COURT OF APPEAL FOR ONTARIO

CITATION: Chubb Insurance Company of Canada v. Zurich Insurance Company, 2026 ONCA 302
DATE: 20260430
DOCKET: COA-25-CV-0088

Paciocco, Zarnett and Favreau JJ.A.

In the Matter of the *Insurance Act*, R.S.O. 1990, c. I.8, Section 268 and Ontario Regulation 283/95 made under the *Insurance Act*

And in the Matter of the *Arbitration Act, 1991*, S.O. 1991, c. 17

And in the Matter of an Arbitration

BETWEEN

Chubb Insurance Company of Canada

Appellant (Respondent)

and

Zurich Insurance Company

Respondent (Appellant)

Eric Grossman and Rebecca Brown Greer, for the appellant

Kadey B.J. Schultz and Colin MacDonald, for the respondent

Heard: October 16, 2025

On appeal from the order of Justice R. Lee Akazaki of the Superior Court of Justice, dated May 23, 2024, with reasons reported at 2024 ONSC 2929, allowing an appeal from a decision of Arbitrator J. Douglas Cunningham, dated August 5, 2022.

Favreau J.A.:

A. OVERVIEW

[1] The appellant, Zurich Insurance Company ("Zurich"), and the respondent, Chubb Insurance Company of Canada ("Chubb"), have been involved in a lengthy dispute over which insurance company is responsible for paying accident benefits for an accident that occurred in 2006.

[2] In 2006, Sukhvinder Singh was in an accident while operating a rental vehicle – no other vehicle was involved. At the time, she believed Chubb was the insurer, and her lawyer contacted Chubb to confirm coverage. Chubb refused to pay and made no efforts to identify or notify the insurer responsible for coverage. Over a year and a half later, Chubb's counsel advised Ms. Singh's lawyer that Zurich was the insurer. Zurich started making payments to Ms. Singh in 2012. However, Zurich took the position that Chubb, as the first insurer Ms. Singh notified, should have started adjusting the claim and given notice to Zurich within 90 days pursuant to ss. 2 and 3 of *Disputes Between Insurers*, O. Reg. 283/95 (the "Regulation").

[3] Section 2(1) of the Regulation requires that the first insurer who receives an application for statutory accident benefits pay "benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay

benefits". Section 3 of the Regulation precludes an insurer from disputing its obligation to pay benefits "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".[1]

[4] Zurich and Chubb submitted their dispute to arbitration. The matter went all the way to the Supreme Court, which determined that Chubb was an insurer for the purpose of the Regulation. The parties then participated in a second arbitration to determine which insurer had an obligation to pay benefits to Ms. Singh and the quantum of those benefits.

[5] The second arbitrator decided that Chubb was responsible for paying all benefits to Ms. Singh. On appeal, the appeal judge decided that Chubb and Zurich were both insurers and that they should therefore share responsibility for paying benefits to Ms. Singh.

[6] Zurich submits that the appeal judge erred in finding that it should be required to pay benefits to Ms. Singh. Zurich submits that this is contrary to the intention of the Regulation and previous decisions of this court.

[7] I would allow the appeal and reinstate the second arbitrator's decision. The appeal judge erred in treating Zurich and Chubb as having equal responsibility.

[1] These provisions of the Regulation apply to accidents that occurred before September 1, 2010, as in this case.

There is no basis for this approach in the *Insurance Act*, R.S.O. 1990, c. I.8 or the Regulation. The second arbitrator made no error in requiring Chubb to pay the full amount of benefits owed to Ms. Singh.

B. BACKROUND

a. Ms. Singh's claim for accident benefits

[8] On September 22, 2006, Ms. Singh rented a vehicle from Wheels 4 Rent.

[9] The rental vehicle was insured pursuant to a "motor vehicle liability policy" issued by Zurich. Chubb also issued a policy to Wheels 4 Rent that provided optional accidental death and dismemberment insurance. Ms. Singh did not purchase Chubb's optional coverage.

[10] On September 23, 2006, Ms. Singh had a single vehicle accident while driving the rental vehicle. She returned the vehicle to Wheels 4 Rent on September 25, 2006 in a damaged condition. At the time, she did not notify the rental company about the accident.

[11] After Ms. Singh returned the vehicle, an employee of Wheels 4 Rent noted that it was damaged. Wheels 4 Rent tried to contact Ms. Singh but was unsuccessful. The manager prepared and filed an accident report with the adjuster for Wheels 4 Rent. This was characterized as a "Records Only" report because, at

that time, Wheels 4 Rent did not have property damage coverage with Zurich nor was it aware of any injuries suffered by Ms. Singh.

[12] Sometime later in the fall of 2006, Ms. Singh started experiencing back, shoulder and arm pain. She was not aware that Zurich was the insurer. She remembered seeing reference to insurance coverage from Chubb at the Wheels 4 Rent location. She retained a lawyer to assist her.

