COURT OF APPEAL FOR ONTARIO

CITATION: Kestenberg Siegal Lipkus LLP v. Royal & Sun Alliance Insurance Company of Canada, 2024 ONCA 607
DATE: 20240809
DOCKET: COA-23-CV-0690

Gillese and Copeland JJ.A. and Wilton-Siegel J. (*ad hoc*)

BETWEEN

Kestenberg Siegal Lipkus LLP and Marc Kestenberg

Applicants (Appellants)

and

Royal & Sun Alliance Insurance Company of Canada,
Travelers Insurance Company of Canada,
Axis Reinsurance Company (Canadian Branch),
XL Specialty Insurance Company, operating as AXA XL and
Trisura Guarantee Insurance Company

Respondents (Respondents)

Lawrence Theall and Dylan Cox, for the appellants

Joyce Tam and Thomas Donnelly, for the respondents

Heard: February 7, 2024

On appeal from the judgment of Justice Edward M. Morgan of the Superior Court of Justice, dated May 26, 2023, with reasons reported at 2023 ONSC 3132.

Copeland J.A.:

Introduction

[1] This appeal raises the issue of whether relief from forfeiture is available to an insured under a professional liability insurance policy where the insured failed

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to report the claim to the insurer during the policy period, contrary to the terms of the policy. The answer to this question turns on the interpretation of the insurance policy and the principles that govern the availability of relief from forfeiture.

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[2] For the reasons that follow, I would find no error in the application judge's conclusion that the insurance policy at issue is a claims made and reported policy. The application judge correctly found that the failure by the insured to report the claim to the insurer within the policy period breached a condition precedent to coverage. Because coverage was not triggered, the application judge also correctly found that relief from forfeiture was not available. It is not necessary to consider the application judge's alternative conclusion that he would not have exercised his discretion to grant relief from forfeiture if it was available.

Background facts

[3] The underlying facts giving rise to this appeal are not in dispute. At the relevant times, the appellant law firm, Kestenberg Siegal Lipkus LLP, and the individual appellant lawyer, Marc Kestenberg, (jointly, "the appellants") were insured under three professional liability policies. The primary policy is underwritten by the Lawyers' Professional Indemnity Company ("LawPro" and "the LawPro Policy"). The limit of liability under the LawPro Policy is $1 million per claim. The first excess policy is issued by Certain Underwriters at Lloyd's ("Lloyd's" and "the First Excess Policy"). The limit of liability under the First Excess Policy is

$9 million per claim. The second excess policy is issued by the respondents (“the Second Excess Policy”). The Second Excess Policy covers the period January 1, 2018 to January 1, 2019. The Second Excess Policy does not have to respond until the limits of the LawPro and First Excess Policies have been exhausted (i.e., beyond $10 million per claim). It provides $50 million in coverage.[1] The Second Excess Policy is at the heart of this appeal.

[4] I address the relevant provisions of the Second Excess Policy in the analysis section of these reasons.

[5] The following circumstances led to a claim against the appellants for which they sought professional liability coverage under all three policies. The appellants represented a client in an action in which the client sought to enforce a right of first refusal over a particular property (“the Property Action”). On June 29, 2018, one of the defendants in the Property Action advised the appellants that it intended to move to stay the action on the basis that a settlement entered into by the appellants’ client and another defendant had not been immediately disclosed to it. The appellants understood that if the defendant was successful in seeking a stay of the Property Action, their client would have a professional liability claim against them (“the Claim”).

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[1] There is a dispute between the appellants and their insurance broker as to whether the Second Excess Policy provides coverage for $50 million or $40 million. That issue was not before the court in this appeal and it does not affect the issue of whether relief from forfeiture is available to the appellants in this appeal.

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[6] Accordingly, on July 3, 2018, the appellants provided notice of the Claim to LawPro.

[7] On July 4, 2018, by email, the appellants asked their broker, HUB International HKMB Limited ("the Broker"), to report the Claim to their excess insurers, including the respondents. On July 5, 2018, the Broker responded confirming that it would provide the notice. The Broker promptly reported the Claim to Lloyd's under the First Excess Policy. However, the Broker failed to report the Claim to the respondents under the Second Excess Policy until March 22, 2021 – almost three years after the appellants became aware of the claim and more than two years after the Second Excess Policy had expired.

[8] LawPro appointed counsel to oppose the stay motion in the Property Action. Those efforts were unsuccessful. Ultimately, the stay of proceedings was granted: *Tallman Truck Centre Limited v. K.S.P. Holdings Inc.*, 2021 ONSC 984, 60 C.PC. (8th) 258. An appeal to this court was dismissed: *Tallman Truck Centre Limited v. K.S.P. Holdings Inc.*, 2022 ONCA 66, 466 D.L.R. (4th) 324, leave to appeal to S.C.C. refused, 40118 (October 20, 2022).

