SUPERIOR COURT

CANADA
PROVINCE OF QUEBEC
DISTRICT OF LONGUEUIL

No.: 505-17-012465-219

DATE: 12 March 2026

BY THE HONOURABLE ROBERT LECKEY, J.S.C. (JL5830)

SUSAN HINDLE, *es qualité* liquidator of the **ESTATE OF ROBERT HINDLE**
Plaintiff
v.
TD LIFE INSURANCE COMPANY
– and –
THE CANADA LIFE ASSURANCE COMPANY
Defendants

TRANSCRIPTION OF ORAL JUDGMENT*

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[1] Robert Hindle applied for life insurance to cover the balance on a secured line of credit on 17 July 2014.[1] He died on 9 January 2017.

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* As permitted by article 334 CCP and *Kellog's Company of Canada c PG du Québec*, [1978] CA 258 at 259-60, the Court in transcribing its oral judgment may have modified, expanded, and restructured its reasons to improve their presentation and comprehension.

1 Exhibit P-2.

[2] TD Life refused the succession's claim for payment, alleging that Mr Hindle nullified the contract by fraudulently misrepresenting his medical condition.

[3] The succession claims the $300,000 payment under the life insurance, plus approximately $55,000 for interest accrued on the line of credit since Mr Hindle's death and damages of $25,000. Its liquidator, the deceased's widow, Susan Hindle, experiences TD Life's position – in her view, based on untruths – as an attack on her late husband's integrity.

[4] For the following reasons, TD Life's defence based on fraud prevails.

* * *

[5] An established legal framework applies here:

- As the policy was in force for more than two years when Mr Hindle died, nonfraudulent misrepresentation or concealment would not suffice to nullify the contract;[2]

- An insurer refusing to pay on this basis bears the burden of proving fraud on the civil standard of the balance of probabilities;[3]

- The insurer seeking nullity of a policy must prove "that the insured had intentionally misrepresented a material fact to induce the insurer to issue the policy under the terms and conditions that it did, and that the insured did so knowing that without such misrepresentation the insurer might not have issued the policy";[4]

- A contract null ab initio is deemed never to have existed, entailing the restitution of prestations already received.[5]

* * *

[6] This dispute centres on Mr Hindle's negative answers to three questions about his health when he applied for the insurance.[6]

[7] The succession recognizes that Mr Hindle received a diagnosis of type 1 diabetes in 1964. It argues, though, supported by the testimony of his transplant surgeon and specialist, Dr Tchervenkov, that Mr Hindle ceased to be diabetic after a successful – and historic – simultaneous double transplant of a kidney and pancreas in 1999. From that time, he stopped taking insulin. Certainly, from that time until his death, Mr Hindle took immunosuppressant medication to prevent his body's rejecting the transplants. But for the succession, he did not, in the sense of Question 1, "take a medication for diabetes."

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2 Art 2424 para 1 CCQ.
3 Art 2803 para 2, 2804 CCQ.
4 *Axa Assurances inc c Délicatesse Nourcy inc*, [2002] RJQ 871 at para 38 (CA).
5 Art 1606 para 1 CCQ.
6 Section 2 of the insurance application (Exhibit P-2).

Mr Hindle lived the final years of his life "diabetes-free," as he was described in a posthumous tribute.[7] Undoubtedly, this understanding formed a central part of Mr Hindle's life narrative.

[8] As Dr Tchervenkov testified, after the surgery his patient suffered some conditions more common among diabetics than among others – such as a detached retina and a gangrenous toe requiring amputation – but none that was exclusive to them. In 2007, however, Dr Tchervenkov listed "Type 1 Diabetes" among Mr Hindle's "other conditions" on a "discharge summary."[8]

[9] Had Mr Hindle answered yes to any of the three questions, he would have needed to complete a health questionnaire or undergo a telephone interview. Because he initialed in the box for "No" on this short questionnaire – which "joue le role d'un filtre"[9] – the health disclosure stopped there, depriving the insurer of the possibility of undertaking a full risk assessment of his health.[10] To achieve its goals, a standard screening mechanism such as the form requires of the client "la franchise et 'la plus haute bonne foi.'"[11] At this stage, a false declaration deprives the insurer "du signal d'alarme qui déclenche chez lui le réflexe de faire enquête."[12]

[10] The Court finds, on the balance of probabilities, that Mr Hindle believed fuller answers about his circumstances – "sur des faits importants et pertinents à son assurabilité"[13] – might lead the insurer to refuse his application.

[11] During their testimony, Margaret Leacock and the expert Josée Malboeuf explained that the eligibility for the group product in question was determined, taking a global view, on a binary yes/no basis, without individualized exclusions or premium adjustments. Each insured admitted within the group pays the same, "aggregate" rate.

