IN THE SUPREME COURT OF BRITISH COLUMBIA

2023 BCSC 1913 (CanLII)

Citation: *Akhavan v. The Manufacturers Life Insurance Company/La Compagnie d'Assurance-Vie Manufacturers (Manulife Financial),* 2023 BCSC 1913

Date: 20231031
Docket: S242628
Registry: New Westminster

Between:

Fariman Akhavan also known as Tony Akhavan

Plaintiff

And

The Manufacturers Life Insurance Company/La Compagnie d'Assurance-Vie Manufacturers carrying on business as Manulife Financial

Defendant

Before: The Honourable Madam Justice Morellato

Reasons for Judgment

Counsel for the Plaintiff:	K.H. Wirsig S. Alimirzaee
Counsel for the Defendant:	M.V. Dron
Place and Dates of Hearing:	New Westminster, B.C. April 14, 2022 and February 17, 2023
Date of Written Submissions Received:	October 11, 2023
Place and Date of Judgment:	New Westminster, B.C. October 31, 2023

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I. INTRODUCTION

[1] The defendant, Manufacturers Life Insurance Company ("Manulife"), applies for summary judgment under Rule 9-6(5)(a) of the *Supreme Court Civil Rules* [*Rules*] for an order that the action against the plaintiff, Mr. Fariman Akhavan, be dismissed with costs.

[2] Manulife asserts that Mr. Akhavan's claim for long-term disability has no merit because he "failed to commence his action within the two-year limitation period outlined by [the] relevant statute…". Manulife argues that "the most generous limitation period available" to Mr. Akhavan is two years from December 31, 2015.

[3] Mr. Akhavan submits that the limitation period was not triggered until Manulife advised him on January 4, 2017, of its "final" decision to deny his disability claim. Mr. Akhavan filed his Notice of Civil Claim on May 1, 2018. Accordingly, he argues that his claim was filed well within the applicable statutory limitation period.

[4] The issues before me are: 1) whether this matter is suitable for summary disposition; and 2) whether Mr. Akhavan's claim is statute-barred as having been commenced after the expiry of the applicable limitation period.

II. BACKGROUND FACTS

A. Supporting Affidavit Material

[5] Three affidavits were sworn in support of the parties' respective submissions: (1) Mr. Guy Lizé, a representative of Manulife, (2) Mr. Akhavan, the plaintiff, and (3) Ms. Nancy Boyles, a paralegal for McQuarrie Hunter LLP, counsel for Mr. Akhavan.

[6] Mr. Lizé appended correspondence and other documentation to his affidavit relating to Mr. Akhavan's disability claim. However, the material before me indicates that Mr. Lizé did not have direct contact with Mr. Akhavan and did not assess Mr. Akhavan's claim, although this is not entirely clear.

[7] Mr. Akhavan deposed to his interactions with representatives of Manulife as well as his understanding of the circumstances and decisions related to his disability claim. He also appended relevant documentation to his affidavit, including what he referred to as his “proof of claim” regarding his continuing disability.

[8] Ms. Boyles appended portions of a transcript of the examination for discovery of Ms. Sonthisa Mathouchanh, an appeals specialist with Manulife, who corresponded with Mr. Akhavan.

B. History of Disability Claim

[9] Mr. Akhavan was employed by the Royal Bank of Canada/RBC Life Insurance Company as a Sales Director. As part of his employment benefits, he had disability insurance coverage, under Manulife’s Group Policy No. 0039150 (“Policy”). The Policy holder is the Royal Bank of Canada and it provides benefits to its affiliates.

[10] In or about 2013, Mr. Akhavan experienced symptoms of depression, lack of focus, anxiety and other health issues. He was ultimately diagnosed with major depression.

[11] On September 8, 2013, Mr. Akhavan applied for short-term disability (“STD”) benefits. Manulife was the administrator for the STD benefits which were funded by the employer. Manulife initially denied the STD benefits. On June 2, 2014, after three appeals and further doctor’s information regarding Mr. Akhavan’s mental health, Manulife reversed course and accepted Mr. Akhavan’s STD claim. He was paid STD benefits for the maximum period from September 17, 2013 to January 13, 2014.

[12] In its June 2, 2014 letter regarding Mr. Akhavan’s STD claim, Manulife states:

> Based on a review of the information provided in this case, we have determined that our original non-support decision for this case has been overturned.

[13] On June 12, 2014, Mr. Akhavan applied to Manulife for long-term disability (“LTD”) benefits. Approximately nine months later, on March 25, 2015, Manulife

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accepted his LTD claim. Mr. Akhavan received LTD benefits from Manulife in the amount of $2,333.00 per month from January 14, 2014 until November 30, 2015.

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[14] Manulife deposes through Mr. Lizé, as follows:

> 4. Manulife defends the action because the Plaintiff failed to commence the action within the two-year limitation period outlined by [the] relevant statute and as such there is no merit to his claim.
>
> 5. With respect to [the] legal action the Policy provides as follows:
>
> > "No legal action against Manulife Financial may be commenced less than 60 days after proof has been filed in accordance with the above requirements. **Every action or proceeding against Manulife Financial for the recovery of benefits payable under this Policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation**."
>
> [Emphasis in original.]

[15] Mr. Lizé states further that Mr. Akhavan was paid an additional 10 weeks of LTD benefits for the period between September 17, 2015 to November 30, 2015, on what he describes as "an extra-contractual basis". He explains that Manulife did not consider Mr. Akhavan to be totally disabled for the period between September 17, 2015 to November 30, 2015, but provided disability payments "to assist the Plaintiff's transition back to work".

[16] Mr. Lizé deposes it is his "belief" that the limitation period expired on November 30, 2017, or alternatively, on December 30, 2017.

[17] Mr. Akhavan deposes that he was not advised that Manulife's decision to deny his disability payments was "final" until after he completed three levels of Manulife's appeal process. He refers to a letter dated January 4, 2017, wherein Manulife expressly states its "final position" (reproduced later in these Reasons).

C. Correspondence between Manulife and Mr. Akhavan

[18] In an "Activity Note" emailed to Mr. Akhavan on March 25, 2015, Ms. Wilkins, a disability specialist at Manulife, writes:

> Thank you very much for your prompt response to my email, and for providing the additional information from RBCFI.

> We have now finalized our review of your LTD claim, and will be recommending approval of LTD benefits retroactive to March 16, 2014.

[19] On September 2, 2015, a few months after Mr. Akhavan's LTD claim was accepted, Mr. Akhavan received a letter from Ms. Mladek, described as an LTD case manager at Manulife. In this letter, Ms. Mladek states that she has "completed a review of your claim" and advised Mr. Akhavan that he is no longer eligible for LTD benefits ("September 2015 Letter").

[20] The September 2015 Letter provides in part:

> In order to be eligible for Long Term Disability benefits, you need to meet the definition of total disability outlined in your group contract.
>
> Restriction or lack of ability due to an illness or injury which prevents an Employee from performing the essential duties of:
>
> > (a) his own occupation, during his first 2 years of disability; and
> >
> > (b) any occupation for which the Employee is qualified, by training, education or experience, after the 2 years specified in part a) of this provision and for which the current monthly earnings are 75% or more of the pre-disability Earnings for the Employee's own occupation.
>
> …
>
> During a recent conversation with you on 14th August 2015, we discussed your LTD claim including the upcoming Change of Definition (COD) effective 16th September 2015, and the importance of clinical evidence to support you being totally disabled from your own and alternate gainful employment reflective of your education, training and experience. It was clearly explained to you that your current medical information provided to date, does not preclude you from own and any occupation reflective of your education, training and experience (ET&E) …

[21] In this letter, Ms. Mladek reviews recent conversations with Mr. Akhavan and summarizes her view of a report from his psychiatrist, Dr. Burrell, dated May 2015, and writes:

> **Summary Overview**
>
> Mr. Akhavan, even though we acknowledge and understand the rationale contributing to our initial reported symptoms resulting in you being supported [by] benefits under the LTD plan, to date, we have not been presented with current clinical evidence in support of both physical and cognitive impairment that would continue to preclude you from performing the essential duties of your eliminated pre-disability job and/or alternate jobs reflective of your

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> education, training and experience. As such, given that the medical evidence on file does not support you being totally disabled from working in own and any occupation as per the policy wording, benefits beyond COD effective 16th September 2015 LTD will no longer be supported. Accordingly, your file will close with no liability to Manulife Financial.

