PUZZLING YOUR WAY THROUGH AN INSURANCE CONTRACT

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A. Introduction

This paper is designed to provide an entry level view into the aspects that make up an insurance policy. To a new reader, an insurance policy can appear confusing and difficult to reconcile the various clauses, exclusions, and conditions. In the author's view, the insurance policy is akin to a puzzle and once you understand how the various pieces fit together, then understanding the coverage afforded flows much more easily.

B. The Declaration Page: The Corner Puzzle Pieces

The insurance declaration page is likely the document that most people are familiar with, as it sets out the key terms of the insurance policy. Just as the "corner pieces" are the easiest starting point when putting together a puzzle, the declaration page should be the first stop in reviewing coverage. While the declaration page may appear to be a separate document from the policy wording, it forms part of the insurance policy.

The terms found in the declaration page can be easily identified. Some of the key items include:

- The name of the insured;
- A description of the insured's business;
- The types of coverage available;
- Possible territorial limitations;
- The limit of liability for each of the various coverages;
- The deductible or self-insured retention;
- The policy period which shows the time in which the policy is in force.

This list is not exhaustive and every declaration page must be viewed in full, as it can contain information specific to the insured and the coverages provided to the insured.

The insured has an obligation to fully disclose all information that may be relevant, even where the declarations page does not specifically seek that information. In *Perreira v. Family Insurance Corp.,* 2001 BCSC 1236, the insured was denied coverage for damage to his home under his homeowner's policy for a misrepresentation, as his home was being used as a boarding house[1]. The plaintiff denied the misrepresentation and argued that, even if he did give incorrect answers to the oral questions, the insurer cannot rely on the incorrect answers because the declaration page says that it relies only on the information in the declaration page. Because it did not reference boarders in the declaration, the insured argued that any misrepresentation which may have occurred cannot be relied on by the insurer.

The court did not agree, finding that:

> … The words, quoted above, do not say that the details of the property to be insured are the only representations made by the insured, nor do they say that the insurance was issued only on the basis of these representations or details. The declaration page provides a description and identification of the property. The information is not intended to include all representations but only what is required to describe the property.
>
> As noted by Mr. Justice Burnyeat in a similar case, Lafarge Canada Inc. v. Little Mountain Excavating Ltd., [2001] B.C.J. No. 732, 2001 BCSC 218 (CanLII), there is a duty on the insured (in this case Perreira) to disclose full and accurate information about everything relevant to the proposed insurance. This principle of uberrima fides or utmost good faith, was set out by Lord Mansfield in Carter v. Boehm (1766), 3 Burr. 1905, 97 E.R. 1162 (K.B.).[2]

The importance of the declaration page for coverage analysis is seen when answering the following key questions:

(i) Who or What is Insured by the Policy?

The declaration page will list the entities or persons who are intended to be covered by the policy. The person or entity set out in the declaration page is called the "Named Insured".

[1] *Perreira v. Family Insurance Corp.,* 2001 BCSC 1236.

[2] *Ibid,* at para 30 - 31.

There may be other persons or entities that can obtain insurance under a particular policy, either through the definition of “Insured” in the policy language, or as an Additional Insured or Unnamed Insured. However, the Named Insured has the broadest rights under the policy, as coverage is often limited or qualified for the other types of Insureds.

For example, a common definition of “Insured” found in a Commercial General Liability policy provides:

> 2. Each of the following is also an insured:
>
> a. Your "volunteer workers" only while performing duties related to the conduct of your business, or your "employees", other than either your "executive officers" (if you are an organization other than a partnership, joint venture or limited liability company) or your managers (if you are a limited liability company), but only for acts within the scope of their employment by you or while performing duties related to the conduct of your business. However, none of these "employees" or "volunteer workers" are insureds for:
>
> (1) "Bodily injury" or "personal and advertising injury":
>
> (a) To you, to your partners or members (if you are a partnership or joint venture), to your members (if you are a limited liability company), to a co-"employee" while in the course of his or her employment or performing duties related to the conduct of your business, or to your other "volunteer workers" while performing duties related to the conduct of your business;
>
> (b) To the spouse, child, parent, brother or sister of that co-"employee" or "volunteer worker" as a consequence of Paragraph (1)(a) above;
>
> (c) For which there is any obligation to share damages with or repay someone else who must pay damages because of the injury described in Paragraphs (1)(a) or (b) above; or
>
> (d) Arising out of his or her providing or failing to provide professional health care services.

