act* and its Regulations, the Dispute Resolution Group will:

- (a) deliver written notice of the jurisdictional concerns or deficiencies in the **Response** to the Insurer and its representative; and
- (b) hold the **Response** in abeyance for **20 days** from the delivery of the notice.

27.3 Where the Insurer does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 27.2**, an arbitrator may reject the **Response** and the arbitration will proceed on an uncontested basis.

28. **APPOINTMENT OF AN ARBITRATOR**

28.1 Where the Director has not appointed a private neutral evaluator under **Rule 24.3** or a neutral evaluator at the Commission under **Rule 44.1**, the Director will promptly appoint an arbitrator. The Director may also appoint an arbitrator to conduct a pre-hearing or other interim proceeding.

29. **REPLY BY THE APPLICANT FOR ARBITRATION**

29.1 Within **10 days** of being served with the **Response by Insurer**, the applicant must reply to any new issues raised by:

- (a) serving a **Reply by the Applicant for Arbitration** in **FORM G** on the insurer and any other parties; and
- (b) filing a copy of the **Reply** together with a Statement of Service in **FORM F**

29.2 The Reply by the **Applicant for Arbitration** is optional where no new issues are raised in the Response by Insurer.

30. **COMBINING APPLICATIONS**

30.1 Where two or more **Applications for Arbitration** have been filed and it appears that:

- (a) they have an issue or question of law, fact, or policy in common; or
- (b) the application of this Rule will result in the most just, quickest, and least expensive means to deal with the **Applications**

The Dispute Resolution Group will notify the parties in writing of the intention to:

- (c) combine the proceedings;
- (d) schedule the proceedings to be heard at the same time;
- (e) schedule one or more proceedings to be heard one immediately after the other by the same arbitrator; or

(f) suspend the scheduling of a proceeding or proceedings until the determination of any one of them

30.2 Where a party objects to a notice made under **Rule 30.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

30.3 An arbitrator will consider an objection made under **Rule 30.2** and make an order on such terms as he or she considers just.

31. **SEVERING ISSUES**

31.1 Where an arbitrator considers it appropriate, or where the parties agree and the arbitrator approves, the Dispute Resolution Group will notify the parties in writing that an **Application for Arbitration** in **FORM C** is to be divided into distinct issues to be heard separately.

31.2 If more than one final order is made in an application, each order will stand on its own for the purposes of an appeal or a variation/revocation proceeding.

31.3 Where a party objects to a notice made under **Rule 31.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

31.4 An arbitrator will consider the objection and may make an order on such terms as he or she considers just.

32. **EXCHANGE OF DOCUMENTS BEFORE PRE-HEARING**

32.1 At least 10 days before the pre-hearing discussion, each party must:

- (a) exchange all documents identified in the Application for Arbitration and the Response by Insurer, or explain why a document has not been provided;
- (b) establish reasonable time frames for the exchange of any remaining documents;
- (c) file the key documents the pre-hearing arbitrator will require to understand the issues in dispute;
- (d) file a list of outstanding document requests and identify any disputed items.

32.2 Subject to the time lines under **Rule 39**, the parties have an ongoing responsibility to ensure the prompt and complete exchange of documents that are reasonably necessary to determine the issues being arbitrated, including updates to the information previously exchanged and any additional documents obtained.

32.3 Subject to **Rule 39**, an arbitrator may at any time order the production of documents or the giving of information that he or she considers relevant to the determination of the issues in the arbitration, on such terms as he or she considers appropriate.

33. PRE-HEARING DISCUSSION

33.1 One or more pre-hearing discussions may be held before an arbitrator who will attempt to resolve the dispute, and will assist the parties to prepare for the arbitration by:

- (a) identifying and obtaining agreement as to the issues for arbitration;
- (b) obtaining agreement as to facts;
- (c) deciding any disputes relating to the identification and exchange of documents, making orders and setting time lines for the exchange of outstanding documents;
- (d) dealing with procedural and preliminary issues, and requests for interim relief or interim expenses;
- (e) identifying the expert and lay witnesses to be called at the hearing and determining the length of hearing;
- (f) setting dates for the hearing;
- (g) arranging the form in which document briefs or a joint book of documents will be submitted to the hearing arbitrator; and
- (h) dealing with any other matters that the arbitrator considers appropriate

33.2 A pre-hearing discussion may be held in person, by telephone conference call, electronically, or by any other means that the pre-hearing arbitrator considers appropriate.

33.3 The Dispute Resolution Group will provide parties with reasonable notice of the date and manner of the pre-hearing discussion.

33.4 The Dispute Resolution Group may also notify the parties that they are to endeavour to agree, within 20 days of the date of the notice, to a date and time for the pre-hearing discussion that is no later than 60 days after the date of the notice and for which the Dispute Resolution Group confirms an arbitrator is available.

33.5 If the parties do not notify the Dispute Resolution Group, within the 20-day time period provided for in a notice delivered under Rule 33.4, that they have agreed to a date and time for the pre-hearing discussion in accordance with that Rule, the Dispute Resolution Group may proceed to schedule a date and time for the pre-hearing discussion without the agreement of the parties, and such date and time shall be binding on the parties unless the Dispute Resolution Group or the arbitrator permit otherwise.

33.6 The pre-hearing arbitrator will confirm the results of the pre-hearing discussion to the parties in writing.

33.7 An arbitrator who presides at a pre-hearing discussion at which the parties attempt to settle some or all of the issues in dispute will not preside at the hearing unless the parties consent.

34. **FAILURE TO COMPLY**

34.1 Where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement, an arbitrator may:

- (a) order a party to pay expenses (including interim expenses), or deny expenses to a party;
- (b) exclude a document filed;
- (c) impose a new timetable for compliance;
- (d) draw an adverse inference against a party; and
- (e) make such other order as the arbitrator considers just.

34.2 Either party may make a written request for the resumption of a pre-hearing discussion where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement.

34.3 The Dispute Resolution Group will attempt to accommodate a party's written request for a resumption of the pre-hearing discussion where practicable.

35. SETTLEMENT CONFERENCE PRIOR TO SCHEDULED HEARING DATE

35.1 Either party may contact the Dispute Resolution Group to request a settlement conference.

35.2 The party seeking the settlement conference should confirm the consent of all other parties to the settlement conference and provide times and dates for the conference that are acceptable to all parties.

35.3 The Dispute Resolution Group will attempt to accommodate a joint request of the parties for a settlement conference and may assign a mediator or adjudicator to facilitate resolution of the issues in dispute.

35.4 The Dispute Resolution Group or an arbitrator may also initiate a settlement conference, provided the parties consent.

35.5 An arbitrator who facilitates a settlement conference prior to the scheduled hearing shall not preside at the hearing unless the parties consent.

36. CONFIDENTIALITY DURING SETTLEMENT DISCUSSIONS

36.1 No statements made for the purpose of settlement or any offer to settle made during a pre-hearing discussion or settlement conference shall prejudice any position the parties may take in any subsequent proceeding.

36.2 No person appointed to facilitate the settlement of an issue in dispute before the Dispute Resolution Group shall be compelled to give testimony or produce his or her notes or other documents in a proceeding before the Dispute Resolution Group, in a private arbitration or civil proceeding through the courts, with respect to matters that come to his or her knowledge in the course of exercising his or her duties under these Rules, the *Insurance Act*, or its Regulations.

37. HEARINGS

37.1 The arbitrator may:

- (a) hold an oral hearing;
- (b) hold a written hearing;
- (c) hold an electronic hearing; or
- (d) hold a hearing which combines one or more of the above formats

37.2 The arbitrator will not hold a written hearing where a party satisfies the arbitrator that there is a good reason for not doing so.

37.3 The arbitrator will not hold an electronic hearing where a party satisfies the arbitrator that holding an electronic hearing will significantly prejudice the party.

37.4 **Rules 37.2 and 37.3** do not apply if the only purpose of the hearing is to deal with procedural matters.

37.5 The parties to an arbitration shall be given reasonable notice of a hearing, the manner of the hearing and in the case of a written or electronic hearing, a statement that either party may object to a written or electronic hearing on the grounds set out in **Rules 37.2 and 37.3** (except in the case of a hearing on procedural matters only).

37.6 The Dispute Resolution Group may also notify the parties that they are to endeavour to agree, within **20 days** of the date of the notice, to a date and time for the hearing that is no later than **180 days** after the date of the notice and for which the Dispute Resolution Group confirms an arbitrator is available.

37.7 If the parties do not notify the Dispute Resolution Group, within the **20-day** time period provided for in a notice delivered under **Rule 37.6**, that they have agreed to a date and time for the hearing in accordance with that Rule, the Dispute Resolution Group may proceed to schedule a date and time for the hearing without the agreement of the parties, and such date and time shall be binding on the parties unless the Dispute Resolution Group or the arbitrator permit otherwise.

37.8 The arbitrator will determine all issues in dispute and such other issues as the parties may agree, where mediation has taken place.

37.9 Where notice of hearing has been sent to a party and a party does not attend at an oral or electronic hearing, or participate in a written hearing, the arbitrator may proceed with the hearing in the party's absence or without the party's participation, as the case may be, and the party is not entitled to any further notice in the proceeding.

38. **TIME LINES FOR WRITTEN HEARINGS**

38.1 In a written hearing, the arbitrator:

(a) may, within **30 days** after the last day on which the insured person is entitled to file a **Reply by the Applicant for Arbitration**, request additional materials or written submissions from the parties on any issue or matter in dispute;

(b) may proceed to determine the issues even though a party has failed to file additional materials or written submissions, if the arbitrator is satisfied that the Dispute Resolution Group has delivered the request for additional materials or submissions;

(c) will make the order based on the materials and submissions filed;

(d) will issue an order on the later of:

(i) **60 days** after the last day on which the insured person is entitled to file a **Reply**; and

(ii) **30 days** after the last day on which the parties are required to file additional materials or written submissions

39. **EVIDENCE**

39.1 Subject to **Rule 39.2**, all documents, reports (including experts' reports) and assessments to be introduced at a hearing by either party must be served on the other party at least **30 days** before the first day of the hearing.

39.2 In extraordinary circumstances, a party may seek an arbitrator's permission to serve a document, report or assessment on the other party for use at a hearing less than **30 days** before the first day of hearing.

39.3 The hearing arbitrator will determine the relevance, materiality, and admissibility of evidence submitted at the hearing, but will not admit evidence at a hearing that:

- (a) would not be admissible in a court by reason of any privilege under the law of evidence; or
- (b) is not admissible under the *Insurance Act*; or
- (c) was not served on the opposing party in accordance with **Rules 39.1 and 39.2**, unless the hearing arbitrator is satisfied that extraordinary circumstances exist to justify an exception.

40. **SURVEILLANCE EVIDENCE**

40.1 If a party intends to rely on any portion of surveillance or investigative evidence, including videotapes, photographs, reports, notes and summaries of surveillance observations or investigations, at least 30 days before the hearing, the party shall provide:

- (a) the names and qualifications of the persons who secured the investigative or surveillance evidence, the dates, times and places where any surveillance or investigation was undertaken; and
- (b) copies of all videotapes, photographs, investigative reports, notes and summaries taken or prepared in connection with the issues in dispute.

41. **WITNESSES**

41.1 Each party must provide the other parties with the names of witnesses that the party intends to call and the names of persons the party requires to attend for cross-examination on a report, at least **30 days** before the first day of the hearing.

41.2 Every party must notify a potential witness of the intention to call him or her to give evidence at the hearing at least **30 days** before the first day of the hearing.

41.3 An arbitrator may:

- (a) excuse a witness from attending at the hearing, if the witness was not identified at the pre-hearing under **Rule 33**, or notified at least **30 days** before the first day of hearing under **Rule 41.2**; or
- (b) make such other order as the arbitrator considers just.

41.4 An arbitrator has the power to summon and enforce the attendance of a witness and require him or her to give evidence on oath or otherwise, and to produce documents, records, and things.

41.5 A party may require the attendance of a witness by serving a ***Summons to Witness*** in **FORM N**, in accordance with **Rule 73**.

See **Practice Note 8** "Attendance of a Witness to an Arbitration Hearing by Summons" found in **Section C** of the **Code**.

42. ***EXPERT WITNESSES***

42.1 If a party intends to introduce a report by an expert, the full name and qualifications of the expert who prepared the report must accompany the report.

42.2 If a party intends to call an expert witness to present evidence at a hearing, that party must serve and file a document setting out the following:

- (a) the full name, address and qualifications of the expert witness;
- (b) the subject matter of the testimony to be presented; and
- (c) the substance of the facts and opinion which the witness will present.

The time lines and requirements set out under **Rule 39 and Rule 41** apply.

42.3 Where a party does not comply with the requirements of this Rule, an arbitrator may exclude a witness from the hearing or make such other order as the arbitrator considers just.

42.4 No party may call more than two expert witnesses to give opinion evidence at a hearing, unless otherwise ordered by an arbitrator.

43. **REOPENING OF HEARING**

43.1 The arbitrator may reopen a hearing at any time before he or she makes a final order disposing of the arbitration.

43.2 **Rules 37 to 42** apply to the reopening as modified by the arbitrator.

44. **NEUTRAL EVALUATION AT THE COMMISSION**

44.1 Upon receipt of a completed **Agreement to Neutral Evaluation at the Commission** in **FORM D** and confirmation of the consent of the parties, the Director will:

- (a) suspend the appointment of an arbitrator;
- (b) promptly appoint a person to perform the neutral evaluation; and
- (c) confirm the appointment with the parties.

44.2 Within **30 days** of notice of the appointment of a neutral evaluator from the Director (see **Rule 44.1**), the parties must file a **Joint Statement for Neutral Evaluation at the Commission** in **FORM H** containing:

- (a) a description of the legal and factual issues to be evaluated;
- (b) confirmation that all documents listed in the **Report of Mediator** and all other documents necessary for an evaluation of the issues have been exchanged by the parties; and
- (c) two proposed half-day dates for the neutral evaluation which are no later than **60 days** after the date of the appointment of the neutral evaluator.

44.3 If it appears that the **Joint Statement for Neutral Evaluation at the Commission** has not been completed in accordance with all requirements of **Rule 44.2** or the dispute is otherwise unsuitable for neutral evaluation, the Director will:

- (a) deliver written notice of the deficiencies or concerns identified;
- (b) hold the neutral evaluation in abeyance for **10 days** from the delivery of the notice

44.4 Where a party does not address the deficiencies or concerns within the **10 days** provided under **Rule 44.3(b)**, the Director may terminate the neutral evaluation and promptly appoint an arbitrator.

44.5 In deciding whether a case is suitable for neutral evaluation, the Director shall have regard to the considerations set out in **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" found in **Section C** of the **Code**.

44.6 Upon receipt of the parties' completed **Joint Statement**, the Director shall promptly select one of the dates for the neutral evaluation and shall notify the parties of the date, time, and location of the neutral evaluation.

45. **CASE SUMMARY FOR NEUTRAL EVALUATION**

45.1 At least **10 days** prior to the date of the neutral evaluation, each party must exchange and file a **case summary** containing:

- (a) a summary of their submissions on the issues to be evaluated; and
- (b) copies of the key documents required for an evaluation of each issue.

45.2 The parties shall promptly provide any additional information requested by the neutral evaluator.

46. **TERMINATION OF NEUTRAL EVALUATION**

46.1 A party withdrawing from neutral evaluation must notify the other parties and the Dispute Resolution Group in writing.

46.2 Where a party withdraws from neutral evaluation, fails to comply with any of the requirements for neutral evaluation as set out in **Rules 44 and 45**, or fails to attend or participate in neutral evaluation, the Director may terminate the neutral evaluation.

46.3 Where neutral evaluation is terminated pursuant to **Rule 46.2**, the Director will promptly appoint an arbitrator by written notice to the parties.

46.4 **Rule 33** and following apply to an arbitration hearing conducted after the withdrawal from or termination of neutral evaluation under this Rule.

47. **OPINION OF THE NEUTRAL EVALUATOR**

47.1 Where neutral evaluation proceeds, the neutral evaluator will give the parties an oral opinion on the probable outcome of a proceeding in court or an arbitration.

47.2 The opinion given in neutral evaluation is for the purpose of settlement and is confidential.

47.3 A neutral evaluator shall not be required to testify in a civil proceeding or in a proceeding before any tribunal respecting the evaluation or respecting information obtained in the discharge of the neutral evaluator's duties.