[13] The lawyer contacted Wheels 4 Rent's corporate office. He provided some information about Ms. Singh and the date of the accident, and asked Wheels 4 Rent to provide particulars of its insurance. Wheels 4 Rent refused to provide any information about its insurance coverage on the basis that it did not have a report of Ms. Singh's accident.

[14] On November 9, 2006, Ms. Singh's lawyer submitted an application for accident benefits to Chubb.

[15] By letter dated November 21, 2006, Chubb denied the application, stating: "This is not a personal automobile policy and thus the coverage of Ontario Statutory Accident Benefits does not apply."

[16] Over a year and a half later, by correspondence dated May 28, 2008, Chubb advised Ms. Singh's lawyer that Zurich was Wheels 4 Rent's automobile insurer.

[17] Once Zurich became aware of the claim, it agreed to adjust it on a without-prejudice basis, pending the outcome of its priority dispute with Chubb. Zurich then initiated a priority dispute against Chubb.

b. First arbitration

[18] Chubb and Zurich submitted their dispute to arbitration.

[19] The arbitration agreement set out the three following issues for resolution:

> The questions submitted for determination by the Arbitrator with respect to the priority of payment of Statutory Accident Benefits with respect to Sukhvinder (Susan) Singh, are as follows:
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> 1) Is Chubb Insurance Company of Canada an "insurer" under Section 268 of the *Insurance Act* and Ontario Regulation 283/95 – Disputes Between Insurers;
>
> 2) If it is decided that Chubb Insurance Company of Canada is an insurer under Section 268 of the *Insurance Act* and Ontario Regulation 283/95 – Disputes Between Insurers, then there will be an issue as to whether Chubb Insurance Company of Canada has complied with the provisions of the Ontario Regulation 283/95; and
>
> 3) What amounts, if any, is Chubb responsible for indemnifying Zurich?

[20] The parties selected Stanley C. Tessis as arbitrator (the "first arbitrator"). In a decision dated March 13, 2012, Mr. Tessis found that Chubb was not an insurer under s. 268 of the *Insurance Act*.[2] He further found that there was no nexus between Chubb and Ms. Singh, and that Chubb therefore had no obligation to pay any benefits to Ms. Singh pursuant to s. 2 of the Regulation pending the resolution of the coverage dispute.

[21] Zurich appealed the first arbitration award to the Superior Court. Goldstein J. allowed the appeal and found that Chubb was an insurer: *Zurich Insurance v. Chubb Insurance*, 2012 ONSC 6363, 15 C.C.L.I. (5th) 287. He reasoned that there was a sufficient nexus between Chubb and Ms. Singh:

> The connection between Ms. Singh and Chubb may have been remote, but it was not arbitrary. Ms. Singh rented a vehicle from Wheels4Rent. Wheels4Rent was insured by Chubb. Chubb made the optional policy available to Ms. Singh through Wheels4Rent. Although Ms. Singh did not take up the optional policy, the obvious inference that the parties agree can be drawn is that she learned of it through Wheels4Rent when she rented the vehicle.

[22] Chubb appealed that decision to this court. This court allowed the appeal: *Zurich Insurance Co. v. Chubb Insurance Co. of Canada*, 2014 ONCA 400, 120 O.R. (3d) 161. The majority found that Chubb was not an insurer. In dissent,

[2] As detailed below, s. 268(2) of the *Insurance Act* sets out the order of priority for determining which insurer is required to pay statutory accident benefits to the occupant of an automobile involved in an accident.

Juriansz J.A. would have dismissed the appeal on the basis that Chubb was an insurer for the purpose of s. 2 of the Regulation. He agreed with Goldstein J. that there was a nexus between Chubb and Ms. Singh and that it was not arbitrary. He concluded that to hold otherwise would erode the Regulation's policy rationale which is "to provide timely delivery of benefits to all persons injured in car accidents in Ontario, despite the inconvenience to insurance companies who must provide benefits immediately and seek reimbursement from the correct insurance company later."

[23] The Supreme Court granted leave to appeal and allowed the appeal. The Supreme Court's decision adopted the dissenting reasons of Juriansz J.A.: *Zurich Insurance Co. v. Chubb Insurance Co. of Canada*, 2015 SCC 19, [2015] 2 S.C.R. 134.

c. Second arbitration

[24] Following the Supreme Court's determination in 2015 that Chubb was an insurer for the purpose of s. 2 of the Regulation, Chubb took over the payment of benefits to Ms. Singh from Zurich. By this point, Ms. Singh had become catastrophically impaired. Chubb ultimately reached a full settlement with Ms. Singh.

[25] Chubb and Zurich proceeded to a second arbitration for the purpose of deciding the remaining issues under the arbitration agreement, namely whether Chubb complied with its obligations under the Regulation and what amounts, if any, Chubb owed Zurich.