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[22] Ms. Mladek continues her letter by setting out Mr. Akhavan's "Appeal Rights". Included within that section of her September 14, 2015 Letter is a reference to the "time limit" for taking "legal action". It states as follows:

> **Appeal Rights**
>
> If you disagree with his decision, you may request a review of your claim. Your request along with additional information should be submitted within 60 days from the date of this letter and should include the reasons for disagreement, and any medical information not previously submitted that you would like to be considered.
>
> - Clinical Evidence plus…any assessment carried out from May 2015 to present dated in addition to copies of chart/record notes from your General Physician (GP)…medical evidence must clearly support your reported restrictions and limitations.
> - A detailed summary of current medically substantiated restrictions and limitations.
> - A comprehensive summary of your symptoms including the frequency, duration and severity of symptoms experienced to date.
> - All treatment details including medication listing (from January 2015 to present), dosage, therapy – type and with whom, as well as response to treatment and any pending treatment dates, consultations and/or investigations.
>
> Obtaining these reports and any accompanying charges are your responsibility.
>
> Provincial legislation in British Columbia requires us to inform you that the time limit for taking legal action is set out in the British Columbia Insurance Act or other legislation that applies to your claim. For the above claim, the time limit for taking legal action is 2 years from 30th November 2015 to 30th November 2017.

[23] Mr. Akhavan notes in his affidavit that Manulife's Policy states "no legal action against Manulife Financial may be commenced less than 60 days after proof has been filed." As well, he acknowledges the Policy also provides that "Every action or proceeding against Manulife Financial is absolutely barred unless commenced within

the time set out in the Insurance Act or other applicable legislation." However, Mr. Akhavan deposes that Manulife "did not explain the impact of these terms on the appeal process or on the time limit described in the [September 2015] letter".

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[24] Mr. Akhavan deposes that he understood, in light of his previous successful appeal relating to his STD benefits, that Manulife was affording him the opportunity to prove his continuing entitlement to LTD benefits if he provided further and more current medical information. He also deposes that based on the language of the Policy relating to the proof of claim, he did not understand that the applicable statutory limitation period was running during the period he was providing Manulife with proof of his continuing disability.

[25] Manulife acknowledges that on October 14, 2015, it received a letter from Mr. Akhavan in response to its September 2015 Letter, wherein he provided further information about his condition; this included the July 14, 2015 report from his psychiatrist, Dr. Burrell in support of his disability claim. Mr. Akhavan states in that October 14, 2015 letter:

> …
>
> I continue to suffer from serious limitations and even though I agree that currently I have regained some functionality, I remain very far away from performing the essential duties of my job.
>
> In my current situation, I can concentrate on a basic task for an hour or two with limited success. I often find myself having to withdraw from a task in order to recover and it may take hours or even days to recover … I frequently get over taken with depression and anxiety that becomes disruptive and difficult for me to maintain any level of reasonable functionality …

[26] On October 19, 2015, Manulife responds with a letter addressed from Mr. Ramsingh, described as an Appeals Specialist. This letter states:

> Your request for reconsideration of our decision to end you claim for LTD benefits was received on October 14, 2015.
>
> …We will provide you with a status update within the next 30 days.

[27] On November 5, 2015, Mr. Ramsingh writes Mr. Akhavan advising that "a full review" of Mr. Akhavan's claim had been completed based on the information

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available, including the additional information Mr. Akhavan had forwarded after the September 2015 Letter. Mr. Ramsingh advised Mr. Akhavan that:

> … In summary and as discussed, Mr. Akhavan, the information on file does not support that you have a psychiatric illness of such a severity [that] you are precluded from working. As such, we are unable to conclude that you are Totally Disabled and the decisions to terminate your claim is upheld.
>
> …
>
> Should you wish to again appeal our decision, your appeal should include but not be limited to:
>
> - Copies of chart notes, tests/investigations results, consultation and assessment reports not previously submitted by all treating physicians /care providers
> - A copy of your file from USTAT [Urgent Short Term Assessment and Treatment] from January 1, 2015 onward, which would also include the original discharge from Dr. Burrell
> - A complete copy of Dr. Murray's (treating GP) chart/records from January 1, 2015 onward including the result of all recent tests/investigations
> - A complete print out of your pharmacy records from January 1, 2015.
>
> Please note that obtaining these reports and any accompanying charges are your responsibility. The appeal should be submitted within 60 days. Also, please note that you may only appeal three times (this is your first appeal) and that all three appeals must be submitted in a timely manner.

[28] Mr. Akhavan notes that the only time limits this letter referenced was the 60-day appeal period, and the limit of three appeals.

[29] Mr. Akhavan deposes that on January 5, 2016, he lodged a complaint by email with Manulife regarding his dissatisfaction with the manner in which his claim was handled:

> … I do object to the manner that my disability file was closed off. The main reason has been repeatedly stated as that there is not enough information on my file to indicated the level and severity of my condition and the degree to which it limits my ability to perform my occupation.
>
> This is despite the fact that both my physician and specialist reports have indicated that I suffer continuing and major limitations to perform my job duties
>
> …

> My question is why didn't Manulife do the assessment they needed when I was on disability … and before closing my file?
>
> Isn't Manulife responsible t request and order any additional requirements in order to facilitate their decision during a claim? Why did Manulife rely on old and incomplete reports in order to assess and close my file.
>
> If additional information was required to assess my continued entitlement, why wasn't [that] initiated by Manulife before closing my claim and basing the decision o incomplete or not up to date reports?
>
> By closing my file, Manulife threw me back into the appeal process loop which is a very frustrating process as I have been through nearly 9 months of battling through this process at the start of my disability claim with burden and responsibility of proof on me, the disabled individual.

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[30] Mr. Akhavan deposes that on May 10, 2016, he received a letter from Manulife "wherein Manulife apologized for the customer service I received" and states that:

> It is important to note that you have not exhausted the appeal process available to you. You are able to appeal your claim 3 times. You have undergone the first level appeal and the second and third appeals may be submitted in writing and include any additional information not previously submitted. It is important to note that Manulife will not consider any further appeals submitted after September 16, 2016. If you wish to pursue the second level of appeal, please submit the following documentation:
>
> - Copies of chart notes, tests/investigations results, consultation and assessment reports not previously submitted by all treating physicians /care providers;
> - A copy of your file from USTAT from January 1, 2015 onward, which would also include the original discharge from Dr. Burrell
> - A complete copy of Dr. Murray's (treating GP) chart/records from January 1, 2015 onward including the result of all recent tests/investigations
> - A complete print out of your pharmacy records from January 1, 2015 onward …

[31] On September 12, 2016, Mr. Akhavan emailed Manulife to confirm he wished to pursue a second appeal. In this email, he enclosed:

> …as continuing proof of claim, a record of prescriptions, a discharge letter dated July 2, 2015 from Dr. Burell and a copy of a psychiatric assessment of Dr. Brian Murray dated March 31, 2016 direct to RBC.

[32] Mr. Akhavan reiterates in this email that his condition started to deteriorate in the fall of 2015, and that by early 2016, much of the ground that he gained during his previous treatment was lost. He adds that his family physician, Dr. Murray, submitted a referral for him and, after waiting months, he was once again accepted as an outpatient at USTAT for urgent short-term assessment and treatment.

[33] In his September 2016 letter, Mr. Akhavan points out that Manulife's assessment regarding his claim was not consistent with his initial USTAT assessment from Dr. Burell's in July 2015, which had been provided to Manulife. Dr. Burell's assessment includes the following passage:

> Mr. Akhavan previously worked as an insurance manager, meaning that he was central to the jobs of many employees and in a very high demand position. He had to handle multiple requests at once and there was quite a stress load to this position. I do not believe that he could work with this level of energy demand and stress again, without have a relapse of his illness.

[34] Mr. Akhavan's September 12, 2016 letter to Manulife was copied to his then legal counsel. The record is not clear as to when he first retained legal counsel.

[35] On October 7, 2015, Manulife advises Mr. Akhavan by email that it would be referring his claim to its in-house psychiatric consultant for review. Mr. Akhavan deposes that he understood the in-house psychiatrist would be assessing his claim and providing an opinion as to whether or not he met the definition of Total Disability under the Policy. Mr. Akhavan further deposes:

> I understood that the psychiatric assessment and report was continuing proof of claim under the Policy.

[36] On October 7, 2016, Mr. Akhavan sent Manulife an updated medical report, from Dr. Yaxley, a psychiatrist, dated September 22, 2016. Mr. Akhavan forward this updated report to Manulife the same day he received a copy from his physician, Dr. Murray.

