IN THE MATTER OF the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, and Ontario Regulation 283/95

AND IN THE MATTER OF the *Arbitration Act*, S.O. 1991, c.17

AND IN THE MATTER OF AN ARBITRATION

B E T W E E N:

FARMERS MUTUAL INSURANCE COMPANY (LINDSAY)

Applicant

- and -

THE COOPERATORS

Respondent

AWARD

Counsel Appearing

Linda Matthews for the Applicant

Mark K. Donaldson for the Respondent

Introduction

This matter comes before me as an arbitrator pursuant to the Arbitrations Act, 1991.

The parties to this proceeding are automobile insurers carrying on the business of automobile insurance in the Province of Ontario. They are engaged in the dispute as to which insurer is obliged to pay Statutory Accident Benefits, sometimes known as "no fault" benefits. The dispute arises as a result of the operation of Section 268 of the Insurance Act and the regulations thereunder.

In accordance with the regulations under the Insurance Act, the parties have referred the dispute to Arbitration for determination.

Statutory and Regulation Background

As a result of the shift of automobile insurance injury compensation from a tort basis to a no fault system, the legislature reconfigured the applicability of no fault benefits. Effective in 1990,

the legislature redefined how such benefits would be made available to accident victims. In order to ensure that all accident victims would have access to these benefits, the legislature chose to define very broadly the range of individuals who might make a claim against any policy of insurance in respect to an injury. Thus, when an insurer has issued a contract of automobile insurance in respect to somebody involved in an automobile accident, that insurer may have obligations to a broad array of individuals. Conversely, an injured individual may have access to a number of different insurers, as a result of being in the status of an "insured person" under a number of those insurance arrangements.

To accommodate the likely multiplicity of insurance coverage, and to allow insurers to know and understand their obligations with respect to providing benefits, the legislature enacted Section 268 of the Insurance Act to set out priority between insurers. That provision provides as follows:

> **Statutory accident benefits**
>
> **268. (1) Every contract evidenced by a motor vehicle liability policy, including every such contract in force when the *Statutory Accident Benefits Schedule* is made or amended, shall be deemed to provide for the statutory accident benefits set out in the *Schedule* and any amendments to the *Schedule*, subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule*. 1993, c. 10, s. 26 (1).**
>
> **(1.1)-(1.3) REPEALED: 1996, c. 21, s. 30 (1).**
>
> **Indexation**
>
> **(1.4) Subject to subsection (1.5) and to the terms, conditions, provisions, exclusions and limits established by the *Statutory Accident Benefits Schedule, the Schedule* shall provide that, in respect of incidents involving the use or operation, after December 31, 1993 and before section 29 of the *Automobile Insurance Rate Stability Act, 1996* comes into force, of an automobile,**
>
> **(a) every continuing periodic amount payable by an insurer as an income replacement benefit, education disability benefit, caregiver benefit or loss of earning capacity benefit in accordance with the *Schedule* shall be revised, effective the 1st day of January in every year after 1994, using the indexation percentage published under subsection 268.1 (1); and**
>
> **(b) every monetary amount set out in the *Schedule* shall be revised, effective the 1st day of January in every year after 1994, by adjusting the amount by the indexation percentage published under subsection 268.1 (1). 1993, c. 10, s. 26 (1); 1996, c. 21, s. 30 (2).**
>
> **No decrease in payments**
>
> **(1.5) A continuing periodic amount payable by an insurer in accordance with the *Statutory Accident Benefits Schedule* shall not be reduced by the operation of the indexation percentage referred to in subsection (1.4). 1993, c. 10, s. 26 (1).**
>
> **Liability to pay**
>
> **(2) The following rules apply for determining who is liable to pay statutory accident benefits:**
>
> **1. In respect of an occupant of an automobile,**
>
> **i. the occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured,**
>
> **ii. if recovery is unavailable under subparagraph i, the occupant has recourse against the insurer of the automobile in which he or she was an occupant,**
>
> **iii. if recovery is unavailable under subparagraph i or ii, the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to statutory accident benefits arose,**
>
> **iv. if recovery is unavailable under subparagraph i, ii or iii, the occupant has recourse against the Motor Vehicle Accident Claims Fund.**
>
> **2. In respect of non-occupants,**
>
> **i. the non-occupant has recourse against the insurer of an automobile in respect of which**

the non-occupant is an insured,

ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,

iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to statutory accident benefits arose,

iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund. R.S.O. 1990, c. I.8, s. 268 (2); 1993, c. 10, s. 1; 1996, c. 21, s. 30 (3, 4).