[12] Indeed, in testimony that cross-examination did not undermine, Ms Leacock confirmed that TD Life, better informed of the 24 months preceding the application in July 2014,[14] would have declined to insure Mr Hindle. Ms Malboeuf substantiated this assessment with reference to excerpts from their risk-assessment manual.[15] No evidence provides a basis to suppose that TD Life departed from the approach of a reasonable insurer.

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7 Exhibit P-1.
8 Exhibit P-10, Documents divers – 2007, 2007 at 1; see also Exhibit P-10, Documents divers – 2005 at 9.
9 *Assurance-vie Desjardins Laurentienne c Poirier-Wilson*, [2003] RRA 1098 at para 24 (CA) [*Poirier-Wilson*].
10 *Ibid* at para 19.
11 *Ibid* at para 26.
12 *Ibid* at para 27.
13 *Desjardins sécurité financière, compagnie d'assurance-vie c Tétreault*, 2009 QCCA 2183 at para 3.
14 Exhibits D-7, D-9.
15 Exhibit D-10.

[13] Mr Hindle's probable awareness of the possible consequences of an ample disclosure of his medical condition is established. But a finding of fraud also requires that he made intentional misrepresentations when completing the application. Determining whether he did so requires examining the application form he completed and signed.

[14] Questions 1 and 2 included bulleted lists of medical issues or events. For present purposes, two excerpts are especially relevant:

1. Within the past 24 months, have you consulted a doctor, received treatment, counselling, taken any medication for or been told by a doctor or other health practitioner that you have or have had any of the following: […]
    - diabetes, stroke, high blood pressure, elevated cholesterol, multiple sclerosis, paralysis? […]
    - any disease or disorder of the glands (including but not limited to thyroid), kidneys, liver […]
2. Within the past 24 months have you: […]
    - been referred for testing, investigation, or treatment or been seen by a specialist?

* * *

[15] Mr Hindle should have answered Question 2 affirmatively.

[16] This conclusion arises from the evidence, without TD Life requiring the attenuated burden of proof where a client of sound mind is presumed to know the consequences of his statements.[16]

[17] Ms Malboeuf testified as to the importance of Question 2. She asserted that, given Mr Hindle's history with specialists, he could not but answer that question affirmatively. She explained that, had he done so, he would have had to answer the full health questionnaire, the questions of which reach beyond the preceding 24 months ("Have you ever […]?").[17] During cross-examination, she shared her understanding of the question – which appears faithful to the text's plain meaning – by which "have you been seen by a specialist" does not distinguish follow-ups or "routine" appointments from other kinds. Contrary to the succession's contention, Question 2 appears "conçu[e] de façon à ne pas créer d'ambiguïté dans l'interprétation."[18] There is thus no need to interpret that question in favour of the adhering party or consumer, supposing it to be assimilable to a contractual clause.[19]

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16 *Union-Vie, compagnie mutuelle d'assurance c Laflamme*, [2005] RRA 332 (CA).
17 Exhibit D-13.
18 *Gagnon c Unum Life Insurance Company of America*, 2010 QCCS 4224 at 73, aff'd, 2012 QCCA 1150.
19 Art 1432 CCQ.

[18] The testamentary and documentary evidence proves the following for the crucial 24 months running back to 17 July 2012:

- In Dr Tchervenkov's words, "This man was followed two to three times per year";
- Mr Hindle had regular follow-up appointments with his nephrologist, Dr Cantarovich, including on 5 December 2013 and 17 July 2014;
- He underwent eye surgery on 22 April, 16 May, and 24 May 2013, which led to a follow-up with a specialist on 23 December 2013, as well as another eye operation on 10 February 2014;
- He regularly saw a dermatologist, as he was at risk of developing skin cancer; he had basal cell carcinomas burned from his left shoulder in 2013;
- Notes from 5 December 2013 mention issues to discuss with a gastro-intestinal specialist, while follow-up notes from 17 July 2014 indicate that an appointment with a GI the preceding winter was cancelled and would be rescheduled.

[19] To reprise the language of Question 2, Mr Hindle could not affirm reasonably that he had not "been referred for testing, investigation, or treatment or been seen by a specialist" in the preceding 24 months. Indeed, he saw a specialist the morning of the day he completed the application.

[20] Even accepting Dr Tchervenkov's understanding by which, post-transplant, Mr Hindle was no longer diabetic, nothing in the surgeon's testimony provided a basis for denying being referred to or seen by specialists. The obligation to answer truthfully "est indépendante de la perception que pouvait avoir la répondante de son véritable état de santé."[20] Put otherwise, the client "n'a pas à se substituer à l'assureur pour apprécier le risque."[21]

[21] The succession's claim that Mr Hindle was not "seen" by specialists during the 24 months in question because he merely had follow-ups with his established team is unreasonable. On the contrary, the fact that a person regularly sees several specialists is plainly relevant to a potential insurer, which should have the opportunity, fully informed, to undertake its risk assessment.