[37] On October 14, 2016, Manulife's psychiatric consultant, Dr. Betsy Bishop, issued a report based on the documentation on file. She did not conduct an

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examination of Mr. Akhavan. She reported that “the diagnosis of major depressive disorder is well established”, and she also states in part:

> … It is difficult to determine categorically whether the psychiatric symptoms persisting from November 30, 2015 are of such severity that this individual could not have worked.
>
> …
>
> The dilemma is that we have very little medical evidence during that period of time to draw on to make this conclusion…
>
> … So again, although this individual continues to report significant residual symptoms of a partially remitted major depressive disorder it’s difficult to assess during this time period how severe and functionally limiting they were.

[38] On October 19, 2016, Ms. Sonthisa Mathouchanh writes to Mr. Akhavan and states in part:

> We have completed a review of the decision to end your LTD benefits under the terms and provisions of your group policy. As outlined in our decision letters of September 2, 2015 and November 5, 2015, LTD benefits ended as the medical information on file does not substantiate the presence of an ongoing psychiatric condition and/or symptoms of such a degree which preclude your from performing your own occupation.

[39] This October 19, 2016 letter refers to and addresses Mr. Akhavan’s previous correspondence, as well as the materials that he provided to Manulife after November 2015, such as: his pharmacy records (to May 12, 2016), Dr. Burell’s discharge report of July 2015; Dr. Murray’s complete psychiatric assessment questionnaire dated March 31, 2016; and Dr. Yaxley’s psychiatric assessment dated September 22, 2016. This letter also refers to Manulife’s in-house psychiatric assessment. Manulife then concludes:

> In summary, while we understand that you continue to experience residual psychological symptoms, we have not been presented with the medical evidence to support that these symptoms are of the severity which warrant ongoing Total Disability for the period beyond November 30, 2015. As such we regret to inform you that we are unable to change our prior decision to end benefits.
>
> …
>
> … Should you wish to again appeal our decision, your appeal should include, but not be limited to any additional medical document(s) not previously provided to Manulife Financial (as suggested in our decision letter dated November 15, 2015). Obtaining these reports and any accompanying

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> charges are your responsibility. The appeal should be submitted within 60 days. Please note that you may only appeal three times (this is your second appeal) and that all three appeal must be submitted in timeline (sic) matter.

[40] On December 2, 2016, Mr. Akhavan sent Manulife copies of Dr. Murray's clinical notes dating back to 2015, as well an updated psychiatric report from Dr. Yaxley, dated November 14, 2016.

[41] Mr. Akhavan deposes that this additional medical information was provided as his "continuing proof of claim". Notably, Mr. Lizé deposes that Manulife considered the new information to be a further appeal by Mr. Akhavan. As noted earlier in these Reasons, Ms. Mathouchanh, who was dealing directly with Mr. Akhavan, agreed under cross-examination at her discovery, that Mr. Akhavan was advised that he had the option to submit further proof of his disability claim after the September 2015 Letter.

[42] Mr. Akhavan asked his family physician, Dr. Murray, to disclose his clinical notes to Manulife, which was done. Dr. Murray's clinical notes in March 2016 confirm that Mr. Akhavan had once again been referred to a psychiatrist for ongoing treatment and indicated that Mr. Akhavan "may need to go back to USTAT", which he eventually did need to do.

[43] In Dr. Yaxley's updated psychiatric report, dated November 16, 2016, states in part:

> Fariman is not doing well …His level of depression is worse. He has been overwhelmed by the multiple problems that he is confronted by, and finds his mind going in circles, unable to concentrate or focus and sometimes feeling that he is losing his ability to get things done as a result. He is not able to sleep unless he receives Ativan in the evening. He has been using Ativan, both during the day and at night to help with sleep the last few weeks. His level of depression is worse.
>
> … It certainly seems from my involvement that he is significantly functionally impaired and not able to return to his former employment, and it would be very challenging to imagine him working in any capacity that might generate 75% of his previous income…
>
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> … I will attempt to see him at the next possible time. It is important for his insurance company to know that they have argued in the past apparently to him that the fact it took 11 months from the time of referral for him to be seen by a psychiatrist is not an indication that he was not particularly sick or functionally impaired. It is more a reflection that time delay illustrates the difficulties and lack resources in the mental health system within the province. It will be challenging to see him again within a short period of time, given the lack of resources that exists, but we will attempt to see him as soon as possible.

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[44] Notably, Dr. Yaxley was seeing Mr. Akhavan again as part of USTAT treatment and there was no discharge date noted.

[45] On December 6, 2016, Manulife wrote Mr. Akhavan and acknowledged receipt of the clinical notes and advised that this was his “final level of appeal”.

[46] On December 19, 2016, Ms. Mathouchanh emailed Mr. Akhavan and requested information regarding his income. She also advised that his file had been transferred to another in-house medical consultant for further assistance in evaluating his claim. Mr. Akhavan deposes that he understood that Manulife’s internal expert assessment process was an “ongoing proof of claim under the Policy” relating to his continuing disability claim.

[47] On December 19, 2016, Dr. Roberts at Manulife issued an internal report to Manulife. His report states in part:

> Medical evidence on file does not support psychiatric symptoms of the severity to substantially impact on EE’s ability to function consistently beyond November 30, 2015. I agree with Dr. Bishop’s findings in the previous PC review.

[48] Like Dr. Bishop, Dr. Roberts did not assess Mr. Akhavan in person. Notably, Dr. Roberts agreed with Dr. Bishop, but Dr. Bishop had reported on Mr. Akhavan’s file without the benefit of Dr. Yaxley’s updated examination and assessment of Mr. Akhavan in November 2016.

[49] On December 20, 2016, Mr. Akhavan provide Manulife with his income information as requested by Manulife in its December 19, 2016 email.

[50] On January 4, 2017, Mr. Akhavan received what he deposes he understood to be Manulife's final decision regarding his claim.

[51] In this January 4, 2017 letter, Manulife acknowledged the additional information that Mr. Akhavan provided in November and December 2016, including the clinical notes of Dr. Murray and Dr. Yaxley's assessment. The letter states: "detailed information with regards to persisting psychiatric symptoms was not provided".

[52] The January 4, 2017 letter also provides:

> In summary, Mr. Akhavan, while we understand that you continue to report some symptoms, you would not be limited and precluded from performing the duties of your own occupation. As Total Disability is not supported by the information on file, the Senior Appeal Committee is upholding the previous decision to terminate your claim effective September 17, 2015.
>
> I trust the information in this letter has addressed your concerns and has explained Manulife's Disability claims department's final position in this matter. Please note that no further appeals will be reviewed. We appreciate that this is not the outcome you were hoping for. Under our complaint resolution process, your next recourse is Manulife's Client Relations team. The role of client relations is to ensure that any complaints you may have receive a full and fair review in accordance with our complaint handling process and will provide you with a response in writing. However, the Client Relations office will not review an additional appeal or make claims decisions and as such, no additional information in support of your claim will be reviewed/considered …

[53] Mr. Akhavan deposes:

> It was not until Manulife's letter of January 4, 2017 that I understood Manulife's decision to deny my benefits was final and that Manulife would not consider and further proof of claim under the Policy.
>
> Throughout both the STD and LTD claim period, my experience with Manulife was that there would be long delays during the adjudication process and the provision of continuing proof of claim leading eventually to an acceptance of the claim.
>
> I have read the affidavit of Guy Lizé date March 1, 2022 and filed in this proceeding in support of Manulife's application herein. I understood that my Manulife file was "closed" in so far as receiving benefits was concerned but I also understood that during the appeal process Manulife was seeking, accepting and considering new proof of claim and that a final decision had not been made. I had not yet suffered an irrecoverable loss as Manulife was actively reconsidering it decision and I therefore had no reason to sue. I

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> believed Manulife might well changes its mind and reverse its denial as it had done previously.

[54] Mr. Akhavan deposes that Manulife did not advise him that the limitation period would be running during its appeal process. He also deposes that Manulife did not advise him of its view that the new medical information submitted was not a continuing proof of claim under the Policy. He adds that Manulife "never" advised him that the "Policy term prohibiting a law suit until a final proof of claim was filed was somehow inoperative."

[55] Mr. Akhavan states that he is not aware of any prejudice suffered by Manulife because he filed his lawsuit after he was told by Manulife that its position was final in the January 4, 2017 letter.

