KING'S BENCH FOR SASKATCHEWAN

Citation: **2024 SKKB 151**

Date: **2024 08 20**
File No.: QBG-RG-00238-2014
Judicial Centre: Regina

BETWEEN:

JUDY SJOGREN-ZUCK

PLAINTIFF

- and -

3sHEALTH SHARED SERVICES SASKATCHEWAN (FORMERLY SASKATCHEWAN ASSOCIATION OF HEALTH ORGANIZATIONS)

DEFENDANT

Appearing:

Judy Sjogren-Zuck	self-represented plaintiff
Reginald A. Watson, K.C. and Brooklyn R. Ireland	for the defendant

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JUDGMENT
AUGUST 20, 2024

MEGAW J.

INTRODUCTION

[1] The plaintiff has commenced an action against the defendant seeking to recover damages as a result of a denial of coverage by the defendant for disability benefits under the Disability Income Plan [Plan]. There are three issues for the court to determine. The first is whether, pursuant to the terms of the Plan, the plaintiff's application was made too late to allow for coverage. Second, if the application was filed outside the timelines set forth in the Plan, the court must then decide if the plaintiff should be relieved from forfeiting any benefits under the Plan despite such failure to

comply with its terms. The third issue is to determine whether the plaintiff was, in fact, disabled such as to qualify for benefits under the defendant's Plan, either from her own occupation period or from any occupation thereafter.

[2] I have determined that the application for benefits by the plaintiff was made outside the time limits set forth in the Plan and I decline to exercise my discretion in these circumstances to provide relief from forfeiture. I have further determined that the plaintiff has failed to prove on a balance of probabilities that she was disabled pursuant to the terms of the Plan. As a result, I have determined that the plaintiff's claim must be dismissed.

[3] The defendant additionally sought to have the plaintiff's claim dismissed on the basis that she had failed to comply with treatment options and accordingly was in violation of the Plan terms. I decline to determine that issue in view of the lack of evidence in that regard.

[4] The defendant requested that I reserve the issue of costs for further argument once this decision was rendered. The parties may make arrangements to make submissions with respect to costs, through the local registrar's office.

[5] The plaintiff represented herself in this action and some comment is made on that in this judgment. However, it is important to note that the judgment provided herein is arrived at from a review of the evidence tendered in this action. The court is not entitled to arrive at a decision based on anything outside of that evidence which was called. During final argument the plaintiff advanced comment on certain matters which were not in evidence. Counsel for the defendant voiced his objection to this occurring. None of that which might have transpired in this action, but was not in the evidence presented, has been considered in this decision.

[6] My reasons follow.

BACKGROUND

[7] The defendant is the administrator of the Plan. The Plan is a negotiated benefit between the union, SEIU-West, and the health care employer. The Plan is found at Exhibit A, Tab 1 of the trial brief of the plaintiff, filed July 6, 2023. There is a commentary that comes with the Plan, and it is found at Exhibit A, Tab 2. The parties are agreed that at all material times, the plaintiff was a member of the Plan. The defendant, as the Plan provider, is a distinct and separate entity from both the plaintiff's employer and from the union which represented her during her employment.

[8] In 2009, the plaintiff was employed at the Wakaw, Saskatchewan hospital in the dual roles of a laboratory and x-ray technician. On May 22, 2009, while at work, the plaintiff injured her back when she was attending to a patient who was to receive an x-ray. There is no dispute but that the plaintiff did suffer an injury. Rather, it is the extent of the injury which is at issue. The plaintiff attended on her family physician and was diagnosed with a back strain. It appears she worked for a few days after the incident but then stopped working on June 2, 2009.

[9] The plaintiff initially applied for and received Workers' Compensation [WCB] benefits. Her physician originally directed that the plaintiff remain off work for two weeks. He then directed that she commence a gradual return to work program. This was done through the WCB claim which the plaintiff had filed and under the auspices of the WCB.

[10] Through the WCB claim, the plaintiff was initially engaged in a gradual return to work program with her employer and with the assistance of an assessment which had been completed by the Saskatoon Musculoskeletal Rehabilitation Centre. The plaintiff voluntarily discontinued her involvement in that return to work program on August 24, 2009, without clearance being provided either by the WCB or her physician.

[11] This action by the plaintiff resulted in the WCB discontinuing its coverage of her and denying her claim. The plaintiff did not subsequently return to her employment and the last day recorded for her at work was August 25, 2009. The plaintiff indicated that, essentially throughout this time, her employer was difficult to deal with and had expressed their displeasure with her not being at work. The plaintiff was ultimately formally dismissed from her employment on January 18, 2010, presumably as a result of her failure to return to work as requested by the employer. However, the actual interactions between the plaintiff and her employer were not detailed in any respect in the evidence presented at the trial.