Liability

(3) An insurer against whom a person has recourse for the payment of statutory accident benefits is liable to pay the benefits. R.S.O. 1990, c. I.8, s. 268 (3); 1993, c. 10, s. 1.

Choice of insurer

(4) If, under subparagraph i or iii of paragraph 1 or subparagraph i or iii of paragraph 2 of subsection (2), a person has recourse against more than one insurer for the payment of statutory accident benefits, the person, in his or her absolute discretion, may decide the insurer from which he or she will claim the benefits. R.S.O. 1990, c. I.8, s. 268 (4); 1993, c. 10, s. 1.

Same

(5) Despite subsection (4), if a person is a named insured under a contract evidenced by a motor vehicle liability policy or the person is the spouse or a dependant, as defined in the *Statutory Accident Benefits Schedule*, of a named insured, the person shall claim statutory accident benefits against the insurer under that policy. 1993, c. 10, s. 26 (2); 1999, c. 6, s. 31 (9); 2005, c. 5, s. 35 (13).

Same

(5.1) Subject to subsection (5.2), if there is more than one insurer against which a person may claim benefits under subsection (5), the person, in his or her discretion, may decide the insurer from which he or she will claim the benefits. 1993, c. 10, s. 26 (2).

Same

(5.2) If there is more than one insurer against which a person may claim benefits under subsection (5) and the person was, at the time of the incident, an occupant of an automobile in respect of which the person is the named insured or the spouse or a dependant of the named insured, the person shall claim statutory accident benefits against the insurer of the automobile in which the person was an occupant. 1993, c. 10, s. 26 (2); 1999, c. 6, s. 31 (10); 2005, c. 5, s. 35 (14).

Excess insurance

(6) The insurance mentioned in subsection (1) is excess insurance to any other insurance not being automobile insurance of the same type indemnifying the injured person or in respect of a deceased person for the expenses. R.S.O. 1990, c. I.8, s. 268 (6).

Idem

(7) The insurance mentioned in subsection (1) is excess insurance to any other insurance indemnifying the injured person or in respect of a deceased person for the expenses. R.S.O. 1990, c. I.8, s. 268 (7).

Payments pending dispute resolution

(8) Where the *Statutory Accident Benefits Schedule* provides that the insurer will pay a particular statutory accident benefit pending resolution of any dispute between the insurer and an insured, the insurer shall pay the benefit until the dispute is resolved. R.S.O. 1990, c. I.8, s. 268 (8); 1993, c. 10, s. 1.

As a result of the enactment of Section 268, insurers and insureds can see that an injured individual is required to claim benefits first from a policy where that person is the named insured, or the spouse of a named insured, among other things. In this particular case, the spousal status is particularly germane.

For a few years there was no procedure mandated for resolving disputes between insurers. Before long however, the legislature promulgated Ontario Regulation 283/95 setting out the procedure to be followed when there were disputes between insurers about payment of the benefits. This regulation is procedural in nature and sets out the requirements upon an insurer and time limits for various steps to be taken.

It is the operation of this regulation which forms the subject matter of this appeal. In particular, Section 1, 2 and 3 of the regulation provide as follows:

> **1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation. O. Reg. 283/95, s. 1.**
>
> **2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act. O. Reg. 283/95, s. 2.**
>
> **3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section. O. Reg. 283/95, s. 3 (1).**
>
> **(2) An insurer may give notice after the 90-day period if,**
>
> **(a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and**
>
> **(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period. O. Reg. 283/95, s. 3 (2).**
>
> **(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7. O. Reg. 283/95, s. 3 (3).**

Essentially this dispute revolves around the notice obligations contained in section 3.