[9] On April 11, 2022, the appellants' client in the Property Action commenced an action against the appellants alleging that the appellants acted negligently in their representation in the Property Action (i.e., an action arising out of the Claim).

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In the action, the appellants' client seeks damages of $125 million, plus the legal fees paid to the appellants and special damages.

[10] As a result of the failure of the appellants to report the Claim to the respondents during the policy period of the Second Excess Policy, the respondents denied coverage for the Claim on October 14, 2021. The basis for the denial of coverage was that notice of the Claim was not given until March 2021, outside the policy period.

[11] The appellants brought an application for a declaration that the respondents are responsible for coverage of the Claim. The application was dismissed on May 26, 2023. The appellants now appeal that decision.

[12] Although the insured law firm and lawyer are the named appellants, the reality is somewhat different. On June 8, 2022, the appellants commenced an application against the Broker for failing to report the Claim to the respondents. On August 16, 2022 (before the application giving rise to this appeal was filed), the appellants and the Broker signed an agreement in which the Broker admitted it was negligent in failing to report the Claim to the respondents. As part of the agreement, the appellants allowed the Broker to bring the application in their name and the Broker agreed to indemnify the appellants for any damages awarded against the appellant in the action arising out of the Claim that would have been covered by the Second Excess Policy.

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The application judge's decision

[13] The application judge considered the interpretation of the Second Excess Policy. He found it was a "claims made and reported" policy. In particular, he found that the requirement that the appellants provide notice of a claim to the respondents during the policy period was a condition precedent to coverage for the Claim. It was not in dispute that notice of the Claim was given to the respondents in March 2021, after the expiration of the Second Excess Policy. As such, following this court's decision in *Stuart v. Hutchins* (1998), 40 O.R. (3d) 321 (C.A.), the application judge found that relief from forfeiture was not available.

[14] Although this conclusion meant that the application judge was not required to address whether he would exercise the discretion to grant relief from forfeiture, he considered that issue in the alternative. He saw no contract-based or equitable grounds to grant the appellants relief from forfeiture. Because of the agreement with their Broker, the appellants would suffer no prejudice. The Broker had its own professional liability insurance. As the application was a contest between the Broker's insurer, who was notified on time, and the appellants' insurer (the respondents), who was not, he saw no basis to intervene and support the insurer who did get proper notice.

Grounds of appeal

[15] The appellants raise two grounds of appeal:

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1. The application judge erred in finding that relief from forfeiture was not available to the appellants; and
2. If relief from forfeiture was available, the application judge erred in finding that it should not be granted.

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Analysis

(1) Did the application judge err in finding that relief from forfeiture was not available to the appellants?

[16] The appellants argue that relief from forfeiture is available unless the insured's breach was substantial and it caused the insurer prejudice, relying on this court's decision in *Kozel v. Personal Insurance Co.,* 2014 ONCA 130, 119 O.R. (3d) 55. The appellants argue that the application judge erred in relying on this court's decision in *Stuart*. According to the appellants, *Stuart* is distinguishable because in *Stuart* the insuring agreement clause expressly required the reporting of a claim in order to trigger coverage under the policy. The appellants argue that reporting is not a trigger to coverage under the Second Excess Policy. I pause to note that these arguments turn on the interpretation of the Second Excess Policy and whether it is a "claims made" or a "claims made and reported" policy.

[17] The respondents argue that, properly interpreted, the Second Excess Policy is a claims made and reported policy. The respondents argue that relief from forfeiture is not available because this court held in *Stuart* that failing to report a

claim during the policy period under a claims made and reported policy is non-compliance and not imperfect compliance. In other words, coverage is not triggered. Relief from forfeiture is only available to excuse imperfect compliance. In this case, the claims made and reported clause is not found in the insuring agreement clause (i.e., it is located elsewhere in the policy). However, the policy is clear that it only provides coverage where a claim is both made and reported during the policy period. The respondents submit that the jurisprudence does not support the appellants' proposition that for reporting during the policy period to be a trigger to coverage, the claims made and reported requirement must be located in the insuring agreement clause.

[18] These reasons explain my conclusion that the appellants are not entitled to seek relief from forfeiture by addressing the following issues: (i) the difference between occurrence-based, claims made, and claims made and reported insurance policies; (ii) the principles governing availability of relief from forfeiture and, in particular, whether relief from forfeiture is available under a claims made and reported policy when the claim is not reported during the policy period; and (iii) the interpretation of the Second Excess Policy, and in particular, whether the application judge erred in finding that the Second Excess Policy is a claims made and reported policy and that reporting during the policy period is a condition precedent to coverage. The analysis of these issues leads to the conclusion that the application judge was correct in finding that relief from forfeiture is not available

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to the appellants because reporting during the policy period is a condition precedent to coverage under the Second Excess Policy.