As can be seen from the definition, while there is coverage for an employee of a Named Insured, that coverage is limited to “acts within the scope of their employment by you”. This limitation becomes an issue where the employee is acting in a manner that could be

construed to be outside of the scope of his or her employment, such as getting into a fist fight outside of a bar, when the employee is supposed to be bartending.

The declaration page may also set out certain property, locations, or projects, that are insured, such as a construction project. However, as the case of *Wingtat Game Bird Packers (1993) Ltd. v. Aviva Insurance Company of Canada,* 2009 BCCA 343[3] exposes, some property may be insured, even where not specifically listed on the declaration page. In *Wingtat*, the insured had frozen poultry stock damaged while stored at an off-site frozen storage facility. The court found that the property location at issue was not listed in the declaration page. However, there was an extension for stock and equipment while located at a temporary location and the court ultimately found that it applied.

Therefore, even where a person, company or property is not specifically set out in the declaration page, the analysis does not end there and further investigation into the policy wording is required.

(ii) What Time Period is Covered by the Policy?

The Policy will set out a time period for which coverage is in place. While this is seemingly a non-controversial element, it plays an important role in determining what insurer was on risk at the time of the "occurrence" (in an occurrence based insurance policy) or when a claim is made (in a claims made insurance policy).

For certain claims it can be difficult to determine when the "occurrence" took place, such as with long term asbestos exposure or water infiltration in a development project. In that case, the courts have devised various ways to determine if the loss or damage occurred during the time the policy was in effect. The theories include:

- "exposure" theory – coverage is triggered by the first exposure to the condition causing the loss or damage;
- the "manifestation" theory – the coverage is triggered when the damage first becomes noticeable;

[3] *Wingtat Game Bird Packers (1993) Ltd. v. Aviva Insurance Company of Canada,* 2009 BCCA 343

- the “injury-in-fact” theory – coverage is triggered when the damage first occurs, whether or not it was noticeable at the time; and
- the “continuous trigger” theory – coverage is triggered throughout the period from first exposure through to the time it was noticed.

The “injury-in-fact” theory appears to be most popular with the courts in British Columbia.

(iii) How Much Insurance Money is Available?

Perhaps one of the most important issues for both an insurer and an insured is how much insurance money is available to respond to the claim or loss. This is referred to as the limit of insurance, or limit of liability. As counsel acting for an insured on a claim, it is important to immediately identify the limit of insurance available and whether it will be sufficient to cover the claim or loss. If it is not, then investigations into whether excess insurance is available should be undertaken. If there is no excess insurance, and there is a significant uninsured exposure, then the insured should retain their own counsel for advice, separate from the defence counsel that may be appointed by the insurer.

There may be two limits of insurance listed, one per claim or occurrence and one in the aggregate. The aggregate limit of liability is the most that the insurer is obligated to pay during a specified period, typically the period of the policy as listed in the declarations page. Therefore, while the policy may provide for a $1,000,000 limit of liability per claim, it may have a limit of $2,000,000 in the aggregate, regardless of the number of claims filed. This means that if the limit of insurance is already utilized by prior claims there is no insurance money available for any future claims or loss arising within that period. As such, it is important to determine what other claims the insured may have made under the policy during the policy term as part of determining the limit of liability available.

It is not always entirely clear whether one limit of liability applies, or if multiple limits are triggered. For example, in *Simpson (Receiver of) v. Lloyd's Underwriters* (2008), 92 O.R. (3d) 551[4], 25 real estate deposits were stolen, ranging in size from $5,000 to $400,000, from 22 different victims. The policy provided that each claim has a limit of liability of $100,000, but that the aggregate liability for each "occurrence" or "series of related

[4] *Simpson (Receiver of) v. Lloyd's Underwriters* (2008), 92 O.R. (3d) 551, 25

occurrences" was $500,000. The court reviewed whether the claims constituted separate occurrences (invoking separate limits of liability) or whether they were part of a series of related occurrences, limiting them to the $500,000 limit.