[26] Since the first arbitrator had passed away, the Superior Court appointed the Honourable J. Douglas Cunningham as the arbitrator to decide this aspect of the parties' dispute (the "second arbitrator"): *Zurich Insurance Company v. Chubb Insurance Company*, 2018 ONSC 1907, 80 C.C.L.I. (5th) 207.

[27] The second arbitrator stated that he was required "to determine which insurer is liable to pay statutory accident benefits to Ms. Singh as the priority insurer." Specifically, Zurich sought reimbursement from Chubb of the $998,386.99 it paid in benefits to Ms. Singh from when it started paying benefits on a without-prejudice basis to when Chubb took over paying benefits after the Supreme Court released its decision. For its part, Chubb sought $1,537,229.04 for the amounts it had paid Ms. Singh since the Supreme Court's decision.

[28] The second arbitrator found that Chubb did not comply with its obligations and required Chubb to reimburse Zurich all amounts it had previously paid to Ms. Singh.

[29] In reaching this conclusion, the second arbitrator reviewed the available evidence and concluded that Zurich had no notice of Ms. Singh's claim prior to 2008. He further found that had Chubb met its obligations as an "insurer" under ss. 2 and 3 of the Regulation, it could have easily determined that Zurich was the insurer for Ms. Singh's claim and given it notice. He then considered the appropriate sanction for Chubb's failure to meet its obligations:

> Here, there can be little doubt that Chubb was not an insurer of this loss. Nevertheless, it did have an obligation under the pay now, dispute later regime to pay Ms. Singh's benefits. The question I must determine is whether Chubb, by essentially ignoring her application, taking no steps to investigate who the proper insurer was and failing to give any notice at all, let alone within 90 days, ought to be sanctioned.
>
> I recognize what the courts have said about the failure to provide notice as mandated by section 3(2)(a) of Ontario Regulation 283/95 as not automatically determining that the breaching insurer should be obliged to pay benefits permanently. However, when I consider section 3(2), it is clear there must be a reasonable investigation to determine whether another insurer should be liable, and here there wasn't. So what are the consequences of that?
>
> …
>
> Chubb was the "first insurer" here and it failed its obligation to pay. Moreover, as already noted, it failed its obligation to investigate and notify the insurer it believed should be responsible within 3 months or indeed at all. These failures must not go unsanctioned.

[30] The second arbitrator next reviewed several decisions of this court and the Superior Court that addressed breaches of the obligations under ss. 2 and 3 of the Regulation. Based on this review, he concluded that:

> For there not to be consequences would be to defeat the legislation's public policy: pay now and dispute later. A policy that ensures the provision of accident benefits in a timely manner such that claimants do not end up in the middle of disputes between insurers.

[31] Based on his conclusion that Chubb should be sanctioned and his review of the relevant case law, the second arbitrator allowed Zurich's claim and concluded that, in the circumstances of this case, Chubb should be responsible for paying Ms. Singh's accident benefits permanently. He directed Chubb to reimburse Zurich for the $998,368.99 it had paid Ms. Singh plus the costs of the arbitration.

d. Appeal judge's decision

[32] Chubb appealed the second arbitrator's decision to the Superior Court. The appeal judge allowed the appeal. He agreed with the arbitrator that Chubb did not meet its obligations under ss. 2 and 3 of the Regulation. He further held that the consequence of this breach was that Chubb had a permanent obligation to pay benefits to Ms. Singh:

> The consequences of Chubb's breaches of ss. 2 and 3 of the regulation must follow the regulation and the statute. The immediate consequence was that Chubb had an

> obligation to pay benefits as the first insurer to receive the OCF-1. The second consequence, 90 days later after it performed no investigation of the proper recipient, was that it precluded itself from disputing its obligation to pay the benefits. I agree with Chubb's submission that, according to the case law, breach of s. 2 does not result in an insurer being required to pay benefits to the claimant permanently. The failure to avail itself of s. 3 does. Chubb's permanent liability to pay benefits was a self-inflicted consequence of its failure to adhere to the requirements of both s. 2 and s. 3. This combination of provisions in the regulation transformed Chubb's provisional liability to Ms. Singh into a permanent one.

[33] However, the appeal judge held that this did not end the analysis regarding the dispute between the two insurers. The appeal judge stated that, once Chubb was deemed to be an insurer, due to its breaches of ss. 2 and 3 of the Regulation, it was to be treated as an insurer of equal priority with Zurich under s. 268(2) of the *Insurance Act*:

> This does not end the interpretation of the regulation and the statute. If Chubb's failure to follow the regulation made it Ms. Singh's insurer, the statute did not relieve Zurich of its responsibility under s. 268(3) and provided no mechanism for it to be relieved itself of that obligation. Because of the physical impossibility of an injured claimant to have been the occupant of more than one vehicle in a traffic accident, ordinarily an insurer in Zurich's position would stand alone as priority insurer. Chubb, however, inserted itself into that priority ranking alongside Zurich, by operation of ss. 2 and 3 of the regulation.