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[19] The parties agree that the standard of review on these issues is correctness. The interpretation of the Second Excess Policy is reviewed on a correctness standard because it is a standard form insurance policy: *Ledcor Construction Ltd. v. Northbridge*, 2016 SCC 37, [2016] 2 S.C.R. 23, at paras. 24 and 34-39. The question of whether the application judge erred with respect to the legal principles applicable to the availability of relief from forfeiture[2] is reviewable on a correctness standard because it is a question of law: *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at para. 8.

(i) The difference between occurrence-based, claims made, and claims made and reported insurance policies

[20] As context for the issues raised in this appeal, it is helpful to understand the different types of coverage available under liability insurance policies. The different types of policies determine what event or events trigger coverage under the policy.

[21] The occurrence-based approach focuses on the timing of the negligent act and damage. In an "occurrence" policy, the occurrence of a negligent act giving

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[2] The legal question of whether relief from forfeiture is available is a distinct issue from a judge's exercise of discretion whether or not to grant relief from forfeiture in circumstances where relief is legally available. If relief from forfeiture is legally available, the exercise of discretion by a judge of first instance is reviewable on a deferential standard: *Pinder Estate v. Farmers Mutual Insurance Company (Lindsay)*, 2020 ONCA 413, at para. 117.

rise to damage or loss during the policy period triggers coverage: *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, 2006 SCC 21, [2006] 1 S.C.R. 744, at para. 23; *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 260; *Stuart*, at pp. 326-27.

[22] Purely occurrence-based policies led to difficulties for insurers in areas where the damage from a negligent act may not be immediately apparent, such as professional liability in medical or legal services. They can lead to "long-tail" liability where claims are made long after a policy has expired. In addition, developments in the law and science may make it difficult for insurers to estimate potential liability arising from claims made many years in the future. Finally, where an insured has changed insurers various times, occurrence-based policies can result in disputes over which insurance company is liable for coverage where the timing of the negligence is unclear or where it was of an ongoing nature: *Jesuit Fathers*, at para. 24; *Reid Crowther*, at pp. 262-64; *Stuart*, at pp. 326-27.[3]

[23] As a result, policies based on the timing of a claim were developed. "Claims made" policies are more affordable, since there is no possibility of claims arising after the end of the policy period; however, they provide more limited coverage: *Jesuit Fathers*, at para. 25; *Reid Crowther*, at p. 264.

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[3] This court recently considered this type of issue in *Loblaw Companies Limited v. Royal & Sun Alliance Insurance Company of Canada*, 2024 ONCA 145, at para. 65.

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[24] Claims made policies focus on when the claim is made by a third party. Under a claims made policy, the making of the claim against the insured during the policy period triggers coverage: *Jesuit Fathers*, at para. 23; *Stuart*, at p. 328; *Reid Crowther*, at pp. 260-61.

[25] A "claims made and reported" policy provides more restricted coverage than a claims made policy. Under a claims made and reported policy, coverage is only triggered if both the making of a claim against the insured and the reporting of the claim to the insurer occur within the policy period: *Reid Crowther*, at pp. 265-66; *Stuart*, at pp. 326-27. In other words, the making of the claim alone is insufficient to trigger coverage under a claims made and reported policy. It must be combined with the insured reporting the claim to the insurer during the policy period.

[26] These distinctions are not arbitrary. As Moldaver J.A. (as he then was) explained in *Stuart*, under a claims made and reported policy, the insured contracts for coverage of claims that are reported during the term of the policy. This affects the price of the policy. To require the insurer to cover a claim under a claims made and reported policy that was not reported to the insurer during the term of the policy would "distort the plain meaning of the contract and require the insurer to provide coverage for an event outside the scope of the policy … for which it had received no remuneration": *Stuart*, at p. 329; see also *Reid Crowther*, at pp. 265-66.

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[27] While labels such as “claims made” or “claims made and reported” can be useful conceptual tools, ultimately the meaning of an insurance contract is a question of contractual interpretation based on the wording of the particular policy. Indeed, some policies are hybrids with elements of the different types of policies: see, for example *Jesuit Fathers*, at paras. 19, 23; *Reid Crowther*, at p. 261. As the Supreme Court cautioned in *Reid Crowther*, at pp. 261-62:

> The essential is not the label one places on the policy, but what the policy says. The courts must in each case look to the particular wording of the particular policy, rather than simply attempt to pigeonhole the policy at issue into one category or the other.