In concluding that each of the 25 deposit thefts was a separate occurrence, except for the additional deposit thefts from three of the victims, the court stated:

> If we take the definition to be "of the same type; in the same group, category, etc.", any two acts of theft are related, merely in their being thefts, without need for any other connection in time, place or person. By this definition, the aggregate limit would apply to all thefts of all deposits by any registrant for the duration of the policy. This would be an unreasonable interpretation of the policy. Clearly, then, not just any relation is necessary, but a particular kind of relation.
>
> As the word is broad in meaning, we must determine what its scope is in the context of this policy. The term "related" implies degree: things can be closely or tangentially related. The goal, then, is to determine what degree of relatedness fits with the intention of the parties to this insurance contract given the objective of the contract and the facts surrounding it.[5]

(iv) What Does the Insured Have to Pay?

A specific deductible or self-insured retention (“SIR”) will be listed for each type of available coverage. The purpose of an SIR or deductible is the same, which is to set a layer of risk (i.e. a defined monetary amount) that the insured must pay, beyond which the insurance limits apply. For many insureds the deductible and SIR are low enough that no difference between the two is apparent. However, for those with a much higher SIR or deductible, the differences are tangible.

For example, with an SIR the insurer is typically not required to defend until the loss penetrates the insurer’s layer. This differs from a deductible, where typically the insurer defends, pays the loss up to the maximum limit of liability and then seeks reimbursement from the insured up to the amount of the deductible.

In other words, if a claim is made against an insured with a $25,000 SIR and the claim is only $15,000, then the claim does not penetrate the insurer’s layer and it is not obligated to

[5] *Ibid*, at para 27 - 28.

do anything to defend the claim. However, if that was a $25,000 deductible, then the insurer would be obligated to provide a defence and, if it settles the claim for $15,000, then it would seek reimbursement for the amount of indemnity (i.e. the amount paid out for the loss, not the defence costs). It should be noted that in some policies, most common where an insured has a high deductible, the defence costs may erode the limit of liability. This is sometimes referred to as an "eroding policy".

One further difference is that typically the policy's annual aggregate limit is not reduced by the SIR amount. In other words, if the Policy provides $1,000,000 as the limit of insurance, with a $100,000 SIR, that limit of liability $1,000,000 "floats" on top of the SIR. However, with respect to a deductible, the $1,000,000 is reduced by the $100,000 deductible therefore the insured is in actual fact only receiving $900,000 from the insurer.

Therefore, when reviewing the limit of insurance available to an insured, it is important to understand the basis upon which that limit is determined and whether the deductible or SIR reduces the actual dollars that are available through the insurer.

(v) What Types of Coverage Does the Policy Grant?

The declaration page will provide a list of types of coverage available, and may also list any extra exclusions or endorsements. These items will be discussed further below, but the important point is to confirm whether you have the complete policy wording by looking at each form listed in the declaration page and matching it to the policy wording form number.

It is quite common that special endorsements or exclusions are set out in separate forms and when you are provided with the policy these forms are forgotten and only the "main" policy wording is provided. As such, one of the first steps before reviewing coverage is to ensure the entire policy wording has been produced by comparison with the forms listed on the declaration page.

It is also important to not confuse the comprehensive list of all coverages possible that some policies print on the declaration page with confirmation that the insured in fact has that coverage. If the coverage has been purchased, it will typically list beside the coverage a premium cost, it may say "included", or will be left blank. For declaration pages that work

in this manner, if a certain coverage is not listed as "included" or a premium price is not listed next to it, then that coverage was not purchased.

A similar situation was reviewed by the Ontario court in *J.I.L.M. v. Intact Insurance*, 2012 ONSC 6923 (CanLII)[6], where the insured sought replacement cost coverage for contents destroyed and damaged in a fire at the insured's restaurant. The insurer denied coverage on the basis that the policy did not include contents coverage.