[56] Mr. Akhavan deposes:

> I did not seek to sue Manulife during the appeal process as I understood both from my previous experience and by Manulife's acceptance and assessment of my ongoing proof of claim that Manulife might reverse its decision and accept my claim. It was also my understanding the Policy prohibited a lawsuit until 60 days after proof of claim have been provided pursuant to the policy. This only occurred at the end of the third appeal when I realized that Manulife's decision was final. It was at that time that I sought legal counsel.

D. Notice of Civil Claim and Amended Notice of Civil Claim

[57] Based on the record before me, a considerable amount of confusion arises as to when Mr. Akhavan's Notice of Civil Claim was first drafted and signed by Mr. Akhavan's previous counsel. This lack of clarity appears, at least in part, to be a function of Mr. Akhavan changing his legal counsel after the Notice of Civil Claim was amended, as he was entitled to do.

[58] Mr. Lizé appends a copy of Mr. Akhavan's original Notice of Civil Claim to his affidavit. While this Notice of Claim was filed on May 1, 2018, Mr. Akhavan's previous counsel's signature appears beside the date of April 30, 2016. Manulife submits that "the fact that the Notice of Civil in this matter had a signature date of April 30, 2016 is revealing and fatal to the Plaintiff."

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[59] Counsel for Mr. Akhavan submits that the April 30, 2016 signature date is an inadvertent error on the part of Mr. Akhavan's previous counsel. He submits that the original Notice of Civil Claim must have been signed by counsel on April 30, 2018, rather than April 30, 2016. He makes two points in this regard. First, he notes that the original Notice of Civil Claim, with the erroneous signature date of April 30, 2016, contains a pleading, at paragraph 13, that refers to a material fact that occurred in 2017. Specifically, paragraph 13 of this original Notice of Civil Claim states:

> The Plaintiff has submitted appeals of the decision of the Defendant to refuse coverage to the Defendant on three occasions and the Defendant provided a final decision of denial or refusal to pay the applicable sums pursuant to the Policy to the Plaintiff by letter dated January 4, 2017.

[60] Counsel for Mr. Akhavans point out, therefore, that the date by the signature line of "April 30, 2016" was on the original Notice of Civil Claim that contained the above pleading; accordingly, the "2016" date must have been an error simply because the pleading refers to a key material event that occurred later on January 4, 2017, namely Manulife's letter of January 4, 2017.

[61] Second, counsel for Mr. Akhavan notes that the Amended Notice of Civil Claim, filed February 7, 2019 (also filed by Mr. Akhavan's former counsel), includes an amendment to strike out the year "2016" by counsel's signature line, to read 2018. Counsel submit that what actually happened is that Mr. Akhavan's previous legal counsel actually signed the original Notice of Civil Claim on April 30, 2018 (not April 30, 2016), mistakenly dated the pleading, and later corrected it. In light of the record before me, I find this to be the most likely scenario. It makes no sense that the original pleading would refer to the January 4, 2017 letter if the pleading was actually drafted and signed by counsel on April 30, 2016. This would be an absurd inference and conclusion. The only rational explanation is that put forward by Mr. Akhavan's current counsel. However, should counsel for Manulife wish to contest the facts surrounding this issue by proceeding to trial on this or a related question, they may do so.

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E. Examination for Discovery Evidence

[62] Counsel for Mr. Akhavan argues that the designated representative of Manulife, Ms. Sonthisa Mathouchanh, admitted during her examination for discovery that Manulife's initial September 2015 Letter does not comply with the requirement of s. 4 of *Insurance Regulation*, B.C. Reg. 403/2012 [*BC Insurance Reg. 403/2012*]. Such a failure to comply would constitute, at minimum, a genuine issue to be tried.

[63] For ease of reference, s. 4 of *BC Insurance Reg. 403/2012* provides:

> **Notification of limitation period**
>
> 4 (1) In this section:
>
> "applicable statutory limitation period" means the limitation period established for a contract by section 23, 76 or 104 of the Act that applies in respect of the contract;
>
> "business day" means a day other than Saturday or a holiday;
>
> "claimant" includes a judgment creditor referred to in section 25 [third person right of action against insurer] of the Act.
>
> (2) An insurer must give written notice to a claimant of the applicable statutory limitation period
>
> (a) at the time or within 5 business days after the insurer denies liability for all or part of the claim, and
>
> (b) at or within 10 business days after the first anniversary of the date the insurer receives notice of a claim or of an action under section 25 of the Act, unless the insurer has already
>
> (i) adjusted the loss acceptably to the claimant or settled the claim, or
>
> (ii) provided notice to that claimant under paragraph (a).
>
> (3) A notice under subsection (2) must contain a statement that the limitation period is set out in the Act.
>
> (4) An insurer is not required to give notices under subsection (2) to a claimant who is represented by legal counsel.
>
> (5) An insurer is not required to give notice under subsection (2) in respect of a claim for coverage described in paragraph (e) of the definition of "accident and sickness insurance" in section 1 (2) of this regulation.

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> (6) If an insurer fails to comply with subsection (2) in respect of a claim, the running of time with respect to the applicable statutory limitation period is suspended for the period starting on the date the notice was required to be given under that subsection and ending on the earlier of the following dates:
>
> (a) the date that notice is given;
>
> (b) the date that would cause the limitation period to exceed 6 years after the date the cause of action against the insurer arose.

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[64] In light of this provision, counsel for Mr. Akhavan relies on various statements and admissions of Manulife's representative, Ms. Mahouchanh, at her examination for discovery, to the effect that:

a) in the September 2015 Letter, Manulife does not refer to any sections of the *Insurance Act*;

b) there is nothing in the September 2015 Letter that advises Mr. Akhavan that by appealing there would be any effect on the limitation period;

c) the January 4, 2017 letter to Mr. Akhavan advises him that his next recourse is Manulife's client relations team;

d) the September 2015 Letter advises Mr. Akhavan that he had the option to submit a further of claim to be considered for benefits.

[65] More specifically, in regard to item d) above, Ms. Mathouchanh responds as follows to the question of whether Mr. Akhavan had the option to submit a further proof of claim:

> Q. Thank you. In fact, the [September 2015 Letter from Manulife] advises Mr. Akhavan that he can and has the option to submit further proof of claim to be considered for benefits?
>
> A. That's correct.

[66] Also, as regards the October 19, 2016 Manulife letter, Ms. Mathouchanh was asked, "would you agree with me that there's no mention of an applicable statutory

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limitation period," to which she replied, "Yes." I understood this answer to mean that no specific legislative provision was identified by Manulife in this letter.

[67] Ms. Mathouchanh also agrees during her examination for discovery that in the January 4, 2017 letter to Mr. Akhavan, she advises Mr. Akhavan that his next recourse is Manulife's client relations team.

III. POLICY

[68] The Policy that applies in this case contains the follow provisions:

> **Entitlement Criteria**
>
> Manulife Financial will apply the following criteria in determining an Employee's entitlement to Disability Benefits:
>
> …
>
> > (b) Manulife Financial receives medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of:
> >
> > > i) his own occupation, during the first 2 years of disability; and
> > >
> > > ii) any occupation for which the Employee is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part i) of this provision and for which the current monthly earnings are 75% or more of the pre-disability Earnings for the Employee's own occupation.
> >
> > c) the Employee is receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial.
>
> At any time, Manulife Financial may require the Employee to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or valuation by an examiner selected by Manulife Financial.
>
> ***Termination of Benefit Payments***
>
> Disability benefit payments will cease on the earliest of:
>
> > (a) the date the Employee ceases to meet this Benefit's definition of Totally Disabled.
> >
> > (b) the date the Employee does not supply Manulife Financial with appropriate medical evidence documenting how the Employee's illness or injury causes restrictions or lack of

ability, such that the Employee is prevented from performing the essential duties of:

(i) his own occupation, during the first 2 years of disability; and

(ii)any occupation for which the Employee is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part of this provision and for which the current monthly earnings are 75% or more of the pre-disability Earnings for the Employee's own occupation.

(c) the date the Employee does not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

…

Requirement of Proof

No claim for benefits will be paid until Manulife Financial receives satisfactory proof in writing that such benefits are payable under the terms of this Policy.

Manulife Financial reserves the right to request any additional information necessary, as determined by Manulife Financial, to validate the eligibility of a claim for benefits under this Policy. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

Proof that benefits are payable must be submitted by or on behalf of the Employee and received by Manulife Financial at its Head Office for Canadian Operations or one of its Group Claims Offices within:

(a) 90 days from the date of the loss, for claims for Accidental Death and Dismemberment benefits

(b) 180 days from the end of the Qualifying Period, for claims for disability benefits

Continuing Proof

If benefits are being paid or coverage continued on an insured person because of disability, Manulife Financial may require written proof that this person remains Disabled under the terms of this Policy. This proof will be required as often as may reasonably be necessary.