(ii) The principles governing availability of relief from forfeiture

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

> 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.

[29] The jurisprudence under s. 129 of the *Insurance Act* draws a distinction between non-compliance with a condition precedent to coverage and imperfect compliance with a term of a policy after coverage has been triggered. Relief from forfeiture is available where coverage has been triggered but the insured fails to comply with a term of the policy. Relief from forfeiture is not available where an

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insured has not complied with a condition precedent to coverage: *Stuart*, at p. 327-28; *Kozel*, at para. 40.

[30] The distinctions between types of insurance policies discussed above take on importance in determining whether relief from forfeiture is available. If coverage has been triggered, for example by a negligent act and damages having occurred under an occurrence-based policy, a subsequent failure by an insured to comply with a policy term will be imperfect compliance and relief from forfeiture may be available.[4] By contrast, where coverage has not been triggered, relief from forfeiture will not be available. The leading cases explaining this distinction are this court's decisions in *Stuart* and *Kozel*.

[31] *Stuart* involved a negligence claim against a listing real estate agent. After purchasing a property, the purchaser discovered that the well on the premises was not capable of providing safe and sufficient water for household use. The purchaser notified the listing real estate agent of her potential claim against the agent for having misrepresented the suitability of the well during the term of the agent's professional liability policy. However, the agent did not report the potential claim to its insurer until approximately six weeks after the end of the policy period: *Stuart*, at p. 323.

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[4] The insured will still be required to meet the requirements that make it appropriate for a court to exercise its discretion to grant relief from forfeiture: *Saskatchewan River Bungalows Ltd. v. Maritime Life Assurance Co.*, [1994] 2 S.C.R. 490, at p. 504; *Kozel* at paras. 28-31.

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[32] The agent's professional liability policy provided coverage for claims made and reported during the policy period. The policy also contained a provision extending coverage for <u>potential</u> claims for any wrongful act committed prior to or during the policy period, provided the agent reported such potential claims to the insurer during the policy period.

[33] In *Stuart*, this court interpreted the relevant provisions of the insurance policy and found that it was a claims made and reported policy. The court held that failure to report a claim or potential claim during the policy period of a claims made and reported policy was non-compliance with a condition precedent to coverage. As a result, relief from forfeiture was not available. Under a claims made and reported policy, claims are only covered where they are reported to the insurer during the policy period. This is the bargain struck between the insured and the insurer under a claims made and reported policy. The failure to report the claim during the policy period means there is no coverage under the policy. It is not open to a court to excuse the insured's failure to report the claim during the policy period, as that would rewrite the contract and provide coverage that was not part of the policy and that was not paid for. This is so whether or not the insurer suffered prejudice as a result of the failure to report the claim during the policy period: *Stuart*, at pp. 327-31.

[34] The appellants argue that the holding in *Stuart* – that relief from forfeiture is not available under a claims made and reported policy where an insured fails to

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report the claim within the term of the policy – has been limited by this court's decision in *Kozel*. The appellants argue that relief from forfeiture is available in all insurance cases unless the breach of condition is both substantial and prejudices the insurer. I do not agree.

[35] In *Kozel*, the insured injured a motorcyclist in a motor vehicle collision. At the time of the collision, the insured's driver's licence was expired. The expired licence was due to oversight by the insured in failing to renew her licence on or before her birthday (she had no difficulty renewing it following the collision). The expired licence meant the insured was in breach of a statutory condition of her motor vehicle insurance policy. One of the issues before this court was whether relief from forfeiture was available: *Kozel*, at paras. 1-9 and 11.

[36] This court held in *Kozel* that the insured was entitled to relief from forfeiture. The court in *Kozel* maintained the central distinction in *Stuart* between non-compliance with a condition precedent to coverage (for which relief from forfeiture is not available) and imperfect compliance with a term of a policy (for which relief from forfeiture is available). In *Kozel*, the court found that the insured's breach of the statutory condition that she be licenced was imperfect compliance with a term of the policy, rather than non-compliance with a condition precedent to coverage: at paras. 33-35 and 38-47. This conclusion in *Kozel* was based on interpreting the language of the insurance contract (including the statutory term) and not on an analysis of whether there was prejudice to the insurer (at para. 47):

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> In light of the above, my view is that in this case, the respondent's breach of statutory condition 4(1) is not non-compliance with a condition precedent. There are no grounds to believe that 4(1) is a fundamental term or that the respondent's breach of it was of a fundamental nature. While the provision is a condition in name, the appellant pointed to no language in the contract stressing that the insurance coverage was conditioned on the claimant being authorized to drive. 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. Neither was the respondent's breach here a fundamental one. Had the respondent's violation of statutory condition 4(1) been more substantial – for example, if she had been drinking heavily prior to driving – she may have been barred from obtaining relief from forfeiture. This case, however, involves a relatively minor breach. [Emphasis added.]