The court reviewed the wording of the declaration page and noted:

> The wording at the top of page 2 [of the declaration page] is critical in determining whether there is contents coverage under the policy. It states:
>
> > Insurance provided subject to the Declarations, Terms and Conditions of the policy and its Forms only for the coverages for which specific Forms are attached and for which a specific Limit or Amount of Insurance is shown hereunder. (Emphasis added in original)[7]

The declaration page only listed the building, not the contents. However, the policy wording stated:

> This form insures those of the following items for which an amount of insurance is specified on the "Declaration Page" and only while at the "premises."
>
> > "Building"
> > "Equipment"
> > "Stock"
> > "Contents of Every Description"
> > "Property of Every Description"

The insured argued that, as the main policy wording referred to contents coverage, there was coverage for the same. However, the court referred back to the declaration page and found no reference to contents and, therefore, ultimately found there was no coverage for the insured.

[6] *J.I.L.M. v. Intact Insurance*, 2012 ONSC 6923 (CanLII)

[7] *Ibid,* at para 30.

C. The Insuring Agreement: The Filler Pieces in Every Puzzle

The insuring agreements within an insurance policy are the foundational basis for coverage. In other words, this is the “meat”, or the inside pieces of the puzzle, that give the puzzle its picture. If there is no grant of coverage within a particular insuring agreement, then it does not matter if the party is a Named Insured, or what the limit of liability is, as there is no basis for coverage.

(i) Common Insuring Agreements

Once the declaration page has been reviewed, this will be the first place within the policy wording to review in order to determine what coverage is available. Insurance policies typically contain more than one insuring agreement and, therefore, while there may be no coverage within one section of the policy, there could be coverage under another section’s insuring agreement.

For example, a common type of insurance policy that is sold is known as a commercial general liability policy (“CGL”). The CGL will typically contain an insuring agreement for Coverage A, “Bodily Injury and Property Damage Liability”, Coverage B, “Personal and Advertising Injury Liability”, Coverage C, “Medical Payments” and Coverage D, “Tenants’ Legal Liability”. There may also be further coverage for a non-owned automobile risk. A common insuring agreement for bodily injury and property damage reads as follows:

> **COVERAGE A BODILY INJURY AND PROPERTY**
>
> **DAMAGE LIABILITY**
>
> **1. Insuring Agreement**
>
> **a.** We will pay those sums that the insured becomes legally obligated to pay as compensatory damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result. But:
>
> **(1)** The amount we will pay for damages is limited as described in Section **III** – Limits Of Insurance; and

> **(2)** Our right and duty to defend ends when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages **A** or **B** or medical expenses under Coverage **C.**
>
> No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments – Coverages **A** and **B.**

(ii) **Interpretation of Insuring Agreements**

The insuring agreement will usually utilize words that are either in quotations or bold, which signifies that these words have a definition found elsewhere in the policy. As a first step, you should go to the definitions section and insert the defined term so that you can read the insuring agreement as a whole. For example, inserting the definition of "bodily injury" reads as follows:

> We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time"…

By inserting the definition into the insuring agreement, the full meaning of the coverage is more easily reviewed.

The rules governing the construction of insurance contracts have been well canvassed by the courts. In *Brissette Estate v Westbury Life Insurance Co*., 1992 CanLII 32 (SCC), [1992] 3 S.C.R. 87 (S.C.C.), Sopinka J., for the majority, explained:

> In interpreting an insurance contract the rules of construction relating to contracts are to be applied as follows:
>
> 1) The court must search for an interpretation from the whole of the contract which promotes the true intent of the parties at the time of entry into the contract.
>
> 2) Where words are capable of two or more meanings, the meaning that is more reasonable in promoting the intention of the parties will be selected.
>
> 3) Ambiguities will be construed against the insurer.
>
> 4) An interpretation which will result in either a windfall to the insurer or an unanticipated recovery to the insured is to be avoided. See Consolidated-Bathurst Export Ltd. v Mutual