Arbitration Agreement

The parties have agreed to submit this matter to me for arbitration and have agreed that they have reserved the right to appeal, without leave, within 30 days on a question of law or on a question of mixed fact and law. In addition, the parties have agreed that costs shall follow the event with quantum to be in the discretion of the arbitrator.

The Documentary Record

The parties have each submitted documentary briefs and have agreed that the documents contained therein are to be accepted as part of the record and I may choose to accept or reject whatever is in those documents. Exhibit 1 to this proceeding is Farmers' documentary brief. Exhibit 2 to this proceeding is Farmers' supplementary documentary brief. Exhibit 3 to this proceeding is Cooperators' documentary brief.

The Issue Between the Parties

Farmers received the first application for benefits and made a response as to the claim accordingly. More than 90 days after receiving the completed application, Farmers put Cooperators on notice of a priority dispute. The question for me to decide is whether the

circumstances of these transactions allow Farmers to put Cooperators on notice of a priority dispute more than 90 days after having received the completed application for benefits.

At the heart of the matter is Farmers' assertion that it conducted a reasonable investigation, which resulted in misleading information that concealed from Farmers its rights to dispute priority in this case.

The Factual Circumstances

This matter arises out of motor vehicle accident that happened September 26, 2004. Forty-two year old Valerie J.[1] is the involved claimant. She was a passenger in a vehicle operated by her brother James. The vehicle was owned by her father and the vehicle was insured by Farmers. It is important to understand that there is no contractual relationship between Valerie J. and Farmers. She had no history with Farmers. She did not own a vehicle. She was never licensed as a driver. At the outset Farmers had to deal with Valerie J. as a person who is a complete stranger, but someone who was involved by virtue of having been an occupant of a vehicle insured by Farmers at the time of a motor vehicle collision.

On September 29, 2004, Farmers received a report of the accident and assigned an adjuster, Pam Verschuuren, to handle the claim. The testimony of Ms. Verschuuren was filed as part of Exhibit 2 to the proceedings. The parties, in their preparation for this hearing have examined in great detail the transactions, communications, documents and correspondence associated with the handling of this claim during the first months following the accident. There is not much factual dispute as to what transpired. It is the characterization of those events that leads to the current disagreement between the parties.

At the outset Farmers' adjuster conducted a limited investigation. It was conducted over the phone. It consisted of an interview with the claimant and submission of claim forms. The claim forms are reasonably detailed documents that ask for quite a bit of information on a wide range of topics. These are claim forms that are prescribed by the government and are required to be used by the parties to an accident benefits transaction. In addition to this, the adjuster was prudently working from a checklist of information in the form of a questionnaire. In any event, the adjuster was determined in her interview to address the question of the claimant's status vis-à-vis spouse. This is relevant to an accident benefits insurer because if a person is a spouse of another insured person at the time of an accident, their first recourse for accident benefits is to the insurer of the spouse. Hence it is in every insurer's best interest to be aware of whether or not a claimant is the spouse of somebody who is insured.

This is not the only line of inquiry that needs to be explored by a prudent adjuster, it is one of many. For example, the adjuster would be interested in knowing if the person was a listed driver on another policy. The adjuster would be interested in knowing if the person was a named insured under some policy. The adjuster would be interested in knowing if a vehicle under another policy of insurance was being made available to the person for regular use by some business or entity. There is significant nuance associated with evaluating the possible priority of other insurers.

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[1] In recognition of the privacy interests of non parties I have deleted references to surnames from these reasons.

On October 15, 2004 the adjuster conducted a telephone interview and completed the questionnaire in her file. In that questionnaire it is indicated the claimant, Ms. J. indicated that she was a single person. In addition, the freehand log notes for that date indicate that Farmers may be the priority insurer as Ms. J. was "not common law or married".