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[37] Because the court found that failure to comply with the statutory term of the contract requiring licencing was imperfect compliance with a policy term rather than non-compliance with a condition precedent to coverage, the court found that relief from forfeiture was available.

[38] The appellants rely on the following statement at para. 50 of *Kozel* to argue that the court should find that an insured's breach of a term in an insurance policy constitutes non-compliance with a condition precedent to coverage only where the breach prejudices the insurer:

> In light of *Marche*, I believe the decision in *Stuart* should be given a narrow application. A court should find that an insured's breach constitutes non-compliance with a condition precedent only in rare cases where the breach is substantial and prejudices the insurer. In all other

> instances, the breach will be deemed imperfect compliance, and relief against forfeiture will be available.

[39] I disagree with the appellants' submission that *Kozel* limits the holding in *Stuart* that under a claims made and reported policy, relief from forfeiture is not available where an insured fails to report a claim within the policy period – a condition precedent to coverage. Nothing in *Kozel* alters the application of the holding in *Stuart* that reporting within the policy period is a condition precedent to coverage under claims made and reported policies. In particular, I note two aspects of *Kozel* that make clear that it does not undermine the central holding in *Stuart*.

[40] First, *Kozel* maintains the distinction in *Stuart* between non-compliance with a condition precedent to coverage and imperfect compliance with a term of a policy (at paras. 40-41 and 44):

> <u>The difference between imperfect compliance and non-compliance is crucial for the purposes of the relief against forfeiture analysis.</u> If the respondent's breach of statutory condition 4(1) is imperfect compliance with a policy term, relief against forfeiture under s. 98[5] of the *CJA* 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 O.R.
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> As McLachlin J. (as she then was) explained in *Falk Bros.*, at p. 784 S.C.R., the distinction between imperfect

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[5] The request for relief from forfeiture in *Kozel* was pursued under s. 98 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, because the "imperfect compliance" at issue (not being licenced to drive) did not relate to a matter arising after a loss had occurred (i.e., after the collision). As a result, s. 129 of the *Insurance Act* had no application: *Kozel*, at para. 58. However, *Kozel* is clear that the same analysis applies to determining whether there has been non-compliance with a condition precedent to coverage or imperfect compliance with a term of a policy whether the request for relief from forfeiture is made under s. 98 of the *CJA* or s. 129 of the *Insurance Act*.

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> compliance and non-compliance "is akin to the distinction between breach of a term of the contract and breach of a condition precedent". However, in the context of relief from forfeiture, the imperfect compliance/non-compliance analysis does not engage with the contracts jurisprudence on conditions precedent. Rather, the focus is on whether the breach of the term is serious or substantial. Where the term is incidental, its breach is deemed to be imperfect compliance; where the provision is fundamental or integral, its breach is cast as non-compliance with a condition precedent. [Emphasis added.]

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[41] Second, *Kozel* clearly holds that *Stuart* was correctly decided in its central holding that under claims made and reported policies, the requirement to report a claim within the policy period is a condition precedent to coverage. This is clear from para. 44 of *Kozel*, where LaForme J.A. explains why the requirement to report the claim within the policy period was a condition precedent to coverage in *Stuart*:

> Likewise, in *Stuart*, the import of the relevant contract provision – and accordingly, the scale of the breach – was an important factor in determining whether the breach constituted imperfect compliance or non-compliance with a condition precedent. At p. 332 O.R., 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. He stressed the conceptual difference between "occurrence" policies and "claims-made and reported" policies. In these latter policies, the notice provision is "integral".

[42] Reading *Stuart* and *Kozel* together, the statement in *Kozel* that *Stuart* should be given "narrow application" cannot be read as abandoning the distinction in *Stuart* between failure to comply with a condition precedent to coverage and

imperfect compliance with a term of a policy in favour of a broader test. Rather, *Kozel* recognizes that the principles in *Stuart* apply to contractual provisions that contain clear language identifying a condition that must be met to trigger coverage – such as those contained in claims made and reported policies. Where coverage has not been triggered, relief from forfeiture is not available. This court recently reached the same conclusion in *Furtado v. Lloyd's Underwriters*, 2024 ONCA 579, at paras. 76-80; see also *Lavoie v. T.A. McGill Mortgage Services Inc.*, 2014 ONCA 257, 119 O.R. (3d) 651, at para. 42; and *Dams v. TD Home and Auto Insurance Co.*, 2016 ONCA 4, 129 O.R. (3d) 226, at footnote 1.