48. **REPORT OF THE NEUTRAL EVALUATOR**

48.1 The neutral evaluator will promptly provide the parties with a **Report of the Neutral Evaluator** setting out:

- (a) the issues that were evaluated;
- (b) the issues that were settled; and

where any issues referred to neutral evaluation were not settled, the neutral evaluator will record:

- (c) the issues that remain in dispute;
- (d) the insurer's last offer in respect of such issues; and
- (e) a list of materials requested by the neutral evaluator that were not provided by the parties.

48.2 No part of the oral opinion of the neutral evaluator on the probable outcome of a proceeding will be included in the **Report of the Neutral Evaluator**.

49. **REFERRAL TO ARBITRATION AFTER NEUTRAL EVALUATION**

49.1 If any of the issues referred to neutral evaluation are not settled, the Director shall refer the issues remaining in dispute to arbitration **2 business days** after delivery to the parties of the **Report of the Neutral Evaluator**.

49.2 The Director will promptly appoint an arbitrator.

49.3 The neutral evaluator will not preside at the arbitration hearing.

49.4 **Rule 37** and following, apply to an arbitration hearing conducted after neutral evaluation is completed and the parties have not settled an issue in dispute.

SECTION A – RULES OF PROCEDURE

PART 4 - APPEAL OF ARBITRATION ORDER

50. **APPEAL**

50.1 A party to an arbitration may appeal an order of an arbitrator to the Director only on a question of law.

50.2 A party may not appeal a preliminary or interim order of an arbitrator until all of the issues in dispute in the arbitration have been finally decided, unless the Director orders otherwise.

50.3 An appeal does not stop an arbitration order from taking effect, unless the Director orders otherwise.

51. **STARTING AN APPEAL**

51.1 To appeal an arbitration order, the appellant must:

- (a) complete a **Notice of Appeal** in **FORM I** ;
- (b) serve a copy of the **Notice of Appeal** on the respondent's lawyer or if the respondent was not represented by a lawyer at the arbitration hearing, on the respondent;
- (c) file the **Notice of Appeal** and a **Statement of Service** in **FORM F**; and
- (d) pay the application filing fee set out in **Section D** of the **Code**.

51.2 An appeal may be rejected if:

- (a) it is out of time;
- (b) it does not raise a question of law;
- (c) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(d) the **Notice of Appeal** is incomplete or lacks sufficient details to allow the other party to respond; or

(e) the appellant does not pay the required application filing fee

51.3 If the Director determines that a **Notice of Appeal** is incomplete or is rejected under **Rule 51.2**, the Director will notify the parties and their representatives of the rejection.

51.4 Upon receipt of a properly completed **Notice of Appeal, Statement of Service** and the application filing fee, the Director will promptly acknowledge the appeal.

52. **TIME FOR APPEAL**

52.1 Subject to **Rule 52.2**, the appellant must file the **Notice of Appeal** within **30 days** of the date of the arbitration order.

52.2 The Director may extend the time for requesting an appeal on such terms as he or she considers appropriate, either before or after the **30-day** time limit, if he or she is satisfied there are reasonable grounds for granting the extension.

53. **RESPONSE TO APPEAL**

53.1 Within **20 days** of receiving the Director's acknowledgment of the **Notice of Appeal** (see **Rule 51.4**), a respondent must:

(a) complete a **Response to Appeal** in **FORM J**;

(b) serve the **Response** on the appellant's representative or if not represented, on the appellant; and;

(c) file a copy of the **Response** and a **Statement of Service** in **FORM F**.

54. **WRITTEN SUBMISSIONS**

54.1 Unless the Director orders otherwise, the appellant must:

(a) serve and file written submissions within **30 days** of the date on which the **Response to Appeal** was due; and

(b) file a **Statement of Service** in **FORM F**

54.2 If a transcript has been ordered, the time limit for the appellant's written submissions set out in **Rule 54.1(a)** is extended to **30 days** from the date on which the transcript is received.

See **Rule 74** regarding transcripts.

54.3 Within **20 days** of receiving the appellant's written submissions, the respondent must:

(a) serve on the appellant and any other parties any written submissions upon which the respondent intends to rely; and

(b) file the written submissions and a **Statement of Service** in **FORM F**.

55. **APPEAL BY RESPONDENT ("CROSS-APPEAL")**

55.1 If the respondent intends to appeal the arbitration order, a separate **Notice of Appeal** must be completed and the time periods for appeal, as set out above, apply.

56. **THE APPEAL PROCESS**

56.1 The Director may appoint a person to conduct the appeal on his or her behalf and to exercise the powers and perform the duties of the Director relating to the appeal.

56.2 An order made by a person appointed under **Rule 56.1** is considered an order of the Director.

56.3 Unless the Director orders otherwise, an *appeal* will only include issues that were the subject of the arbitration proceeding or dealt with in the arbitration order being appealed.

56.4 The **appeal record** includes the **Notice of Appeal**, the **Response to Appeal**, the written submissions of the parties, and the record of the arbitration hearing, including all arbitration exhibits and, if it is filed, the transcript of the arbitration hearing.

56.5 The Director may decide the appeal: (a) on the record;

56.5 The Director may decide the appeal:

(a) on the record;

(b) by way of an oral hearing or an electronic hearing; or

(c) in any other manner that the Director considers appropriate.

56.6 If the Director decides to schedule an oral or electronic hearing, a **Notice of Hearing** will be delivered to the parties and their representatives.

57. **PRELIMINARY CONFERENCE**

57.1 The Director may require the parties to participate in one or more preliminary conferences.

57.2 **Rule 33** applies with necessary changes to a preliminary conference held under this Part.

58. **NON-PARTICIPATION**

58.1 The Director may proceed with an appeal even though a party fails to file any document required by these Rules.

58.2 Where a **Notice of Hearing** has been delivered to a party, and the party does not attend, the Director may proceed with the oral submissions or the hearing in the absence of the party, and the party is not entitled to any further notice in the proceeding.

59. **INTERVENTIONS**

59.1 The Director may request persons who are not parties to an appeal to make submissions on any issue of law arising in an appeal, and participation will be on such terms as the Director considers appropriate.

59.2 Persons who are not parties to an appeal may apply to make submissions on an issue of law arising in an *appeal*.

59.3 A person who wishes to make submissions on an issue of law arising in an appeal must:

- (a) complete an ***Application for Intervention*** in **FORM K**;
- (b) serve a copy of the ***Application*** on the representative of each of the parties to the appeal or, if a party is not represented, on the party; and
- (c) file the ***Application*** and a ***Statement of Service*** in **FORM F**

59.4 An ***Application for Intervention*** may be rejected if it does not include:

- (a) the applicant's reasons for wishing to participate; and
- (b) a summary of the applicant's submissions on the issues of law.

59.5 Where an ***Application for Intervention*** is rejected, the Director will notify the applicant and the representative of each of the parties to the appeal or, if a party is not represented, the party.

59.6 Within **10 days** of receiving an ***Application for Intervention***, a party may indicate that he or she supports or objects to the intervention by:

- (a) filing his or her written comments; and
- (b) sending a copy of his or her written comments to the representative of the applicant or, if not represented, to the applicant

60. **THE INTERVENTION PROCESS**

60.1 **Rules 56, 57 and 58** apply with necessary changes.

SECTION A – RULES OF PROCEDURE

PART 5 – VARIATION OR REVOCATION OF AN ORDER

61. *APPLICATION FOR VARIATION /REVOCATION*

61.1 Either the insured person or the insurer may apply to the Director to vary or revoke an arbitration order or an appeal order if:

- (a) there has been a material change in the circumstances of the insured;
- (b) evidence not available on the arbitration or appeal has become available; or
- (c) there is an error in the order.

61.2 A party may not apply to vary or revoke a preliminary or interim order of an adjudicator until all of the issues in dispute in the proceeding have been finally decided, unless the Director orders otherwise.

61.3 A party seeking to have an arbitration order or an appeal order varied or revoked must:

- (a) complete an *Application for Variation/Revocation* in **Form L**;
- (b) serve a copy of the **Application** on the respondent's lawyer or, if not represented by a lawyer, on the respondent;
- (c) file the *Application* and a *Statement of Service* in **FORM F**; and

(d) pay the application filing fee set out in **Section D** of the **Code**.

61.4 The ***Application for Variation/Revocation*** may be rejected if:

(a) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(b) it is incomplete or lacks sufficient details to allow the other party to respond;

(c) it is in respect of an order that has been appealed, and the appeal is pending; or

(d) the applicant does not pay the required application filing fee.

61.5 If the Director determines that the ***Application for Variation/Revocation*** is incomplete or is rejected under **Rule 61.4**, the Director will notify the parties and their representatives of the rejection.

61.6 The Director will promptly acknowledge the ***Application for Variation/Revocation*** upon receipt of a properly completed ***Application, Statement of Service***

and the application filing fee.

62. **Response to the application for variation/revocation**

62.1 Within **20 days** of receiving the Director's acknowledgment of the **Application for Variation /Revocation** (see **Rule 61.6**), a respondent must:

- (a) complete a Response to **Application for Variation/Revocation** in **Form M**;
- (b) serve the **Response** on the applicant's representative or if not represented, on the applicant;
and
- (c) file a copy of the **Response** and a **Statement of Service** in **Form F**.

63. **The variation/revocation process**

63.1 The Director may:

- (a) decide the **Application for Variation/Revocation**;
- (b) delegate a person to decide the **Application for Variation/Revocation** on his or her behalf and to exercise the powers and perform the duties of the Director in relation to the **Application**;
or
- (c) appoint the same adjudicator who made the original order or another adjudicator to decide the **Application for Variation/Revocation**.

63.2 **Rules 54, 57 and 58** apply to an **Application for Variation/Revocation** with necessary changes.

SECTION A – RULES OF PROCEDURE

PART 6 – GENERAL PROCEDURES FOR HEARINGS

64. *Applicability of this part*

64.1 This Part applies to all arbitrations, appeals, interventions and variation/revocation proceedings.

65. *Orders*

65.1 An adjudicator will determine the issues before him or her by order and may make an order subject to such terms as he or she considers just.

65.2 An adjudicator may make an oral order with oral reasons where he or she considers it appropriate. The adjudicator will confirm the provisions of an oral order in writing if requested by the parties at the conclusion of the oral order.

65.3 An order which finally decides the issues in dispute will be supported by written reasons.

65.4 The Dispute Resolution Group will deliver a copy of the order and the adjudicator's written reasons, if any, to the parties.

65.5 An adjudicator may, at any time, correct a typographical error, error of calculation, technical error or similar error made in his or her decision or order.

65.6 An adjudicator may at any time clarify a decision or order that contains a misstatement, ambiguity or other similar error.

65.7 An adjudicator may make such orders or give such directions as he or she considers proper to prevent an abuse of process.

66. ***Court enforcement of orders***

66.1 On written request, the Director will provide a party with a certified copy of an order.

66.2 A party may file a certified copy of an order in the Ontario Superior Court of Justice and the order can be enforced by the Court in the same manner as an order of that Court.

66.3 A party who files an order under **Rule 66.2** shall notify the Director within **10 days** after the filing.

67. ***Orders within proceeding: motions***

67.1 An adjudicator may make preliminary or interim orders within a proceeding, pending a final order.

67.2 A party may request a preliminary or interim order, at any stage within a proceeding, pending a final order.

67.3 A party making such a request must, in writing:

- (a) describe the order being sought, the grounds for the order, and provide any documents to be relied on;
- (b) set out the time, date and manner in which the party seeks to have the motion heard; and
- (c) serve this material on the other parties and file it.

67.4 Where a party seeks an order for production against a person who is not a party to the proceeding ("third party"), the party making the request must serve the materials required under **Rule 67.3**, upon the third party and file it together with a **Statement of Service** in **Form F**.

67.5 Within **10 days** of being served, the responding party and third party, if any, must:

- (a) serve a written response and documents to be relied on; and
- (b) file a copy of the written response and documents

67.6 The adjudicator may determine the request on the basis of the documents and written submissions filed, or in such manner as the adjudicator considers appropriate.

67.7 Before making an order for the production of documents against a third party, the adjudicator shall be satisfied that:

- (a) the parties have made reasonable efforts to obtain the document sought;
- (b) the document sought is in the possession, control or power of the third party;
- (c) the third party has had a reasonable opportunity to respond;
- (d) the document is reasonably required to ensure a just and fair hearing.

67.8 A request for an interim order or an order on a preliminary issue may also be made orally during a pre-hearing discussion, a preliminary conference, or at a hearing, and will be dealt with in such manner as the adjudicator considers appropriate.

68. *Dismissal of proceeding without hearing*

68.1 Subject to **Rule 68.2**, an adjudicator may dismiss a proceeding without a hearing where the proceeding is frivolous, vexatious or is commenced in bad faith.

68.2 Before dismissing a proceeding under this Rule, an adjudicator shall deliver written notice to all parties of the intention to dismiss the proceeding on the grounds set out in **Rule 68.1**.

68.3 Where a party objects to a dismissal of the proceeding pursuant to **Rule 68.1** or seeks to make written submissions with respect to the dismissal, the party must:

- (a) provide the grounds upon which the party objects to the dismissal of the proceeding, or set out any other issues or concerns, in writing; and
- (b) serve the material upon the other parties and file it within **20 days** of the date of the notice provided under **Rule 68.2**.

68.4 An adjudicator will consider any written objections or submissions received and may make an order on such terms as he or she considers just.

69. **Settlement**

69.1 The parties may settle any or all issues in dispute at any time, provided at least one year has passed since the date of the accident, or a pre-hearing conference has been completed.

69.2 If a dispute is settled, the Dispute Resolution Group will close its file:

(a) immediately upon receipt of written confirmation from the parties that the entire matter is settled; or

(b) **20 days** following notice of the Dispute Resolution Group's intention to close the file on the basis of a reported settlement.

69.3 Where a party objects to the closure of a file under **Rule 69.2(b)**, the party must promptly notify the Dispute Resolution Group and all other parties, in writing, setting out the reasons for the objection.

69.4 Where a hearing has commenced and an adjudicator has not yet issued an order finally disposing of all the issues in dispute, either party may request an adjudicator to issue an order on consent of the parties dismissing the proceeding. The adjudicator shall determine the documentation required before issuing the order. The request shall be made not more than 20 days after settlement is reported to the adjudicator by either of the parties.

70. **Withdrawal**

70.1 A party may seek permission to withdraw all or part of a dispute by:

(a) serving a request to withdraw on all parties; and

(b) filing the request to withdraw together with a **Statement of Service** in **Form F**; or

(c) making an oral request to withdraw all or part of a dispute during a neutral evaluation, pre-hearing discussion, settlement discussion, preliminary conference or at a hearing.

70.2 An adjudicator may permit a party to withdraw all or part of a dispute where all parties agree.

70.3 Where a party does not agree to the withdrawal, an adjudicator may:

- (a) permit the withdrawal on such terms and conditions as he or she considers just;
- (b) award expenses to either party as permitted by **Rule 75** and following.

71. *Inability of an adjudicator to complete a hearing*

71.1 If an adjudicator becomes unable, for any reason, to complete a hearing or issue a decision, the matter may be reheard by a new adjudicator appointed by the Director.

71.2 Where a transcript of the incomplete hearing is available, the Director may notify the parties of the Director's intention to provide a copy of the transcript to the new adjudicator, with a copy to the parties, at the Dispute Resolution Group's expense; where the Director considers it appropriate, or where the parties agree and the Director approves.

71.3 Where a party objects to the use of the transcript by the new adjudicator, the party must promptly notify the Director and all other parties in writing, setting out the reasons for the objection.

72. *Adjournments*

72.1 A request for an adjournment of a pre-hearing discussion or an arbitration proceeding must be made in writing to the Dispute Resolution Group. A request for an adjournment of an appeal or variation/revocation proceeding must be made in writing to the Director, or to the person delegated by the Director to decide the matter. Such requests must:

- (a) outline the reasons for the adjournment;

(b) indicate whether all parties consent to the adjournment; and

(c) provide alternative dates that are acceptable to all parties

72.2 A request for an adjournment must be served on the other parties and filed **7 days** in advance of the scheduled proceeding or such lesser period of time as the adjudicator may permit.

72.3 In deciding whether an adjournment is appropriate, the adjudicator shall refer to the **Adjournments Policy** found in **Practice Note 9** under **Section C** of the **Code**.

72.4 An adjudicator may adjourn a proceeding on his or her own initiative, or at the request of a party, on such terms he or she considers just.

72.5 An adjudicator may require the parties to attend in person to argue an adjournment, even if it is on consent.

73. **Summons to witness**

73.1 An adjudicator has the same powers to summons as a judge of the Ontario Superior Court of Justice. The adjudicator may, by *Summons to Witness*, require a person to:

(a) attend at or participate in a hearing, and to give evidence on oath or otherwise; and

(b) produce in evidence documents and things set out in the summons.

