COURT OF APPEAL FOR ONTARIO

CITATION: Furtado v. Underwriters, 2024 ONCA 579
DATE: 20240722
DOCKET: COA-23-CV-1203

Lauwers, van Rensburg and Thorburn JJ.A.

BETWEEN

Oscar Furtado

Applicant (Appellant)

and

Lloyd’s Underwriters

Respondent (Respondent)

Gordon McGuire and Kathleen Glowach, for the appellant

Eric Dolden and Paul C. Dawson, for the respondent

Heard: January 29, 2024

On appeal from the judgment of Justice Jasmine T. Akbarali of the Superior Court of Justice, dated October 17, 2023, with reasons reported at 2023 ONSC 5803.

Thorburn J.A.:

A. OVERVIEW

[1] The appellant, Oscar Furtado (”Mr. Furtado”), is the directing mind of Go-To, a real estate development business. Mr. Furtado is the insured.

[2] Lloyd’s Underwriters is a syndicate of Lloyd’s insurance marketplace which carries on business as Neon Syndicate (“the Insurer”).

[3] Mr. Furtado appeals from a decision of the application judge, denying him coverage, or relief from forfeiture under his Directors and Officers insurance policy (the “Policy”). The policy period was from October 6, 2018, to October 25, 2019.

[4] In March 2019, during the term of the Policy, the Ontario Securities Commission (“OSC”) made an inquiry regarding certain of the business activities of Go-To Developments Holdings Inc. (“Go-To”) and sought production of information and documents.

[5] In May 2019, Mr. Furtado was summonsed to an examination at the OSC offices and told to produce documents pursuant to s. 11 of the *Securities Act*, R.S.O. 1990, c. S. 5 (the “Act”). In the May 2019 letter, he was told that s. 16(1) of the Act prohibited him from disclosing the nature or content of the order to anyone except his counsel.

[6] The Policy provided that Mr. Furtado was not required to notify the insurer of an investigation while he was legally prevented from doing so (the “Suspension

Clause"). As such, Mr. Furtado did not advise the Insurer of the OSC investigation at that time.

[7] The law changed in December 2019[1] to permit him to advise the Insurer of the investigation, but again, he did not advise of the investigation at that time.

[8] On December 6, 2021, the OSC commenced an application in Superior Court against Go-To, Mr. Furtado, and 22 affiliated Go-To entities alleging that Mr. Furtado and the Go-To entities had breached the Act and seeking the appointment of a receiver and manager over the assets of the Go-To entities. By March 2022, the OSC had commenced a receivership application and an enforcement proceeding against Mr. Furtado and Go-To entities (the "Claims"). He first reported the Claims in February and March of 2022.

[9] The Insurer denied coverage on September 22, 2022.

[10] Mr. Furtado claims the application judge erred in finding that he breached the notice provisions in the Policy. He claims his obligation to report the investigation was suspended pursuant to the Suspension Clause during the Policy period. Thereafter, in accordance with his contractual undertaking to seek consent to disclose a "Claim or notice of an alleged Wrongful act" should one arise from

[1] While the application judge and the parties say that s. 16(1.1) of the Act came into force on December 1, 2020, a review of the legislative history makes clear that s. 16(1.1) came into force on December 10, 2019. The Act was amended by *Plan to Build Ontario Together Act, 2019*, S.O. 2019, c. 15, Sched. 34, s. 1 (2), which added s. 16(1.1) to the Act to come into force the day the *Plan to Build Ontario Together Act, 2019* received Royal Assent, which was on December 10, 2019 (S.O. 2019, c. 15, Sched. 34, s. 5).

the investigation, he reported the Claims with reasonable promptness after receiving notification. In the alternative, he claims that even if he breached the terms of the Policy, the application judge erred in finding that relief from forfeiture was unavailable because the breach was not substantial and did not prejudice the Insurer.

[11] The Insurer submits that the application judge correctly held that the Suspension Clause only suspended the Policy's notice provisions "whilst" the insured, Mr. Furtado was not permitted by law to report. Mr. Furtado was specifically informed that he could notify his insurer of the investigation on February 16, 2021. Second, the Insurer claims this is a case of non-compliance with a condition precedent to coverage such that the Claims are not covered by the Policy and relief from forfeiture was not available.

[12] For the reasons that follow, I find that Mr. Furtado breached a condition precedent to coverage under the Policy when he did not advise of the investigation that led to the Claims within the Policy period, as extended by the Suspension Clause. He is therefore not entitled to relief from forfeiture. I would therefore dismiss the appeal.

B. THE ISSUE

[13] The central issue in this case is whether Mr. Furtado forfeited coverage under the Directors and Officers insurance policy because he failed to provide timely notice of the claim to the Insurer.

C. BACKGROUND OF THE TERMS OF THE POLICY AND ACTIONS TAKEN BY MR. FURTADO

I. The Terms of the Policy

[14] I begin with a review of the relevant Policy provisions, the changes in the law allowing for disclosure, and the actions taken by Mr. Furtado.

[15] The Insurer issued a series of Directors and Officers insurance policies in effect during consecutive periods from October 6, 2016, to November 10, 2021, that were effected through Miller Insurance Services LLP.