[43] Thus, the holding in *Stuart* – that under a claims made and reported policy, failure to report a claim during the policy period is non-compliance with a condition precedent to coverage and not imperfect compliance with a policy term and thus relief from forfeiture is not available – remains undisturbed by *Kozel*. Accordingly, I reject the appellants' submission that under claims made and reported policies, relief from forfeiture is available where an insured fails to report the claim to the insurer within the policy period, if the insured can establish that the breach of the reporting requirement was not substantial and there is no prejudice to the insurer. If the Second Excess Policy is a claims made and reported policy – and thus, reporting is a trigger to coverage – relief from forfeiture is not available in this case.

[44] Before turning to the interpretation of the Second Excess Policy, I address the appellants' argument based on *McNish and McNish v. American Home*

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Assurance Co. (1989), 68 O.R. (2d) 365 (H.C.J.), affirmed (1991), 5 C.C.L.I. (2d) 222 (C.A.). The appellants argue that *McNish* stands for the proposition that terms in a policy about the timing of reporting a claim to the insurer are not conditions precedent to coverage. As a result, according to the appellants, relief from forfeiture is available where an insured fails to comply with a reporting provision.

[45] The appellants' reliance on *McNish* is misplaced. As this court explained in *Stuart*, the policy at issue in *McNish* was a claims made policy. The only trigger to coverage in *McNish* was the making of a claim during the policy period. Although the policy in *McNish* contained a clause requiring the insured to promptly notify the insurer upon learning of an event that may give rise to a claim, there was no express requirement in the policy that notice be given within the policy period. As such, in *McNish*, notice during the policy period was not "an integral part of the event triggering coverage". In other words, in the absence of a term requiring the reporting of a claim within the policy period, failure to comply with the prompt reporting term was imperfect compliance with a term of the policy, rather than non-compliance with a condition precedent to coverage: *Stuart*, at pp. 328-29.

[46] I agree with the respondents that the jurisprudence supports the conclusion that notice clauses requiring reporting "as soon as practicable" or "promptly" have typically been held to be terms of a policy that apply after coverage has been triggered, and not conditions precedent to coverage. As a result, reporting to an insurer that may be characterized as not being prompt has been held to be

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imperfect compliance with a term of a policy in the absence of a requirement that the claim be reported during the policy term: *McNish*; see also *Qualiglass Holdings Inc. v. Zurich Indemnity Company of Canada*, 2004 ABQB 577, 368 A.R. 171, at paras. 65-76 and 78-85. By contrast, where a policy contains a term that claims must be reported during the policy period, courts have held that reporting during the policy period is a condition precedent to coverage: *Stuart*; *Qualiglass*, at para. 80. This is the essence of a claims made and reported policy. It only provides coverage for claims both made and reported during the policy period. Having said this, each case turns on the wording of the particular policy.

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(iii) Interpretation of the Second Excess Policy – it is a claims made and reported policy

[47] Insurance policies are contracts. In interpreting insurance policies, a court must examine the wording of the policy and its structure, in light of surrounding circumstances, in order to determine the intent of the parties. In addition, a number of principles specific to interpretation of insurance contracts have developed; however, these specific principles only apply where there is ambiguity in the terms of the policy: *Jesuit Fathers*, at paras. 23, 27-30 and 33; *Reid Crowther*, at p. 261-62; *Stuart*, at p. 229-330.

[48] The appellants argue that the Second Excess Policy triggers coverage on a follow form basis by referring to the coverage clause in the First Excess Policy. In

other words, the appellants argue that the trigger to coverage under the Second Excess Policy is the making of a claim within the meaning of the First Excess Policy. The appellants argue that the First Excess Policy is a claims made policy, and therefore, since the Second Excess Policy relies on the coverage clause in the First Excess Policy, the Second Excess Policy is also a claims made policy. In other words, according to the appellants, neither the First Excess Policy nor the Second Excess Policy coverage grants require reporting to the insurer as a trigger to coverage.

[49] I would not accept this submission. It fails to consider the entirety of the insuring agreement clause in the Second Excess Policy and fails to read the policy as a whole.

[50] I begin with the coverage/insuring agreement clauses of the First Excess Policy and the Second Excess Policy:

Coverage clause of the First Excess Policy

The relevant portion of the coverage clause of the First Excess Policy provides that the First Excess Insurer agrees:

> To pay on behalf of the ASSURED all sums in excess of the Retention or any Underlying Insurance (including a compulsory policy) (as described in the Conditions), and which the ASSURED shall become legally obligated to pay as DAMAGES as a result of CLAIMS first made against the ASSURED during the POLICY PERIOD, or the Extended Reporting Period, if elected:

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> a) by reason of any act, error or omission in PROFESSIONAL SERVICES rendered or that have been or should have been rendered by the ASSURED or by any person for whose acts, errors or omissions whether of acts, facts, law or otherwise the ASSURED is legally responsible and arising out of the ASSURED'S profession as a lawyer or notary public;
>
> b) because of a PERSONAL INJURY (as defined herein) which arises out of the PROFESSIONAL SERVICES of the ASSURED as a lawyer or notary public; [Emphasis added.]