Time Limit on Legal Action

No legal action against Manulife Financial may be commenced less than 60 days after proof has been filed in accordance with the above requirements. Every action or proceeding against Manulife Financial for the recovery of benefits payable under this

Policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

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IV. SUBMISSIONS OF THE PARTIES

A. Submissions of Manulife

[69] Manulife submits that Mr. Akhavan filed his claim "outside the applicable limitation period." In its Response to the Amended Notice of Civil Claim, Manulife pleads:

> 7. Manulife submits that pursuant to section 76 of the *Insurance Act,* [RSBC 2012] c.1 the Plaintiff's limitation period expired on October 31, 2017 being 2 years after the date of the next payment had the insurer continued to make periodic payments.

[70] Section 76 of the *Insurance Act,* R.S.B.C. 2012, c.1 [*Act*], states:

> **Limitation of actions**
>
> 76 …
>
> (3) Subject to subsection (5), an action or proceeding against an insurer for the recovery of insurance money not referred to in subsection (1) must be commenced not later than 2 years after the date the claimant knew or ought to have known of the first instance of the loss or occurrence giving rise to the claim for insurance money.
>
> …
>
> (5) **An action or proceeding against an insurer for the recovery of insurance money payable on a periodic basis must be commenced not later than the later of**
>
> (a) the last day of the applicable period under subsection (1), (2), (3) or (4) for commencing an action or proceeding, and
>
> (b) **if insurance money was paid, 2 years after the date the next payment would have been payable had the insurer continued to make periodic payments.**
>
> [Emphasis added by Defendant Manulife.]

[71] Accordingly, Manulife relies in this application on s. 76(5) of the *Act.*

[72] Notably, Manulife also pleads, as follows, in its Response to the plaintiff's Amended Notice of Civil Claim:

> 8. In the alternative, Manulife submits that pursuant to section 23 of the *Insurance Act*, [RSBC 2012] c.1 the Plaintiff's limitation period expired on September 16, 2015 being 2 years from when the cause of action arose.
>
> 9. In the further alternative Manulife submits that the Plaintiff's limitation period expired on November 30, 2017.

[73] Manulife also pleads and submits that Mr. Akhavan’s LTD benefits terminated because he “has not and is not Totally Disabled as of September 17, 2015, or anytime thereafter, within the meaning of the Policy.”

[74] Counsel for Manulife underscores the following three rationales underlying limitation periods set out by La Forest J. in *M.(K.) v. M.(H.)*, [1992] 3 S.C.R. 6. The Court of Appeal in *Haldenby v. Dominion of Canada General Insurance Co.*, [2001] O.J. No. 3317 (C.A.) noted at para. 18 that the application Judge in that case had properly outlined the three rationales as follows:

> Certainty rationale: "a potential defendant should be secure in his reasonable expectation that he will not be held to account for ancient obligations."
>
> Evidentiary rationale: this "concerns the desire to foreclose claims based on stale evidence. Once the limitation period has lapsed, the potential defendant should no longer be concerned about the preservation of evidence relevant to the claim."
>
> Diligence rationale: "plaintiffs are expected to act diligently and not sleep on their rights; statutes of limitation are an incentive for plaintiffs to bring a suit in a timely fashion."

[75] Manulife also relies on the decisions in *Falk. v. The Manufacturers Life Insurance Company*, 2008 BCSC 173 [*Falk*], *Esau v. Co-operators Life Insurance Company*, 2006 BCCA 249 [*Esau*] and *Pekarek v. Manufacturers Life Insurance Company*, 2006 BCCA 250 [*Pekarek*]. It submits, on the strength of these authorities, that the legal test for determining when the limitation period is triggered is “the date of clear and unequivocal denial” of the claim by the insured.

[76] Counsel for Manulife underscores that *Falk* followed the decisions in *Esau* and *Pekarek,* noting that the insurer is under a duty to consider new information and, furthermore, that entertaining an appeal does not render a denial equivocal such that the limitation period continues to run.

[77] Counsel for Manulife also relies on the decision of this Court in *Mani v. Great-West Life Assurance Company*, 2016 BCSC 2243 [*Mani*]. That decision involved a Statement of Special Case under Rule 9(3) of the *Rules.* The question posed was whether the plaintiff’s claim against the defendant was barred by the terms of the

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insurance policy under which the claim was made, and/or the *Act* as it stood at the material time.

[78] The plaintiff in *Mani* alleged that Great-West Life had breached its contractual obligation as an insurance provider in failing to provide him with LTD benefits. Mr. Mani was initially approved for disability benefits on May 23, 2002 but he was a later told in a letter dated May 31, 2002, that he would no longer be eligible for benefits after May 31, 2002. In this May 31, 2002 letter, Great-West Life advised Mr. Mani that in the absence of further medical information, its “decision was final.” The letter also advised the plaintiff that, if there was additional medical information that he wished to supply to Great-West Life, the insurer would review its decision. The letter also advised Mr. Mani that if there was no new medical information and he wanted to appeal the denial of benefits, he could write to Great-West Life and request reconsideration. He was told that any such appeal must be made within two years following the denial of benefits, and the letter provided a specific end date for that purpose of May 23, 2005. For a second time, the letter reiterated that “in the absence of additional relevant information” the position of Great-West Life on the denial of benefits was “final.”

[79] I note that the facts in *Mani* are quite distinct from those before me and the application before the court in that case was made under a different Rule. Furthermore, the insurer offered to review its decision about Mr. Mani’s LTD benefits based on new information. In addition, Mr. Mani was told he could engage the appeal process “if there was no new medical information.”

[80] Justice DeWitt-Van Oosten, as she the was, relying on para. 20 of the Court of Appeal decision in *Pekarek*, notes that leave to appeal from that decision was denied, and reasons that “the limitation period will run from the date the insured receives “’clear and unequivocal notice’ that his or her benefits have been terminated” (at para. 6). Further, she adds at para. 7:

> [7] Moreover, once clear and unequivocal notice has been provided, the fact that the insurer is prepared to review its decision through an appeal

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process or otherwise does not change the start date of the limitation period. See *Essau* at para. 35.

[81] Justice DeWitt-Van Oosten notes that "the plaintiff was explicitly told the decision was "final" and that subsequent letters sent to Mr. Mani "individual and cumulatively, are to the same effect." She found that the limitation period started to run in May 2002 when Mr. Mani was told the decision to deny his benefits was "final" and concluded that his action was statute-barred.

[82] Manulife submits that the above authorities, particularly the reasoning in *Mani, Pekarek and Esau*, support its application that Mr. Akhavan's claim should also be dismissed as being both contractually and statutorily barred by the expiry of the applicable limitation period.

B. Submissions of Mr. Akhavan

[83] Mr. Akhavan submits that Manulife's application must fail on three grounds:

1. Failure to comply with *BC Insurance Reg. 403/2012*: He argues that if the Court finds non-compliance by Manulife of this regulation, then the applicable limitation period does not begin to run until that non-compliance is remedied in accordance with its language. Non-compliance suspends the running of time until the date proper notice is given, or until six years from the date the cause of action arose, whichever is earlier.

2. The terms of the Policy prohibit a lawsuit until 60 days after proof of claim has been filed. Manulife admitted at examination for discovery that it accepted and considered continuing proof of claim under the Policy until October 16, 2016.

3. Manulife did not advise Mr. Akhavan that its decision was final until January 4, 2017. The jurisprudence clearly requires communication by the insurer to the insured that its decision is final before the limitation period begins to run.

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[84] Mr. Akhavan also submits that because the Policy states "that every action against Manulife for the recovery of benefits payable under it is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation", it should therefore set out the provisions in the "*Insurance Act* and other applicable legislation" upon which it relies.

[85] Mr. Akhavan disagree with Manulife's submission that s. 76 of the *Act* applies in this case. He also takes issue with Manulife's alternative positions regarding other possible limitation periods. He submits that the following provisions of s. 104 of the *Act* apply in this case:

> 104 …
>
> (3) Subject to subsection (5), an action or proceeding against an insurer for the recovery of insurance money not referred to in subsection (1) must be commenced not later than 2 years after the date the claimant knew or ought to have known of the first instance of the loss or occurrence giving rise to the claim for insurance money.
>
> …
>
> (5) An Action or proceeding against an insurer for the recovery of insurance money payable on a periodic basis must be commenced not later than the later of
>
> > (a) the last day of the applicable period under subsection (1), (2), (3) or (4) for commencing an action or proceeding, and
> >
> > (b) if insurance money was paid, 2 years after the date the next payment would have been payable had the insurer continued to make periodic payments.