[16] The Policy is a claims-made and reported policy.[2] A claims-made and reported policy, as its name suggests, is a policy that provides coverage on the

[2] As the Supreme Court of Canada observed in *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 261, and *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, 2006 SCC 21, [2006] 1 S.C.R. 744, at para. 23, policies may be "occurrence", "claims-made" or hybrid with provisions that contain both claims-made and occurrence elements. In *Reid Crowther*, McLachlin J. (as she then was) urged, at p. 261, that "claims-made" and "occurrence" "are not legal labels which dictate a certain legal result once a policy is characterized as one or the other." She indicated that the issue is always what the particular policy dictates. The policy term at issue in this appeal relates to the essential requirement of a claims-made and reported policy to notify the insurer that: a claim was made during the policy period and the insurer was notified within the policy period that a claim was made (the "claims-made and reported coverage triggers"). Given the focus in this appeal only on the claims-made and reported triggers, it is unnecessary to conclude how the policy as a whole should be characterized.

condition that claims are both made against the insured and reported to the insurer during the policy period: *Stuart v. Hutchins*, 40 O.R. (3d) 321 (C.A.), at p. 323.

[17] The insuring agreement clauses are found in s. 1 of the Policy entitled "Insurance Cover." While different provisions apply to investment managers/advisers, Funds, and directors and officers, they all contain very similar wording to cover losses arising out of a "Wrongful act" which gives rise to a "Claim" first made during the Policy period which is reported in writing to the Insurer pursuant to the terms of the Policy.

[18] "Claim" is defined in s. 2.2 of the Policy as:

> i) any suit or proceeding, including any legal proceeding, third party proceeding, counter Claim or arbitration proceeding, brought by any person or entity against an Insured for monetary damages or other relief, including non-pecuniary relief;
>
> ii) any written demand from any person or entity that it is the intention of the person or entity to hold an Insured responsible for any alleged Wrongful act;
>
> iii) any official investigation, examination, inquiry or other similar proceeding at which an Individual insured's attendance is required, provided such official investigation, examination, inquiry or other similar proceeding is directly related to an alleged Wrongful act of such Individual insured in their capacity as such;
>
> iv) any regulatory or criminal proceedings brought against an Insured regarding any specified or alleged Wrongful act.

[19] The definition of “Wrongful act” in the Policy differs slightly depending on which insuring agreement clause is at issue, but the definition in s. 2.34 of the Policy which reads, in part, “any actual or alleged act, error or omission, misrepresentations or misleading statements committed by the Insured,” applies to all the “Wrongful act” definitions.

[20] Section 5.8 of the Policy, “How to Give Notice and Report a Claim, Loss or Circumstance,” provides that:

> The Insured shall, as a condition to liability of the Insurer, give written notice of any Claim to the Insurer as soon as practicable either:
>
> i) during the Policy period or within 30 days after the expiry of the Policy period; or
>
> ii) If applicable, during the Discovery period.
>
> If during the policy period, or if applicable, the Discovery period:
>
> 1. written notice of a Claim against an Insured or receipt of notice of a Wrongful act is given to the Insurer pursuant to the terms and conditions of this policy, then any subsequent Claim or Wrongful act based upon and/or related to and/or arising out of a common nucleus of facts or alleging the same Claim or Wrongful act previously notified to the Insurer shall be considered a Claim first made against the Insured or notice of a Wrongful act having been reported to the Insurer at the time the first notification was given.

> 2. the Insured becomes aware of any fact or circumstance which may reasonably be expected by the Insured to give rise to a Claim or an allegation of a Wrongful act and the Insured gives notice in writing to the Insurer of the fact or circumstance together with the reasons for anticipating a Claim or allegation of Wrongful act and with full particulars where reasonably possible as to the dates and persons involved, then any Claim or allegation of Wrongful act which is subsequently made against the Insured and reported in writing to the Insurer based upon and/or related to and/or arising out of a common nucleus of facts or circumstances contained in such fact or circumstance notification shall be considered a Claim first made against the Insured and/or notice of a Wrongful act having been first reported to the Insurer at the time the written notice of the fact or circumstance was first given to the Insurer.
>
> For the purposes of this policy, the Insured shall only be deemed to have knowledge of a Claim or allegation of a Wrongful act or any fact or circumstance as defined in 2 above when the relevant facts or documents are brought to the attention of any Responsible person. [Emphasis added.]

[21] Section 5.8 also contains the Suspension Clause which reads as follows:

> It is understood and agreed by the Insurer that should the Insured be involved in an investigation by a Regulator, the above requirement to notify Claim or notice of an alleged Wrongful act may be suspended whilst communication or notification is prohibited by confidentiality orders imposed by law enforcement agencies or such Regulator. The Insured undertakes to obtain consent for disclosure of the Claim or notice of an alleged Wrongful act to its professional advisers and Insurer and the Insured shall give written notice of any

> Claim or notice to the Insurer as soon as practicable thereafter, but no later than 14 calendar days after such consent for disclosure has been obtained.
>
> Any Claim or allegation of Wrongful act which is subsequently made shall be considered a Claim first made against the Insured and/or notice of a Wrongful act into the applicable Policy period when the investigation was first started. [Emphasis added.]

[22] The Suspension Clause recognizes that there are circumstances when an insured cannot give notice to the insurer in which case the obligation to provide notice of a claim is suspended. The application judge found that this also applied to notice of circumstances that may reasonably be expected by the insured to give rise to a claim. The insured must undertake to obtain consent to disclose the "Claim or notice of an alleged Wrongful act" and give notice of "any Claim or notice" to the insurer "as soon as practicable thereafter, but no later than 14 days after such consent for disclosure has been obtained." While this undertaking could arguably apply to require an insured to obtain consent to disclosure of circumstances giving rise to a Claim, based on the apparent agreement of the parties, the application judge concluded that it did not apply. No issue is taken with this conclusion in this appeal.

II. The OSC Investigation

[23] On March 29, 2019, Mr. Furtado received an inquiry from the OSC about certain of Go-To's business activities. In May 2019, he was summonsed to an examination at the OSC's offices and told to produce documents pursuant to s. 11

of the Act, as the OSC had opened an investigation. The parties agree that this was a circumstance that might reasonably be expected by Mr. Furtado to give rise to a claim.