[34] On the basis of his finding that Chubb and Zurich were to be treated as having equal priority, the appeal judge held that the sanction imposed by the second arbitrator was unreasonable, and that Chubb and Zurich should share responsibility for paying benefits to Ms. Singh.

[35] He further held that the appropriate sanction in this case was for the insurers to each pay any 2% compound interest, as provided for in s. 46 of the *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996*, O. Reg. 403/96 ("*SABS*"), for the delay for which they are each responsible.

C. ANALYSIS

[36] Zurich appeals the appeal judge's decision. Chubb does not.

[37] Zurich raises three issues on appeal that I would summarize as follows:

(a) The appeal judge erred in his analysis of the relationship between ss. 2 and 3 of the Regulation and s. 268 of the *Insurance Act*;

(b) The appeal judge erred in using the attribution of 2% compound interest provided for in the *SABS* as a sanction for Chubb's failure to meet its obligations under ss. 2 and 3 of the Regulation; and

(c) The appeal judge erred by deciding issues that were beyond the scope of the arbitration agreement between the parties.

[38] I agree with Zurich that the appeal judge erred in his interpretation of ss. 2 and 3 of the Regulation and their relationship to s. 268 of the *Insurance Act*. As a result of this error, he further erred in finding that both insurers should be treated as having equal priority and should thereby each pay half of the benefits owed to Ms. Singh. Given my conclusion on the first issue, it is not necessary to address the two other issues raised by Zurich. Ultimately, I find that the arbitrator did not err in requiring Chubb to pay for all of Ms. Singh's benefits, and I would restore his award.

[39] I start by reviewing the appeal rights and standard of review, and the relevant statutory and regulatory scheme. I next address general principles that apply to the interpretation and application of ss. 2 and 3 of the Regulation. I then explain why I find that the appeal judge erred and why I would uphold the arbitration award.

a. Appeal rights and standard of review

[40] Section 45 of the *Arbitration Act, 1991*, S.O. 1991, c. 17, provides for a right of appeal to the Superior Court, with leave, on a question of law, unless the parties agree otherwise. In this case, the arbitration agreement between the parties provided that the parties can appeal the arbitration award on a question of law or a question of mixed fact and law.

[41] Section 49 of the *Arbitration Act* provides for a further right of appeal to this court, with leave.[3]

[42] Where there is a statutory right of appeal from an arbitration decision, the appellate standard of review applies: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at para. 37. Questions of law are to be reviewed on a standard of correctness: *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at para. 8; *Travelers Insurance Company of Canada v. CAA Insurance Company*, 2020 ONCA 382, 151 O.R. (3d) 78, at para. 14; and *Continental Casualty Company v. Chubb Insurance Company of Canada*, 2022 ONCA 188, 22 C.C.L.I. (6th) 1, at paras. 46-48. Absent an extricable question of law, questions of mixed fact and law are to be reviewed on a palpable and overriding error standard: *Housen*, at para. 36.[4]

[43] Finally, this court owes no deference to the appeal judge's decision on questions of law.

[3] This court granted leave to appeal from the appeal judge's decision on January 20, 2025.

[4] In this case, the arbitration agreement between the parties provides that questions of mixed fact and law are to be reviewed on a reasonableness standard. Notably, the agreement predates *Vavilov* and was likely meant to reflect the law at that time. For the purposes of this appeal, it is not necessary to determine whether the reasonableness standard or the palpable and overriding standard applies to errors of mixed fact and law. Nothing turns on this distinction in this case.

b. The legislative and regulatory context

[44] To understand the dispute between Zurich and Chubb, it is helpful to review the legislative context under the *Insurance Act* and the Regulation.

[45] Section 268(1) of the *Insurance Act* stipulates that every motor vehicle liability policy is deemed to provide for statutory accident benefits under the *SABS*. Section 268(2) sets out the order of priority for determining which insurer is required to pay statutory accident benefits to the occupant of an automobile involved in an accident:

> (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.

[46] Section 268(3) requires an insurer against which a person has recourse to pay statutory accident benefits. Section 268(4) provides that, if 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.”

[47] The Regulation addresses disputes between insurers.

[48] Section 1 of the Regulation states that “[a]ll disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation.”

[49] Section 2(1) applies to accidents that occurred prior to September 1, 2010, and it requires that the first insurer who receives an application for statutory accident benefits pay “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.”