> Boiler and Machinery Insurance Co., 1979 CanLII 10 (SCC), [1980] 1 S.C.R. 888.[8]

In the case of *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, the court described the principles applicable to interpretation of insurance contracts as:

> (1) the *contra proferentem* rule;
> (2) the principle that coverage provisions should be construed broadly and exclusion clauses narrowly; and
> (3) the desirability, at least where the policy is ambiguous, of giving effect to the reasonable expectations of the parties".[9]

Practically speaking, one of the most common issues that arise with respect to interpretation is the the *contra proferentem* rule. The S.C.C. court explained this rule in *Non-Marine Underwriters, Lloyd's of London v. Scalera*, [2000] 1 S.C.R. 551:

> Since insurance contracts are essentially adhesionary, the standard practice is to construe ambiguities against the insurer: *Brissette Estate v. Westbury Life Insurance Co.*, [1992] 3 S.C.R. 87, at p. 92; *Wigle v. Allstate Insurance Co. of Canada* (1984), 49 O.R. (2d) 101 (C.A.), *per* Cory J.A. A corollary of this principle is that "coverage provisions should be construed broadly and exclusion clauses narrowly": *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 269; *Indemnity Insurance Co. of North America v. Excel Cleaning Service*, [1954] S.C.R. 169, at pp. 179-80, *per* Estey J. Therefore one must always be alert to the unequal bargaining power at work in insurance contracts, and interpret such policies accordingly.[10]

Therefore, where a provision appears ambiguous or contradicts other provisions in the policy, on the basis of the *contra proferentem* rule the ambiguity should be resolved in the insureds' favour.

As set out above, with respect to the insuring agreement, coverage clauses are construed broadly versus exclusion clauses, which are interpreted narrowly. That means that the

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[8] *Brissette Estate v Westbury Life Insurance Co*., 1992 CanLII 32 (SCC), [1992] 3 S.C.R. 87 (S.C.C.), at para 4.

[9] *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 269

[10] *Non-Marine Underwriters, Lloyd's of London v. Scalera*, [2000] 1 S.C.R. 551 at para 70.

court will provide a broad interpretation of the policy wording in determining whether the insuring agreement is triggered. Further, the onus is on the insured to show that the loss or claim triggers the insuring agreement.[11] However, that onus shifts in relation to the exclusions, discussed below.

It should be noted that while not all of the words within the insuring agreement are specifically defined, there is judicial interpretation on many phrases. For example, with respect to the insuring agreement set out above, there is case law looking at the phrases "legally obligated to pay", "compensatory damages" and "to which this insurance applies". Therefore, every word within the insuring agreement must be considered carefully in determining whether the insuring agreement is triggered. Further, slight differences between the wording of different policies in can effect major differences in coverage. Therefore, when reviewing case law on insurance coverage any differences to the wording in the policies must be carefully considered.

D. Exclusions: The pieces you lost under the table

Once it is determined that the insuring agreement is triggered, then the analysis moves to the exclusions. The exclusions are similar to lost puzzle pieces. Specifically, just when you think you have arrived at a complete picture from the insuring agreement, an exclusion clause comes along and takes away a piece.

(i) Common Exclusion Clauses

Staying with the CGL policy example, there are common exclusion clauses found in many of the CGL policies. The Insurance Bureau of Canada (IBC) publishes advisory wording that many insurers adopt. However, some insurers choose not to update the policy language, or the policy at issue during the relevant time may be an old one.

Perhaps the most often litigated exclusions from the CGL is what is known as the "work/product" exclusions. One example of the wording of these types of exclusions are:

> **2. Exclusions**
>
> This insurance does not apply to:

[11] *British and Foreign Marine Insurance Co. v. Gaunt,* [1921] 2 A.C. 41 (H.L.) and see *B.C. Rail Ltd. v. American Home Assur. Co.* (1991), 54 B.C.L.R. (2d) 228 (C.A.).