[12] Throughout this time, the plaintiff continued to engage with WCB. Even though WCB had discontinued payments, it appears it was continuing to actively assist the plaintiff in attempting to find a return to work program for her that would allow her to resume her employment. It appears they were unable to arrive at a program that the plaintiff was prepared to accept. The plaintiff's personal physicians, Dr. Ardell and Dr. Campbell, provided documentation stating the plaintiff was disabled from work. The evidence does not indicate that these physicians performed any type of complete physical examination of the plaintiff. Rather, it appears they completed their diagnosis based upon the subjective symptoms relayed to them by the plaintiff.

[13] The plaintiff indicated she requested the form necessary to apply for disability benefits from her employer sometime in September 2009. The defendant was not involved with this request and is a separate and distinct entity from the employer. There is no evidence before the court, aside from the plaintiff's extremely brief testimony, either that this request was done or what the outcome of the request was. There was no evidence presented to establish that the plaintiff attempted to complete the application form at any time prior to this time frame.

[14] It appears from the evidence that by December 10, 2010, the plaintiff had received the necessary form(s) to apply for the disability benefits from the defendant. She completed a form and submitted it to the defendant. The defendant denied coverage for the plaintiff's application on the basis the application was received outside the six month period from the time of total disability (Trial Brief Book of Materials of the Defendant, Tab 37).

[15] As indicated, throughout this time, the evidence indicates that WCB, despite having denied ongoing coverage, was continuing to engage with the plaintiff and provide programs for her to engage in to aid in her recovery. It does not appear, from the evidence, that the plaintiff participated in those various efforts.

[16] In early 2012, an assessment by an orthopedic specialist, Dr. Yon-Hing, was arranged. He determined there was a surgical option available for the plaintiff given her back condition. It appears his opinion was based on his conclusions that the back condition was not solely caused by the workplace injury incurred by her but rather was caused by her life factors. However, in order to carry out the proposed surgery, he required her to make certain lifestyle changes including getting exercise, losing weight, and stopping smoking. The plaintiff was not prepared to make those changes and accordingly, the surgical option was not completed, or pursued any further. There is no indication that the plaintiff sought out any other options in this regard.

[17] It may be that the plaintiff filed a grievance against her employer following her workplace injury. The plaintiff did not explain in any way the nature of any action taken by her, or her union, against any actions of her employer. It is not known from the evidence whether this grievance, assuming that is what it was, arose from the employer's actions or inactions concerning her claim for disability, her workplace injury, or her failure to return to work.

[18] This aspect of the background was not developed in any way other than

by reference to a meeting apparently held in late May 2013 between a representative of the Labour Relations Board [LRB], the union, and the employer. Notably, the defendant was not a party either to whatever proceedings were being carried on through the LRB, nor this meeting that was conducted. The plaintiff did not testify as to these proceedings or any detail concerning the meeting.

[19] There is nothing in the evidence to suggest the defendant was aware of the plaintiff's actions against her employer nor whether the plaintiff's concerns regarding her employer were in any way connected to the defendant. There was no evidence presented by the plaintiff on these aspects and there is nothing in the defendant's evidence or documents to suggest otherwise.

[20] Mr. Joe Jaworski, the manager of the disability department with the defendant, received a telephone call on May 29, 2013, from a Fred Bayer, who presumably was the representative of the LRB referred to above. According to Mr. Jaworski's notes of this telephone conversation, found at Tab 45 (Trial Brief Book of Materials of the Defendant), the LRB, the employer, and the union, had reached an agreement that while the plaintiff did not comply with the requirements of the Plan, they requested the defendant review the matter to reassess the plaintiff's entitlement to disability benefits. It is not known on what basis this discussion was had between the various parties. It is clear that this discussion was not, in any way, binding upon the defendant. It is further clear that the defendant was not aware of any such meeting at the time it was held nor was it ever asked to participate in any discussions on this topic. It remains a mystery in these proceedings as to what exactly was the nature of the LRB proceeding and why a representative of the LRB was contacting the defendant with respect to this matter.

[21] As well, it remains a mystery in these proceedings what became of the plaintiff's grievance or proceeding against her employer. It appears that with the

agreement between the non-parties to this litigation, the grievance may have simply come to an end. It does not appear the plaintiff received any type of decision on the grievance and neither does it appear she recovered anything beyond this agreement between non-parties. It was not explained why this is so.