[50] In *Kingsway General Insurance Company v. Ontario*, 2007 ONCA 62, 84 O.R. (3d) 507, at paras. 19-20 (“*Kingsway #2*”), Laskin J.A. explained that the purpose of s. 2 of the Regulation is to avoid a situation where people injured in a car accident are left without benefits because of a dispute between insurers:

> Section 2 of regulation 283 is critically important in the timely delivery of benefits to victims of car accidents. The principle that underlies section 2 is that the first insurer to receive an application for benefits must pay now and dispute later. The rationale for this principle is obvious: persons injured in car accidents should receive statutorily mandated benefits promptly; they should not be prejudiced by being caught in the middle of a dispute between insurers over who should pay, or as in this case, by an insurer's claim that no policy of insurance existed at the time.
>
> Insurers cannot avoid their obligation under section 2 by claiming that another insurer should pay or that an insurance policy was cancelled shortly before the accident. If they could deny an application for accident benefits on either of these grounds, section 2 would be rendered meaningless.

[51] Section 3(1) sets out a 90-day notice requirement for insurers that dispute their obligation to pay benefits:

> 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.

[52] Section 3(2) provides that the 90-day period can be extended in specified circumstances:

> (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.

[53] Disputes between insurers arising from the Regulation are to be resolved by arbitration: ss. 3(3) and 7 of the Regulation.

c. Previous case law dealing with ss. 2 and 3 of the Regulation

[54] This case raises an unusual situation. There is no dispute that Chubb was not the priority insurer under s. 268(2) of the *Insurance Act* at the time of Ms. Singh's accident in 2006. However, because Ms. Singh made a claim to Chubb and because, as the Supreme Court found, there was a sufficient nexus between Ms. Singh and Chubb, Chubb was an insurer for the purpose of s. 2 of the Regulation. Chubb failed to meet its obligation under s. 2 of the Regulation to pay benefits to Ms. Singh, and also failed to meet its obligation to notify Zurich of the dispute in accordance with s. 3 of the Regulation.

[55] The issue in this case is what consequences should flow from Chubb's failure to meet its obligations under ss. 2 and 3 of the Regulation. The second arbitrator determined that Chubb should be responsible for paying the full amount of benefits paid to Ms. Singh. The appeal judge disagreed and decided that Chubb and Zurich should pay equal amounts, subject to each party paying any 2% compound interest for the delay it caused when it handled the claim.

[56] The broader issue engaged by this case is the principles to be applied in determining the consequences that flow from an insurer's failure to meet its obligations under ss. 2 and 3 of the Regulation, particularly for accidents that occurred prior to September 1, 2010.

[57] The Regulation does not explicitly set out the sanctions to be imposed where an insurer fails to meet its obligations under ss. 2 and 3 for accidents that occur prior to September 1, 2010, as in this case.[5] However, a number of decisions from this court and the Superior Court suggest that it can be appropriate, although not inevitable, to require that the first insurer that receives a claim to pay benefits permanently where that insurer fails to give the required notice to other insurers, even where the first insurer does not fall within s. 268(2) of the *Insurance Act*.

[58] Arguably, as a matter of statutory interpretation, where the first insurer who receives an application for benefits fails to meet its obligation to give notice under s. 3 of the Regulation, it should be required to continue paying benefits permanently. This would flow logically from the wording of s. 3(1) to the effect that "[n]o insurer may dispute its obligation to pay benefits under section 268 of the Act

[5] For accidents that occurred on or after September 1, 2010, s. 2.1(7) explicitly sets out the sanction where the first insurer fails to meet various obligations, including by failing to pay benefits pending the resolution of a dispute: "(7) An insurer that fails to comply with this section shall reimburse the Fund or another insurer for any legal fees, adjuster's fees, administrative costs and disbursements that are reasonably incurred by the Fund or other insurer as a result of the non-compliance." For accidents that occurred after September 1, 2010, as with accidents that occurred prior to that date, the Regulation does not set out an explicit sanction for failing to give notice under s. 3.

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" (emphasis added). However, this court has suggested that permanent payment is not inevitable.

[59] In *Kingsway General Insurance Co. v. West Wawanosh Insurance Co.* (2002), 58 O.R. (3d) 251 (C.A.) ("*Kingsway #1*"), the issue was whether the 90-day notice period should be extended pursuant to s. 3(2) of the Regulation. In that context, and while the court was dealing with different factual circumstances than arise here, the court explained, at para. 10, that the Regulation is meant to bring certainty to the resolution of disputes between insurers:

> The Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assume and rely upon the requirement for compliance with those provisions. Insurers subject to this Regulation are sophisticated litigants who deal with these disputes on a daily basis. The scheme applies to a specific type of dispute involving a limited number of parties who find themselves regularly involved in disputes with each other. In this context, it seems to me that clarity and certainty of application are of primary concern. Insurers need to make appropriate decisions with respect to conducting investigations, establishing reserves and maintaining records. Given this regulatory setting, there is little room for creative interpretations or for carving out judicial exceptions designed to deal with the equities of particular cases.