73.2 If a person does not attend or participate in a hearing or does not produce the documents listed in the **Summons to Witness (Form N)**, a judge of the Ontario Superior Court of Justice may order that a warrant for the arrest of that person be issued or that the person be punished in the same way as for contempt of that court.

73.3 A **Summons to Witness** must be prepared in **Form N**.

73.4 The party requesting the summons must:

(a) ensure that the **Summons to Witness** is served personally on the person summoned not less than **5 business days** before the first day of the hearing, or within such shorter time period as the adjudicator considers just;

(b) pay the person summoned the same fees or allowances as are paid to a person summoned to attend before the Ontario Superior Court of Justice; and

(c) file an ***Affidavit of Service for a Summons to Witness*** in **Form O** as proof that the Summons was properly served and that the required fees or allowances have been paid.

See **Practice Note 8** "Attendance of a Witness to an Arbitration Hearing by Summons" found in **Section C** of the **Code**.

73.5 An adjudicator may excuse a witness from the obligation to attend at or participate in a hearing where notice under **Rules 33, 41 and 73.3** has not been provided to the witness.

74. ***Transcripts***

74.1 A hearing may be recorded by a court reporter who has taken an oath or affirmation to report the evidence and proceedings faithfully. The Dispute Resolution Group does not provide reporting services for a hearing. Parties who want a record of the proceedings must make their own arrangements for the attendance of a reporting service, and must pay for this service.

74.2 Where a party hires a reporting service to record the proceedings, the party must:

- (a) inform the other parties and the adjudicator;
- (b) make the necessary arrangements for the reporting service; and
- (c) directly pay the person or agency providing the reporting service.

74.3 Where a party orders all or a portion of the transcript of a proceeding, the party must:

- (a) inform the other parties and the adjudicator;
- (b) provide a copy of the transcript to the other party and the adjudicator; and
- (c) directly pay the person or agency providing the transcript

75. **Award of expenses**

75.1 An adjudicator may award expenses to a party if the adjudicator is satisfied that the award is justified having regard to the criteria set out in **Rule 75.2**. The items and amounts which may be awarded are found in **Rule 78** and the **Schedule** to the **Expense Regulation** found in **Section F** of the **Code**.

75.2 The adjudicator will consider only the criteria referred to in the Expense Regulation found in Section F of the Code. These criteria are:

- (a) each party's degree of success in the outcome of the proceeding;
- (b) any written offers to settle made in accordance with **Rule 76**;
- (c) whether novel issues are raised in the proceeding;
- (d) the conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders;
- (e) whether any aspect of the proceeding was improper, vexatious or unnecessary.
- (f) whether the insured person refused or failed to submit to an examination as required under section 42 of Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996) made under the Act or refused or failed to provide any material required to be provided by subsection 42 (10) of that regulation; and
- (g) whether the insured person refused or failed to submit to an examination as required under section 44 of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act, or refused or failed to provide any material required to be provided under subsection 44 (9) of that regulation.

76. **Offer to settle**

76.1 An adjudicator will consider an **Offer to Settle** in connection with an award of expenses provided that:

- (a) it was made in writing, was served on the other parties and contains:
 - (i) the full terms of the **Offer to Settle**;
 - (ii) the date when the **Offer** was served and the time period during which it remained open for acceptance

AND

(b) the **Offer** was made after the conclusion of mediation and before the conclusion of the hearing, with particular consideration given to any **Offer** served after the conclusion of the pre-hearing discussion or preliminary conference as the case may be, up to 5 days before the commencement of the hearing.

76.2 **Response to an Offer to Settle** will be considered provided that:

(a) it was made in writing, indicates the Offer to which it relates; and

(b) it was served upon the other parties before the conclusion of the hearing.

76.3 An **Offer to Settle** or **Response to an Offer to Settle** may be withdrawn at any time before it is accepted, by serving written notice of the withdrawal on the party to whom the offer or response was made.

76.4 An **Offer** or **Response** will expire on the earlier of the expiry date stated in the **Offer** or **Response**, or at the conclusion of the hearing.

76.5 Acceptance of an **Offer** or **Response** must be made in writing and served upon the party making the **Offer** or **Response**, prior to the withdrawal or expiry of the offer.

77. Communication of an offer to settle or response to an offer to settle

77.1 When no party to an adjudication seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly inform the adjudicator of that fact at the conclusion of the hearing; and the adjudicator will make an award of expenses as part of his or her order on the substantive issues in dispute.

77.2 Where any party seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly advise the adjudicator of that fact at the conclusion of the hearing.

77.3 Upon such advice, the adjudicator will determine all issues in dispute, except expenses and issue his or her order.

77.4 The Dispute Resolution Group will deliver a copy of the order (excluding expenses) and the adjudicator's written reasons, if any, to the parties.

77.5 Within **10 days** of the delivery of the order, either party may file any relevant **Offer to Settle** or **Response to an Offer to Settle** which was made in accordance with **Rule 76**, for consideration by the adjudicator in connection with an award of expenses.

77.6 Either party may request an appointment before an adjudicator for an award of expenses or an assessment of expenses in accordance with **Rule 79**.

78. Expenses of representatives (Also see schedule to expense regulation found in section f of the code)

78.1 The maximum amount that may be awarded to an insured person or an insurer for legal fees, is an amount calculated using:

- (a) the hourly rates established under the *Legal Aid Services Act, 1998* for professional services in civil matters before the Ontario Superior Court of Justice; or
- (b) the hourly rate referred to in **Rule 78.1(a)** adjusted to include, where appropriate, the experience allowance established under the *Legal Aid Services Act, 1998*

Where an adjudicator is satisfied that a higher amount for legal fees to an insured person is justified, an hourly rate of up to **\$150** may be awarded.

78.2 The maximum amount that may be awarded to an insured person or an insurer for agent's fees is an amount calculated using the hourly rates established under the *Legal Aid Services Act, 1998* for law clerks, articling students and investigators.

79. Assessment of expenses

79.1 Where an adjudicator has issued an order determining all issues in dispute except expenses, and the parties cannot agree on the entitlement to or amount of the expenses of the proceeding, either party may request, in writing, an appointment before an adjudicator to determine expenses provided that the request is made within **30 days** from the date the decision on all other issues in dispute was issued.

79.2 Where an adjudicator has issued an order of expenses to be paid and the parties cannot agree on the amounts to be paid under that order, either party may request, in writing, an appointment before an adjudicator provided that:

- (a) within **30 days** from the date of the order awarding expenses, the party awarded expenses provides the other party with an account describing each of the expenses claimed, services received and the costs;
- (b) the party ordered to pay expenses **must** promptly provide the other party with a written response to the account, identifying the items in dispute and the reasons for the dispute;
- (c) the party awarded expenses **must** promptly provide the other party with copies of supporting documentation, such as invoices, receipts, computerized docketts or cancelled cheques in respect of the disputed items;
- (d) if a dispute remains, the parties shall serve and file the above materials, together with a written request for an **assessment of expenses** upon all parties to the proceeding and legal counsel or representatives whose time and disbursements are reflected in the expenses sought;
- (e) the Dispute Resolution Group shall notify the parties and their present and/or former legal counsel or representatives whether the assessment will be conducted by way of written submissions, or by an oral or electronic hearing, the date, time and if necessary, the location of the assessment hearing.

80. Constitutional question and/or charter issue

80.1 Where required by the Courts of Justice Act, a party who intends to raise a constitutional question shall serve notice of the constitutional question on the other parties and on the Attorney General of Canada and the Attorney General of Ontario at least **15 days** before the day on which the question is to be heard by the adjudicator.

80.2 The notice referred to in **Rule 80.1** must clearly set out the reasons for the question and any evidence that the party intends to rely on must be attached to the notice.

80.3 The Attorney General of Canada and the Attorney General of Ontario may intervene in the proceeding.

80.4 A constitutional question refers to the following circumstances:

- (a) the constitutional validity or constitutional applicability of legislation, of a regulation or by-law made under legislation, or of a rule of common law, is in question.
- (b) a remedy is claimed under subsection 24(1) of the *Canadian Charter of Rights and Freedoms*, in relation to an act or omission of the Government of Ontario.

81. ***Waiver of procedural requirements***

81.1 Subject to the requirements of the *Insurance Act* and the *Statutory Powers Procedure Act*, the adjudicator may on such terms as he or she considers just:

- (a) set aside any time limit set out in these Rules for doing any act, serving any notice, filing any document or holding any hearing.
- (b) decide that any Rule does not apply in respect of a proceeding.

81.2 Any procedural requirement set out in the *Insurance Act* or the *Statutory Powers Procedure Act* that applies to a hearing held under these Rules may be set aside with the agreement of the parties and the adjudicator.

82. ***Testimony and civil proceedings***

82.1 An adjudicator shall not be required to testify in a civil proceeding or in a proceeding before any other tribunal respecting information obtained in the discharge of his or her duties.

SECTION B - GUIDELINES

Updated Professional Services Guideline and Pre-approved Framework Guideline

Bulletin

No. A-04/09

– Auto

Property & Casualty

[To the attention of all insurance companies
licensed to transact automobile insurance in Ontario]

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These bulletins may include forms that are no longer up-to-date or accurate. Readers should visit the [forms](#) section of the FSCO website, to ensure they are using the most recent version of a FSCO form.

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing an updated Professional Services Guideline and an updated Pre-approved Framework (PAF) Guideline for Grade I and II Whiplash Associated Disorders (WAD I and WAD II).

The updated guidelines incorporate a 2.3 per cent increase in fees based on the 2008 Consumer Price Index for expenses related to services rendered on or after August 1, 2009.

Authority

The Professional Services Guideline is issued by FSCO under subsection 268.3 (1) of the Insurance Act for the purposes of subsections 14 (4), 15 (6), 17 (2) and 24 (2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS). The PAF Guideline is issued by the Superintendent under subsection 268.3 (1.1) of the Insurance Act.

Changes

The updated Professional Services Guideline released with this Bulletin increases the maximum hourly rates by 2.3 per cent for services rendered on or after August 1, 2009. The effective date for the updated Professional Services Guideline is August 1, 2009. The fees outlined in Appendix B and C of the PAF Guideline for WAD I and WAD II are also being increased by 2.3 per cent for services rendered on or after August 1, 2009.

The updated PAF Guideline for WAD I and WAD II is effective August 1, 2009. It will apply to all new Pre-approved Framework Treatment Confirmation Forms (OCF-23) that are submitted by a health practitioner on or after August 1, 2009, or when the insurer has waived the requirement for an OCF-23 on or after August 1, 2009.

Expenses prior to August 1, 2009

The Superintendent's Professional Services Guideline No. 01/08 continues to apply to expenses related to services rendered between July 1, 2008 and July 31, 2009, whether they are billed before or after August 1, 2009. Similarly, the Superintendent's PAF Guideline for WAD I and II Injuries No. 02/08 continues to apply to goods and services rendered between July 1, 2008 and July 31, 2009.



Copies

The Professional Services Guideline and the PAF Guideline for Grade I and II Whiplash Associated Disorders are attached for your information and can also be downloaded from the FSCO website at www.fSCO.gov.on.ca. The guidelines will also be published in a forthcoming edition of *The Ontario Gazette*.

Bob Christie
Chief Executive Officer and
Superintendent of Financial Services

July 13, 2009

Attachments:

- [Pre-approved Framework Guideline for Grade I and II Whiplash Associated Disorders](#) (PDF)
- [Professional Services Guideline](#) (PDF)

Minor Injury Guideline and Revised Minor Injury Treatment Discharge Report (OCF-24)

Bulletin

No. A-10/10

– Auto

Property & Casualty

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To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing the Minor Injury Guideline (MIG) for the purposes of the Statutory Accident Benefits Schedule – Effective September 1, 2010 (SABS).

The MIG will apply to accidents that occur on or after September 1, 2010.

Superintendent's Guideline No. 02/09, the Pre-approved Framework (PAF) Guideline for Grade I and II Whiplash Associated Disorders issued in July 2009, will continue to apply to accidents that occur before September 1, 2010.

The MIG has been developed in consultation with insurance industry stakeholders, health care professionals and legal representatives.

The MIG is interim with the expectation that it will be replaced in the future with a more comprehensive Guideline that will prescribe evidence-based treatment as identified by the Neck Pain Task Force and other expert authorities.

The SABS and the MIG are intended to encourage and promote the broadest use of the Guideline, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under the MIG are appropriate.

Usage of the MIG by stakeholders will be monitored on an ongoing basis, with a view to early identification and response to inappropriate application or interpretation of the SABS and the MIG.

Effective Date

The MIG will be effective for any Treatment Confirmation Form (OCF-23) submitted on behalf of an insured person or when the insurer has waived the requirement for a Treatment Confirmation Form (OCF-23), in respect of an accident that occurred on or after September 1, 2010.

The PAF Guideline for Grade I and II Whiplash Associated Disorders (Superintendent's Guideline No. 02/09) remains in effect for Treatment Confirmation Forms (OCF-23) that are submitted on behalf of an insured person, or when an insurer has waived the requirement for a Treatment Confirmation Form (OCF-23), in respect of an accident that occurred before September 1, 2010.

The Minor Injury Treatment Discharge Report (OCF-24) accompanying this Bulletin is to be used for accidents that occurred on or after September 1, 2010 while the existing OCF-24/198 will continue to be used for accidents that occurred before September 1, 2010.

Authority

The MIG is issued pursuant to section 268.3 of the Insurance Act for the purposes of the SABS. As required by section 268.3 (2) of the Insurance Act, the MIG shall be considered in any determination involving the interpretation of the SABS.

Copies of the MIG and the Minor Injury Treatment Discharge Report (OCF-24)

Copies of the MIG and OCF-24 are attached and are also available on FSCO's website at www.fSCO.gov.on.ca. The MIG will also be published in a forthcoming edition of The Ontario Gazette.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

June 14, 2010

Attachments:

- [Minor Injury Guideline \(PDF\)](#)
- [Minor Injury Treatment Discharge Report \(OCF-24\)](#)

Revised Accident Benefit Claims Forms and New Attendant Care Hourly Rate Guideline

Bulletin

No. A-13/10

– Auto

Property & Casualty

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To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is issuing a number of amended forms approved by the Superintendent for use in connection with accident benefits claims.

These forms have been amended to reflect changes resulting from automobile insurance reforms that will become effective on September 1, 2010.

Changes to these forms have been made in consultation with insurance industry stakeholders, health care professionals and legal representatives.

The Assessment of Attendant Care Needs (Form 1) has been changed from a prescribed form to a Superintendent-approved form. The hourly rates listed for attendant care services, which were previously printed on the form, will, for accidents occurring on or after September 1, 2010, henceforth be those published in the Attendant Care Hourly Rate Guideline (attached).

Highlights of changes

Changes to the forms include, but are not limited to, the following:

- Modifying references to the Pre-approved Framework Guideline for Grade I and II Whiplash Associated Disorders to accommodate the new Minor Injury Guideline as applicable.
- Reflecting loss of an arm or a leg as criteria for catastrophic impairment for accidents occurring on or after September 1, 2010.
- Amending the basis for calculation of the Income Replacement Benefit (IRB) from 80% of net income to 70% of gross income for accidents occurring on or after September 1, 2010.
- Deleting references to rebuttal examinations under s. 24(1)9 and s. 24.1(1) of the Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996, as rebuttal examinations are not available in the new Statutory Accidents Benefits Schedule – Effective September 1, 2010 (new SABS).
- Reflecting that only occupational therapists and registered nurses can complete an Assessment of Attendant Care Needs (Form 1).
- Deleting questions related to income tax status in the Accident Benefits Application Package (OCF-1).
- Clarifying in the Election of Income Replacement, Non-Earner or Caregiver Benefit (OCF-10) that once a choice of benefits has been submitted to the insurer, it cannot generally be changed, as per s. 35(3) of the new SABS.

- Reflecting that an Application for Determination of Catastrophic Impairment (OCF-19) must be prepared by a physician or, where the impairment is only a brain impairment, by a neuropsychologist.
- Reflecting in the Settlement Disclosure Notice the changes to the new SABS coverages.

The following five forms will no longer be Superintendent's approved forms:

- Explanation of Benefits (OCF-9)
- Activities of Normal Life (OCF-12)
- Declaration of Post-Accident Income and Benefits (OCF-13)
- Notice of Examination (OCF-25)
- Voluntary Consent for Pre-Claim Examination (OCF-26).

In addition, the Application for Approval of an Assessment or Examination (OCF-22) has been eliminated as it has been merged with the Treatment and Assessment Plan (OCF-18).