[24] The May 2019 correspondence also brought to Mr. Furtado's counsel's attention s. 16(1) of the Act, which prohibited a person subject to an order under s.11 from disclosing the nature or content of the order to anyone except his or her counsel, except in accordance with s. 17, which is discussed below.

[25] On the advice of counsel not to disclose the summons to any third party, Mr. Furtado did not disclose the summons to the Insurer.

III. Changes to the Act to Enable Notification to the Insurer

[26] On December 10, 2019, s. 16(1.1) of the Act was enacted to permit disclosure to insurance companies and insurance brokers if advance notice of the intended disclosure was given to the OSC along with prescribed information regarding the insurer/broker and a written acknowledgment was obtained from the insurer/broker that it was bound by the Act's confidentiality requirements.

[27] The full text of ss. 16(1) and (1.1) reads as follows:

> **Non-disclosure**
>
> **16** (1) Except in accordance with subsection (1.1) or section 17, no person or company shall disclose at any time,

(a) the nature or content of an order under section 11 or 12; or

(b) the name of any person examined or sought to be examined under section 13, any testimony given under section 13, any information obtained under section 13, the nature or content of any questions asked under section 13, the nature or content of any demands for the production of any document or other thing under section 13, or the fact that any document or other thing was produced under section 13.

Exceptions

(1.1) A disclosure by a person or company is permitted if,

(a) the disclosure is to the person's or company's counsel; or

(b) the disclosure is to the person's or company's insurer or insurance broker, and the person or company, or his, her or its counsel,

(i) gives written notice of the intended disclosure to a person appointed by the order under section 11 at least 10 days before the date of the intended disclosure,

(ii) includes in that written notice the name and head office address of the insurer or insurance broker and the name of the individual acting on behalf of the insurer or insurance broker to whom the disclosure is intended to be made, as applicable, and

(iii) on making the disclosure, advises the insurer or insurance broker that the insurer or insurance broker is bound by the confidentiality requirements in subsection (2) and

> obtains a written acknowledgement from the insurer or insurance broker of this advice. [Emphasis added.]

[28] Section 17 of the Act, which was in force when the investigation started in 2019, provides a mechanism that allowed a person to seek an order from the Capital Markets Tribunal authorizing the disclosure to any person or company of, among other things, the nature or content of an order under ss. 11 or 12.

IV. Notice of the Change in Legislation Enabling Disclosure to the Insurer

[29] On December 16, 2020, a summons was delivered to Mr. Furtado, care of counsel, which cited s. 16(1.1) without explanation. Three more summonses were delivered on February 16, March 31, and June 7, 2021, all of which, as stated by the application judge, "on their face, drew [Mr. Furtado's] attention to the change in legislation" including his ability to disclose the investigation to the Insurer. These three summonses stated that: "We wish to bring to your attention subsections 16(1) and 16(1.1) of the Act." They further stated that "[t]he person or company identified in subsection 16(1) of the Act may disclose the information associated with this matter to the [person's] legal counsel, insurer or insurance broker, as applicable, and only in accordance with subsection 16(1.1) of the Act."

V. Proceedings Commenced Against Mr. Furtado

[30] On December 6, 2021, the OSC froze all funds in Mr. Furtado's primary investment account, and commenced a receivership application against Go-To,

Mr. Furtado, and other affiliated Go-To entities, claiming they had breached the Act (the “Receivership Proceeding”). The receivership application was granted.

[31] On March 30, 2022, the OSC commenced an enforcement proceeding against Mr. Furtado and various Go-To entities for alleged breaches of securities laws (the “Enforcement Proceeding”).

[32] The parties agree that the Receivership Proceeding and the Enforcement Proceeding were “Claims” within the meaning of the Policy.

VI. Timing of Notification to the Insurer

[33] On January 5, 2022, Go-To’s insurance broker emailed Go-To’s head of accounting and operations about the proceedings. Go-To’s counsel began the process under s. 16(1.1) of the Act by which a person subject to a s. 11 order can notify their insurer. Steps were completed in February 2022 by which time the Insurer’s agent was notified of a claim. On or around March 31, 2022, counsel reported the Enforcement Proceeding.

[34] On September 22, 2022, the Insurer denied coverage. The Insurer summarized its position as follows:

> Underwriters acknowledge that [Go-To Development Holdings Inc. (“GTDH”)] and Go-To Spadina Adelaide Square Inc. (“GT Adelaide Inc.”) are “Insured Entities”, and that Mr. Furtado is an “Insured Individual” with respect to his conduct as a director or officer of those entities. However, Furtado Holdings Inc. (“FHI”) and Go-To Spadina Adelaide Square LLP (“GT Adelaide LP”) are

> *not* “Insured Entities”, and Mr. Furtado is not an “Insured Individual” with respect to his conduct as a director or officer of those entities.
>
> The requests and Summonses issued by the Ontario Securities Commission between March 2019 and June 2021 do not constitute “Claims” under the Policies because they do not allege and are not related to any alleged “Wrongful Act”.
>
> The OSC’s application to appoint a receiver-manager over various Insureds in December 2021 constitutes a “Claim”, as does the OSC’s issuance in March 2022 of a Statement of Allegations. However, neither of those “Claims” were *first made* during any of the Policies’ periods, and are thus not covered under the Policies.
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> …
>
> Finally, if any of the OSC’s actions were held to constitute a “Claim”, it is Underwriters’ position that the Insureds failed to satisfy a condition to Underwriters’ liability, *i.e.*, to notify Underwriters as soon as practicable about such “Claims”. Accordingly, no such “Claims” would be covered under the Policies. [Emphasis in original.]