[60] In *Kingsway #2*, the court dealt with a situation where an insurance policy issued by Kingsway General Insurance Company ("Kingsway") was cancelled two days before an accident. The injured person made a claim for benefits to Kingsway. Kingsway refused to pay on the basis that the injured person was not insured on the date of the accident because the insurance policy was cancelled for non-payment of premiums. The Motor Vehicle Accident Claims Fund (the "Fund") paid the benefits and sought reimbursement from Kingsway at an arbitration. The arbitrator found that there was a sufficient nexus between Kingsway and the claimant, and that Kingsway was therefore required to pay benefits and then dispute the claim in accordance with the Regulation. Because Kingsway did not follow this process, the arbitrator ordered Kingsway to pay accident benefits to the claimant on a permanent basis.

[61] On appeal, this court noted that Kingsway may have improperly terminated the insurance policy because the record suggested that Kingsway overcharged the insured by including amounts it was not entitled to charge. If Kingsway was not entitled to cancel the policy, the injured person was still insured at the time of the accident. The court agreed with the arbitrator that, even if Kingsway was entitled to cancel the insurance, there was a sufficient nexus between Kingsway and the claimant for Kingsway to be obligated to pay first and dispute later as required by ss. 2 and 3 of the Regulation.

[62] In this context, the court remitted the matter back to the arbitrator to first determine whether Kingsway improperly cancelled the insurance, in which case it would have an obligation to pay benefits permanently. Alternatively, even if Kingsway was entitled to terminate the policy, the arbitrator was to decide what sanction should be imposed for Kingsway's breach of s. 2 of the Regulation. The court directed that, in doing so, the arbitrator was to consider "not only the effect of Kingsway's breach of section 2 of regulation 283, but as well the effect of Kingsway's failure to give timely notice of its intent to dispute its obligation to pay in accordance with section 3 of the regulation."

[63] In *Wawanesa Mutual Insurance Company v. Lombard Canada*, 2010 ONCA 383, 267 O.A.C. 32, the court dealt with circumstances similar to those in *Kingsway #2*. In that case, the passenger in a van was injured in an accident involving a taxi. The passenger made a claim for benefits to Wawanesa Mutual Insurance Company ("Wawanesa"), on the understanding that Wawanesa insured the van. Wawanesa refused to pay, taking the position that the insurance coverage had lapsed. The passenger then made a claim to Lombard Canada, which insured the taxi. Lombard began paying benefits. Four years later, Lombard notified Wawanesa that it should be responsible for paying the claim and initiated arbitration. The arbitrator found, in two preliminary decisions, that Wawanesa was not precluded from disputing who the priority insurer was, despite having breached

ss. 2 and 3(1) of the Regulation. The parties brought applications to set aside both preliminary decisions, which were dismissed. The arbitrator and application judge found they were bound by *Kingsway #2* to first determine whether Wawanesa was an insurer at the time of the accident. On appeal, Lombard took the position that Wawanesa could not contest its obligation to pay because it was the first insurer to receive a claim for benefits, and because it had failed to pay and give notice as required by ss. 2 and 3 of the Regulation. This court upheld the arbitrator's ruling. Again, this decision stands for the proposition that when the first insurer who receives a claim breaches ss. 2 and 3 of the Regulation, it is not automatically required to pay benefits to the injured person on a permanent basis.

[64] In *Lombard Canada Ltd. v. Royal & SunAlliance Insurance Co.* (2008), 94 O.R. (3d) 62 (S.C.), Strathy J., as he then was, dealt with a situation that is closest to the circumstances of this case. In *Lombard*, the claimant was catastrophically injured in a car accident in October 2002. Lombard Canada Limited ("Lombard") had insured the vehicle, but cancelled the policy two months before the accident. The claimant submitted a claim for benefits to Lombard, but it denied the claim on the basis that it had cancelled the policy. The Fund then denied the claim for benefits on the basis that Lombard should have paid pursuant to s. 2 of the Regulation. In October 2003, Lombard discovered that the claimant was listed as a driver under a policy issued to his employer by Royal and SunAlliance Insurance

Co. (“RSA”). Lombard gave notice to RSA, which refused to pay because Lombard failed to give notice to RSA within 90 days of receiving the claim contrary to s. 3 of the Regulation.

[65] The matter went to arbitration. The arbitrator found that there was a sufficient nexus between Lombard and the claimant such that Lombard was required to pay benefits in accordance with s. 2 of the Regulation as the first insurer that received a claim. The arbitrator refused to extend the 90-day period under s. 3(2)(b) of the Regulation because Lombard did little, if anything, during the first 90 days to determine if there was another insurer responsible for payment. The arbitrator thereby held Lombard responsible for paying benefits to the claimant on a permanent basis.

[66] Lombard appealed to the Superior Court. Strathy J. upheld the arbitration award and dismissed the appeal. In reaching his conclusion, Strathy J. reviewed this court’s decisions dealing with the interpretation of ss. 2 and 3 of the Regulation.[6] He noted this court’s direction in *Kingsway #2* that, when deciding on the appropriate remedy for a breach of s. 2 of the Regulation, the arbitrator should consider the effect of Kingsway’s breaches of ss. 2 and 3 of the Regulation.