Insuring agreement clause of the Second Excess Policy

> The **Insurer** shall provide insurance coverage to the **Insured** in accordance with the terms and conditions of the **designated underlying policy** [i.e., the First Excess Policy] subject to the terms and conditions otherwise provided herein. [Bold in original; underlining added.]

[51] As can be seen from the extract above, the insuring agreement clause in the Second Excess Policy uses a "follow form" structure. A follow form structure in an excess insurance policy means that the insurance coverage is intended to be the same as the underlying policy (in this case, the First Excess Policy), but with coverage limitations that are prescribed by the excess policy: see *Cronos Group Inc. v. Assicurazioni Generali S.p.A.*, 2022 ONCA 525, at footnote 1 at para. 1; and *Vale Canada Limited v. Royal & Sun Alliance Insurance Company of Canada*, 2022 ONCA 862, at footnote 5 at para. 7 (both citing *Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London* (2007), 449 Mass. 621, 87 N.E. 2d 418).

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[52] The impact of the follow form structure of the insuring agreement in the Second Excess Policy is that in order to understand the triggers to coverage under the policy, one looks not only to the coverage provided by the underlying First Excess Policy, but also to coverage limitations contained in other provisions of the Second Excess Policy.

[53] It is not necessary to come to a firm conclusion on the nature of the First Excess Policy in order to interpret the Second Excess Policy.[6] Even if the appellants are correct that the First Excess Policy is a claims made policy, the terms of the Second Excess Policy modify the language of the coverage grant in the First Excess Policy to clearly include claims made and reported triggers to coverage.

[54] Consistent with its follow form structure, the insuring agreement clause in the Second Excess Policy refers back to the coverage clause in the First Excess Policy and provides that coverage is subject to limits set out in the Second Excess Policy.

[55] After stating that coverage is in accordance with the terms and conditions of the First Excess Policy, the insuring agreement clause in the Second Excess Policy continues that coverage is "subject to the terms and conditions otherwise

[6] There is language in some provisions of the First Excess Policy which support interpreting it as a claims made and reported policy. The application judge found that the First Excess Policy was a claims made and reported policy.

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provided herein". That is, the insuring agreement clause of the Second Excess Policy expressly conditions the grant of coverage on further terms and conditions in the Second Excess Policy. The insuring agreement clause in the Second Excess Policy is not simply a duplicate of the coverage clause in the First Excess Policy. The follow form language of the insuring agreement clause in the Second Excess Policy specifically anticipates that coverage triggers may be located in other provisions of the Second Excess Policy.

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[56] The "terms and conditions otherwise provided" in the Second Excess Policy include a claims made and reported clause. Clause D of Part IV of the Second Excess Policy provides as follows:

> This policy only covers **claims** first made against the **Insured** and reported to the **Insurer** during the **policy period** and provided that such **claim** arises out of an act, error or omission committed or alleged to have been committed on or after the retroactive date set forth at Item. 6 of the Declarations. [Bold in original; underlining added.]

[57] Reading together the insuring agreement clause of the Second Excess Policy and clause D of the policy, the terms are clear that the policy "only covers claims" which are both made against the insured and reported to the insurer "during the policy period". In other words, clause D clearly indicates that to trigger coverage under the Second Excess Policy, a claim must be both made and reported during the policy period.

[58] The appellants argue that clause D, requiring that claims be reported to the insurer "during the policy period", is not a condition precedent to coverage because it is not contained in the insuring agreement clause of the Second Excess Policy. The appellants rely on *Stuart* for this proposition. I disagree with this argument for two reasons.

[59] First, *Stuart* does not support the proposition that a claims made and reported requirement must be contained in the coverage clause/insuring agreement for it to be a condition precedent to coverage. Rather, it supports the proposition also set out in *Jesuit Fathers* and *Reid Crowther* that a court must interpret the insurance policy as a whole, and ordinary principles of contractual interpretation apply in the absence of ambiguity.

[60] It is true that the policy at issue in *Stuart* included a reporting requirement in the coverage clause; however, that was not the clause considered by this court. Rather, the reporting requirement that the court considered in *Stuart* was contained in the "Special Reporting Clause". The Special Reporting Clause was the provision in the contract that covered potential claims (as distinct from actual claims, which were addressed in the coverage clause of the policy). The Special Reporting Clause required written notice to the insurer of the potential claim during the policy period (or extended reporting period, if purchased): *Stuart*, at pp. 325-26 and 330-31. This court nonetheless held that the policy in *Stuart* was a claims made and reported policy.