A few weeks later, on November 9, 2004, Farmers received J.'s completed application for accident benefits. In that form the claimant, J., affirmatively indicated that she was "single" notwithstanding having been presented with alternate choices including "common law". The application form is found at Tab 5 of Exhibit 1 of the proceedings. The application form is duly signed by the claimant and includes the following attestation:

> **"I certify that the information provided is true and correct. I understand that it is an offense under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under contract of insurance. I further understand that it is an offense under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company."**

At that point Farmers did not further challenge the issue of the spousal status and proceeded to administer the claim in the usual fashion. It is important in the context of this case to have some understanding of the volume of paper which is involved in the administration of a Statutory Accident Benefits claim. The insurer has the obligation to provide the claimant not with a form but with a "package" of materials which is quite extensive and consists of numerous forms and explanations. The claimant is to return a number of forms and, quite often, a lot of additional documentation in the nature of narrative descriptions of injury and proposal for treatment plans, etc. It would be misleading to form the impression that an accident benefits claim is a simple transaction consisting of a few unambiguous documents which clearly delineate entitlement decisions rapidly and without controversy. To the contrary, the adjustment of an accident benefits claim is more likely to be mired in a morass of paperwork, forms, serial and overlapping treatment proposals, and numerous assessments of various nature. Furthermore, the administration of accident benefits claim puts positive obligations on insurers to provide certain documentation and disclosure and to respond to submitted claims by following regulated procedures, referral for additional assessments, and responses within time limits as short as two days for certain items.

Nonetheless, it is important to recognize that in the documentation received by Farmers on November 19, 2004, there was a form described as an "activities of normal life" form. This is a form in which the claimant self-reports limitations on carrying on the normal activities of life in a number of areas. In the introductory section to this form the claimant did indicate that she lived in a house comprised of four residents. This may be significant because Farmers was otherwise led to believe that the claimant was a single person with two daughters cohabiting. Thus, it is argued that the indication of four residents, contrasted with the other information, might have prompted additional investigation as to the identity of the four residents, etc. Conceivably this might have led to realization that Ms J. was in fact a common law spouse.

With the foregoing information in the file, Farmers administered the claim in the normal way. In a few months, well into 2005, there were some controversies with respect to various benefits. At some point the claimant engaged legal counsel with respect to her claims and it appears that the legal counsel arranged for an occupational therapist to conduct an in-home assessment of the plaintiff's needs as a result of her impairment. This resulted in the generation of a document described as the Kurtach report in July 2005. That report indicated that the claimant lived with her husband.

Farmers asserts that this was the first time that they had any indication that the claimant was married or was involved in a common law relationship. Within days, the adjuster for Farmers identified this discrepancy and wrote to Ms. J. asking for an explanation. The file documentation further indicates that Ms. Verschuuren had telephoned the claimant at various locations attempting to contact her about this. Further telephone messages were left on September 14, 2005, and finally contact was made on September 15, 2005. It is asserted that at that time Ms. J. indicated that she would confirm, in writing, that she was neither married nor common law and that she was single. Ms J. acknowledged a boyfriend, but denied cohabitation. Ms J. in fact did this, writing by letter dated September 21, 2005. Moreover, Ms J. contacted Kurtach and arranged for Kurtach to make a correction and an apology with respect to the spousal references in the earlier report. Farmers' position is that at the end of September 2005, having received the written explanation from J., and the follow up correcting report from Kurtach, they were satisfied that they had been provided the appropriate information as to J.'s marital status. It is to be noted that this is nearly one year after the original application process.

On November 18, 2005, Farmers received a medical report from a Dr. Connell, generated at the request of Ms. J.'s legal counsel. That medical report contained the unambiguous assertion "she has been living for the past eight years with her boyfriend of 15 years..." Again Farmers recognized the discrepancy between the Connell report and the earlier claims information about marital status. They wrote to J.'s legal counsel and raised this issue.

Legal counsel was not immediately cooperative in providing clarification. Before he did, Farmers received clinical notes and records of the family physician which contained a reference to the fact that J. had reported being in a common law relationship and was describing her relationship as a marriage.

On January 23, 2006 Farmers sent a notice of dispute to J. and to Cooperators who they had determined to be the insurer of the "spouse".