[6] He did not deal with *Wawanesa* because it postdates *Lombard*.

Strathy J. then held, at para. 61, that the effect of the breaches in the circumstances of the case before him justified requiring Lombard to pay:

> In this case, the obvious consequence of Lombard's breach of s. 2 was to leave the Claimant without benefits, at a time when those benefits were most needed, for a substantial time, a result that offends the very purpose of the legislation. The obvious effect of the failure to give prompt notice to RSA was to deprive that insurer of any opportunity to make timely investigation of the claim and to take appropriate and early claim management measures. While we have no specific evidence of the direct results of these breaches, it is a reasonable inference that it was highly prejudicial to the Claimant and caused at least some prejudice to RSA. Indeed, as Lombard did not take ownership of the claim, no insurer was taking steps, in the crucial early stages, to come to grips with, investigate and manage the claim.

[67] Strathy J. further commented, at para. 62, that there would be a benefit to imposing an inflexible rule that insurers who fail to meet their obligations under ss. 2 and 3 of the Regulation should be required to pay benefits permanently but that he was not required to make that determination in the case before him:

> In my view, there is much to be said for an inflexible rule that an insurer who fails to pay benefits and fails to put other insurers on notice on receipt of an application, with which there is some nexus, should be found permanently responsible for the claimant's benefits. This promotes compliance with the statutory scheme. It is no more inequitable than fixing permanent responsibility on the first insurer, who initially pays the claim but fails to give timely notice to the other insurer under s. 3(2). It is not necessary, in this case, to decide whether the rule should

> be inflexible. It is sufficient to say that I agree with the Arbitrator's decision on the facts of this particular case.

[68] I too agree that there would be a benefit to having an inflexible rule. As Sharpe J.A. stated in *Kingsway #1*, at para. 10, when addressing notice provisions in s. 3 of the Regulation and the circumstances where the 90-day deadline can be extended, "[i]nsurers are entitled to assume and rely upon the requirement for compliance with those provisions." In addition, the wording of s. 3 of the Regulation would support such a rule.

[69] However, in the absence of a five-judge panel, this court, courts below and arbitrators are bound by the approach set out in *Kingsway #2*, which I would describe as the following three-part inquiry:

(a) If there is a live issue regarding whether the insurer who received the claim first is the priority insurer, this should first be determined because it puts an end to the dispute.

(b) If the first insurer who received a claim is not the priority insurer, the next step is to determine whether the first insurer who received a claim breached ss. 2 and/or 3 of the Regulation. This includes determining whether there is a sufficient nexus between the insurer and the claimant to trigger the insurer's obligation to pay under s. 2, and, if the insurer did not provide the 90-day notice to other insurers it claims

should pay, whether the notice period should be extended pursuant to s. 3(2) of the Regulation.

(c) If it is determined that the first insurer who received a claim breached ss. 2 and 3 of the Regulation, the arbitrator has the discretion to determine whether the insurer should be required to pay benefits permanently, having regard to factors such as the effects of the ss. 2 and/or 3 breaches.

[70] I now turn to the application of this framework to this case. First, I address the appeal judge's errors in reviewing the arbitrator's decision and, second, I show that, based on the framework above, the arbitrator committed no errors.

d. The appeal judge erred in finding that Zurich and Chubb should be treated as having equal priority under s. 268 of the *Insurance Act*

[71] As reviewed above, the appeal judge found that the second arbitrator erred by failing to treat Zurich and Chubb as having equal priority under s. 268 of the *Insurance Act* for the purpose of determining the appropriate remedy for Chubb's breaches of ss. 2 and 3 of the Regulation. He further held that Zurich and Chubb should be treated as having equal priority and should pay equal amounts for Ms. Singh's benefits, subject to treating their responsibility for the 2% compound interest differently based on the length of delay for which they were each

responsible. There was no legal basis for this approach. It is inconsistent with the framework established by this court as reviewed above.

[72] The appeal judge first stated that a breach of s. 3 of the Regulation automatically required Chubb to pay benefits permanently. This is inconsistent with this court's case law. As reviewed above, while there may be good reason to impose an inflexible rule, at this point, even where an insurer has breached s. 3 of the Regulation, the arbitrator retains discretion to decide whether the appropriate remedy is to require the first insurer who receives a claim to pay benefits permanently, even if it is not the priority insurer or an insurer at all under s. 268 of the *Insurance Act*.

[73] Then, somewhat inconsistently with the holding referred to above, the appeal judge proceeded to treat Chubb and Zurich as having equal priority under s. 268 of the *Insurance Act*. In effect, he approached the matter on the basis that the consequences for a breach of ss. 2 and 3 of the Regulation are limited by a further consideration—the insurer who would have been liable if ss. 2 and 3 were not breached must maintain some of its liability. There was no basis for this approach in the case law, nor is it provided for in the *Insurance Act* or the Regulation. Notably, the list of insurers in s. 268 does not include insurers found to have breached ss. 2 and/or 3 of the Regulation. Rather, the Regulation and the

common law govern the consequences of an insurer within the meaning of s. 2 of the Regulation breaching ss. 2 and 3.