[86] As regards *BC Insurance Reg. 403/2012*, Mr. Akhavan argues that Manulife did not comply with this regulation because none of the communications between Manulife and himself actually referred to the actual "applicable statutory limitation period"; that is, Manulife never referenced or clarified the specific *Act*, applicable section, or legislative provision it relied upon in asserting the limitation period upon which it relied. As a result of Manulife's failure to comply with *BC Insurance Reg. 403/2012*, Mr. Akhavan asserts that the limitation period is postponed to six years after the date the cause of action arose, which would clearly result in his claim, filed on May 1, 2018, not being statute-barred.

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[87] As noted earlier in these Reasons, in regard to any limitation period in the Policy, Mr. Akhavan notes that the Policy prohibits any action until 60 days after filing of proof of claim. He submits that the proof of claim encompasses information that Manulife sought and considered in assessing his continued eligibility for disability benefits under the Policy. Mr. Akhavan emphasizes that Manulife sought additional information from Dr. Bishop and Dr. Roberts in late 2016, and that their opinions affected Manulife's decision to approve or deny his claim for benefits. He adds that Manulife also considered new medical assessments from Dr. Yaxley and Dr. Murray in late 2016. Accordingly, he submits his proof of claim continued well past the September 2015 Letter.

[88] In this light, counsel for Mr. Akhavan also underscore that similar contractual provisions were considered in *White v. The Manufacturers Life Insurance Company*, 2011 BCSC 1615 [*White*]. In that case, the Court held:

> [70] The Manulife policy proscribes actions being commenced less than 60 days after "proof" has been filed in accordance with the policy. The language changes in the second part of that paragraph to set the limitation to 2 years after the last day on which the proof of claim (as distinct from proof mentioned in the first part of this provision) would be accepted under the terms of the policy.
>
> [71] The combined effects of Sections 66 (the right to request additional information) and 66 (the obligation to use examination results to determine whether benefits are payable) of the policy give Manulife the right to extend the time for receiving written proof until it has received information necessary to validate the eligibility of a claim for benefits under the policy. This process extends to their right and obligation to accept and use information they have commissioned under Section 66.
>
> [72] In Ms. White's case, the policy required Manulife to use the results of their medical examination to assess whether benefits would be paid under the policy. They had a contractual obligation to use the results. The actions of Manulife indicate that the evidence provided by Dr. Coughlan would have been accepted as part of the proof of claim in determining the claimant's entitlement to benefits and not simply to address Ms. White's appeal. The fact that Manulife continued to use the words indicating the process was an appeal is contrary to Manulife's reliance on the provisions of the contract that required the claimant to undergo an independent medical examination, the results of which would be used to determine whether benefits were payable.

[89] In light of the Court's reasoning in *White*, counsel for Mr. Akhavan submit that his proof of claim continued well beyond September or November 2015 into

December 2016, when Manulife’s internal medical consultants considered and assessed the new evidence provided by Dr. Yaxley in November 2016. They also underscore the evidence of Ms. Mathouchanh, Manulife’s representative at examination for discovery, that Mr. Akhavan had the option of submitting further proof of claim after the September 2015 Letter. Accordingly, counsel for Mr. Akhavan submit that the limitation period in Mr. Akhavan’s case could not possibly have started running until he had submitted his further proof of claim and Manulife “clearly and unequivocally” advised him on January 4, 2017, that his claim was denied and that this was its “final position.”

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[90] Counsel for Mr. Akhavan also submit that the question of whether a limitation period has expired prior to the issuance of a statement of claim is a question of mixed fact and law: *Longo v. MacLaren Art Centre Inc.*, 2014 ONCA 526, [2014] O.J. No. 3242, at para. 38. They submit that the question of when Mr. Akhavan "discovered" his claim is essentially a question of fact. Counsel argue that there must be a determination as to whether Mr. Akhavan knew or ought to have known he had a claim and that it would be appropriate for him commence an action to seek a remedy: see *Gillham v. Lake of Bays (Township)*, 2018 ONCA 667, 294 A.C.W.S, (3d) 739, at para. 38; *Western Life Assurance Company of Canada v. Penttila*, 2019 ONSC 14 [*Penttila*].

[91] Counsel for Mr. Akhavan point out that in *Penttila*, at para 56, the right to appeal was not simply part of an insurer's general obligation to accept any material; the court held it was a specific and agreed right of appeal, a clear articulation of the process to be followed, and a specific decision in respect of the appeal.

[92] Accordingly, a reasonable person in Ms. Penttila's position would have pursued her right of appeal. Until that process ran its course, it would be premature to commence legal proceedings against the insurer (*Penttila*, at para 57). Further, counsel add that the court found that the plaintiff in *Penttila* made good faith efforts to avoid unnecessary litigation believing Western was considering her appeal. There was no suggestion that Ms. Penttila engaged in a tactical delay of the proceeding.

Lastly, the court found that the motion's judge decision was consistent with the policy objective of avoiding unnecessary litigation and discouraging parties from rushing to litigation, provided there is no tactical delay. Counsel submit that the same principles apply in the instant case to Mr. Akhavan to prevent the expiry of the limitation period. Further, Mr. Akhavan was prompt and responsive in providing his further proof of claim.

[93] Counsel for Mr. Akhavan argue that it is an error to equate knowledge that a loss was occasioned with a conclusion that a court proceeding would be an appropriate means to seek a remedy from the insurer for the loss. They rely on the decision of the Ontario Court of Appeal in *Presidential MSH Corp. V. Marr, Foster & Co. LLP*, 2017 ONCA 325, at para. 49.

[94] Next, counsel for Mr. Akhavan rely on the decision in *Kassburg v. Sun Life Assurance Co. of Canada*, 2014 ONCA 922. In that case, a police officer was denied LTD benefits but was offered the opportunity to appeal provided she deliver new material. She did so and, on being told that the material she provided was insufficient, provided further information. The final decision refusing the claim on appeal was delivered on February 24, 2011. The Court of Appeal determined that was the date on which the limitation period began to run. The Court reasoned:

> [42] … [I]t was appropriate for the motion judge to consider what was in fact communicated to the respondent at that time, and whether the claim had been clearly and unequivocally denied, as asserted by the appellant. His conclusion that the denial was not clear was open to him on the evidence, which included the contract wording and the communications between the parties.

[95] Counsel for Mr. Akhavan also point out that the approach in *Kassburg* was followed in *Clarke v. Sun Life Assurance Co. of Canada*, 2019 ONSC 2942 where, as in the instant case, the plaintiff pursued an insurer's internal appeal process before bringing an action in Court.

[96] I must observe that the limitation and insurance legislation in Ontario is quite different from that in British Columbia. This attenuates the applicability of the

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reasoning of the Ontario courts in these cases, although compelling, within British Columbia.

[97] Counsel for Mr. Akhavan acknowledge the decisions in *Pekarek*, *Esau* and *Falk*, but argue that these and other cases have found that the actual language insurers use in their denial letters will determine whether a clear and unequivocal notice was provided to the insured.

[98] Counsel for Mr. Akhavan also rely on the decision in *Balzer v. Sun Life Assurance co. of Canada*, 2003 BCCA 306 [*Balzer*], where our Court of Appeal reasoned as follows at para. 17:

> [17] …it is not clear to me how any insured under the Canada Safeway policy in receipt of benefits under "own occupation" coverage could determine "the date upon which the insurer receives a reasonable amount of information permitting it to carry out an assessment of liability in good faith," when an insurer asks for more detailed information as a condition of continued coverage, as Sun Life did in this case. This request is more comparable to a termination of benefits for want of proof of continuing eligibility than to the contractual requirement for a new proof of claim for benefits under "any occupation" coverage that was specified in the group policy under which Ms. Watterson was insured.

[99] The Court also reasons that "where disability is continuous, an insured would understand the contract as requiring her to provide information requested on a continuing basis about her illness and its effect on her ability to work" in order to establish that she was "totally disabled" during any given month and, therefore, entitled to the benefit for that month: *Balzer* at para 18.