Effective date of forms

The amended forms other than the Form 1 are effective on or after September 1, 2010 and apply to accidents occurring before and on or after September 1, 2010.

The amended Form 1 is for use on or after September 1, 2010, in respect of accidents occurring on or after March 31, 2008.

For accidents that occurred before March 31, 2008, the version of Form 1 previously prescribed for use for such accidents continues to be the appropriate form for making a claim for attendant care benefits, even if submitted on or after September 1, 2010.

Copies of revised forms

Copies of the revised forms are attached and are also available on FSCO's website at www.fsco.gov.on.ca. The Attendant Care Hourly Rate Guideline will also be published in a forthcoming edition of *The Ontario Gazette*.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

June 16, 2010

Attachments:

- [Assessment of Attendant Care Needs \(Form 1\)](#)
- [Attendant Care Hourly Rate Guideline](#)
- [Accident Benefits Application Package \(OCF-1\)](#)
- [Disability Certificate \(OCF-3\)](#)
- [Permission to Disclose Health Information \(OCF-5\)](#)
- [Expenses Claim Form \(OCF-6\)](#)
- [Election of Income Replacement, Non-Earner or Caregiver Benefit \(OCF-10\)](#)
- [Application for Determination of Catastrophic Impairment \(OCF-19\)](#)
- [Settlement Disclosure Notice](#)

Updated Professional Services Guideline

Bulletin

No. A-14/10

– Auto

Property & Casualty

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To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing an updated Professional Services Guideline – Superintendent's Guideline No. 04/10 (Guideline).

This updated Guideline recognizes the change from the Goods and Services Tax (GST) to the Harmonized Sales Tax (HST), which goes into effect on July 1, 2010. It also incorporates a 0.3 per cent increase in fees based on the 2009 Consumer Price Index for expenses related to services rendered on or after July 1, 2010.

This Guideline will be in effect from July 1, 2010. A revised Guideline will be issued subsequently to take into account the reforms under the Statutory Accident Benefits Schedule – Effective September 1, 2010.

Authority

This Guideline is issued by FSCO under subsection 268.3 (1) of the Insurance Act for the purposes of subsections 14 (4), 15 (6), 17 (2) and 24 (2) of the Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996.

Changes

With the implementation of the HST, this Guideline provides direction on how the tax is to be applied. When applicable, the HST is payable by an insurer in addition to the rates and fees that are outlined in this Guideline.

The applicability of the HST falls under the jurisdiction of the federal government's Canada Revenue Agency (CRA). For additional information regarding the applicability of the HST, please visit the CRA's website at www.cra-arc.gc.ca or contact them by telephone at 1-800-959-5525.

Copies

The Guideline is attached for your information and can also be downloaded from the FSCO website at www.fSCO.gov.on.ca. In addition, the Guideline will be published in a forthcoming edition of *The Ontario Gazette*.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

June 18, 2010

Attachment:

- [Professional Services Guideline – Superintendent's Guideline No. 04/10 \(PDF\)](#)

Revised Professional Services Guideline and Revised Transportation Expense Guideline - Effective September 1, 2010

Bulletin

No. A-19/10

– Auto

Property & Casualty

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These bulletins may include forms that are no longer up-to-date or accurate. Readers should visit the [forms](#) section of the FSCO website, to ensure they are using the most recent version of a FSCO form.

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing a revised Professional Services Guideline and a revised Transportation Expense Guideline, that both become effective on September 1, 2010.

Revised Professional Services Guideline

The revised Professional Services Guideline – Superintendent’s Guideline No. 06/10 (revised Professional Services Guideline) reflects the reforms under the Statutory Accident Benefits Schedule – Effective September 1, 2010.

Consistent with the current Professional Services Guideline – Superintendent’s Guideline No. 04/10, the Harmonized Sales Tax (HST) is payable in addition to the rates and fees outlined in the revised Professional Services Guideline, when applicable. The applicability of the HST falls under the jurisdiction of the federal government’s Canada Revenue Agency (CRA). For additional information regarding the applicability of the HST, please visit the CRA’s website at: www.cra-arc.gc.ca or contact them at: 1-800-959-5525.

The fees for the completion and submission of the forms listed in the revised Professional Services Guideline are capped at \$200. These fees include all assessments and work that are required to complete and submit the forms.

Revised Transportation Expense Guideline

The revised Transportation Expense Guideline – Superintendent’s Guideline No. 05/10 (revised Transportation Expense Guideline) applies to all travel that occurs on or after September 1, 2010, regardless of the date of the accident.

For travel occurring on or after September 1, 2010, the transportation expense rate has increased from \$0.34/km to \$0.38/km.

Authority

Both Guidelines are issued by FSCO under section 268.3 (1) of the Insurance Act.

Copies

The revised Professional Services Guideline and the revised Transportation Expense Guideline are attached for your information and can also be downloaded from the FSCO website at www.fSCO.gov.on.ca. Both Guidelines will also be published in a forthcoming edition of *The Ontario Gazette*.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

July 21, 2010

Attachments:

- [Professional Services Guideline – Superintendent's Guideline No. 06/10](#)
- [Transportation Expense Guideline – Superintendent's Guideline No. 05/10](#)

Optional Indexation Benefit Guidelines

These guidelines are issued pursuant to section 268.3 of the *Insurance Act* and apply to accidents occurring on or after November 1, 1996.

Purpose

The purpose of the *Optional Indexation Benefit Guidelines* is to set out the procedures and formulas for indexation as referred to in section 29 of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996*.

General Application

These guidelines apply to named insured persons who have purchased the optional indexation benefit, their spouse, dependants and persons specified as drivers under the policy.

Indexation applies to the following benefits and monetary limits:

1. the weekly amount of any income replacement benefit
2. the weekly amount of any non-earner benefit
3. the weekly monetary limits applicable to income replacement benefits
4. the weekly monetary limits applicable to caregiver benefits
5. the monthly attendant care monetary limits
6. the outstanding balance of medical and rehabilitation benefits available
7. the outstanding balance of attendant care benefits available
8. the outstanding balance of medical, rehabilitation and attendant care benefits available to persons who have access to the optional increased medical, rehabilitation and attendant care benefit

Benefit amounts and monetary limits are indexed on January 1 of each year immediately following the accident.

Indexation Percentage

The indexation percentage is the percentage change in the Consumer Price Index for Canada (All Items), as published by Statistics Canada under the authority of the Statistics Act (Canada), for the period from September in the year immediately preceding the previous year to September of the previous year.

The indexation percentage for January 1, 1997 will be published by the Ontario Insurance Commission once it is available.

Indexation of Income Replacement Benefit (IRB) and Non-Earner Benefit

The weekly amount of a person's income replacement benefit (80 per cent of net income) and the applicable monetary limit (\$400, \$600, \$800 or \$1,000, depending on whether optional IRBs were purchased), are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the weekly benefit and limit from the previous year are adjusted. Indexation is applied before taking into account any collateral source income.

Similarly, with respect to the non-earner benefit, the benefit limits (\$185 and \$320, as applicable to the person) are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the previous year's limit is adjusted. Indexation is applied before taking into account any collateral source income.

Indexation of Weekly Limits for Caregiver Benefit and Monthly Limits for Attendant Care Benefit

The indexation percentage is applied to the monetary limits for the caregiver benefit and the attendant care benefit on January 1 of the year immediately following the accident. In each subsequent year, the limits from the previous year are adjusted.

Indexation shall be performed in accordance with the following formula:

A=B x (1+(C÷100)) where,

A=the new amount (i.e. the new monetary limit or the new weekly benefit)

B=the previous year's amount

C=the indexation percentage

Indexation of Medical, Rehabilitation and Attendant Care Limits

The outstanding balance with respect to medical and rehabilitation benefits and the outstanding balance with respect to the attendant care benefit are indexed on January 1 of each year immediately after the accident. Indexation of these limits is performed using a declining balance method.

Incurred medical, rehabilitation and attendant care expenses up to December 31 of the year are subtracted from the insured person's limits for that year, for each benefit. The indexation percentage is applied to the outstanding balance (i.e. the unused portions). The indexed amounts become the insured person's new monetary limits for the year. Indexation using the declining balance method applies to each of the following:

1. the combined medical and rehabilitation monetary limit,
2. the attendant care monetary limit, and
3. the combined medical, rehabilitation and attendant care monetary limit, if the optional medical, rehabilitation and attendant care benefit was purchased.

Indexation using the declining balance method shall be applied in accordance with the following formula:

$A=(B-C) \times (1+(D \div 100))$ where,

A= the new monetary limit (i.e. new medical and rehabilitation monetary limit, new attendant care monetary limit or new combined monetary limit available to the person)

B= the previous year's monetary limit

C= the sum of all incurred expenses for the previous year (i.e. sum of medical expenses, rehabilitation expenses or attendant care expenses)

D= the indexation percentage

Notice of Outstanding Balance

Upon the request of the insured person, insurance companies are to provide a notice stating the outstanding balance, as indexed, of the medical and rehabilitation benefits and the attendant care benefit and the outstanding balance of the combined benefits, if applicable, as of January 1 of the year

Revised Professional Services Guideline and Revised Transportation Expense Guideline - Effective September 1, 2010

Bulletin

No. A-19/10

– Auto

Property & Casualty

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These bulletins may include forms that are no longer up-to-date or accurate. Readers should visit the [forms](#) section of the FSCO website, to ensure they are using the most recent version of a FSCO form.

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing a revised Professional Services Guideline and a revised Transportation Expense Guideline, that both become effective on September 1, 2010.

Revised Professional Services Guideline

The revised Professional Services Guideline – Superintendent’s Guideline No. 06/10 (revised Professional Services Guideline) reflects the reforms under the Statutory Accident Benefits Schedule – Effective September 1, 2010.

Consistent with the current Professional Services Guideline – Superintendent’s Guideline No. 04/10, the Harmonized Sales Tax (HST) is payable in addition to the rates and fees outlined in the revised Professional Services Guideline, when applicable. The applicability of the HST falls under the jurisdiction of the federal government’s Canada Revenue Agency (CRA). For additional information regarding the applicability of the HST, please visit the CRA’s website at: www.cra-arc.gc.ca or contact them at: 1-800-959-5525.

The fees for the completion and submission of the forms listed in the revised Professional Services Guideline are capped at \$200. These fees include all assessments and work that are required to complete and submit the forms.

Revised Transportation Expense Guideline

The revised Transportation Expense Guideline – Superintendent’s Guideline No. 05/10 (revised Transportation Expense Guideline) applies to all travel that occurs on or after September 1, 2010, regardless of the date of the accident.

For travel occurring on or after September 1, 2010, the transportation expense rate has increased from \$0.34/km to \$0.38/km.

Authority

Both Guidelines are issued by FSCO under section 268.3 (1) of the Insurance Act.

Copies

The revised Professional Services Guideline and the revised Transportation Expense Guideline are attached for your information and can also be downloaded from the FSCO website at www.fSCO.gov.on.ca. Both Guidelines will also be published in a forthcoming edition of *The Ontario Gazette*.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

July 21, 2010

Attachments:

- [Professional Services Guideline – Superintendent's Guideline No. 06/10](#)
- [Transportation Expense Guideline – Superintendent's Guideline No. 05/10](#)

Interpretation Costs and Assessments and Examinations Under the Statutory Accident Benefits Schedule - Effective September 1, 2010

Bulletin
No. A-23/10
- Auto
Property & Casualty

To the attention of all insurance companies licensed to transact auto insurance in Ontario and all health care providers

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing the Cost of Assessments and Examinations Guideline – Superintendent's Guideline No. 08/10 (Guideline), which applies to all accidents occurring on or after November 1, 1996.

The cost of services that are sometimes provided by interpreters in connection with assessments or examinations of insured persons who have a language barrier are not intended to be covered under the Statutory Accident Benefits Schedule - Effective September 1, 2010 (SABS). This does not prevent an insurer from paying or arranging for these services as an adjusting expense.

Health care providers and other persons acting on their behalf should not be arranging for interpreters unless they have prior approval by the insured person and the insurer for payment.

FSCO expects insurers to use their own internal policies and procedures that comply with best practices and legislative requirements, when determining whether interpreters are required.

The Insurance Bureau of Canada released Standards of Sound Marketplace Practice on March 6, 2006. Standard 4, Fair Claims Settlement and Claims Handling, describes best practices that insurers should follow when adjusting a claim. In particular, Standard 4 directs that insurers should have internal policies and procedures that are well understood, fully in place and utilized to ensure "that claims are handled as expeditiously as possible and in accordance with any legal requirements, with fairness and transparency to the claimant". In addition, insurers' standards and guidelines for dealing with claimants and policyholders should ensure "that similar claim situations are treated consistently, and that in all cases insurance contracts are interpreted in ways that are deemed to be in the spirit of fairness".

Authority

The Guideline is issued pursuant to section 268.3 of the Insurance Act for the purposes of the SABS and becomes effective when published in The Ontario Gazette. As required by section 268.3 (2) of the Insurance Act, the Guideline shall be considered in any determination involving the interpretation of the SABS.

Copies

The Guideline is attached for your information and can also be downloaded from the FSCO website at www.fSCO.gov.on.ca. In addition, the Guideline will be published in The Ontario Gazette.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

November 23, 2010

Attachment:

- Cost of Assessments and Examinations Guideline – Superintendent's Guideline No. 08/10

Revised Optional Indexation Benefit Guideline, 2011 Indexation Percentages, and Revised Deductibles/Monetary Amounts under Bill 164

Bulletin

No. A-24/10

– Auto

Property & Casualty

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These bulletins may include forms that are no longer up-to-date or accurate. Readers should visit the [forms](#) section of the FSCO website, to ensure they are using the most recent version of a FSCO form.

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing the following:

- revised Optional Indexation Benefit Guideline – Superintendent's Guideline No. 09/10 (Guideline);

- 2011 indexation percentage for the Optional Indexation Benefit under section 30 of the Statutory Accident Benefits Schedule – Effective September 1, 2010 (new SABS);
- 2011 indexation percentage for the Optional Indexation Benefit under section 29 of the Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996 (old SABS); and
- 2011 indexation percentage and revised deductibles/monetary amounts applicable to claims under the Statutory Accident Benefits Schedule – Accidents after December 31, 1993 and before November 1, 1996 (Bill 164 SABS).

The Guideline and the 2011 indexation percentage and revised deductibles/monetary amounts applicable to claims under the Bill 164 SABS will appear in a forthcoming edition of The Ontario Gazette, in accordance with sections 268.3 (3) and 268.1 (1) of the Insurance Act.

The indexation percentage for the new SABS, old SABS and Bill 164 SABS reflects the year-over-year "Consumer Price Index for Canada (All Items)" from September 2009 to September 2010, as published by Statistics Canada.

Authority

The Guideline is issued by FSCO under section 268.3 (1) of the Insurance Act.

Revised Optional Indexation Benefit Guideline

The Guideline replaces the Optional Indexation Benefit Guidelines – No. 7/96 released on October 28, 1996.

The Guideline applies to insured persons in respect of whom the optional indexation benefit was purchased and who had accidents that occurred on or after November 1, 1996.

Indexation under the new SABS

The 2011 indexation percentage is 1.9 per cent. It is applied in accordance with the Guideline. Under the new SABS, indexation applies to named insureds, spouses of named insureds, and dependants of any of these and specified drivers, if the optional indexation benefit was purchased.

The 2011 indexation percentage applies to benefits that are required to be indexed pursuant to section 30 of the new SABS, in respect of insured persons who were involved in accidents on or after September 1, 2010.

Indexation under the old SABS

The 2011 indexation percentage is 1.9 per cent. It is applied in accordance with the Guideline. Under the old SABS, indexation applies to named insureds, spouses of named insureds, and dependants of any of these and specified drivers, if the optional indexation benefit was purchased.

The 2011 indexation percentage applies to benefits that are required to be indexed pursuant to section 29 of the old SABS, in respect of insured persons who were involved in accidents on or after November 1, 1996 and before September 1, 2010.

Indexation under Bill 164 SABS

The 2011 indexation percentage is 1.9 per cent. It applies to benefits that are required to be indexed pursuant to section 80 of the Bill 164 SABS, in respect of insured persons who were involved in accidents after December 31, 1993 and before November 1, 1996.

The 2011 indexation percentage, the revised deductibles and monetary amounts are listed on the enclosed chart, entitled 2011 Indexation Percentage, Revised Deductibles and Monetary Amounts for Automobile Insurance under the Insurance Act and Statutory Accident Benefits Schedule – Accidents after December 31, 1993 and before November 1, 1996.