[22] In any case, the succession's effort at wordsmithing and to downplay the significance of Mr Hindle's follow-up appointments misunderstands the aims of the initial questionnaire. Such a device may capture information that is not fully "material," but it also captures proxies for issues warranting investigation.[22]

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20 *La Compagnie d'assurance-vie Transamerica du Canada c Nourcy*, 1999 CanLII 13769 at 10 (QC CA).
21 *Poirier-Wilson*, *supra* note 9 at para 37.
22 *Ibid* at para 28.

[23] In any event, even by the succession's theory that Question 2 excludes mere "follow-ups," by 2013 Mr Hindle was "referred" to a GI specialist, which he should have disclosed.

[24] To sum up, given his extensive knowledge of his complex health situation and the context, it is likelier than not that Mr Hindle deliberately answered Question 2 in the negative to avoid such information influencing TD Life's assessment of his application. In other words, he committed "l'omission flagrante […] de divulguer des informations qui avaient clairement une incidence sur son assurabilité."[23]

* * *

[25] Subsidiarily, there is a basis for finding, on the balance of probabilities, that Mr Hindle answered Question 1 fraudulently. This basis is weaker than the finding regarding Question 2.

[26] It arises from the client's duty "to represent all the facts known to him which are likely to materially influence an insurer in the setting of the premium, the appraisal of the risk or the decision to cover it."[24]

[27] For example, in *Paul-Hus*, where a person with progressive muscle atrophy falsely answered negatively to numerous questions during an interview with the insurer's representative, the Court of Appeal held that, given "le caractère important de son problème de santé et des investigations médicales extensives en cours, que l'appelant connaissait manifestement," he "avait clairement l'obligation de divulguer" his situation to the insurer, "même en l'absence de toute question précise."[25]

[28] This notion that the duty to disclose may crystallize absent an explicit question is significant since, as Ms Malboeuf admitted under cross-examination, Question 1 nowhere includes the word "transplant" (an omission explained, however, by the rarity of transplants and the screening form's broad readership).

[29] There may be factual distinctions: as Mr Hindle's negative answers saved him from reaching the health questionnaire or the phone interview, he differed from Mr Paul-Hus in never providing numerous false answers. Moreover, it is possible that Mr Hindle's health situation in 2014 was less serious than Mr Paul-Hus's at the relevant time. Still, although no extensive medical investigations were in progress, Mr Hindle was to undergo a colonoscopy, based on years of difficulties with his digestion following his bowel resection in 2007.

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23 *Paul-Hus c Sun Life Canada, compagnie d'assurance-vie*, 2025 QCCA 41 at para 9 [*Paul-Hus*].
24 Art 2408 CCQ.
25 *Paul-Hus*, supra note 23 at para 9.

[30] Recall Mr Hindle's medical history. After the successful double transplant, his ongoing anti-rejection medication increased his susceptibility to several conditions. After the 1999 transplant, he underwent the following:

- regular follow-ups with several specialists;
- surgeries to bowel, toe, and multiple times to his eye;
- and removal of cancerous cells.

[31] A reasonably prudent and informed client could not have thought that this situation would spare him from proceeding to the health questionnaire. Moreover, if in doubt, Mr Hindle should have answered Question 1 affirmatively, allowing TD Life to investigate and draw its conclusions. Like Mr Paul-Hus, he was bound to disclose his situation, "même en l'absence de toute question précise."

[32] Having answered the three questions negatively, and been dispensed from the health questionnaire, a reasonable person in Mr Hindle's circumstances would have felt that it was all too easy.

[33] Given the firm finding regarding Question 2, and the subsidiary one just presented, it is unnecessary to examine TD Life's further arguments regarding Question 1. Doing so would require ruling on contradictory evidence regarding Mr Hindle's knowledge of his high blood pressure and the reasons for his taking Norvasc, as well as interpreting terms such as "treatment" and "disorder" in a context where Mr Hindle – encouraged by his attending surgeon – considered himself cured of his diabetes.

* * *

[34] Mr Hindle should have answered Question 2 in the application for insurance affirmatively. Subsidiarily, he should also have so answered Question 1. A "yes" for either would have required him to complete the health questionnaire.

[35] In conclusion, his fraud nullifies the contract for life insurance from the outset.

FOR THESE REASONS, THE COURT:

[36] **DISMISSES** the originating application modified on 14 January 2022;

[37] **DECLARES** null *ab initio*, from 17 July 2014, the life insurance coverage of the late Robert Hindle under the Defendant Canada Life's Group Insurance Policy no. G/H.60158;

[38] **DECLARES** good, valid and sufficient the offer of the Defendant Canada Life to pay to the Plaintiff the amount of $11,143.95, representing the refund of all premiums paid under the said policy, and **ORDERS** it to execute that payment;

[39] With legal costs.

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ROBERT LECKEY, J.S.C.

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Hearing date: 10-12 March 2026