> …
>
> **k. Damage To Your Product**
>
> "Property damage" to "your product" arising out of it or any part of it.
>
> **l. Damage To Your Work**
>
> "Property damage" to "your work" arising out of it or any part of it and included in the "products completed operations hazard".
>
> This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

The seminal construction defect case of *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada,* [2010] 2 S.C.R. 245, looked at three versions of the work/product exclusion.[12] The court explained:

> The central exclusion in this appeal is the "work performed" exclusion. This common exclusion clause and its relationship to work completed by subcontractors have received a great deal of attention, both in Canada and the United States (*Annotated Commercial General Liability Policy*, vol. 2, at pp. 22-4 and 22-11). The standard form version of the "work performed" exclusion precludes coverage for damage to the insured's own work once it is completed…[13]

The insurer argued that the "work performed" exclusion excludes coverage for damage to the worked performed by the insured who was a general contractor who oversaw the construction of four housing units in their entirety. There were two separate versions of the exclusion, one of which contained an exception for damage caused by subcontractors.

Ultimately, the court concluded that the insurer did not discharge its burden of showing that the "work performed" exclusion clearly and unambiguously applied to all of the claims and, found that there is a possibility of coverage under each version of the policy. As such, the exclusions did not apply.

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[12] *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada,* [2010] 2 S.C.R. 245 ["*Progressive Homes*"].

[13] *Ibid,* at para 53.

(ii) Interpretation of Exclusion Clauses

Whereas the insuring agreement will be construed broadly, the exclusion clause is construed narrowly as against the insurer. Further the insurer bears the burden of proving that the exclusion "clearly and unambiguously excludes coverage".[14] As with the insuring agreement, the wording of the exclusion clause is extremely important and even slight differences between versions of an exclusion clause can result in different coverage results.

The rules of insurance contract interpretation set out in relation to the insuring agreement apply equally to exclusion clauses. This was confirmed in *Buchanan v. Wawanesa Mutual Insurance Company,* 2010 BCCA 333[15]. In that case, the insureds had an "all-risk" policy of insurance for their home and contents. The home was damaged when water escaped from a leaking public water main and caused soil failure and settlement of the home.

The question was whether the damage fell within the wording of the exclusion clauses. The Court of Appeal found that there were two completely contradictory clauses. The two relevant clauses stated (emphasis added):

> You are insured against all risks of direct physical loss or damage to the property described in Coverage A and B except:
>
> ...
>
> (2) settling, expansion, contraction, moving, bulging, buckling, cracking, or the failing of ceiling or wall plaster.
>
> …
>
> (9)(c) water below the surface of the ground, including water which exerts pressure on or flows, seeps or leaks through sidewalks, driveways, foundations, walls, basement or other follows or though doors, windows or any other openings;
>
> If the loss or damage is the result of the escape or water from a swimming pool or attached equipment or a public water main, you are insured.[16]

[14] *Ibid,* at para 51.

[15] *Buchanan v. Wawanesa Mutual Insurance Company,* 2010 BCCA 333.

[16] *Buchanan v. Wawanesa Mutual Insurance Company,* 2010 BCCA 333 at para 7.

The trial court found that the damages claimed fell within exclusion clause 2 and determined that there was no coverage. However, the Court of Appeal disagreed, pointing to the two contradictory exclusion clauses. In particular, the exception to exclusion clause (9)(c) brought back in coverage in the case of a public water main escape. The Court of Appeal referred to the *contra proferentem* rule, and found that where there is an ambiguity it should be resolved in accordance with the reasonable expectations of the parties. A person reading the policy would reasonably assume that there was coverage for damage resulting from the escape of water from a public water main and, therefore, the court found accordingly.