[22] Mr. Jaworski testified that on behalf of the defendant, he agreed to complete a further review of this matter for the plaintiff. There is nothing to suggest that by providing such agreement Mr. Jaworski or the defendant was committing to do anything under the Plan or to provide any benefits to the plaintiff. There was no indication from the conversation with Mr. Bayer as to what, if any, further information would be forthcoming from, or on behalf of, the plaintiff. Mr. Jaworski indicated that they were looking to receive any information which might assist in having them change their minds regarding the plaintiff's eligibility for disability insurance coverage. There is no evidence to suggest either there was additional information provided in this regard, or that the plaintiff, or anyone on her behalf, sought an opportunity to provide any such further information.

[23] Mr. Jaworski completed this further review of the file. It appears from the evidence of this individual that he carefully and fully reviewed the complete file material with respect to the plaintiff's claim. He reviewed in his testimony the plaintiff's file and the text of the Plan. It was clear that, despite the unusual way in which the request for such a review had come before him, his review was intended to be thorough and complete.

[24] Mr. Jaworski authored a letter to the plaintiff advising that the denial of coverage was being maintained on the basis that the timeline within which the application for benefits was required to be made under the Plan was not complied with. He indicated that in these circumstances the defendant was not prepared to overlook this requirement.

[25] In addition to the denial of coverage by the defendant and the denial of further coverage by WCB, the plaintiff's application for disability coverage pursuant to the Canada Pension Plan was also denied on March 5, 2014.

[26] By agreement between the parties, during the course of this action, the plaintiff was referred to Dr. Hillel Sommer to have an independent medical examination completed as part of this litigation. From that examination, Dr. Sommer produced his independent medical examination report. That report is found at Exhibit C-1, Tab A (Exhibit Book, Volume I), and is 43 pages long. Dr. Sommer reviewed some 218 documents and reports, and completed a complete physical examination of the plaintiff, in order to arrive at the conclusions in his report. He identified his task at being to provide an opinion on the following:

> REASON FOR REFERRAL
>
> To provide an opinion on:
>
> - Whether the Plaintiff's [*sic*] was able to perform the duties of her own occupation as a Certified Laboratory and X-Ray Technician from late May of 2009 until the end of her own occupation period which was September 29, 2011?
>
> - Whether the Plaintiff's [*sic*] was able to perform the duties of an occupation to which she was reasonably suited by virtue of her education, training and experience after September 29, 2011 and continuing to the date of this examination?

[27] Dr. Sommer testified at trial and provided detail as to his qualifications, the independent medical examination, his method of completing his analysis, together with his conclusions regarding the questions asked of him on the reasons for referral. He concluded that the plaintiff was not disabled from her own occupation as a result of the injury to her back. He further concluded that following the applicable period of time in the Plan, she was not disabled from any occupation. He stated as follows:

> To summarize, it appears that the Plaintiff's physical injuries were not a primary barrier for her returning to her workplace on July 17, 2009.

> Rather, it appears that the Plaintiff's perception of her activity limitation is incompatible with her objective physical findings. This, combined with adverse relationship issues that evolved in the workplace, where the primary factors that likely led to the Plaintiff not returning to work in 2009.
>
> Notwithstanding the Plaintiff's perception of her physical abilities, none of the mental healthcare practitioners who have assessed the Plaintiff, have identified a psychiatric diagnosis that precluded her from returning to the essential tasks of her occupation. Further opinion on this issue is deferred to a mental healthcare practitioner.
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> …
>
> In summary, with regard to the Plaintiff's low back "injury" sustained on May 22, 2009, it would have been reasonable to provide a brief period of time away from the workplace to permit the Plaintiff to attend to treatment of her condition with medication and to access rehabilitation services with physiotherapy and chiropractic. Although arbitrary, a duration of 6-8 weeks appears reasonable for a non-ominous nor neurogenic diagnosis, as is consistent with a lumbar strain.
>
> …
>
> Following this arbitrary time interval off work, when she returned to work July 17, 2009, it is medically probable that the Plaintiff was physically capable of safely carrying out the essential tasks of her own occupation as a Certified Laboratory and X-Ray Technician. Since there is no ensuing injury or medical condition identified in the file records, or change in the physical diagnosis thereafter, it is likely that she would have been physically fit to continue to perform the essential tasks of her occupation until the end of her own occupation period on September 29, 2011.