[35] Mr. Furtado commenced an application in the Superior Court seeking relief from forfeiture with respect to his “imperfect compliance” with the Policy, and indemnification for his defence costs and loss in connection with the Enforcement Proceedings and the Receivership Proceedings.

D. THE APPLICATION JUDGE’S REASONS

[36] The application judge noted that the parties agreed on certain things, stating that:

a. The [OSC] investigation that commenced in 2019 was not a Claim or an allegation of a Wrongful act. It was, however, a circumstance that, if reported during the Policy period, would have led to a subsequent Claim arising out of the investigation being covered.

b. The receivership proceeding and the enforcement proceeding are both Claims within the meaning of the policy.

c. The suspension clause, although drafted to suspend the requirement to give notice of a "Claim or notice of an alleged Wrongful act", also operates to suspend the requirement to give notice of a circumstance. Apart from being agreed to by the parties, this interpretation of the clause makes sense when one recalls that the paragraph immediately following the operative suspension clause contemplates a "Claim or allegation of Wrongful act which is subsequently made [i.e. after the investigation has begun], and which will be considered a Claim first made in the applicable Policy period when the investigation was first started." In other words, the policy itself contemplates that a Claim may arise from an investigation which is subject to confidentiality requirements, and the Claim shall be considered to have been made at the time the investigation began.

d. The suspension clause is subject to the undertaking contained in the clause which requires an insured to obtain consent to disclose the "Claim or notice of an alleged Wrongful act" to the insurer. By its plain wording, it does not impose on an insured the obligation to obtain consent to disclose a circumstance that may give rise to a Claim or allegation of a Wrongful act in the future.

e. There is no disagreement that the provisions of the *Securities Act* imposed a duty of confidentiality on [Mr. Furtado] and Go-To that prohibited disclosure of the investigation to the insurer, at least at the outset. [Emphasis added.]

[37] The application judge held that the notice obligation was suspended "whilst communication or notification is prohibited by confidentiality orders imposed by law enforcement agencies or [the regulator]." She concluded however that no relief from forfeiture was available. She stated:

> [45] [T]he obligation[3] to report the circumstance of the investigation arose when the legislation changed to permit disclosure of the investigation to the insurer on taking the steps laid out in s. 16(1.1) because at that time, disclosure was permitted as long as the person followed the steps set out in the legislation. At the very latest, [Mr. Furtado] should have started the process to disclose the investigation to the respondent when he received the February 16, 2021 summons that expressly drew his attention to his ability to disclose the investigation to the insurer.
>
> [46] It was nearly a year later when notice was finally given to Miller. In my view, this delay is a substantial breach in a claims-made policy, where notice is the triggering event for coverage…
>
> ...
>
> [52] In effect, the question comes down to this: does prejudice accrue to the respondent on a failure to provide timely notice because of the nature of the policy as a claims-made policy in which notice is a condition of coverage?
>
> [53] In my view, when notice comes around a year after it is required in a claims-made policy where notice is a

[3] Contrary to the application judge's finding, the notice of circumstance clause did not impose an obligation. Mr. Furtado's delay in reporting the investigation was not a breach of his obligations under the Policy, but rather, a failure to take advantage of a provision that, had he properly exercised it, would have resulted in coverage for the subsequent Claims.

> condition of coverage, the delay causes prejudice to the insurer. …
>
> ...
>
> [55] [T]he breach at issue is non-compliance with a condition precedent, because it is a substantial breach and it has caused prejudice to the insurer.
>
> [56] It follows that relief from forfeiture is not available.

[38] The application judge found that the Insurer's agent was notified of a claim by February 18, 2022.

[39] She held that the delay in reporting from February 16, 2021, to February 2022 constituted a substantial breach of this "claims-made" Policy, and that it caused prejudice to Mr. Furtado, such that relief from forfeiture was not available.

[40] In so concluding, she adopted the words of Moldaver J.A. (as he then was) in *Stuart*, at p. 329, quoting from *Gulf Insurance Co. v. Dolan, Fertig and Curtis*, 433 So. (2d) 512, at p. 515 (Fla. Sup. Ct. 1983):

> If a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained. This *extension of coverage*, by the court, so very different from a mere condition of the policy, in effect rewrites the contract between the two parties. This we cannot and will not do. [Italics in original; underlining added.]

E. THE POSITIONS OF THE PARTIES

[41] Mr. Furtado claims that the application judge erred in holding that (i) he breached the terms of the Policy, and that (ii) relief from forfeiture was not available as a matter of law.

[42] Mr. Furtado submits that he did not breach the Policy. When the investigation began, his obligation to report the investigation was suspended pursuant to the Suspension Clause, subject to his contractual undertaking to seek consent to disclose a "Claim or notice of an alleged Wrongful act" should one arise from the investigation. He submits that he satisfied the conditions of the Suspension Clause during the Policy period:

- His obligation to report a circumstance that may reasonably be expected by the insured to lead to a claim, was suspended pursuant to the Suspension Clause during the Policy period;
- No requirement to notify the Insurer of a circumstance applied after the Policy expired; and
- When a claim was commenced with the Receivership and Enforcement Proceedings, he reported the Claims with reasonable promptness after receiving notification.

[43] As such, per the Suspension Clause, the Claims ought to have been deemed to have been made during the Policy period and covered under that Policy.