In response to this litany of investigative information, Cooperators takes the position that the work done by Farmers was not a reasonable investigation which would be necessary to allow Farmers to serve its notice of a dispute outside of the 90-day time limit. Without question, the notice of dispute was far outside the 90-day limitation contained in the regulation. The regulation does, however, contemplate that the notice may be served outside the 90 days if the insurer had conducted a reasonable investigation and if 90 days was an insufficient time to make a determination that another insurer or insurer is liable.

Law and Analysis

An insurer can only give notice after the 90-day period, if 90 days was not a sufficient period of time to make a determination that another insurer was liable and the insurer made reasonable investigation necessary to determine if another insurer was liable within the 90-day period.

I start by examining the investigation of Farmers Mutual to determine whether or not it was indeed a reasonable investigation. As counsel have noted in their legal briefs, a line of case law has established that the investigation need not be perfect. There are perceptive observations made about the likelihood that hindsight would yield imperfections in almost any investigation. The standard is not a standard of perfection it is a standard of reasonableness. And in my view reasonableness has to be evaluated in a manner that is sensitive to the claims handling environment that applies to these kinds of claims. We must resist the temptation to isolate the

transactions of one claim and to analyze those transactions as if they happened in a vacuum. They do not happen in a vacuum. They happen in a context and the context is one where there are significant public policy goals in favor of expeditious and efficient claims handling with minimal cost.

Cooperators points to various parts of the investigation done by Farmers that could have been done in more depth or where other searches or inquiries could have been launched about extraneous issues such the status of a driver's license. In my view this is a search for perfection, not reasonableness. In this case, Farmers has utilized an internal claims form which prompted the question about marital status appropriately. I find that the question was asked and answered indicating that the claimant was single. Not only did Farmers record that question, but their records indicate that they recognized the gravity of the answer in terms of determining the priority. Their documentation demonstrates that they fully grasped the significance of the inquiry and this, in my view, corroborates the evidence that the inquiry was made and recorded accurately.

Furthermore, the claimant submitted an accident benefits claims form which affirmatively stated that she was single and did so in a manner which negated the implication that she had a common law relationship, as that was one of the alternative options. That accident benefits claim form was completed fully, and signed. It contained the certification and the acknowledgement of possible criminal sanctions for inaccurate statements. In addition, it is a statement in an atmosphere requiring good faith on the part of an insured person in support of an advanced claim.

The record is rife with evidence of surrounding circumstances about the absence of language difficulties, about the availability for clarification if necessary and so forth. Given how matters played out in July of 2005, there is little doubt that the information provided by J. to Farmers about the spousal status at the outset was not a misunderstanding. J. repeatedly took overt steps to conceal the true nature of her marital status.

I resist the suggestion that Farmers should have been suspicious about this assertion from the outset. Indeed, it is hard to discern any motivation, vis-à-vis the automobile insurer, for the inaccuracy about marital status. There is no obvious benefit flowing to the claimant as a result of being a single person and I don't suspect that a reasonable adjuster would look at this as a point that has to be examined with some skepticism.

In my view, the evaluation of whether or not an insurer has conducted a reasonable investigation ought to take into account factors such as:

1. The apparent severity of the loss and claims being presented.

2. The apparent credibility of the sources of information.

3. The probability or improbability of the asserted facts.

4. The ease of access to additional sources of information.

5. The cost of further investigation.

6. The delays that would be associated with additional investigation.

7. The possibility of misunderstanding or miscommunication.

As to whether or not the second branch of the test is met -- as to whether or not 90 days was a sufficient time period to make a determination -- that, in my view is partly determined by the reasonableness of the investigation. If a reasonable investigation was conducted, and if that reasonable investigation would not yield information pointing towards another insurer within a 90-day time period, then, necessarily, 90 days was not a sufficient period of time to make a determination that another insurer is liable. The requirement of Clause (2) (a) is not defeated simply by hypothesizing a line of inquiry that might have disclosed a higher priority insurer. It would have to be a line of inquiry that would be part of any reasonable investigation.

In my view this approach is consistent with the legal authorities and the approaches of other arbitrators with respect to these cases. Necessarily the cases are very dependent upon the facts of particular transactions.

However, I distinguish these factually dependent cases from those cases where insurers have made determinations based on erroneous perceptions of law. That, in my view, is quite a different matter and is not the problem before me in this arbitration.