[28] With respect to the question of whether she was disabled from any occupation after September 29, 2011, Dr. Sommer concluded:

> It is worth noting that individuals with objective loss of physical function including those with limb amputation, stroke, and spinal cord injury, successfully undergo rehabilitation that permits them to return to similar occupations as they performed prior to developing their clinical condition. From a physical perspective, the Plaintiff's condition has minimal objective loss of physical function, and is certainly quantifiably less than those patient categories noted above.
>
> Consequently, with regard to the state of the Plaintiff's current health status, it is medically probable that [*sic*] physically capable to perform

> the duties of any occupation to which she is reasonably suited by virtue of her education, training and experience after September 29, 2011 and continuing to this date.

[29] This action was commenced on December 9, 2013. The plaintiff represented herself at the trial of the action. The plaintiff called two witnesses, herself and her friend, Shirley Fotheringham. The defendant called the plaintiff's family physician, Dr. Campbell for purposes of cross-examination. The defendant then called two additional witnesses as part of its case, Mr. Jaworski and Jade Lea Wilson, both employees of the defendant. Finally, Dr. Sommer was called as a court witness. The defendant led the bulk of the evidence from this independent medical expert.

ISSUES

1. The status of the plaintiff as a self-represented litigant.

2. What is the effect of the plaintiff's delay in applying for benefits under the Plan?

3. Was the plaintiff disabled either from her own occupation or from any occupation in accordance with the terms of the Plan?

DECISION

1. The status of the plaintiff as a self-represented litigant

[30] The plaintiff represented herself in these proceedings. She called two witnesses at the trial, her friend and herself. She gave quite brief and limited evidence on her own behalf, and she participated in an extremely limited way both in the questioning of witnesses and in presenting her final argument. Specifically, in view of the plaintiff's limited involvement in the trial, the court determined that oral closing arguments should be provided to permit the plaintiff, in particular, a full opportunity to make such submissions as she wished. Again, she participated in an extremely limited

and abbreviated way and did not indicate any desire to present anything more complete.

[31] The defendant arranged for the compilation of a complete documentary record with respect to the plaintiff's claim for disability coverage. The defendant endeavoured to enter into an agreement with the plaintiff as to which documents should be submitted as exhibits at the trial and further endeavoured through the examination of the witnesses to have a full presentation of the evidence. Without these efforts, the evidentiary record would be even less complete.

[32] Throughout the trial, and during closing argument, the plaintiff was encouraged by the court to engage in the questioning of witnesses and in the presentation of a full and complete argument. With respect to the testimony of the witness, Mr. Jaworski, the plaintiff did not question the witness in any meaningful way, and accordingly the court engaged in questioning of the witness. With respect to the testimony of Dr. Campbell, the plaintiff was permitted to engage in some questioning in the interests of assisting her with her case. Regardless of these efforts, the plaintiff declined to engage further with the witness or to present any further evidence.

[33] In particular, the plaintiff did not really, or effectively, challenge the evidence presented by either Mr. Jaworski or Dr. Sommer. These two witnesses provided the defendant's evidentiary response to all three of the questions identified in the introduction to this judgment. As will be discussed, these two witnesses provided a full and complete explanation of those matters upon which they were called.

[34] It is unclear why the plaintiff determined to so limit her engagement at the trial of the action. It appears she was provided with the opportunity to become more fully engaged. Despite the plaintiff's general failure to present either any challenge to the evidence of the defendant or to present more full and complete evidence on her own behalf, I am satisfied that the evidentiary record is complete to allow for this decision to be rendered. This is so principally through the defendant's efforts to ensure

everything relevant was placed before the court.

[35] There was some evidence before the court regarding the difficult road this action has followed and the plaintiff's general ill-will towards the defendant. That ill-will does not factor in this judgment. At the end of the day, the court is compelled to render its decision based on the evidence called and the submissions advanced.

2. What is the effect of the plaintiff's delay in applying for benefits under the Plan?

[36] The Plan provides as follows:

> 5.2 Long Term Disability Benefit
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> Long Term Disability benefits shall be paid to any Member who:
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> (i) has not attained age sixty-five (65); and
>
> (ii) is Totally Disabled on the date her Qualifying Period expires and has remained Totally Disabled throughout the Qualifying Period; and
>
> Amend 2(a) (iii) supplies proof of Total Disability during the Qualifying Period; and
>
> (iv) is not denied payment by any limitations as set forth in Section 5.3; and
>
> (v) satisfies the conditions outlined in Article 3; and
>
> (vi) has applied for Long Term Disability benefits within six (6) months of the Member's date of Total Disability unless the Member has received full indemnity for the disability from any source referred to in Article 6, in which case the Member shall have applied not later than ninety (90) days from the discontinuation of the benefits or indemnity received; and
>
> (vii) furnishes from time to time as required by the

Administrator, information on prescribed forms from a Physician as to the cause, nature, and duration of such Total Disability; and

(viii) if so required by the Administrator, undergoes therapy or treatment recommended by a Physician and/or consults with and takes treatment or such corrective measures as may be recommended and prescribed by a qualified medical specialist.