[44] Second, Mr. Furtado claims the application judge erred in holding that relief from forfeiture was not available as a matter of law. Mr. Furtado submits that this court's decision in *Kozel v. The Personal Insurance Company*, 2014 ONCA 130, 119 O.R. (3d) 55, held that relief from forfeiture is only categorically unavailable in rare cases when the breach is substantial and prejudices the insurer. There was no substantial breach or prejudice to the Insurer.

[45] Mr. Furtado submits that the three factors a court is to consider in deciding whether to exercise its discretion to grant relief from forfeiture are: (1) the conduct of the applicant; (2) the gravity of the breach; and (3) proportionality, or the disparity between the value of the property forfeited and the damage caused by the breach. These factors weigh in favour of granting relief from forfeiture.

[46] The Insurer takes the position that the application judge correctly interpreted and applied the Suspension Clause: it only suspended the Policy's notice provisions whilst Mr. Furtado was not permitted by law to disclose. The Suspension Clause preserved *both* the *right* to give notice of a circumstance under the circumstances clause and the *duty* to give notice of a "Claim" while under "legal disability."

[47] When the law changed to allow subjects of OSC investigations to notify their insurers about investigations, the "legal disability" ended. On February 16, 2021, and twice thereafter, summonses were delivered which specifically advised

Mr. Furtado that he had the right to give notice to his insurer about the investigation. He could have exercised his rights but did not. Had Mr. Furtado exercised his right to advise of a circumstance that may reasonably have been expected by Mr. Furtado to give rise to a claim when his “legal disability” ended, and by February 16, 2021, at the latest, the claim would have been treated as if it had been reported during the Policy period. Mr. Furtado’s failure to properly exercise his rights under the circumstances clause after February 2021 was a failure to take advantage of a provision that, had he exercised it, would have resulted in coverage for the subsequent Claims.

[48] The Insurer submits that nothing in the Policy suggests that the rights conferred by the circumstances clause apply differently during the Policy period and after the Policy has expired; that if the right to notify of a circumstance is not exercised during the Policy period, the right need not ever be exercised thereafter; or that if a “legal disability” lasts throughout the Policy period, any subsequent claim would be covered as if notice of a circumstance had been given during the Policy period.

[49] Moreover, the Insurer claims that Mr. Furtado did not argue that he had complied with the Policy’s provisions before the application judge, and as such, he cannot now assert such a position.

[50] Finally, the Insurer claims that *Kozel* is distinguishable as it does not involve notice provisions under a claims-made and reported policy. Rather, the Insurer submits that this court's decision in *Stuart* should be followed as it involves a condition precedent to coverage.

[51] While the Insurer submits that the application judge incorrectly stated that the distinction between "imperfect compliance, or non-compliance with a condition precedent" turns on "whether the breach is substantial and prejudices the insurer," she nonetheless correctly held that relief from forfeiture was not available.

F. ANALYSIS

[52] As noted above, the central issues are the interpretation of the Suspension Clause and whether the delay in giving written notice of the investigation leading to the Claims constituted imperfect compliance with a term of the Policy or non-compliance with a condition precedent to coverage, thereby foreclosing the availability of relief from forfeiture.

[53] In order to understand the meaning of the Policy provisions and their effect, I will outline the distinctive characteristics of claims-made and reported policies and compare and contrast them with occurrence policies. I will then review the case law in respect of relief from forfeiture, especially the two leading decisions of this court in *Stuart* (a claims-made and reported policy where relief from forfeiture

was denied) and *Kozel* (an occurrence policy where relief from forfeiture was granted), followed by my analysis.

I. The Standard of Review

[54] Mr. Furtado asserts that the application judge made two errors of law: misinterpreting the Suspension Clause, and misapprehending the jurisprudence regarding non-compliance with a condition precedent versus imperfect compliance with a term of the policy.

[55] These are questions of law, that involve the interpretation of a standard form insurance policy, which attract a correctness standard: *Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co*., 2016 SCC 37, [2016] 2 S.C.R. 23, at paras. 24, 36.

II. The Difference Between Occurrence and Claims-Made and Reported Policies

[56] This Policy is a form of claims-made and reported policy. It differs from occurrence policies in several important respects.

[57] As the Supreme Court of Canada described in *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 260: “Every insurance policy must provide a mechanism for determining the claims for which the insurer is liable in a temporal sense.”

[58] In occurrence policies, “[i]f the negligent act giving rise to the damages occurred during the policy period, the insurer is required to indemnify the insured for any damages arising from it regardless of when the actual claim is made”: *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, 2006 SCC 21, [2006] 1 S.C.R. 744, at para. 23.

[59] The triggering event for occurrence policies is whether the *occurrence* took place within the policy period, not whether *notice* of the claim was given during the policy period. Occurrence policies therefore provide coverage for incidents that took place during the policy period, regardless of when the claim is brought: see e.g., *Reid Crowther*, at pp. 260, 262-63. For example, where an accident occurs within the policy period, the damage or loss is covered regardless of when the claim is brought.

[60] Claims-made policies on the other hand, focus on when the claim is made against the insured, not when the negligent or injurious occurrence took place. As such, “[i]f a claim is made by a third party during the policy period, the insurer is required to indemnify regardless of when the negligent act giving rise to the claim occurred”: *Jesuit Fathers*, at para. 23.