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[61] Similarly, in *Furtado,* while the Director and Officer liability policy included a reporting requirement in the coverage clause itself, the reporting requirement that the court construed as a coverage trigger was, like *Stuart*, found in the notice of circumstance clause which required written notice of potential claims during the policy period. In *Furtado*, the notice of circumstance clause was contained in the General Conditions of that policy: *Furtado* at paras. 83-84 and 91. As in *Stuart*, this court held that the policy was a claims made and reported policy.

[62] Thus, both *Stuart* and *Furtado* support the proposition that a policy can be construed as a claims made and reported policy even if the reporting requirement is not contained in the coverage clause itself.

[63] Second, the follow form nature of the insuring agreement clause in the Second Excess Policy and its specific wording explain why the triggers to coverage are not express in the insuring agreement clause. Although it is not essential that a claims made and reported clause be contained in the insuring agreement clause of a policy, in a primary policy, typically, the triggers to coverage are included in the insuring agreement clause for reasons of clarity.

[64] In a follow form excess insurance policy like the Second Excess Policy, the insuring agreement clause departs from the typical language of an insuring agreement clause. A comparison between the insuring agreement clauses in the First Excess Policy and the Second Excess Policy demonstrates the difference.

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The First Excess Policy sets out both the grant of coverage and the limitations on coverage:

> To pay on behalf of the ASSURED all sums in excess of the Retention or any Underlying Insurance (including a compulsory policy) (as described in the Conditions), and which the ASSURED shall become legally obligated to pay as DAMAGES as a result of CLAIMS first made against the ASSURED during the POLICY PERIOD… [Emphasis added.]

[65] In contrast, the insuring agreement clause of the Second Excess Policy does not reference the insurer’s obligation to indemnify, nor does it expressly enumerate the triggers to coverage. Rather, the insuring agreement clause in the Second Excess Policy incorporates by reference the coverage grant in the underlying policy (the First Excess Policy) and provides that any coverage triggers will be found both in the underlying policy and in other terms and conditions of the Second Excess Policy.

[66] The insuring agreement clause in the Second Excess Policy expressly makes the scope of coverage “subject to the terms and conditions” otherwise provided in the Second Excess Policy. As a result, the reporting requirement contained in clause D of Part IV of the Second Excess Policy, which clearly states that the policy “only covers claims” that are both made and reported “during the policy period” is incorporated as a trigger to coverage under the policy.

[67] For these reasons, I agree with the application judge that the requirement in the Second Excess Policy to report a claim “during the policy period” is a condition

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precedent to coverage. The language in the insuring agreement clause when read together with clause D makes clear that reporting the claim during the policy period is a condition precedent to coverage.

(iv) Relief from forfeiture is not available because the Second Excess Policy is a claims made and reported policy

[68] In light of my conclusion that reporting the claim to the insurer during the policy period is a condition precedent to coverage under the Second Excess Policy, the application judge was correct in concluding that relief from forfeiture was not available.

[69] The appellants failed to report the claim to the respondent during the policy period. Because reporting the claim during the policy period was a condition precedent to coverage, coverage was not triggered. This was a breach of a condition precedent to coverage and not imperfect compliance with policy terms after the triggering of coverage. In accordance with *Stuart*, because the failure to report the claim to the respondent was a failure to comply with a condition precedent to coverage, relief from forfeiture is not available.

[70] There is no unfairness to the appellants from this result. As this court held in *Stuart*, under claims made and reported policies the requirement of reporting the claim to the insurer during the policy period is central to the bargain struck between the insured and the insurer. In exchange for lower premiums, coverage is only

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triggered if the claim is reported during the policy period. As this court noted in *Stuart*, excusing reporting outside the policy period under a claims made and reported policy would rewrite the policy to cover a non-covered claim. This is because the bargain struck by the parties did not include coverage for claims that are not reported to the insurer during the policy period.

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(2) If relief from forfeiture was available, did the application judge err in his analysis of whether he should not exercise his discretion to order such relief?

[71] In light of my conclusion that relief from forfeiture is not available, it is not necessary to consider the application judge's conclusion in the alternative that he would not have exercised his discretion to grant relief from forfeiture.

Disposition

[72] I would dismiss the appeal. As agreed by the parties, I would order the appellants to pay the respondents' costs of the appeal in the amount of $28,000, inclusive of disbursements and applicable taxes.

Released: August 9, 2024 "E.E.G."

"J. Copeland J.A."
"I agree. E.E. Gillese J.A."
"I agree. Wilton-Siegel J. (*ad hoc*)"