Also note that certain indexed amounts under the Bill 164 SABS have been identified in the indexation schedule as possibly no longer being relevant in certain cases. Please refer to the relevant provisions in the Bill 164 SABS to determine if these indexed amounts apply to your situation.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

December 8, 2010

Attachments:

- [Optional Indexation Benefit Guideline – Superintendent's Guideline No. 09/10](#)
- [2011 Indexation Percentage for Statutory Accident Benefits under the Statutory Accident Benefits Schedule – Effective September 1, 2010](#)
- [2011 Indexation Percentage for Statutory Accident Benefits under the Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996](#)
- [2011 Indexation Percentage, Revised Deductibles and Monetary Amounts for Automobile Insurance under the Insurance Act and the Statutory Accident Benefits Schedule – Accidents after December 31, 1993 and before November 1, 1996](#)

Updated Professional Services Guideline

Bulletin

No. A-03/13

Property & Casualty - Auto

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

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With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing an updated Professional Services Guideline (Guideline).

The revised Guideline recognizes that kinesiologists are now regulated health professionals as defined in the Statutory Accident Benefits Schedule.

The hourly rates are unchanged from the 2012 level. This is in line with the auto insurance rate reduction strategy outlined in the government's 2013 Spring Budget.

Authority

This Guideline is issued by FSCO under subsection 268.3 (1) of the Insurance Act.

Copies

The revised Guideline is attached for your information and can also be downloaded from the FSCO website at www.fsco.gov.on.ca. In addition, the revised Guideline was published in the August 3, 2013 edition of The Ontario Gazette.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services
August 6, 2013

Attachments

- [Professional Services Guideline No. 02/13](#)



SECTION C – PRACTICE NOTES

Practice Note 1: Using Medical Evidence to Support Your Claim for Accident Benefits

Note: This Practice Note is currently being revised.



Practice Note 2: Reaching a Settlement within the Dispute Resolution Process

Note: This Practice Note is currently being revised

Practice Note 3: Participation and representation at dispute resolution ("Authority to Bind")

Anyone representing an insurance company or an insured person at mediation, neutral evaluation, or arbitration will be discussing and negotiating agreements and settlements regarding accident benefit disputes. It is essential that people claiming benefits participate in mediation, neutral evaluation or arbitration to hear and discuss settlement offers and give instructions to any representative.

A representative must be able to speak to and negotiate on all issues in dispute. The mediator, neutral evaluator or adjudicator may request written or verbal confirmation that a representative is authorized to discuss the dispute with FSCO, to negotiate, and to enter into an agreement or settlement of any and all issues in dispute. Appointing a representative does not relieve any party of their obligation to participate in the dispute resolution process, except in extenuating circumstances (for example, confinement in a hospital).

A lawyer or an employee representing an insurance company must have the authority to change the company's position based on the evidence presented by the insured at a mediation, neutral evaluation or arbitration. In the case where an insurer's representative has limited authority to enter into an agreement or settlement, an officer of the company **with the requisite authority** must attend or be available by telephone for the duration of the proceeding.

WHAT HAPPENS IF THERE IS NO AUTHORITY TO BIND?

If a party is unable to attend (for example, confinement to hospital), the mediator, neutral evaluator or adjudicator can adjourn a proceeding, with or without conditions, if the representative is not authorized to bind that party to an agreement. The adjournment can be on whatever terms the mediator, neutral evaluator or adjudicator considers appropriate.

An adjudicator has authority to make an interim order of expenses, subject to such terms and conditions as may be established by the adjudicator, should a representative attend without full authority.

WHY IS AUTHORITY TO BIND SO IMPORTANT?

If the representatives do not have authority to bind, a settlement discussion can break down into a series of statements like "I'll have to check that with my client." This can lead to drawn-out, fruitless discussions that waste the time of everyone involved.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

Cette publication est également disponible en français.

Practice Note 4: Exchange of Documents

This Practice Note outlines the role and the need for early disclosure of supporting documents in FSCO's dispute resolution process. The note offers general guidelines as to the type of documents that may be relied upon to support a claim, and when they should be gathered and exchanged with the other party. In certain cases, documents relating to a period more than one year prior to the accident may be relevant and ought to be produced.

A. DOCUMENTS

Documents that may assist to resolve a dispute vary with the issues in dispute, but can include the following:

1. Where disability benefits are in dispute:

- **Clinical notes and records of physicians** who treated the insured person during the year leading up to the accident and after the accident.
- **Ambulance call reports** if the insured person was transported from the accident by ambulance.
- **Hospital records** if the insured person has received treatment at a hospital in the year before the accident or after the accident.
- **Records of the Workplace Safety & Insurance Board (formerly the Workers' Compensation Board)**, if the insured person was receiving workers' benefits at the time of the accident or in the preceding year.
- **Reports and clinical notes of any medical examination of the insured person that was requested by the insurance company** under the Statutory Accident Benefits Schedule.
- Any **report of a Designated Assessment Centre (DAC)** that conducted an assessment of the insured person under the Statutory Accident Benefits Schedule.
- **Medical reports** in the possession of the insurance company, such as those prepared by the insured person's treating physicians.

- **An OHIP statement** listing the physicians who have treated the insured person in the year before the accident and after the accident, if it is unclear who has treated the insured person.
- **Surveillance or investigative evidence** if a party intends to rely on any portion. The party must provide particulars of the names and qualifications of any person who took such evidence, including the dates, times and places where any surveillance or investigation was undertaken. The party must provide copies of all surveillance evidence taken or prepared by anyone in connection with the issues in dispute if the party intends to rely on any portion of the surveillance at the hearing.
- **Certain employment records**, such as a job description.

2. Where the amount of benefits is in dispute:

- **Certified income tax returns** from Revenue Canada for the year before the accident, and the year of the accident.
- **Financial statements** for the year before the accident and the year of the accident in the case of self-employed claimants. In certain circumstances, more detailed raw financial documentation may be required such as bank statements and records.
- **Any application for Canada Pension Plan disability benefits** and a copy of the granting letter, if it appears that the insured person has applied for or received these benefits.
- **A copy of any health or disability insurance policy**, if it appears that the insured person had coverage at the time of the accident, and a copy of any application form or granting letter.
- **Certain employment records**, such as payroll records, for the year before the accident.

B. DOCUMENTS IN MEDIATION

It is important that parties start discussions about exchanging documents **BEFORE** applying for mediation. Parties should immediately begin to collect material from sources, such as doctors, employers, or accountants. Producing documents and providing them to both the other party and the mediator at an early stage, greatly improves the chances for a successful mediation. Recent amendments to the *Insurance Act*, include a provision respecting early disclosure of key materials required to discuss the resolution of the issues in dispute. As a result of this amendment, parties should review their file early to determine whether they will require any materials from the other party to discuss settlement, and **request these materials, in writing from the other party, as soon as possible**. Claimants will be required to list available documents to which they intend to refer in mediation as well as existing documents they wish to obtain from other sources, at the time they file their *Application for Mediation*.

Remember that the request for documents at the mediation stage should be realistic and limited to those items which are critical to settlement discussions. The amount and type of documentation necessary to discuss settlement will vary from case to case. The intent of this provision is to facilitate settlement at this early stage of the dispute resolution process, not to introduce a time consuming and costly process of document exchange.

In the majority of cases the documents necessary to settle disputes at mediation, such as income tax returns, employment records and DAC reports, are readily available. In some instances, documents such as bank statements must be secured at a nominal cost. It is not anticipated that in the majority of cases, historical records such as past medical clinical notes and records and OHIP statements will be necessary to discuss settlement at mediation. Records of this nature are expensive and take a significant amount of time to secure. They are more commonly requested at the arbitration stage of dispute resolution.

If either party objects to providing documents requested by the other, they should immediately communicate their objection and their reasons for objecting in advance of the mediation.

If mediation fails, the **Report of Mediator** will contain a list of materials that were requested by the parties in writing but have not been produced that, in the opinion of the mediator, were required for the purpose of discussing settlement of the issues in dispute at mediation.

The **Report of Mediator** will not necessarily list all of the materials requested by the parties for discussion at mediation.

The failure to produce relevant documentation by a party as outlined in the **Report of Mediator** may delay the commencement of an arbitration or may be considered by an arbitrator at the conclusion of a hearing, when deciding a claim for expenses.

C. DOCUMENTS IN NEUTRAL EVALUATION

Parties wishing to proceed to neutral evaluation within an arbitration proceeding at FSCO, must jointly certify that all the documents listed in the **Report of Mediator** have been exchanged, and that no other documentation is required for an evaluation of the issues in dispute. The person appointed to conduct the neutral evaluation may request additional information to assist in evaluating the issues in dispute.

If the dispute does not settle as a result of neutral evaluation, the evaluator will prepare a **Report of the Neutral Evaluator** listing any materials he or she requested that were not provided by the parties.

The failure to produce relevant documentation by a party as outlined in the **Report of the Neutral Evaluator** may delay the commencement of an arbitration or may be considered by an arbitrator at the conclusion of an arbitration hearing, when deciding a claim for expenses.

D. DOCUMENTS IN AN ARBITRATION HEARING

Parties to an arbitration should exchange all documents necessary to decide the issues in dispute at the earliest possible stage. Applicants will be required to list key documents in their possession as well as documents they intend to obtain from other sources as part of their ***Application for Arbitration***.

The exchange of documents should be worked out between parties and their representatives as soon as possible, and in any event, well before the pre-hearing discussion.

The parties should contact each other and:

- disclose what documents they intend to use at the hearing;
- arrange to give the documents to the other side;
- request any documents that they think they require from the other side; and
- arrange to share documents obtained from third parties.

As a general rule, the party asking for the document is responsible for paying the cost of getting it. When an insurance company arranges to collect documents directly from a third party, it may require the applicant to authorize the collection beforehand. The company must give copies of any documents it obtains to the applicant, as soon as possible.

Where the parties to the arbitration cannot agree which documents to exchange, the pre-hearing arbitrator will rule on what is required.

Where third parties (like hospitals or doctors) are asked to supply documents, the arbitrator will insist that parties make their own reasonable efforts to obtain the documents from the third party before issuing an order requesting the third party to release the documents. One exception to this practice is a request for information from OHIP where, to speed up the process, an arbitrator will make an order at the parties' request. The pre-hearing arbitrator has the final say on what documents must be produced or exchanged **prior** to the arbitration hearing. The hearing arbitrator has the final say on what documents will be considered **during** the hearing.

Arbitration is designed to be relatively informal and quick. It does not have the broad discovery and disclosure processes of the court system. Parties to an arbitration can participate most effectively by promptly disclosing all relevant documents well before the date of the arbitration pre-hearing discussion.

Failing to produce documents well in advance of a hearing can result in adjournments and delays. Furthermore, if documents are not produced promptly, the hearing arbitrator may refuse to admit the documents into evidence or may draw an adverse inference against the party who failed to produce the document. The hearing arbitrator may also deny expenses to that party or award expenses to the other party.

HOW DO I GET MORE INFORMATION?

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Practice Note 5: Mediator Referral to Private Neutral Evaluation - Financial Services Commission of Ontario

WHAT IS NEUTRAL EVALUATION?

Neutral evaluation is a process designed to encourage the settlement of disputes in certain types of cases. A neutral evaluator will give you and your insurance company a frank review of both of your positions, as well as an assessment of the probable outcome, or range of outcomes, should the dispute be decided in private arbitration, arbitration at FSCO or in court.

Neutral evaluation provides the parties with an additional opportunity to settle outstanding disputes and avoid adjudication. This step in the dispute resolution process has the potential to save the parties time and the expenses associated with taking the dispute through the full process of arbitration or to court. Under the *Insurance Act*, neutral evaluation takes place after mediation fails and before a case proceeds to arbitration or court.

HOW DO I OBTAIN NEUTRAL EVALUATION?

Neutral evaluation can be obtained privately or at the Commission, as part of FSCO's arbitration process. To obtain neutral evaluation at FSCO you must first apply for arbitration and pay the filing fee. You must indicate on your Application for Arbitration that you wish to participate in neutral evaluation. If the insurer agrees, the Director of Arbitrations will appoint a neutral evaluator from within FSCO and will suspend the arbitration process until the neutral evaluation has been completed. If your case does not settle at neutral evaluation, your dispute will normally be fast-tracked to an arbitration hearing, bypassing the pre-hearing stage. (See Practice Note 6 "Neutral Evaluation at the Financial Services Commission of Ontario" for more information on this option.)

If you and your insurer choose private neutral evaluation (under the *Insurance Act*), you must agree upon the choice of the neutral evaluator, negotiate the fee, and determine who will pay. The evaluator must then be appointed by FSCO's Director of Arbitrations. The appointment process is simple. The parties write the Director of Arbitrations providing the name, address and telephone number of the neutral evaluator. You must also include written confirmation that the

parties agree to pay for the evaluation and that the neutral evaluator has agreed to conduct the evaluation in accordance with the requirements of the *Insurance Act*. Based on this information, the Director of Arbitrations will appoint this individual as your neutral evaluator and provide him or her with a copy of the Report of the Mediator as well as an approved format for the Report of the Neutral Evaluator.

FSCO is not responsible for payment of the private evaluator's fees nor does it maintain an approved or recommended list of private neutral evaluators.

If a mediator recommends that you and your insurance company engage in neutral evaluation, your case must proceed through private neutral evaluation that is recognized under the Insurance Act. This process must be completed before your dispute can proceed to private arbitration, arbitration at FSCO, or court.

WHEN DOES A MEDIATOR MAKE A REFERRAL TO NEUTRAL EVALUATION?

Mediators consider stringent criteria before recommending a referral to neutral evaluation.

First, the mediator must be of the opinion that the neutral evaluation process will likely result in a settlement of your dispute. This opinion will be based on many factors, including the nature of the dispute, the parties' understanding of their case, their expectations, and their reasonableness.

Second, the mediator will evaluate whether the parties have fully documented their positions. Have they provided disclosure to the other side at mediation or can they realistically exchange the documents required within 30 days of the date of the Report of the Mediator?

Third, if both parties agree to proceed to neutral evaluation it will be noted in the Report of the Mediator. In this case, a mediator referral is not required. The mediator will outline the features of both private and FSCO-delivered neutral evaluation. The parties then may choose the route they will pursue.

Fourth, if mutual consent cannot be reached, but the insured person wishes neutral evaluation, the mediator can consider a referral. Under these circumstances the mediator will outline the features of private neutral evaluation as detailed under the *Insurance Act*.

Fifth, before making the referral to private neutral evaluation, the mediator must ensure that the parties have agreed how they will pay for these services. The parties will have to agree on who will perform the evaluation and obtain the appointment of this person's service by the Director of Arbitrations, as outlined above.

HOW DO I CONTACT THE OFFICE OF THE DIRECTOR OF ARBITRATIONS?

The Director of Arbitrations' office can be contacted at:

Financial Services Commission of Ontario
Dispute Resolution Group
Arbitrations Unit
5160 Yonge Street, 14th Floor
Toronto ON M2N 6L9
phone (416) 590-7202
fax (416) 590-8462
Toll-Free 1-800-517-2332

Cette publication est également disponible en français.

Practice Note 6: Neutral Evaluation at the Financial Services Commission of Ontario

WHAT IS NEUTRAL EVALUATION?

Neutral evaluation is a voluntary dispute resolution option within the arbitration process at the Financial Services Commission of Ontario designed to provide the parties, in appropriate cases, with an additional opportunity to settle their disputes. Neutral evaluation has the potential to save both parties the time and expense associated with taking disputes through to a full arbitration hearing.

Neutral evaluation is conducted before a neutral evaluator, who is an arbitrator with FSCO. The neutral evaluator provides an early, authoritative, independent, yet non-binding opinion of the probable outcome, or range of outcomes, should the dispute continue to a hearing.

Not all cases are suitable for neutral evaluation. Most arbitration cases at FSCO are scheduled for a pre-hearing discussion prior to a hearing (See Practice Note 7, "The Arbitration Pre-hearing Discussion")

Neutral evaluation is not a substitute for a pre-hearing discussion. The neutral evaluator will not decide disputes relating to the identification and exchange of documents, make procedural rulings or deal with preliminary issues or requests for interim relief.

WHAT CASES ARE APPROPRIATE FOR NEUTRAL EVALUATION?

For neutral evaluation to be effective, both parties must already have requested, produced and received all documents that are necessary and relevant for a determination of the issues in dispute. The neutral evaluator can only provide an authoritative opinion of the probable outcome of the dispute, if the parties are aware of the pertinent facts of the case. The parties to neutral evaluation ought to have all of the Documents they would have during final submissions at the conclusion of a hearing. Therefore, cases where important documentation is not yet available are not appropriate for neutral evaluation.