[74] The Supreme Court found that Chubb was an insurer for the purpose of s. 2 of the Regulation. Contrary to the appeal judge's approach, this finding did not convert Chubb into an insurer of equal priority with Zurich under s. 268(2) of the *Insurance Act*. Nor did Zurich's status as the entity that would have been the priority insurer had Chubb not breached ss. 2 and 3 of the Regulation limit the consequences that should be imposed on Chubb for its breach. Rather, as held in *Kingsway #2*, *Wawanesa* and *Lombard*, once there was a determination that Chubb breached its obligations under ss. 2 and 3 of the Regulation, the next step was to determine the appropriate remedy having regard to the effects of the breach in accordance with this court's jurisprudence.

[75] As reviewed below, this was the approach taken by the second arbitrator. The appeal judge's approach was legally flawed. That flawed approach directly led to his finding that the second arbitrator's award was legally incorrect and unreasonable.

e. The second arbitrator's award should be restored

[76] I see no error in the second arbitrator's conclusion that Chubb should be required to permanently pay Ms. Singh's benefits. He made no error of law in

identifying the legal principles he was required to apply or any palpable and overriding error of fact or mixed fact and law, and he exercised his discretion reasonably.

[77] The second arbitrator reviewed the relevant authorities from this court and the Superior Court. He explicitly recognized that the courts have held that the failure to provide notice under s. 3 of the Regulation does not automatically determine that the breaching insurer should be required to pay benefits permanently. He then turned to the question of what the consequence of the breach should be given the facts in this case. He stated that "there must be a reasonable investigation to determine whether another insurer should be liable, and here there wasn't." The second arbitrator relied heavily on *Lombard* and concluded that Chubb should be required to pay Ms. Singh's benefits permanently due to its breaches of ss. 2 and 3.

[78] While the second arbitrator did not set out in detail why the effects of Chubb's breach justify the remedy he imposed, it is evident from the factual background and his reliance on *Lombard* that his conclusion was reasonable in the circumstances of this case.

[79] Indeed, when Chubb received the claim, it simply refused to pay; it made no efforts to identify Zurich as an insurer. Given that Chubb had a relationship with

Wheels 4 Rent, it would have been easy for Chubb to identify and notify Zurich as the correct insurer. Instead, Chubb waited a year and a half to provide this information to Ms. Singh. By this point, Ms. Singh was left without benefits and her condition had seriously worsened. In addition, given the delay, Zurich was not able to investigate and adjust the claim in a timely way.

[80] Section 2 of the Regulation is designed to guard against the type of harm Ms. Singh experienced; the provision is meant to ensure that disputes between insurers do not interfere with the prompt payment of claims to people who were injured in motor vehicle accidents. Section 3 is designed to guard against the prejudice Chubb's delay in notifying Zurich caused; the insurer who is ultimately responsible for paying a claim should have a chance to investigate as soon as possible after the accident to adjust the claim and assess its risk.

[81] Given the circumstances of this case, the second arbitrator made no errors in exercising his discretion to require Chubb to pay the full amount of benefits owed to Ms. Singh permanently. As indicated above, there is no inflexible rule requiring Chubb to pay all amounts owed to Ms. Singh permanently but his decision was factually grounded, reasonable and consistent with the law.

f. Additional issue raised by Chubb

[82] Before concluding, I take the opportunity to address one issue raised by Chubb in response to the appeal. As noted above, Chubb does not appeal the appeal judge's decision. It was therefore prepared to accept shared responsibility for the amounts paid to Ms. Singh. In response to the appeal, Chubb nevertheless argues that, because the parties entered into a written arbitration agreement to dispute priority despite the lack of notice under s. 3, the arbitrator was precluded from finding a breach or ordering a sanction under s. 3.

[83] I see no basis for this position.

[84] The Supreme Court determined the first issue between the parties, namely that Chubb was an insurer for the purpose of the Regulation and the legislation. The arbitration agreement provided that the second and third issues to be determined were, if Chubb was an insurer, whether it breached its obligations under the Regulation, and, if so, how much it should pay. There is no basis for finding that this broadly worded agreement precludes Zurich from seeking a remedy for a breach of s. 3.

D. DISPOSITION

[85] I would allow the appeal and reinstate the second arbitrator's award.

[86] As agreed between the parties, I would order costs to Zurich as the successful party in the amount of $25,000 all inclusive.

Released: April 30, 2026 “D.M.P.”

“L. Favreau J.A.”
“I agree. David M. Paciocco J.A.”
“I agree. B. Zarnett J.A.”