As arose in the *Buchanan v. Wawanesa Mutual Insurance Company,* case some exclusion clauses contain an exception clause and the two should not be conflated. While an exclusion clause removes items from coverage, an exception clause operates within an exclusion clause to bring back in coverage in certain instances. The court in *Progressive Homes* also commented on this, stating:

> A CGL policy may also contain exceptions to exclusions. Exceptions also do not create coverage — they bring an otherwise excluded claim back within coverage, where the claim fell within the initial grant of coverage in the first place (*Annotated Commercial General Liability Policy*, vol. 1, at p. 1-10). Because of this alternating structure of the CGL policy, it is generally advisable to interpret the policy in the order described above: coverage, exclusions and then exceptions.[17]

E. Endorsements: Do these pieces belong to my puzzle?

Not every policy will have endorsements, as typically these are issued during the policy term to modify the coverage. An endorsement can be issued for many reasons, such as changing, adding, or removing Named Insureds, adding or removing Additional Insureds, changing the policy term, changing the limit of insurance, changing, adding or removing exclusions, or extending coverage. Given the varied nature of endorsements, they are similar to finding a left over puzzle piece, even when it appears that there are no gaps in the picture.

[17] *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada, supra,* at para 28.

If there are any endorsements attached to a policy, this should be listed on the declaration page. However, it is common that the insured will not provide the most up to date copy of the declaration page and, therefore, it should always be confirmed whether there are any further endorsements not provided.

The endorsements will be subject to the other terms in the policy, except where they explicitly state otherwise. The court in *J.I.L.M. v. Intact Insurance, ibid,* addressed this issue. Specifically, in its attempt to find coverage, the Plaintiff turned to the endorsements, one of which referred to Building and/or Contents coverage. The court explained of the endorsement:

> …It is an extension of coverage to include such things as inflation protection and replacement cost rather than actual cash value. However, under the heading, "Buildings and/or Contents", Form EP04 states:
>
> The following extensions are subject to all terms, conditions, exclusions, stipulations and provisions applicable to the Commercial Building and Contents Broad Form (BF02) and the Limit of Insurance specified in the Summary of Coverages in this Form
>
> The reader of the policy therefore is directed back to the provisions of Form BF02, which limit insurance to those coverages for which a limit of insurance is shown on the declarations page.[18]

Therefore, the court did not accept that the endorsement could be read in isolation of the other parts of the policy, in this case the declaration page. As such, an endorsement, albeit on a separate form, acts as if it was part of the main policy wording, whether it be an insuring agreement, exclusion, or some other change.

F. Conditions: The fold up card table supporting your puzzle

Every policy contains conditions, which typically apply to all insuring agreements equally. In certain circumstances, even where the insuring agreement is triggered and there are no applicable exclusions, coverage may still be declined if the conditions are not complied with. As such, it is like having the table drop out from under your perfectly arranged puzzle.

[18] *J.I.L.M. v. Intact Insurance, supra* at note 6, at para 37 - 38.

Some conditions may be for the benefit of the insured, such as a “separation of insureds” condition, which provides that all policy provisions apply separately to each insured against whom a claim is made or suit is brought. However, most conditions are for the benefit of the insurer.

One of the more common conditions, which imposes requirements on the insured in the case of a claim or knowledge of a potential claim, reads as follows:

> **2. Duties In The Event Of Occurrence, Offense, Claim Or Suit**
>
> a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:
>
> (1) How, when and where the "occurrence" or offense took place;
>
> (2) The names and addresses of any injured persons and witnesses; and
>
> (3) The nature and location of any injury or damage arising out of the "occurrence" or offense.
>
> b. If a claim is made or "suit" is brought against any insured, you must:
>
> (1) Immediately record the specifics of the claim or "suit" and the date received; and
>
> (2) Notify us as soon as practicable.
>
> You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

This clause requires that the insured take certain actions upon learning of a claim or circumstances that could give rise to a claim. If the conditions are not complied with, then the insurer may argue that the insured is in breach of the policy and there is no coverage for the claim.