Neutral evaluation is intended to resolve the entire dispute between the parties. A neutral evaluation will generally not be arranged for only part of the overall dispute.

Cases especially suited for neutral evaluation are those where the facts are not in dispute or the dispute centres on a question of legal interpretation which has been canvassed to some extent by either FSCO or by the courts.

Cases involving allegations of fraud or significant credibility issues are generally less likely to benefit from neutral evaluation. In such cases, the opinion of the neutral evaluator may only succeed in further polarizing the parties thereby reducing the probability of settlement.

HOW DO I OBTAIN NEUTRAL EVALUATION AT THE FINANCIAL SERVICES COMMISSION OF ONTARIO?

Neutral evaluation can be requested by an insured person as part of the Application for Arbitration (Form C). Where an insured person has requested neutral evaluation, through the application process, the insurer may consent to neutral evaluation by completing an Agreement to Neutral Evaluation at the Commission, in FORM D and filing it by facsimile transmission within 20 days of the receipt of the Application for Arbitration.

The insurer may also initiate neutral evaluation by obtaining the written consent of the Applicant and by completing an Agreement to Neutral Evaluation at FSCO, in FORM D and by filing both by facsimile transmission within 20 days of the receipt of the Application for Arbitration.

FSCO will not schedule a neutral evaluation unless both parties agree.

HOW SHOULD I PREPARE FOR NEUTRAL EVALUATION?

Parties need not be represented by legal counsel at neutral evaluation. However, legal and factual issues which are evaluated are often complex. Most parties are represented by lawyers during the arbitration process, including neutral evaluation.

A date for neutral evaluation will not be scheduled until the parties file a Joint Statement for Neutral Evaluation at the Commission (Form H) under Rule 44 of the Dispute Resolution Practice Code setting out each issue in dispute. In addition, each party must prepare a case summary under

Rule 45, setting out exactly what the party seeks, and an outline of the evidence being relied upon, at least 10 days prior to the date set for the evaluation.

Each party must also provide copies of the relevant and necessary documents which support their case and which the neutral evaluator should read and consider before giving an opinion.

Each party should be completely familiar both with their own case, and the other side's case before attending the neutral evaluation. Neither side calls witnesses at a neutral evaluation. In the exceptional case a party may wish to consider having a key individual, such as a bookkeeper or doctor, attend the neutral evaluation to help the evaluator understand the evidence. To do this, it will be necessary to obtain the written consent from the Office of the Registrar prior to the evaluation.

DO I NEED TO ATTEND AT THE NEUTRAL EVALUATION?

ABSOLUTELY.

The neutral evaluation can only be effective if both parties, as well as their representatives are present to hear the information and the opinion of the neutral evaluator.

WHAT HAPPENS AT NEUTRAL EVALUATION?

Before the neutral evaluation occurs, the neutral evaluator will read the summaries of the parties and the documentation filed.

The neutral evaluation will be scheduled for one half day and can take place either at the offices of FSCO in Toronto, or by telephone conference.

The format of the neutral evaluation is flexible and can be adapted to meet the particular needs of the parties and the circumstances of the case. At the beginning of the evaluation the neutral evaluator will generally review various alternative approaches to the neutral evaluation and ask the parties which format would be most conducive to resolving their dispute.

Usually the neutral evaluator will hear brief oral submissions from each party, highlighting the positions and supporting evidence of each side. The neutral evaluator may then have questions of each party regarding the evidence, the conclusions to be taken from the evidence, or the parties' interpretation of the pertinent legislation.

After considering all of the evidence and arguments, both written and oral, the neutral evaluator will generally attempt to facilitate settlement between the parties, prior to providing an oral opinion of the probable outcome of a hearing. The neutral evaluator may meet with each side on consent, or may break to allow parties a private opportunity to discuss settlement options generated during the process. When the dispute settles, the neutral evaluator will prepare a report identifying the issues that were evaluated and settled.

WHAT HAPPENS IF THE CASE DOESN'T SETTLE AT NEUTRAL EVALUATION?

If the neutral evaluation does not resolve all of the issues in dispute, the neutral evaluator will set a date for the arbitration hearing. A pre-hearing discussion will not be scheduled. Therefore, neither party will be able to obtain any production orders prior to the arbitration hearing, except in extraordinary circumstances where new information, which could not have been anticipated, has come to light since the neutral evaluation.

The neutral evaluator will prepare a written report confirming issues which remain in dispute. The opinion of the neutral evaluator is confidential and will not be included in the written report. The parties cannot communicate the neutral evaluator's opinion to the hearing arbitrator. The hearing arbitrator will not be the same person as the neutral evaluator.

For information about arranging a Private Neutral Evaluation, see Practice Note 5, "Mediator Referral to Private Neutral Evaluation".

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1- 800 517-2332

Cette publication est également disponible en français.

Practice Note 7: The Arbitration Pre-Hearing Discussion

Parties to an arbitration are usually required to participate in one or more pre-hearing discussions of their case before the actual arbitration hearing. This discussion generally takes place within 6 to 8 weeks after the applicant receives the insurance company's **Response by Insurer**.

Parties are expected to have exchanged all documents identified in the **Application for Arbitration** and the **Response by Insurer**, or to have provided the other party with a written explanation why a document has not been provided, prior to the pre-hearing discussion.

WHY DO WE HAVE A PRE-HEARING DISCUSSION?

The pre-hearing discussion gives the parties an opportunity to talk with an arbitrator about the case before the hearing. The arbitrator will:

- attempt to settle some or all of the issues in dispute;
- clarify the issues to be arbitrated;
- explain the rules of the hearing;
- review what witnesses and evidence will be brought to the hearing;
- review each party's list of outstanding document requests and disputed items;
- decide which documents should be exchanged where the parties cannot agree;
- set a mutually convenient date and location for the hearing.

DOES EVERYONE MEET IN PERSON?

The pre-hearing discussion can be held in person or by telephone conference call, at the arbitrator's discretion.

Whether the discussion is in person or by telephone, both the applicant and the representative from the insurance company should take part. Arbitrators have noted that the absence of parties from the pre-hearing frequently impedes settlement discussions – even when the parties are represented by legal counsel who participate in the pre-hearing on their behalf.

Clients who cannot participate in person are expected to be available to participate in the pre-hearing discussion by phone.

An arbitrator will chair the discussion. The arbitrator who chairs the pre-hearing discussion will generally not be the one who hears the case.

WHAT DO I BRING TO THE PRE-HEARING DISCUSSION?

Don't wait for the pre-hearing discussion to begin preparing your case.

Get updated medical information, financial documents, or recent tax returns **BEFORE** the pre-hearing discussion.

Parties must exchange copies of all the documents they intend to use at the actual hearing well before the pre-hearing discussion. (See **Practice Note 4**, "Exchange of Documents").

If you have been unable to exchange documents in advance, please bring along two sets of photocopies: one for the arbitrator and one for the other party. These photocopies will be exchanged at the pre-hearing.

The arbitrator will ask about the witnesses who will be called during the hearing. Witnesses typically provide information about the accident, about the applicant's employment and income, or about the applicant's medical condition.

HOW LONG AFTER THE PRE-HEARING DISCUSSION UNTIL THE HEARING?

At the pre-hearing, the arbitrator will set a convenient date for the hearing. Generally, this date will be within four to six months of the pre-hearing discussion. Once this date is set, changes will only be made in special circumstances. (See **Practice Note 9**, "Adjournments").

You must have all your papers, updated medical reports and witnesses ready for the hearing date set.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1- 800-517-2332

Practice Note 8: Attendance of a Witness to an Arbitration Hearing by Summons

If you need a witness to attend an arbitration hearing you must arrange four things: advanced notification to the potential witness, the summons, an affidavit attesting to the summons, and the correct attendance fees.

First, you must notify a potential witness of your intention to call him or her to give evidence at the hearing at least **30 days** before the first day of your arbitration hearing.

Next, the witness must receive a summons (called a **Summons to Witness**) to the hearing and payment for attending at least 5 business days before the first day of the hearing.

Finally, the person who delivers the summons must file an affidavit (swearing that the summons and witness fees were delivered in person) with FSCO.

SUMMONING A WITNESS

Step 1: Notice of intention to call witness to attend the arbitration

The Dispute Resolution Practice Code requires each party to identify the expert and lay witnesses they intend to call to the hearing, as part of the pre-hearing process. In addition, **Rule 41** of the **Code** requires every party to notify a potential witness of the intention to call him or her to give evidence at the hearing at least **30 days** before the first day of the hearing. A failure to provide proper notice to a potential witness may result in the arbitrator excusing the witness from attending at the hearing.

Step 2: Getting the proper forms

If you wish to summon a witness, get a **Summons to Witness** form (**Form N** found in **Section G** of the **Code**) from FSCO. FSCO can mail or fax the form to you, or it can be picked up in person. If you wish to have a witness at your hearing, you should start this process as early as possible before the hearing date.

Step 3: Filling out the form

Be sure you include all necessary information on the **Summons to Witness** form before you pass it to your witness:

- FSCO's file number;
- your name;
- the name of the insurance company;
- the name and address of the person receiving the summons (witness);
- the date, time and place of the hearing;
- a list of the documents the witness should bring to the hearing.

Step 4: Delivering the Form

The summons must be delivered to the witness in person not less than 5 business days before the first day of hearing. (**Rule 73** of the Dispute Resolution Practice Code). You or your representative can deliver the summons, or you can hire a process server (check the Yellow Pages of your telephone directory). You must also be sure to pay the witness at this time. Remember, you must deliver the **Summons to Witness** at least 5 business days before the commencement of the hearing.

CALCULATING PAYMENT TO THE WITNESS

The standard witness fee is \$50 a day for each day of the hearing the witness attends. But an expert witness, like a doctor or an accountant, often charges more. You should speak directly to your doctor or other expert witness to determine any additional fees they may charge in connection with their attendance at the hearing. You are also responsible for paying travel expenses to the witness. These vary:

- If a witness lives in the city where the hearing is held, you are responsible for \$3 per day in traveling expenses;
- If a witness lives outside of the city but within 300 kilometres, you must pay 24 cents a kilometre each way;
- If the witness lives more than 300 kilometres from the hearing, you must pay travel expenses equalling the minimum return air fare, plus 24 cents a kilometre, each way, from the witness's home to the airport and from the airport to the hearing;
- Overnight accommodation and meals can be up to \$75 per day.

Remember, the witness must receive this payment when he or she receives the summons.

IMPORTANT

Be sure you keep your copies of the summons and of the money order or cheque that goes to the witness for fees and expenses. At the end of your hearing, you can ask the arbitrator to award you your costs for witness fees, travel expenses and swearing the ***Affidavit of Service for a Summons to Witness***. (For more information, see **Schedule to Expense Regulation** found in **Section F** of the **Code**).

GETTING AN AFFIDAVIT OF SERVICE

Before the hearing, FSCO must receive a signed affidavit (called an ***Affidavit of Service for a Summons to Witness, Form O***, found in **Section G** of the **Code**) swearing that the witness was handed the summons in person and paid to attend the hearing. The affidavit can be delivered to FSCO in person or by regular, registered or certified mail. It can also be faxed to FSCO as long as the original is mailed to FSCO.

In the ***Affidavit of Service for a Summons to Witness***, the person who delivered your summons swears an oath that he or she has personally handed the summons and required witness fee to the witness. Swearing, or affirming, is done in front of a commissioner of oaths such as a lawyer, notary public, or a designated law clerk or paralegal. Forms will be available wherever you find a designated commissioner of oaths. You may have to pay the commissioner of oaths for this service.

WHAT HAPPENS IF A WITNESS DOESN'T SHOW UP FOR THE HEARING?

Having your witness attend the hearing may be critical to your case. It is vital that your witness is properly summoned and that you keep copies of all documents. If your witness does not attend the hearing, fails to stay, or does not bring the documents listed on the summons, you may not be able to prove your case.

What happens next depends largely on whether the summons, the affidavit and witness fees were properly prepared and delivered a minimum of 5 business days before the first day of the hearing. The arbitrator will review the affidavit to ensure that everything that needed to be done was properly done. If your copies of the documents show that the witness was summoned properly, the arbitrator may grant an adjournment and set another hearing date, or a sheriff's warrant may be obtained through the courts, to have the witness brought to the hearing.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

Cette publication est également disponible en français.

Practice Note 9: Adjournments

FSCO has an obligation to conduct arbitrations efficiently and speedily. Parties are contacted and agree to pre-hearing and hearing dates well in advance of the dates set. Therefore, adjournments are granted only sparingly once dates have been set.

WHEN WILL ADJOURNMENTS BE GRANTED?

Requests for adjournments will only be considered in three circumstances:

- in cases of personal emergencies, such as serious illnesses or deaths in the family
- for valid reasons relating to the hearing itself, such as an imminent settlement, or medical or other critical evidence that is **UNAVOIDABLY** delayed
- when a lawyer is involved in a trial or other proceeding that was scheduled to conclude before the start of FSCO proceeding and which has continued or been held over into the time scheduled for FSCO proceeding.

WHEN WILL ADJOURNMENTS BE REFUSED?

Adjournments will normally be refused if they do not fall into one of the three categories mentioned above. Common circumstances in which adjournments are refused include the following:

- scheduling conflicts for the parties or their lawyers (except for conflicts with pre-set trial dates as noted above)
- where the parties have not made reasonable efforts to comply or delayed their compliance with undertakings and orders made at the prehearing
- where the parties have not made early arrangements to ensure availability of documents or the attendance of witnesses
- where parties have not made early arrangements for further medical examinations, assessments or follow-up.

NOTICE REQUIREMENTS

Seven days notice is generally required for an adjournment request. A request for an adjournment of a pre-hearing discussion or arbitration proceeding must be made in writing to the Office of the Registrar with a copy to the other parties. A request for an adjournment of an appeal or variation/ revocation must be made to the Director of Arbitrations. Such requests must outline the reasons for the adjournment and indicate whether all other parties consent to it. Alternative hearing dates that are acceptable to all parties must be proposed. The party requesting an adjournment should contact the other parties involved in the hearing to arrange acceptable alternative dates before asking for the adjournment.

The Office of the Registrar, the Director, or an adjudicator may deal with requests on less than seven days notice by conference call.

THE NEW HEARING DATE

It is advisable to provide more than one alternative hearing date for the proposed adjournment. An adjournment "sine die" (that is, with no new hearing date set) will rarely be granted except in extraordinary circumstances.

WRITTEN CONFIRMATION OF ADJOURNMENT FROM THE COMMISSION

Every request for an adjournment receives a written response from FSCO. No adjournment is granted without written confirmation to the parties and their representatives. If you have not received written confirmation of your adjournment request prior to the scheduled date of the proceeding, you are required to attend at the proceeding on the originally scheduled date to speak to an arbitrator on the issue of the adjournment request.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

Cette publication est également disponible en français

Practice Note 10: Process for Settling Disputes Between Auto Insurance Companies

Archived Content

The following content was [published/archived] on **September 2010**, and is provided for historical reference. Information is subject to change and may no longer be accurate.

- [Current FSCO forms](#)
- [Current information on individuals or entities licensed by FSCO](#)

This Note is to advise claimants and insurers of the provisions of Regulation 283/95 **Disputes Between Insurers** ("the Regulation"). The Regulation ensures that claimants will have access to statutory accident benefits where two or more insurers are disputing which one has the responsibility to pay accident benefits. The Regulation also requires that disputes between insurers about which insurer is required to pay accident benefits be referred to private arbitration under the Arbitration Act, 1991. Such disputes between insurers are no longer dealt with through the dispute resolution process at the Commission. A copy of this Regulation is included with this Practice Note.

BACKGROUND – SECTION 268 OF THE *INSURANCE ACT*

Section 268 of the *Insurance Act* creates rules for determining which automobile insurance company is responsible for paying accident benefits in a given set of circumstances. The section is used to determine which insurer is liable to pay benefits when the claimant does not have an auto insurance policy of his or her own, or where coverage may be available under more than one policy. In some circumstances, s.268 requires a specific insurance company to deal with the claim. In other situations, two or more companies may be liable to pay benefits, and a claimant may choose the insurer from which to claim benefits. An excerpt from s.268 outlining the priority rules for paying benefits is attached.

Disputes between insurers can arise in various ways. For example, in cases where a passenger involved in a car accident has no auto insurance of his or her own, it may not be clear whether the passenger looks to the insurance policy of their spouse, parents, or another vehicle involved in the accident. A spouse or dependant of a named insured must look to that policy for payment of accident benefits. A person who is not a spouse or dependant will have to look to the insurance policy of a vehicle involved in the accident.