I would caution against a rule of interpretation which puts too high an onus on insurers to conduct investigation. This can only serve to increase the cost of delivering the insurance product. It will delay delivery of benefits which should be provided as quickly as possible. It would create confrontation with claimants and foster the development of acrimonious relationships when collaboration and support are called for. In my view neither the interests of the insureds nor the interest of the insurers is well served by putting too high a standard on the obligation of an insurer to conduct an investigation about priority at the outset of the claim. We should read the regulation for no more than what it says. The investigation must be reasonable and nothing more. We should not require insurers to be suspicious of circumstances that are not suspicious, nor should we encourage probing investigation that is either immaterial or disproportionate to the matters under consideration. All insurers should have the comfort approaching these claims with the knowledge that a reasonable investigation, which is reasonable in all of the circumstances, is called for and nothing more. In my view this is in the interest of all insurers as well. If the result is that there are more claims of priority disputes launched more than 90 days after an application, then this is a very small price to pay for the trade off of enhancing the service to the customers and reducing the initial demands on the accident benefits adjusters.

In the facts of this particular case, the only criticism of the investigation that has any potential merit, in my view, is the observation that the activities of normal life claim form showed four residents at the insured's address. Truly, the adjuster might have noted this as being different that what would have been expected in view of the earlier information that there were two daughters and no spouse. However, I do not see the failure to pick up on this as unreasonable in the context of the case. The resident could have been any number of other persons other than a spouse. It might have been a boarder or some other relative. It was not necessarily inconsistent. And subsequent events demonstrate that any inquiry made at that point would not have evoked a truthful report. To the extent that this aspect of the Farmers' investigation may have been imperfect, it was not unreasonable.

On the other hand, the reaction of the company with respect to the home assessment report and the subsequent medical report and subsequent clinical notes and records shows that the adjusters were very much alive to the possible inconsistencies in the file materials.

As for the investigation that subsequently indicated ownership of the premises by the person subsequently revealed to be a common law spouse, I do not find this piece of information probative of the spousal status. It is only with the benefit of hindsight that we can recognize that the identification of the owner of the property was and identification of a common law spouse.

In reference to the criteria outlined above I observe:

- This claim did not appear to be unduly serious at the outset, with benefits expected to be in the limited ranges associated with the Pre Approved Framework for treatment of soft tissue injuries;

- The claimant's credibility appeared satisfactory, at the outset of the claims handling, and when challenged in the summer of 2005 the ardent response on several levels was notable;

- The asserted fact of being single was not improbable;

- Farmers points out that there is no database, registration system, or other resource which would readily disclose whether a person has a common law spouse or not. The claimant was not forthright, and her legal counsel was not immediately responsive when the spousal status issue was raised;

- Further investigation might have been conducted at various points. But at what point could the company have focused on the marital status as a question for investigation? Any further investigation would have been general in nature and accordingly would have broad and expensive;

- If the insurer chose to conduct additional investigation it might have entailed delays, which possibly could adversely affect rehabilitation efforts;

- There was no reason to suspect any communication errors or misunderstanding.

In my view this investigation far surpassed the standard of being a reasonable investigation in all of the circumstances. The investigation did not reveal the common law relationship. Ninety days was an insufficient time to determine that another insurer was liable to pay the benefits.

Therefore, I conclude that Farmers was entitled to serve its notice of dispute outside of the time period defined in Ontario Regulation 283/95.

During argument counsel raised the question of what time constraint would apply if an insurer would be entitled to give notice more than 90 days after an application. In my view the regulation does not address this issue. I am satisfied that, in this case, the notice was timely. The notice was given within 90 days of the last major revelations about spousal status. I am not deciding that there is an implied 90 day timeframe for giving notice in such circumstances, but note that this is the window that the legislature has allowed for the giving of notice for priority disputes that are disclosed in the application process.

Costs of this proceeding will follow the event. Counsel may make submissions within 30 days with respect to costs if they are unable to agree.

Dated at Toronto this 3rd day of July, 2009.

LEE SAMIS
Arbitrator