However, all is not lost for the insured. The B.C. *Insurance Act*, R.S.B.C. 2012 c. 1[19], as with many other jurisdictions across the country, includes recourse for the insured in the

[19] *Insurance Act*, R.S.B.C. 2012 c. 1

case of failure to comply with a condition. Specifically, the *Insurance Act* provides relief from forfeiture as follows:

> **Court may relieve against forfeiture and termination**
>
> 13. Without limiting section 24 of the Law and Equity Act, if
>
> (a) there has been
>
> (i) imperfect compliance with a statutory condition as to the proof of loss to be given by the insured or another matter or thing required to be done or omitted by the insured with respect to the loss, and
>
> (ii) a consequent forfeiture or avoidance of the insurance in whole or in part, or
>
> …
>
> and the court considers it inequitable that the insurance should be forfeited or avoided on that ground or terminated, the court, on terms it considers just, may
>
> (c) relieve against the forfeiture or avoidance,

In *Falk Bros. Industries Ltd. v. Elance Steel Fabricating Co.*, 1989 CanLII 38 (SCC), the Supreme Court of Canada addressed the courts discretion to grant relief from forfeiture due to the late reporting of an insurance claim[20]. The Court stated:

> The case law has generally treated failure to give notice of claim in a timely fashion as imperfect compliance whereas failure to institute an action within the prescribed time period has been viewed as non-compliance, or breach of a condition precedent. Thus, courts have generally been willing to consider granting relief from forfeiture where notice of claim has been delayed…
>
> On the other hand, cases in which failure to meet a time requirement has been held to be non-compliance rather than imperfect compliance have largely been cases in which the time period was for the commencement of an action rather than for the giving of notice…
>
> The reasons for the distinction are bi-fold. First, failure to give notice of claim has been viewed as a breach of a term rather than a breach of a condition. Clearly, being akin to failure to meet a limitation period, failure to bring an action within the time required is a more serious breach than failure to give timely notice. A notice of a claim simply informs the insurer of the possibility of a future action, thereby allowing the insurer some time to investigate the

[20] *Falk Bros. Industries Ltd. v. Elance Steel Fabricating Co.*, 1989 CanLII 38 (SCC)

> merits of the claim and to negotiate a settlement: the actual bringing of an action, however, is the legal crystallization of the claim which sets its parameters and magnitude. Second, and probably more importantly, failure to give notice of the claim within the time required is a defect in provision of proof of loss for which relief against forfeiture is, by the terms of the statute, available.[21]

Therefore, typically a court will look at whether the insurer has suffered some prejudice as a result of the condition breach and weigh that against the prejudice to the insured. If there is no prejudice to the insurer, then a court will most likely grant relief from forfeiture for failure to comply with a condition.

The *Insurance Act* also now contains a further "save" for the insured, as per s. 32, as follows:

> **Unjust contract provisions**
>
> 32 If a contract contains any term or condition, other than an exclusion prescribed by regulation for the purposes of section 33 (1) or established by section 34 (2) or (3), that is or may be material to the risk, including, but not restricted to, a provision in respect of the use, condition, location or maintenance of the insured property, the term or condition is not binding on the insured if it is held to be unjust or unreasonable by the court before which a question relating to it is tried.

There is limited B.C. case law on the application of s. 32. However, it was referenced briefly in the case of *Precision Plating Ltd. v. Axa Pacific Insurance Company,* 2014 BCSC 602, which reviewed the application of a pollution exclusion clause.[22] One of the insured's arguments was that the pollution exclusion should be not be binding because it was "unjust or unreasonable". It appears that the court would have applied s. 32 to relieve against the exclusion, when it stated:

> Given my earlier conclusions I do not propose to discuss this in detail. Suffice it to say that for the same reasons as already discussed I find the pollution exclusion to be unjust or unreasonable insofar as it purports to exclude coverage for most of the consequences of fires in circumstances where the

[21] *Ibid*, at p. 784 - 785.

[22] *Precision Plating Ltd. v. Axa Pacific Insurance Company,* 2014 BCSC 602

> Insurer has conceded the exclusion does not apply to typical fire damage.[23]

As such, while an insured must comply with the policy provisions, the court may be willing to assist the insured and relieve against forfeiture or decline to give effect to the provision.

G. Conclusion

Just like puzzling, the more time you spend reading insurance policies and researching about their interpretation, the easier it becomes to review coverage under a policy. The above is just a sampling of the various wordings found in the different types of insurance policies and is intended as a starting guide.

[23] *Ibid*, at para 75