[100] The Court further reasons in *Balzer* at para. 40:

> [40] It is at denial of coverage or termination of benefits that an insured would have reason to sue the insurer. That is when a limitation period should begin to run, not while benefits are being received, not on some later date when an insured decides to file a proof of loss or commence an action. This sensible result is at the root of the reasoning in the authorities cited to us.

[101] As regards the "clear and unequivocal" test, the Court went on to reason:

> [44] Here, there was no unequivocal denial, Ms. Balzer had been paid some benefits, and when payment stopped she was left with the impression

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> that her coverage could be reconsidered if additional medical information was supplied. Sun Life never effectively engaged s. 22(1), and as time never commenced to run under it no part of her claim is time-barred.
>
> [45] Any ambiguity in the communication of a refusal of benefits, as to whether it is a clear and unequivocal denial, should be resolved in favour of the insured. To avoid any doubt, the preferred course for an insurer intending to deny coverage should be to include an alert in the letter drawing the insured's attention to the one year limitation in s. 22(1) and informing the insured that the insurer will rely on the denial as starting the running of time. The communications of Sun Life in *Watterson* are not that explicit but they are sufficiently unambiguous in the circumstances of that case to support Pitfield J.'s conclusion, and that is the essential difference between the two cases.

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[102] In summary, counsel for Mr. Akhavan submit that he was not advised that Manulife's decision regarding his entitlement to LTD benefits was final until its letter of January 4, 2017. They argue that, during the appeal process, Manulife actively solicited "continuing proof of claim", received, accepted and analyzed continuing proof of claim and engaged the services of two different medical experts to provide opinions as to whether the claimant was totally disabled and benefits therefore payable. They underscore that Manulife's representative admitted at her examination for discovery that the new information it was considering during the appeal process, including the two psychiatric opinions, were used by her to determine whether or not benefits were payable. They submit that this new information was clearly a continuing proof of claim under the Policy, and that a final decision was only made in the aftermath of Manulife considering the final psychiatric opinion of Dr. Roberts.

C. Further Submissions of the Parties

[103] After reviewing and considering counsels' respective submissions, the authorities cited, and the record as a whole, I requested further written submissions regarding the question of the applicable limitation period in this case. By way of background in this regard, during the course of submissions, counsel referred to *BC Insurance Reg. 403/2012*. Counsel also referred to the decision of *Mattern Estate v. Manulife Financial*, 2014 BCCA 404 (*sub nom. Buhr v. Manulife Financial - Canadian Division*). At para. 30 of *Mattern Estate*, the Court reasons:

> [30] The *Insurance Regulation,* B.C. Reg. 403/2012, came into effect on December 19, 2012. Section 14(5)(a), the transitional provision in the regulation, provides that the limitation period under the new *Insurance Act* does not apply to insurance contracts in effect on or before the date the new *Insurance Act* came into force: July 1, 2012. The respondent says, and I agree, the relevant limitation provision is that established by s. 65 of the former *Insurance Act.*

[104] The Policy in the instant case appears to have been in effect since July 1, 2004. According to s.14(5)(b), a transitional provision in *BC Insurance Reg. 403/2012*, and pursuant to the Court's reasoning in *Mattern* at para. 30, it appeared that the limitation period found in s. 65 of the former *Insurance Act* might possibly apply.

[105] Section 65 of the former *Insurance Act* states:

> 65 (1) Subject to subsection (2), proceedings against an insurer for the recovery of insurance money must not be commenced more than one year after the furnishing of the evidence required by section 62 or more than 6 years after the happening of the event on which the insurance money becomes payable, whichever period first expires.

[106] In light of the Court's reasons in *Mattern* and the transitional provision in *BC Insurance Reg. 403/2012,* I requested counsel to provide further written submissions on the issue of whether s. 65 applies and, if so, how it ought to be applied on the facts before me. Counsel for both parties responded with a single joint submission as follows:

> In review of s.14(5)(b) of the Regulation it appears to apply only to subsections 1 – 4 of S.76 of *the Insurance Act* R.S.B.C. 2012 c.1 (the "New Act").
>
> We agree that s.14(5)(b) may apply to subsection 3 of S.76 of the New Act; however, the triggering event must have occurred prior to the New Act coming into force.
>
> S.14(6) of the Regulation applies to the case at bar as it deals with subsection 5 of S.76 of the New Act.
>
> S.14(5)(b) of the Regulation sets out that S.76 of the New Act does not apply if the loss giving rise to the claim had occurred prior to S.76 coming into force. S.14(6) sets out that S.76 of the New Act does not apply if the "continued periodic payment" was due before S.76 came into force.
>
> Subsections 3 and 5 of S.76 of the New Act came into force on March 31, 2014.

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> In this case the Plaintiff's benefits were terminated on September 16, 2015 with a payment made to November 30, 2015. Had payments continued, the next payment would have been due on December 31, 2015.
>
> Accordingly, the loss giving rise to the claim (the termination of benefits in 2015) occurred after S.76 of the New Act came into force. Furthermore, the "continued periodic payment" was not due before S. 76 of the New Act came into force.
>
> We therefore submit that S.76 and/or 104 of the New Act are the only provisions that may be applicable to the case.

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[107] I turn now to my discussion of the suitability of the issues before me for disposition by summary judgment.

V. DISCUSSION

A. Is this matter suitable for summary disposition?

[108] Manulife applies for summary judgment pursuant to Rule 9-6(5)(a) provides:

> (5) On hearing an application under subrule (2) or (4), the court,
>
> (a) if satisfied that there is no genuine issue for trial with respect to a claim or defence, must pronounce judgment or dismiss the claim accordingly,

[109] Manulife relies on the decision in *Leger v. Metro Vancouver YWCA*, 2013 BCSC 2021, at paras 16-17, and argues that it is plain and obvious or beyond doubt that Mr. Akhavan's action cannot succeed. That is, it submits there is no genuine issue for trial since his claim is barred contractually and by statute.

[110] In *Beach Estate v. Beach*, 2019 BCCA 277, the Court addresses the requirement in Rule 9-6 applications that it must be "beyond a reasonable doubt" that there is "no genuine issue for trial":

> [65] …"Beyond a reasonable doubt" is the high bar set by Justice Esson (then of the Supreme Court) in *Progressive Construction Ltd.,* quoted with approval by this Court in *Montroyal Estates Ltd. v. D.J.C.A. Investments Ltd.* (1984), 55 B.C.L.R. 137. There the court (per Lambert J.A.) adopted this summary of the law stated by Esson J. in Progressive Construction Ltd.:
>
>> The cases do not establish an invariable rule as to what steps must be taken to resist a R. 18 [now Rule 9-6] application for summary judgment. On all such applications the issue is whether on the relevant facts and applicable law, there is a bona fide triable issue.

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> The onus of establishing that there is not such an issue rests upon the applicant, and must be carried to the point of making it "manifestly clear", which I take to mean much the same as beyond a reasonable doubt. If the judge hearing the application is left in doubt as to whether there is a triable issue, the application should be dismissed.
>
> In essence, if the defendant is bound to lose, the application should be granted, but if he is not bound to lose, then the application should be dismissed.

[111] Accordingly, for a claim to be dismissed on a summary judgment application, it must be manifestly clear that there is no matter to be tried.

[112] In *Beach Estate*, the Court further reasons at para. 48 that a defendant "can succeed on a Rule 9-6 application by showing the case pleaded by the plaintiff is unsound or by adducing sworn evidence that gives a complete answer to the plaintiff's case". The Court added:

> [48] … Conversely, if the plaintiff submits evidence contradicting the defendant's evidence in some material respect or if the defendant's evidence in support of the Rule 9-6 application fails to meet all of the causes of action raised by the plaintiff's pleadings, the application must be dismissed: *B & L Holdings Inc.* at para. 46, quoting *Progressive Construction Ltd.* at 335.

[113] Further, although Rule 9-6 applications invoke the court's consideration of evidence, it is not a summary trial. The Court states in *Beach*:

> [49] Although an application under Rule 9-6 invokes the court's consideration of evidence, it is not a summary trial: *Century Services Inc. v. LeRoy*, 2015 BCCA 120 at para. 32. <u>The judge is not permitted to weigh evidence on a Rule 9-6 application beyond determining whether it is incontrovertible: any further weighing may only be done in a trial:</u> *Tran v. Le, 2017 BCCA 222; Skybridge Investments Ltd. v. Metro Motors Ltd.,* 2006 BCCA 500 at paras. 8-12.
>
> [50] The summary trial procedure is of course covered in Rule 9-7. It is just that – a trial in summary form based on affidavit evidence, answers to interrogatories, evidence taken at examinations for discovery, and admissions in addition to other forms of evidence (Rule 9-7(5)).
>
> [51] Because it is a trial, the chambers judge hearing a Rule 9-7 application must weigh the evidence, make findings of fact and apply the law thereto unless the conditions set out in Rule 9-7(15)(a)(i) or (ii) are found to exist. The burden of proof to apply is the traditional civil burden of proof on the balance of probabilities.
>
> [Emphasis added.]