[61] In *Reid Crowther*, at pp. 262 and 264, the Supreme Court of Canada described the development of claims-made policies this way:

> Although there is evidence of "claims-made" and hybrid policies having been utilized to at least some extent for

> decades in Canada, and as far back as the first half of this century in the United States, "claims-made" and hybrid policies have come into widespread use in the liability insurance industry only within the past 25 years or so in the United States, and apparently somewhat more recently in Canada. The expanded utilization of "claims-made" and hybrid policies was resorted to by insurance companies in response to serious problems that had developed in the use of "occurrence" policies. These problems were rooted in the "long-tail" nature of liability claims against some types of insureds.
>
> …
>
> The "claims-made" type of policy was seen (as were hybrid policies) as a means of providing liability insurance at reasonable rates while avoiding the problems associated with the "long-tail" nature of "occurrence" policies. The date at which a claim was made would be easier to ascertain than the date at which an "occurrence" happened, and more importantly, insurers would be better able to project the likely level of claims that would be payable under liability insurance policies.
>
> But "claims-made" and hybrid policies (the latter in particular), while increasing predictability for insurers and reducing premiums to insureds, exact their price—the price of diminished coverage. [Emphasis added.]

[62] Finally, claims-made and reported policies make coverage subject to two conditions precedent: that the claim be both made and reported to the insurer during the policy period.

III. When Relief from Forfeiture Can be Granted

[63] Section 129 of the *Insurance Act*, R.S.O. 1990, c. I.8, provides that:

> Where there has been imperfect compliance with a statutory condition as to the proof of loss to be given by

> the insured or other matter or thing required to be done or omitted by the insured with respect to the loss and a consequent forfeiture or avoidance of the insurance in whole or in part and the court considers it inequitable that the insurance should be forfeited or avoided on that ground, the court may relieve against the forfeiture or avoidance on such terms as it considers just.

[64] The court's power under s. 129 however, applies only to those policy conditions – statutory or contractual – that relate to proof of loss: *Kozel*, at para. 35 and *Williams v. York Fire & Casualty Insurance Co*., 2007 ONCA 479, 86 O.R. (3d) 241, at para. 33. In particular, in *Dams v. TD Home and Auto Insurance Co.*, 2016 ONCA 4, 129 O.R. (3d) 226 at para. 18, this court held that the court's power under s. 129 "concerns things or matters required to be done in relation to the loss – i.e. to instances of imperfect compliance with the terms of a policy after a loss has occurred". As such, it does not apply in this case.

[65] Section 98 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 ("CJA"), also provides that, "A court may grant relief against penalties and forfeitures, on such terms as to compensation or otherwise as are considered just."

[66] Forfeiture is defined in *Black's Law Dictionary*, 11th ed. (Saint Paul: Thomson Reuters, 2019) as: "The loss of a right, privilege, or property because of a crime, breach of obligation, or neglect of duty." Similarly, the *Concise Oxford English Dictionary*, 12th ed. (New York: Oxford University Press, 2011) defines "forfeit" as "lose or be deprived of (property or a right or privilege) as a penalty for wrongdoing" or "lose or give up as a necessary consequence".

[67] However, relief from forfeiture under s. 98 of the CJA only applies if the breach constitutes imperfect compliance with a policy term, not where the breach amounts to non-compliance with a condition precedent to coverage under the policy.

IV. The Legal Principles Regarding Relief from Forfeiture

[68] In *Falk Bros. Industries Ltd. v. Elance Steel Fabricating Co.*, [1989] 2 S.C.R. 778, McLachlin J. (as she then was) noted the distinction to be drawn between imperfect compliance and non-compliance with a condition of coverage and that relief from forfeiture was available only for “imperfect compliance”. She stated, at p. 784, that:

> The distinction between imperfect compliance and non-compliance is akin to the distinction between breach of a term of the contract and breach of a condition precedent. If the breach is of a condition, that is, it amounts to non-compliance, no relief [from forfeiture] is available.

[69] In *Stuart*, Moldaver J.A. (as he then was) noted that, although relief from forfeiture was granted in *Falk*:

> A review of the authorities cited by McLachlin J. for the proposition that "failure to give notice of claim in a timely fashion constitutes imperfect compliance" reveals that the insurance policies in question were all of the "occurrence" type. Unlike the case at hand, the notice requirement in those policies did not form an integral part of the event triggering coverage. That distinction is crucial because, in my opinion, it has the effect of transforming Re/Max's failure to give notice from one of

> imperfect compliance to non-compliance. [Emphasis added.]

[70] In the claims-made and reported policy in *Stuart,* the insuring agreement clause expressly contained the two triggers to coverage: a claim had to be made during the policy period, and it had to be reported to the insurer during the policy period. It stated:

> To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages resulting from any claim or claims first made against the Insured and reported in writing to the Company during the Policy Period for any Wrongful Act of the Insured or of any other person for whose actions the Insured is legally responsible, but only if such Wrongful Act occurs during or prior to the Policy Period and solely in rendering or failing to render professional services for others for a fee as a Real Estate Salesperson or Real Estate Broker. [Emphasis added.]

[71] Because no "claim" had been asserted within the policy period in *Stuart*, the court was not interpreting the insuring agreement clause. The focus of the analysis in *Stuart* was instead on the "notice of occurrence" provision in the Special Provisions section of the policy. The Special Reporting Clause provided for an extension of coverage with respect to occurrences that may reasonably be expected to give rise to a claim:

> 4. SPECIAL REPORTING CLAUSE
>
> If during the Policy Period or during the extended reporting period (if the right is exercised by the Insured in accordance with Provision 5), the Insured shall become aware of any occurrence which may reasonably be

> expected to give rise to a claim against the Insured for a Wrongful Act which first occurs during or prior to the Policy Period, and provided the Insured gives written notice to the Company during the Policy Period or the extended reporting period (if applicable) of the nature of the occurrence and specifics of the possible Wrongful Act, any claim which is subsequently made against the Insured arising out of such Wrongful Act shall be treated as a claim made during the Policy Period. [Emphasis added.]