REGULATION 283/95 – DISPUTES BETWEEN INSUREES

This Regulation ensures that accident victims will not be denied statutory accident benefits simply because the first insurer applied to for benefits thinks another insurer should pay. Section 2 of the Regulation requires the **first** insurer that receives an application to adjust the claim and to pay benefits to which the insured person is entitled, pending resolution of any dispute as to which insurer is required to pay benefits (see s.2 of the Regulation). The first insurer cannot refuse to pay accident benefits on the basis that the insured person may have approached the wrong insurance company.

If an insurer believes that another insurance company ought to be paying the claim, it is obliged to notify the other company **within 90 days** of receiving a completed application for statutory accident benefits. It also must notify the insured person that it believes another company is responsible, and that it proposes to transfer the claim to that company. If the insured person objects to the claim being transferred, he or she must notify the insurer of the objection **within 14 days**. Otherwise, the insured person will not be able to participate as a party in the dispute between insurers as to which insurer should pay.

The Regulation removes these disputes between insurers from the dispute resolution process at the Commission. Disputes between insurers are now settled through private arbitration under the *Arbitration Act, 1991*. If the insured person has given notice that he or she objects to the transfer of the claim, the insured person, or his or her representative, may take part in the arbitration of the dispute under the *Arbitration Act*. All such arbitrations must be commenced **within a year** from the date that the first insurance company gave notice that it believes another company is liable.

OBLIGATION OF INSURERS

The Regulation requires the insurer who first receives an application for benefits to consider entitlement and adjust the claim as it would any other, including seeking an independent medical examination, or initiating the designated assessment or mediation process as appropriate. It does not allow the insurer to ignore a claim where it believes another insurer is liable to pay under s.268 of the *Insurance Act*.

Where the first insurer believes it is the wrong insurer and also claims that the insured person is not entitled to benefits under the *Statutory Accident Benefits Schedule*, it must respond to the claim on two separate fronts – issuing the notice to the insurer it believes is responsible under s.268, and following the procedures for denying a claim through the normal dispute resolution process at the Commission.

OBLIGATIONS OF CLAIMANTS

The Regulation is intended to ensure that a claimant is not caught between two insurers, each of which disputes its liability to pay benefits. However, the Regulation cannot operate properly without a clear record as to which insurer first receives an application for benefits. As a result, claimants are advised to carefully consider which insurer is obligated to pay the claim under the provisions of s.268 of the *Insurance Act*, **before** submitting an application. In order to prevent disputes over which insurer first received an application, **the claimant is advised to initially submit only one application for benefits.**

If the insurer to whom the application was submitted does not respond to the claim, or delays or denies coverage on the basis that another insurer is liable to pay, under s.268 of the *Insurance Act*, the claimant should contact the Office of the Insurance Ombudsman of the Commission. The claimant may also file an ***Application for Mediation*** against the first insurer regarding a delay in payment or failure to respond.

Under the Regulation a claimant is required to provide the insurers with all the relevant information that is needed to determine which insurer is required to pay (see s.6 of the Regulation). He or she is not required to participate in the private arbitration that will occur if the dispute is not settled. A claimant is entitled to object to the transfer of a claim (unless the claim has been made against the Motor Vehicle Accident Claims Fund – s.11) and to participate as a party in the private arbitration if he or she files an objection **within 14 days** of receiving notice of the dispute (see s.5 of the Regulation).

LIABILITY UNDER SECTION 268 OF THE *INSURANCE ACT* VERSUS ENTITLEMENT UNDER THE *STATUTORY ACCIDENT BENEFITS SCHEDULE*

In some cases insurers have expressed uncertainty about how they should deal with a claim where there is a dispute between insurers.

If the insurer's position is that the claimant is not eligible for accident benefits, then the dispute should be addressed by commencing mediation at the Commission.

If the insurer's position is that responsibility to pay belongs to another insurer, then it is a dispute under Regulation 283/95. The first insurer must notify the other insurer and the claimant, as outlined above, and resolve that dispute through private arbitration.

If the first insurer has a number of reasons for denying the claim, some of which are based on lack of entitlement, and others based on a liability question, it should dispute the claim in the normal manner before the Commission on the entitlement dispute. It should also issue a notice under the Regulation to the insurer that it believes would be required to pay, in the event it is unsuccessful on the entitlement issues. The second insurer may seek permission to join the proceeding concerning entitlement to accident benefits started by the first insurer at the Commission.

This is a brief summary of a complex topic. Please refer to Regulation 283/95 and the Insurance Act for more precise information.

HOW DO I GET MORE INFORMATION?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714
From outside Toronto, phone: 1-800-517-2332

To reach the Office of the Insurance Ombudsman at the Commission, the telephone numbers are:

From Toronto, call (416) 250-7250
From outside Toronto, phone 1-800-668-0128

- [Excerpt From the Insurance Act R.S.O 1990, C.1.8 Statutory accident Benefits](#)
- [Excerpt From the Insurance Act R.S.O 1990, C.1.8 Ontario Regulation 283/95](#)

Cette publication est également disponible en français

Practice Note 11: Jurisdictional Issues Arising in Mediation

This Practice Note is to advise claimants and insurers of the policy of the Financial Services Commission of Ontario ("FSCO") on jurisdictional issues which frequently arise upon entry to the mediation process.

A. GENERAL JURISDICTION:

Mediation at FSCO helps to resolve disputes concerning benefits available under the various *Statutory Accident Benefits Schedules* ("SABS") passed since June 22, 1990. These benefits are available in respect of personal injuries from motor vehicle accidents. Mediation does not deal with claims that arose out of accidents occurring before June 22, 1990.

1. NO MEDIATION OF CLAIMS FOR PROPERTY DAMAGE

Mediation Services does not accept applications to mediate disputes concerning damage to automobiles or other property except as specifically set out in the SABS.

2. NO MEDIATION OF A CLAIM FOR WEEKLY BENEFITS FOR THE FIRST WEEK OF DISABILITY

The SABS provide that no weekly benefit is payable for the first week of disability. Mediation Services does not accept applications to mediate a claim for entitlement to a weekly benefit for the first week of disability.

3. NO MEDIATION WHERE A CLAIM FOR ACCIDENT BENEFITS HAS NOT BEEN SUBMITTED TO INSURER

Claimants may use the services of mediation when an accident benefit has been claimed from an automobile insurer and denied. Claimants are entitled to receive written notice from the insurer of a refusal to pay a claim along with an explanation for the refusal. Mediation Services does not accept an **Application for Mediation** where the claimant has not first submitted his or her claim to the insurer. Where a claim has been submitted to an insurer and the time specified in the regulation for reviewing the claim by the insurer has expired, Mediation Services will accept the **Application for Mediation** on the basis of the insurer's deemed denial.

4. PREVIOUSLY MEDIATED ISSUES

Mediation Services does not re-mediate issues that have been dealt with in a previous mediation and the Report of Mediator states that the issue was not resolved. The options after a failed mediation, are:

- take no further steps;
- file an **Application for Arbitration** at FSCO;
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act*;
- request Neutral Evaluation, privately or through an Application for Arbitration at FSCO;
- commence a court action.

5. SPECIAL AWARD

Mediation Services does not accept an **Application for Mediation** of a claim for a Special Award, as this is not a benefit provided under the *SABS*. A special award is a matter of the exercise of an arbitrator's discretion.

6. LEGAL EXPENSES

Mediation Services does not accept applications to mediate a dispute over legal fees and disbursements, as this is not a benefit provided under the *SABS*.

An award of legal expenses is a hypothetical matter that does not arise until the arbitration or court proceeding is concluded. Therefore, the issue must be addressed as part of the arbitration or court proceeding.

B. EXPIRY OF LIMITATION PERIODS

1. TIME LIMIT TO APPLY TO INSURER FOR ACCIDENT BENEFITS

- i. The *Statutory Accident Benefits Schedules* establish time limits for applying for accident benefits. However, late applications must be accepted if the insured person has a "reasonable excuse" for the delay.

Disputes concerning whether a delay was reasonable will be accepted for mediation. The preliminary issue concerning the reasonableness of the delay will be mediated along with the disputes concerning the statutory accident benefits claimed in the **Application for Mediation**.

- ii. Exception. There is an exception for accidents that occurred on or after June 22, 1990 and before January 1, 1994. The Schedule (Bill 68) provides that an injured person must apply to their insurer for accident benefits within two years after the accident. If no claim for accident benefits is made to the insurer within two years, FSCO has no jurisdiction to mediate. However, disputes concerning whether a claim for benefits was made to the insurer within two years will be accepted for mediation. The preliminary issue of whether the limitation period to claim benefits has expired, will be mediated along with the disputes concerning statutory accident benefits claimed in the Application for Mediation.

2. TIME LIMIT TO APPLY TO FSCO FOR MEDIATION OF DISPUTES OVER BENEFITS

The SABS provide that a claimant may commence mediation at FSCO within two years of the insurer's written refusal to pay the benefit claimed. Mediation Services does not accept an **Application for Mediation** if it is made to FSCO beyond two years. However, disputes concerning whether an **Application for Mediation** was made to FSCO within two years of the insurer's written refusal to pay benefits will be accepted for mediation. The preliminary issue of the expiry of the limitation period will be mediated, along with the disputes concerning statutory accident benefits claimed in the **Application for Mediation**.

If the limitation period issue arises in the Mediation intake process, the mediation caseworker will notify the claimant of the limitation period and will require the claimant to provide a letter confirming that he or she wishes to dispute the expiration of the time limit. If the issue is raised by the insurer during the mediation process, no letter from the claimant is required.

C. DISPUTES BETWEEN INSURERS – REGULATION 283/95

Mediation Services does not deal with disputes about which of several insurers is required to pay the claimant's SABS in accordance with applicable regulation(s). Please refer to [Bulletin No. A-07/10 Property & Casualty – Auto](#).

D. FULL and FINAL RELEASE – SETTLEMENT REGULATION 664 AS AMENDED

Mediation Services does not accept an ***Application for Mediation*** where a claimant has signed a valid full and final release of his or her entitlement to SABS arising from the motor vehicle accident in question and the insurer has complied with the requirements of the **Settlement Regulation**.

Mediation Services will accept an Application for Mediation where:

- i. the claimant disputes the validity of the settlement, such as whether the insurer has complied with the requirements of the **Settlement Regulation**.
- ii. a court or private arbitrator has set aside a previous settlement on such grounds as fraud, duress or misrepresentation;
- iii. the parties agree to set aside the settlement;
- iv. the claimant resiles from a settlement within the 48 hour cooling off period in accordance with the **Settlement Regulation** (See **Practice Note 2**, "Reaching a Settlement within the Dispute Resolution Process");

The preliminary issue of the validity of the settlement will be mediated along with the disputes concerning statutory benefits claimed in the ***Application for Mediation***.

Mediation Services will not re-mediate issues that have been dealt with in a previous FSCO mediation as reflected in the **Report of Mediator**. The options after a mediation where issues were reported as resolved but the validity of the settlement is now in dispute, are:

- take no further steps
- file an ***Application for Arbitration*** at FSCO
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act*.
- request Neutral Evaluation, privately or through FSCO
- commence a court action.

E. APPLICATION FOR A NON- EARNER BENEFIT SUBMITTED TO THE INSURER PRIOR TO 26 WEEKS

For accidents occurring on or after November 1, 1996 (Bill 59), a claimant may be eligible to receive a Non-Earner Benefit, 26 weeks after the onset of disability. Mediation Services does not accept applications to mediate the issue of entitlement to a Non-Earner Benefit prior to the expiry of the 26 week period.

HOW DO I GET MORE INFORMATION?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714

From outside Toronto, phone: 1-800-517-2332

To reach the Office of the Insurance Ombudsman at the Commission, the telephone numbers are:

From Toronto, call (416) 250-7250

From outside Toronto, phone 1-800-668-0128

Cette publication est Également disponible en français

Practice Note 12: What Claimants Need to Know About Designated Assessment Centres

Archived Content

The following content was [published/archived] on **September 2010** and is provided for historical reference. Information is subject to change and may no longer be accurate.

- [Current FSCO forms](#)
- [Current information on individuals or entities licensed by FSCO](#)

This Practice Note has been removed.

SECTION D – FEES AND ASSESSMENTS

1. Fees - (An application filing fee is charged to the party that initiates an arbitration, an appeal or a variation/revocation proceeding.)

1.1 The application filing fee for an arbitration is **\$100**. Only insured persons can file an ***Application for Arbitration***.

1.2 The application filing fee for an appeal of an arbitration order is **\$250**. Either an insured person or an insurer can file a ***Notice of Appeal*** of an arbitration order.

1.3 The application filing fee for a variation/revocation of an arbitration or appeal order is **\$250**. Either an insured person or an insurer can file an ***Application for Variation/Revocation***.

1.4 The fee for photocopies of a document from FSCO is **\$0.50** per page with a **\$5** minimum.

1.5 The fee for handling a cheque returned to FSCO as having insufficient funds is **\$35**.

2. Insurer Assessment - (An assessment is charged to an insurer that is a named party to an arbitration, an appeal or a variation/revocation proceeding.)

2.1 The insurer assessment charged to an insurer that is named as a party to an arbitration proceeding after March 31, 1997 where an arbitrator is appointed without a neutral evaluation being commenced at FSCO is **\$3,000**. The insurer assessment is triggered by FSCO on the due date for filing the ***Response by Insurer to an Application for Arbitration (FORM E)***. The insurer assessment will not be charged where FSCO has received written confirmation that all issues in dispute in the arbitration proceeding have been resolved, provided that the written confirmation is received by FSCO prior to the due date for filing the ***Response by Insurer to an Application for Arbitration***.

2.2 The insurer assessment charged to an insurer that is named as a party to an arbitration after March 31, 1997 where a neutral evaluation is commenced at FSCO is **\$1,000**. The insurer assessment is triggered by FSCO upon receipt of a completed ***Agreement to Neutral Evaluation at the Commission (FORM D)***.

2.3 The insurer assessment charged to an insurer where an arbitrator has been appointed to conduct a hearing after the termination or completion of a neutral evaluation conducted at FSCO and the insurer has been assessed the **\$1,000** referred to in 2.2 is **\$2,000**. This insurer assessment is triggered when the Neutral Evaluation is terminated or withdrawn or when the **Report of the Neutral Evaluator** is issued and settlement of the issues in dispute is not confirmed in writing within two days of the issuance of the Report.

2.4 The insurer assessment charged to an insurer that is named as a party to an appeal is **\$500**.

2.5 The insurer assessment charged to an insurer that is named as a party to a variation/revocation proceeding is **\$500**.

2.6 Where there are two insurers named in a proceeding, both insurers must pay assessments. Insurer assessments are not refundable except as outlined under subparagraph 2.8.

2.7 Where a proceeding is consolidated with another proceeding, the insurer will be assessed only once.

2.8 Arbitration assessments may not be assessed to an insurer **before** the due date for filing the **Response by Insurer to an Application for Arbitration (FORM E)** as set out in 2.1 or when an arbitrator has determined by order that there is no jurisdiction to decide the case (for example, expired time limits).

3. **Payment of Fees - By the Insured Person**

3.1 An insured person must pay the fees outlined above in 1.1, 1.2, and 1.3, at the time of filing their application(s).

3.2 All fees must be paid by cash (in person only), cheque, or money order. Do not send cash through the mail.

3.3 All cheques and money orders must be made payable to the order of the **MINISTER OF FINANCE**.

3.4 Filing fees may not be waived under the *Insurance Act*, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

3.5 Payment of filing fees may not be deferred under the *Insurance Act*, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

3.6 Filing fees will not be refunded by FSCO but may be recovered as part of an applicant's expenses under the Insurance Act, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

4. **Payment of Fees and Insurer Assessment - *By the Insurer***

4.1 FSCO will invoice insurers on a quarterly basis for the fees outlined above in 1.2 and 1.3 and the insurer assessments outlined above in 2.1, 2.2, 2.3, 2.4 and 2.5. The invoice will provide each insurer with an accounting of the fees and assessments charged to their company for that quarter.

4.2 The Dispute Resolution charges (as outlined in 4.1) will be combined with the regular assessment for FSCO costs for those insurers who pay the regular assessment on a quarterly basis.