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[114] Later in its judgment, the Court in *Beach Estates* cautions against conflating Rules 9-7 and 9-6 and reasons:

> [67] …On an application under Rule 9-6, if the evidence needs to be weighed and assessed, then the test of "plain and obvious" or "beyond a doubt" has not been satisfied and the application is to be dismissed: *Skybridge Investments Ltd. v. Metro Motors Ltd.* at paras. 8-12.

[115] More recently, and in a similar vein, in *Aubichon v. Grafton*, 2022 BCCA 77, the Court states:

> [18] In relation to the R. 9-6 application, the judge again correctly sets forth the proper legal framework for her analysis:
>
>> [21] On a Rule 9-6 application, the court must determine if there is a genuine issue for trial. The court must assume that uncontested material facts as pleaded by the plaintiff are true, matters of fact cannot be weighed, and inferences from the facts must be viewed in a light most favourable to the plaintiff: *Sandhu v. Sun Life Assurance Company of Canada,* 2016 BCSC 1077 at para. 12. If the court is satisfied that there is no genuine issue for trial, then it must dismiss the claim – Rule 9-6(5) is mandatory …

[116] In *McLean v. Law Society of British Columbia*, 2016 BCCA 368, the Court clarified that it is an error in principle to conclude that Rule 9-6 is not available when there are disputed facts in the pleadings and in declining to consider the evidence submitted on the application. The Court noted that in *Canada (Attorney General) v. Lameman*, 2008 SCC 14, the Supreme Court of Canada explained the importance of the summary judgment rule, noting it has advantages to the administration of justice that are distinct from those provided by a summary trial. The Court in *Lameman* reasons:

> [10] This appeal is from an application for summary judgment. The summary judgment rule serves an important purpose in the civil litigation system. It prevents claims or defences that have no chance of success from proceeding to trial. Trying unmeritorious claims imposes a heavy price in terms of time and cost on the parties to the litigation and on the justice system. **It is essential to the proper operation of the justice system and beneficial to the parties that claims that have no chance of success be weeded out at an early stage. Conversely, it is essential to justice that claims disclosing real issues that may be successful proceed to trial.**
>
> [11] **For this reason, the bar on a motion for summary judgment is high.** The defendant who seeks summary dismissal bears the evidentiary

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> burden of showing that there is “no genuine issue of material fact requiring trial”: [cite omitted]. The defendant must prove this; it cannot rely on mere allegations or the pleadings [cite omitted]. If the defendant does prove this, the plaintiff must either refute or counter the defendant’s evidence, or risk summary dismissal: [cite omitted]. Each side must “put its best foot forward” with respect to the existence or non-existence of material issues to be tried: [cite omitted]. **The chambers judge may make inferences of fact based on the undisputed facts before the court, as long as the inferences are strongly supported by the facts:** [citations omitted].
>
> [Emphasis added.]

[117] Having very carefully considered the application materials and the submissions of the parties, I am unable to conclude that it is “beyond a reasonable doubt” that there is “no issue for trial.” The question of when the limitation period is triggered in this case is a question of mixed fact and law, and the supporting facts and necessary inferences are highly contested: see *Hryniak v. Mauldin*, 2014 SCC 7 at paras. 81-85. When the limitation period began to run in this case is rooted in the contested facts relating to when Manulife made a “clear and unequivocal” decision that Mr. Akhavan was not entitled to disability benefits. The assessment of when that determination was made by Manulife is far from clear on the record before me. Therefore, this application cannot be fairly decided by way of summary judgment.

[118] The record raises material issues that are in dispute. Manulife deposes it made its “clear and unequivocal” decision to deny Mr. Akhavan’s LTD benefits in September 2015. Yet, Manulife’s representative at her examination for discovery agreed that, when Manulife wrote its September 2015 Letter to Mr. Akhavan, it advised him that he had the “option to submit further proof of claim to be considered for benefits”. That, of course, is precisely what Mr. Akhavan did and continued to do in the months that followed, with the assistance of his family doctor and psychiatrist. In December 2016, Manulife sought the opinion of its own medical consultants in light of Mr. Akhavan’s further additional evidence, which included an update from Dr. Yaxley in November 2016 that affirmed Mr. Akhavan’s fragile mental state and continuing depression. It was not until its January 4, 2017 Letter that Manulife expressly stated that its denial of Mr. Akhavan’s claim was its “final position.” This factual matrix raises, at least, a triable issue as to whether the limitation period

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began to run in September 2015 or on January 4, 2017. Yet, the authorities addressed earlier in these Reasons, such as *Beach Estate,* make it clear that I cannot weigh the conflicting evidence in this regard on this application.

[119] In summary, while I am very mindful of the decisions in *Pekarek, Esau, Falk and Mani*, each case must be determined on its particular facts. In this case, a number of facts create ambiguity as to when Manulife actually made a “clear and unequivocal decision” to deny Mr. Akhavan his LTD benefits: 1) Manulife’s admission at discovery that it was considering Mr. Akhavan’s “further proof of claim” after it sent its letters to Mr. Akhavan in September and November 2015; 2) Manulife’s reliance on its internal medical consultants in December 2016 to analyze the additional proof of claim provided by Dr. Yaxley in November 2016 (and earlier); 3) Manulife’s letter of January 4, 2017 stating what it characterized as its “final” position; and 4) the conflicting evidence of Mr. Akhavan and Mr. Lizé. Mr. Lizé deposed that Manulife made its final decision to deny disability benefits and relayed that decision to Mr. Akhavan in its September 2015 Letter. Mr. Akhavan deposed he was involved in a further proof of claim exercise where he was required to substantiate and did substantiate his ongoing disability benefits by provided further medical and other information as late as December 2016.

[120] Mr. Akhavan’s evidence cannot be summarily dismissed. It is at least plausible not only because of the admission at examination for discovery by Ms. Mathouchanh, but also in light of the language of the Policy itself, which I reproduce below for ease of reference:

> If benefits are being paid or coverage continued on an insured person because of disability, Manulife Financial **may require written proof that this person remains Disabled under the terms of this Policy. This proof will be required as often as may reasonably be necessary**.
>
> [Emphasis added.]

[121] In light of the jurisprudence that a judge is not permitted to weigh evidence on a Rule 9-6 application beyond determining whether it is incontrovertible and that any

further weighing may only be done at trial, I have no choice but to dismiss this application: see *Beach Estate* at para. 48.

[122] I am also of the view that Manulife's evidence at the examination for discovery, addressed earlier in these Reasons, raises a triable issue as to whether it complied with the notice requirement of s. 4 of *BC Insurance Reg. 403/2012.* This also constitutes a genuine issue to be tried. A failure to comply with this provision could very well extend the limitation period and undermine Manulife's limitation defence.

[123] I am satisfied that the question of whether Manulife complied with s. 4 of *BC Insurance Reg. 403/2012* is a question of mixed fact and law. The factual matrix and the proper interpretation of this regulation are contested, and this issue is also undeveloped on the record before me. The legislative context in this case is complex. Counsel's various and opposing submissions on what particular provisions of the Policy and the *Act* apply are indicative of that complexity. Considering the record before me, the proper determination of this issue can, in my view, only be addressed fairly at trial. Not only is there a genuine issue to be tried in regard to s. 4 of *BC Insurance Reg. 403/2012*, but the complexity of this particular legal issue and its associated facts are not suitable for summary judgment.

[124] In the final analysis, I am simply unable to conclude that there is no genuine issue for trial, particularly as to when the limitation period started running in this case. The facts in dispute are material and I cannot weigh them in this application. It is not manifestly clear or beyond a reasonable doubt that:1) the limitation period began running no later than December 30, 2015; or 2) the limitation period expired on December 30, 2017 (as Manulife asserts), before Mr. Akhavan filed his Notice of Civil Claim.

[125] A just determination of the questions before me cannot be made without a broader factual inquiry.

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[126] Manulife's application is dismissed. Mr. Akhavan is entitled to his costs at Scale B.

"Morellato J."

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