[72] The Special Provisions section also contained a notice clause:

> 3. LOSS PROVISIONS
>
> The Insured shall, as a condition precedent to the availability of the rights provided under this policy, give written notice to the Company as soon as practicable during the Policy Period, or during the extended reporting period (if applicable), of any claim made against the Insured. [Emphasis added.]

[73] Moldaver J.A. recognized that "relief from forfeiture may be granted under a 'claims-made' policy in appropriate cases," citing as an example *McNish v. American Home Assurance Co.* (1989), 68 O.R. (2d) 365 (H.C.), aff'd (1991), 5 C.C.L.I. (2d) 222 (Ont. C.A.) where the reporting requirement was not a condition of coverage. The critical question however, was whether, according to the specific terms of the policy, the breach of the Special Reporting Clause constituted imperfect compliance with a term of the policy, or non-compliance with a condition precedent to coverage.

[74] Moldaver J.A. held that the wording of that Clause was clear that the requirement to provide the insurer with notice of the potential claim during the

policy period was a condition of coverage: pp. 330-31. Relief from forfeiture was not available because the failure to provide written notice of the potential claim during the policy period was not imperfect compliance; it was "non-compliance with a condition precedent to coverage." He held at p. 330 that, "[t]rite though it may be, an insurer has the right to limit coverage in a policy issued by it and when it does so, the plain language of the limitation must be respected."

[75] Mr. Furtado claims however, that the application judge erred in not following the more recent ruling and possibly broader approach of this court in *Kozel*.

[76] In *Kozel*, the insured was involved in a traffic accident while driving with an expired licence and did not renew her licence until after the accident. She breached a statutory condition of her insurance policy not to drive or operate an automobile unless authorized by law to do so. She brought an application seeking coverage. LaForme J.A. noted, at paras. 37 and 47, that although the insurer took the position that authorization to drive was a condition precedent to coverage, there was nothing in the policy stressing that the insurance coverage was conditioned on the claimant being authorized to drive. As he observed, at para. 40:

> The difference between imperfect compliance and non-compliance is crucial for the purposes of the relief against forfeiture analysis. If the respondent's breach of statutory condition 4(1) is imperfect compliance with a policy term, relief against forfeiture under s. 98 of the [*Courts of Justice Act*] is available. If, however, the breach amounts to non-compliance with a condition precedent, the court

> cannot award relief under s. 98: *Stuart* at p. 333. [Emphasis added.]

[77] He observed, at para. 44, that in *Stuart,* Moldaver J.A. held that:

> … the failure of the broker to report the claim within the policy period amounted to non-compliance with a condition precedent to coverage, rather than imperfect compliance with a term of the policy.

[78] Accordingly, there can be no relief from forfeiture where there is an obligation on the insured to satisfy claims-made and reported conditions *before* the obligation to provide coverage arises. This is different from occurrence policies where the breach of a condition affects a pre-existing obligation on the part of the insurer to provide coverage.

[79] LaForme J.A. noted the conceptual difference between "occurrence" policies and "claims-made and reported" policies and distinguished *Stuart* on the basis that in *Stuart*, "plain language in the contract identified the relevant contractual term as a condition precedent": at paras. 44, 47. He went on to comment, at paras. 48 and 50, that "[g]oing forward, this court's strict holding in *Stuart* should be applied narrowly" and that "[a] court should find that an insured's breach constitutes noncompliance with a condition precedent only in rare cases where the breach is substantial and prejudices the insurer." I read those comments not as suggesting that the *Stuart* reasoning should be abandoned in favour of a broader test, but as confining the application of *Stuart* to contractual provisions like

those contained in claims-made and reported policies that contain clear language identifying the provision as a condition that must be met to trigger coverage.

[80] In sum, where the wording of a claims-made and reported policy makes clear that the making and reporting of a claim are the triggering events for coverage, the failure to comply with a notice provision constitutes non-compliance with an essential condition of coverage such that there can be no relief from forfeiture. To decide otherwise "would be to distort the plain meaning of the contract and require the insurer to provide coverage for an event outside the scope of the policy which it had not agreed to cover and for which it had received no remuneration": *Stuart*, at p. 329. As stated in *Stuart*, at p. 329, this would be akin to allowing coverage in an occurrence policy where the accident took place after the policy period.

V. Application of the Governing Principles

[81] In this case, the insuring agreement clauses are found in s. 1 of the Policy entitled "Insurance Cover". Different provisions apply to investment managers/advisers, Funds, and directors and officers, although all provisions are very similarly worded. The provisions apply to "claims." Each of the clauses contains direct reference to the two claims-made and reported triggers.

[82] Like *Stuart,* the insuring agreement provisions demonstrate that this is intended to be a form of claims-made and reported policy. For example, s. 1.3(i) states:

> The Insurer shall pay on behalf of each of the Individual insureds of the Fund all Loss arising out of any Wrongful act which gives rise to a Claim first made against the Individual insured during the Policy period or, if applicable, the Discovery period, and which is reported in writing to the Insurer pursuant to the terms of this policy. [Emphasis added.]

[83] Also like *Stuart*, the appeal in this case focuses on notice of circumstances and the relevant coverage provision is the extended coverage provided by s. 5.8 of the Policy (as set out in paras. 20 and 21 above). Section 5.8 also prescribes how notice is to be given for claims and for circumstances which may reasonably be expected by the insured to lead to claims.

[84] Section 5.8 provides that it is a condition precedent to coverage (a "condition to liability of the Insurer") that claims must be reported within 30 days after the expiry of the Policy period. Section 5.8 goes on to say that if a "circumstance which may reasonably be expected by the Insured to give rise to a Claim" is reported within the Policy period, any future claim arising from that circumstance will be considered to be a claim first made against the insured "at the time written notice of the … circumstance was first given to the Insurer." The claim is thereby back-dated to the date that the circumstance was reported to the insurer.