SECTION E – SETTLEMENT REGULATION

For Settlements Made on or After March 1, 2002. Excerpt From R.R.O. 1990, Reg. 664, as amended

SETTLEMENTS - STATUTORY ACCIDENT BENEFITS

9.1

1. In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.
2. The insurer shall give the insured person a written disclosure notice, signed by the insurer, with respect to the settlement.
3. The disclosure notice shall be in a form approved by the Superintendent and shall contain the following information:
 1. The insurer's offer with respect to the settlement.
 2. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule*.
 3. A statement that the insured person may, within two business days after the later of the day the insured person signs the disclosure notice and the day the insured person signs the release, rescind the settlement by delivering a written notice to the office of the insurer or its representative and returning any money received by the insured person as consideration for the settlement.
 4. A description of the consequences of the settlement on the benefits described under paragraph 2 including,
 - i. a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280 to 284 of the Act, and
 - ii. a statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 2.
 5. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

6. A statement for signature by the insured person acknowledging that he or she has read the disclosure notice and considered seeking independent legal, financial and medical advice before entering into the settlement
4. The insured person may rescind the settlement within two business days after the later of the day the insured person signs the disclosure notice and the day the insured person signs the release.
5. The insured person may rescind the settlement after the period referred to in subsection (4) if the insurer has not complied with subsections (2) and (3).
6. Subsections (4) and (5) do not apply with respect to a settlement that has been approved by a court under Rule 7 of the Rules of Civil Procedure (Parties under Disability).
7. The insured person shall rescind a settlement under subsection (4) or (5) by delivering a written notice to the office of the insurer or its representative and returning any money received by the insured person as consideration for the settlement.
8. No person may commence a mediation proceeding under section 280 of the Act with respect to benefits that were the subject of a settlement or a purported settlement unless the person has returned the money received as consideration for the settlement.
9. If the insured person returns money to the insurer under subsection (7) or (8) and a dispute arises between the insurer and the insured person with respect to the validity of the purported settlement or the right of the insured person to rescind the settlement, the insurer shall hold the money in trust until the matter is determined, at which time the amount and any income on the amount,
 - (a) shall be paid to the insured, if it is determined or agreed that there was a valid settlement that was not rescinded; and
 - (b) shall be returned to the insurer, if it is determined or agreed that there was no settlement, or that the settlement was invalid or was rescinded.
10. A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280 to 284 of the Act is not void under subsection 279 (2) of the Act if,
 - (a) the restriction is contained in a settlement;
 - (b) the settlement is entered into on or after the first anniversary of the day of the accident that gave rise to the claim; and

(c) the insurer complied with subsections (2) and (3).

11. Despite clause (10) (b), a restriction contained in a settlement entered into before the first anniversary of the day of the accident that gave rise to the claim is not void under subsection 279 (2) of the Act if, in respect of the claim,

(a) the insured person brought a proceeding in a court of competent jurisdiction under clause 281 (1) (a) of the Act and examinations for discovery have commenced;

(b) the insured person referred the issues in dispute to an arbitrator under clause 281 (1) (b) of the Act and a pre-hearing conference has been completed; or

(c) the insurer and the insured agreed under clause 281 (1) (c) of the Act to submit the issues in dispute for arbitration in accordance with the *Arbitration Act, 1991* and an arbitration agreement under that Act has been entered into.

12. Clause (10) (b) and subsection (11) apply to claims that have not settled before October 1, 2003, unless a disclosure notice under subsection (2) in respect of the settlement or purported settlement was given to the insured person before that date.

For Settlements Made Before March 1, 2002. Excerpt From R.R.O. 1990, Reg. 664, as amended

SETTLEMENTS - STATUTORY ACCIDENT BENEFITS

9.1

1. In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.
2. Before a settlement is entered into between an insurer and an insured person, the insurer shall give the insured person a written notice that contains the following:
 1. A description of the benefits that may be available to the insured person under the Statutory Accident Benefits Schedule and any other benefits that may be available to the insured person under a contract of automobile insurance.
 2. A description of the impact of the settlement on the benefits described under paragraph 1, including a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act.
 3. A statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer.
 4. A statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 1.
 5. If the settlement provides for the payment of a lump sum in an amount offered by the insurer and, with respect to a benefit under the Statutory Accident Benefits Schedule that is not a lump sum benefit, the settlement contains a restriction on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act, a statement of the insurer's estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value.
 6. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

3. A settlement may be rescinded by the insured person, within two business days after the settlement is entered into, by delivering a written notice to the insurer
4. If the insurer did not comply with subsection (2), the insured person may rescind the settlement after the period mentioned in subsection (3) by delivering a written notice to the insurer.
5. A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act is not void under subsection 279(2) of the Act if,
 - (a) the restriction is contained in a settlement; and
 - (b) the insurer complied with subsection (2).

Auto Insurance Claims Forms (OCF Forms)

Please note that pursuant to Regulation 7/00 (Unfair or Deceptive Acts or Practices), the use of a document in place of a form approved by the Superintendent constitutes an unfair or deceptive act or practice unless none of the deviations in the document affects the substance or is calculated to mislead.

Below are the most recent versions of the forms. To find an older version visit the [archive section](#).

[OCF-1: Application for Accident Benefits](#)

(Effective as of July 1, 2011)

[OCF-2: Employer's Confirmation Form](#)

(Effective as of December 1, 2004)

[OCF-3: Disability Certificate](#)

(Effective September 1, 2010)

[OCF-4: Death and Funeral Benefits Application](#)

(Effective March 1, 2006)

[OCF-5: Permission to Disclose Health Information](#)

(Effective September 1, 2010)

[OCF-6: Expenses Claim Form](#)

(Effective September 1, 2010)

[OCF-9: Explanation of Benefits Payable by Insurance Company](#)

(Effective March 1, 2006)

(Discontinued as of September 1, 2010.)

[OCF-10: Election of Income Replacement, Non-Earner or Caregiver Benefit](#)

(Effective September 1, 2010)

[OCF-12: Activities of Normal Life](#)

(Effective March 1, 2006)

(Discontinued as of September 1, 2010.)

[OCF-13: Declaration of Post-Accident Income and Benefits](#)

(Effective as of December 1, 2004)

(Discontinued as of September 1, 2010.)

[OCF-18: Treatment and Assessment Plan](#)

(Effective September 1, 2010)

[OCF-19: Application for Determination of Catastrophic Impairment](#)

(Effective September 1, 2010)

[OCF-21: Auto Insurance Standard Invoice](#)

(Effective September 1, 2010)

[OCF-22: Application for Approval of an Assessment or Examination](#)

(Discontinued as of September 1, 2010.)

[OCF-23: Treatment Confirmation Form](#)

(Effective September 1, 2010)

[OCF-24: Minor Injury Treatment Discharge Report](#)

(Effective September 1, 2010)

[OCF-25: Notice of Examination](#)

(Effective March 1, 2006)

(Discontinued as of September 1, 2010.)

[OCF-26: Voluntary Consent for Pre-Claim Examination](#)

(Effective March 1, 2006)

(Discontinued as of September 1, 2010.)

[Settlement Disclosure Notice](#)

(Effective July 1, 2011)

[Form 1: Assessment of Attendant Care Needs](#)

(Effective September 1, 2010)

Other Automobile Insurance Forms

- [Certificate of Automobile Insurance \(CAI\)](#) - Use this Certificate for policies first issued or renewed between September 1, 2010 and August 31, 2011.
- [Certificate of Automobile Insurance \(CAI\)](#)
 - [Data Elements for Certificate of Automobile Insurance](#)
 - [Explanatory Notes on Data Elements for the Revised Certificate of Automobile Insurance](#)
- [Garage Certificate of Insurance - Ontario](#)
- [Notice to Applicant of Dispute Between Insurers](#)
- [Insurer Remittance Form for Disputes Between Insurers Arbitration Decisions](#)
- [Direct Compensation - Property Damage Undertaking](#)
- [Protected Defendant Undertaking](#)

SECTION F – EXPENSE REGULATION

Excerpt from Regulation 664, R.R.O. 1990, Made Under the Insurance Act, as amended.

12.

1. The expenses set out in the Schedule are prescribed for the purpose of subsection 282(11) of the Act.
2. An arbitrator shall, under subsection 282 (11) of the Act, consider only the following criteria for the purposes of awarding all or part of the expenses incurred in respect of an arbitration proceeding:
 1. Each party's degree of success in the outcome of the proceeding.
 2. Any written offers to settle made in accordance with subsection (3).
 3. Whether novel issues are raised in the proceeding.
 4. The conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders.
 5. Whether any aspect of the proceeding was improper, vexatious or unnecessary.
 6. Whether the insured person refused or failed to submit to an examination as required under section 42 of Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996) made under the Act or refused or failed to provide any material required to be provided by subsection 42 (10) of that regulation.
 7. Whether the insured person refused or failed to submit to an examination as required under section 44 of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act, or refused or failed to provide any material required to be provided under subsection 44 (9) of that regulation.
3. Upon the request of the insurer or the insured person, the arbitrator shall, for the purposes of awarding expenses, take into account all written offers to settle, if any,

- (a) that were made after the conclusion of mediation and before the conclusion of the arbitration; and
 - (b) that were made in accordance with the rules of practice and procedure applicable to the proceeding.
4. If the arbitrator is requested to take into account a written offer under subsection (3), the arbitrator shall have regard to the terms of the offer, the timing of the offer, the response to the offer and the result of the proceeding.

SCHEDULE

DISPUTE RESOLUTION EXPENSES

(Subsection 282 (11) of the Act)

1. The filing fees paid by the insured person when applying for arbitration may be awarded to the insured person.
 2. The filing fees paid by the insured person or the insurer when appealing the order of an arbitrator or applying to vary or revoke an order may be awarded.
 3. (1) The legal fees payable by the insured person or the insurer for the following matters may be awarded:
 1. For all services performed before an arbitration, appeal, variation or revocation hearing.
 2. For the preparation for an arbitration, appeal, variation or revocation hearing.
 3. For attendance at an arbitration, appeal, variation or revocation hearing.
 4. For services subsequent to an arbitration, appeal, variation or revocation hearing.
- (2) The number of hours for which legal fees may be awarded shall be determined by the arbitrator, having regard to the criteria set out in subsection 12 (2) of this Regulation.
- (3) The maximum amount that may be awarded for legal fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.

3.1

1. The agent's fees payable by the insured person or the insurer for the following matters may be awarded:
 1. For the preparation for an arbitration, appeal, variation or revocation hearing.
 2. For attendance at an arbitration, appeal, variation or revocation hearing.
 3. For services subsequent to an arbitration, appeal, variation or revocation hearing.
2. The maximum amount that may be awarded for agent's fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.
4. The amount of the following disbursements made by or on behalf of the insured person or the insurer may be awarded:
 1. For long distance telephone, facsimile and other telecommunication charges.
 2. For typing, printing and reproducing copies of documents.
 3. For the delivery, by mail or courier, of items relating to the arbitration, appeal, variation or revocation hearing.
 4. For other out-of-pocket expenses incurred in furtherance of the arbitration, appeal, variation or revocation hearing.
 5. Any applicable taxes paid in respect of the expenses referred to in this section.
5.
 1. The amount of the following witness fees paid by or on behalf of the insured person or the insurer may be awarded:
 1. For the attendance of witnesses, in accordance with subsection (2).
 2. For the attendance of an expert witness who gives opinion evidence at the arbitration or hearing or whose attendance is necessary, in accordance with subsection (3).

3. For a report prepared by an expert, provided to the other parties to the arbitration or hearing and necessary for the conduct of the arbitration or hearing, in accordance with subsection (4).
 2. The maximum amount that may be awarded for the attendance of a witness is the amount of the attendance allowance for the witness that may be allowed under Rule 58.05 of the rules of court as a disbursement.
 3. The maximum amount that may be awarded for the attendance of an expert witness is \$200 per hour of attendance, up to a maximum of \$1,600 per day.
 4. The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert witness for preparation for a hearing at which the witness testifies may be awarded, to a maximum of \$500.
 5. The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert for the preparation of a report may be awarded, to a maximum of \$1,500.
 6. Despite subsection (5), the maximum amount that may be awarded in respect of expenses paid by or on behalf of the insured person or the insurer to a member of a designated body within the meaning of the Public Accounting Act, 2004 for the preparation of a report in connection with a claim for income replacement benefits is \$2,500.
6.
 1. The amount of the following expenses paid by or on behalf of the insured person, the insured person's lawyer or agent, the insured person's attendant, if one is required, or the insurer's lawyer or agent may be awarded:
 1. For travelling expenses, in accordance with subsection (2).
 2. For overnight accommodation and meals, in accordance with subsection (3).
 2. The maximum amount of travelling expenses that may be awarded for a person,
 - (a) for an arbitration or a hearing that takes place in the municipality in which the person resides is the amount incurred by the person for each day of his or her necessary attendance at the arbitration or hearing;
 - (b) for an arbitration or a hearing that takes place outside the municipality in which the person resides and within 300 kilometres of his or her residence is the lesser of,

(i) 30 cents per kilometre for one return trip between the person's residence and the place in which the arbitration or hearing takes place, or

(ii) the amount incurred by the person

(c) for an arbitration or a hearing that takes place 300 or more kilometres from the person's residence is the lesser of,

(i) the amount of the return economy airfare for the person plus 30 cents per kilometre for one return trip between his or her residence and the airport and for one return trip between the airport and the place of the arbitration or hearing, or

(ii) the amount incurred by the person.

3. The maximum amount that may be awarded for overnight expenses and meals is \$150 per night for each overnight stay required for the person.

7. There may be awarded to an insurer the total of all amounts in respect of a claim by an insured person that are included under section 4 of Ontario Regulation 11/01 (Assessment of Expenses and Expenditures) made under the *Financial Services Commission of Ontario Act, 1997* in determining the amount of the insurer's total assessment for arbitrations under section 282 of the Act, total assessment for appeals under section 283 of the Act or total assessment for applications under section 284 of the Act, if the insured person, on or after March 1, 2006,

(a) refused or failed to submit to an examination relating to the claim under section 42 of Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996) made under the Act or under section 44 of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010) made under the Act; or

(b) refused or failed to provide any material relating to the claim that was required to be provided by subsection 42 (10) of Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996), made under the Act, or by subsection 44 (9) of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act.



SECTION G – FORMS

Dispute Resolution Services Forms

Effective August 1, 2011, FSCO's Dispute Resolution Forms A and B have been revised to reflect recent amendments to the Statutory Accident Benefits Schedule – Effective September 1, 2010. Forms A, B, C, D, E, G, I, J, K, L, M and P have been amended to provide for the mandatory inclusion of email addresses of the parties' representatives.

The updated forms are:

- Application for Mediation ([Form A](#))
- Response to an Application for Mediation ([Form B](#))
- Application for Arbitration ([Form C](#))
- Agreement to Neutral Evaluation at the Commission ([Form D](#))
- Response by Insurer to an Application for Arbitration ([Form E](#))
- Reply by the Applicant for Arbitration ([Form G](#))
- Notice of Appeal ([Form I](#))
- Response to Appeal ([Form J](#))
- Application for Intervention ([Form K](#))
- Application for Variation/Revocation ([Form L](#))
- Response to Application for Variation ([Form M](#))
- Representing Minors and Mentally Incapable Persons ([Form P](#))

*** The old forms will not be accepted after September 30, 2011**

Please refer to Bulletin A-04/11, Revisions to the Fourth Edition of the Dispute Resolution Practice Code and Revised Forms.



If additional information is required, please contact FSCO's Dispute Resolution Services:

For information about mediation forms call:

In Toronto: 416-590-7210 or

Toll Free: 1-800-517-2332 ext. 7210

For information about arbitration forms call:

In Toronto: 416-590-7202 or

Toll Free: 1-800-517-2332 ext. 7202

For information about appeal forms call:

In Toronto: 416-590-7222 or

Toll Free: 1-800-517-2332 ext. 7222



[Form A - Application for Mediation \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form B - Response to an Application for Mediation](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form C - Application for Arbitration \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form D - Agreement to Neutral Evaluation at the Commission](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form E - Response by Insurer to an Application for Arbitration](#)

(Latest Release: September 1, 2010)

[Form F - Statement of Service](#)

(Latest Release: March 1, 2001)

[Form G - Reply by the Applicant for Arbitration](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form H - Joint Statement for Neutral Evaluation at the Commission](#)

(Latest Release: March 1, 2001)

[Form I - Notice of Appeal \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form J - Response to Appeal \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form K - Application for Intervention](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form L - Application for Variation/Revocation \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)



[Form M - Response to Application for Variation/Revocation \(Guide\)](#)

(Released September 1, 2010 valid to September 30, 2011)

[Form N - Summons to Witness](#)

(Latest Release: March 1, 2001)

[Form O - Affidavit of Service for a Summons to Witness](#)

(Latest Release: March 1, 2001)

[Form P - Representing Minors and Mentally Incapable Persons](#)

(Released September 1, 2010 valid to September 30, 2011)