[85] The Policy also contains a Suspension Clause. However, that provision at s. 5.8 of the Policy, only suspends the notice provisions "*whilst* communication or notification is prohibited by confidentiality orders imposed by law enforcement agencies or [the regulator]" (emphasis added). The parties agreed and the application judge found that this part of the Suspension Clause applies both to claims and notice of circumstances that may reasonably be expected by the insured to give rise to a claim.

[86] The parties agree that, although no claim was made during the Policy period, there was a "circumstance which may reasonably be expected by the Insured to give rise to a Claim or an allegation of a Wrongful act." That is, Mr. Furtado was told in May of 2019, during the Policy period, to attend the OSC offices with relevant documents as they were investigating the business activities of Go-To.

[87] At that time and throughout the Policy period that ended on October 25, 2019, Mr. Furtado was not permitted by law to, and did not, advise the Insurer of the investigation.

[88] However, on December 10, 2019, the legislation was amended to allow subjects of investigations to notify their insurers about the investigation on certain terms. Mr. Furtado was specifically advised of this fact in the summonses from the OSC starting on February 16, 2021, which "expressly drew his attention to his ability to disclose the investigation to the insurer."

[89] The Insurer contends that Mr. Furtado did not argue that he had complied with the Policy provisions before the application judge, and as such, he cannot now assert that he did. Mr. Furtado's counsel disputed this and said that this argument was raised before the application judge. This court was not provided with all of the materials filed on the application and I am therefore not able to confirm whether it was properly raised before the application judge.

[90] In any event, I reject Mr. Furtado's argument that he did not have to notify the Insurer of the investigation (the "circumstance") after the Policy ended and he was advised that the law had changed allowing him to advise the Insurer of the investigation, but could simply give notice to the Insurer of the subsequent Claims relating to the circumstances.

[91] The notice provision in this Policy, subject to the Suspension Clause, required notice of claims as soon as practicable during the Policy period or within 30 days after the expiry of the Policy period. The Policy also requires written notice of a fact or circumstance during the Policy period. The delay in giving notice of the circumstance, when he was permitted to do so, constituted "non-compliance with a condition precedent to coverage," for which no relief from forfeiture can be granted.

[92] Moreover, while Mr. Furtado purports to distinguish *Stuart* on the basis that the *Stuart* policy, unlike this Policy, contained no suspension clause, this argument

does not address why the language of the notice of circumstance clause itself should not be construed as a coverage triggering requirement. It is very similar to the Special Reporting Clause considered in *Stuart*, and if there was any doubt that the language of the notice of circumstance clause clearly prescribes a condition precedent, s. 5.8 specifically contains “condition to liability” language.

[93] *Kozel* is distinguishable. Unlike this case, *Kozel* does not involve claims-made and reported coverage triggers, but rather the breach of a statutory condition in a motor vehicle liability insurance policy. Notice was not required to trigger coverage or create an obligation on the insurer to cover the claim. Moreover, in *Kozel*, there was no policy language stressing that the insurance coverage was conditional on the claimant being authorized to drive which was the failure to comply in issue. As noted above, the court in *Kozel*, specifically adverted to *Stuart* stating, at para. 47, that, “This fact renders our case different than the facts in *Stuart,* where plain language in the contract identified the relevant contractual term as a condition precedent.”

[94] Finally s. 98 of the *Courts Justice Act* does not assist Mr. Furtado in this case, as this is not a case of imperfect compliance leading to forfeiture of a right otherwise available. Rather it is a breach amounting to non-compliance with a condition precedent to coverage.

[95] As such, where the insured is not prevented by law from reporting the circumstance, the core of coverage in this Policy is to cover subsequent claims where notice of circumstance has been properly given. Granting relief from forfeiture of the notice of circumstance pre-requisite would undermine the core intention of the Policy as to the claims to be covered.

[96] In my view, once the law changed to permit Mr. Furtado to inform the Insurer (and thereby trigger coverage for a claim), and certainly after he was specifically advised of this fact in February 2021, notice of the circumstance had to be given in order to trigger coverage for any Claims arising therefrom.

[97] Mr. Furtado's failure to report the circumstance to the Insurer when the law permitted him to do so, and at the very least when he was informed of his ability to do so in February 2021, meant that any claim arising from the circumstance could not be treated as reported within the Policy period. Mr. Furtado did not report anything to the Insurer until around February 2022, almost three years after the investigation began as the OSC investigation had begun by May 2, 2019, more than two years after the law changed to permit him to advise the Insurer of the investigation in December 2019, and more than two years after the Policy term expired on October 25, 2019.

[98] By failing to meet the condition precedent to coverage, that is, to report the OSC investigation once the prohibition on disclosure was altered by law,

Mr. Furtado did not *lose* the benefit of coverage; *he never met the requirements* for coverage in the first place as he only reported the Claims in 2022.

[99] In short, coverage for the Claims was never triggered. As the Claims were never covered, to provide relief from forfeiture would be tantamount to extending coverage under the Policy which was not what the parties bargained for.

[100] In light of my finding that relief from forfeiture is not available, it is unnecessary to consider whether relief from forfeiture should be granted.

G. DISPOSITION

[101] For these reasons, I would dismiss the appeal. On the agreement of the parties, costs in the amount of $22,000 are payable to the Insurer.

Released: July 22, 2024 “P.D.L.”

“Thorburn J.A.”
“I agree. P. Lauwers J.A.”
“I agree. K. van Rensburg J.A.”