5.3 Limitations

No payment will be made for claims resulting from a Total Disability:

(i) for which the Members is not under continuing medical supervision and treatment considered satisfactory by the Administrator;

(ii) caused by intentional self-inflicted injuries or self-induced illness while sane or self-inflicted injuries while insane;

(iii) from bodily injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country, or participation in a riot;

(iv) which occurred during the commission or the attempted commission of an indictable offence under the Criminal Code for which the Member is convicted and incarcerated;

(v) experienced during the first year of membership which resulted from injury or illness related to any injury or illness for which medical attention was received during the six (6) months prior to the Employee becoming a Member of the Plan. This limitation will only apply to Employees hired after June 30, 1978 and is applicable to Long Term Disability benefits only;

(vi) which occurred during the period of cessation of work due to a strike, except that the benefits may be claimed to commence immediately following the end of the strike if the Member is still qualified in accordance with all of the other terms of the Plan; or

> (vii) if the Member has established permanent residence outside of Canada.
>
> Where an Employee has been transferred from one facility to another under the same ownership of a Contributing Member, or where a Contributing Member takes ownership of a facility, the continuous membership in the Plan of the prior facility or prior owner will count towards the first year of membership in this Plan for the purposes of clause 5.3(v).

[37] The evidence establishes that the plaintiff's last day of work appears to have been June 2, 2009. Her WCB benefits were then denied originally on September 5, 2009. While she was reinstated for these benefits on February 2, 2010, and again denied coverage on August 21, 2010, due to her non-compliance with the directions of the WCB, she was effectively denied on the earliest of these dates. She initially applied for benefits from the defendant on December 7, 2010. Prior to that time, the defendant had not been contacted by the plaintiff nor did it have any knowledge of her medical condition or of any potential disability claim that she might advance.

[38] According to the terms of the defendant's Plan, the plaintiff was required to apply for benefits on or before December 4, 2009. According to the terms of the Plan, she must apply within 90 days from the discontinuation of the benefits or indemnity received. She did not do this. As a result, she did not comply with the terms of the Plan in making her application in a timely manner.

[39] The plaintiff argues that due to the reinstatement of her WCB benefits, her timeline was extended to November 18, 2010. The Plan is clear that the application must be made within 90 days of the discontinuation of benefits. That occurred on September 5, 2009.

[40] The plaintiff did not present any argument disputing that she had failed to comply with the timelines as set forth in the Plan. She did not deal with this aspect in either her evidence or in the closing argument. There was some evidence presented

regarding errors which had been made on the form as submitted to the defendant. It is unclear who made those errors as they appear on the form. But, regardless, the issue is not whether errors were made but rather whether the plaintiff is entitled to pursue her claim under the Plan despite having failed to comply with the time requirement set forth in the Plan.

[41] As a result of the failure to comply with the terms of the Plan, the court must consider whether this is an appropriate case in which to grant relief to the plaintiff despite such failure. This Court has the jurisdiction to grant relief from forfeiture for the failure to comply with timelines in an insurance contract pursuant to the provisions of both *The King's Bench Act*, SS 2023, c 28 and *The Insurance Act*, SS 2015, c I-9.11:

> *The King's Bench Act*:
>
> **Power to relieve against penalties, forfeitures**
>
> 3-5 The court may grant relief against penalties and forfeitures and, in granting that relief, may impose any terms with respect to costs, expenses, damages, compensation and any other issues that the court considers appropriate.
>
> *The Insurance Act*:
>
> **Relief from forfeiture**
>
> 8-12 The court may relieve against a forfeiture or avoidance of insurance on any terms it considers just if the court considers it inequitable that there has been a forfeiture or avoidance of insurance, in whole or in part, on the ground that there has been imperfect compliance with a Statutory Condition, or a condition or term of a contract of insurance, as to:
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> (a) the proof of loss to be given by the insured or the claimant; or
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> (b) another matter or thing done or omitted to be done by the insured or the claimant with respect to the loss.

[42] The considerations for the court in applying this discretionary remedy are completely set forth in the recent Court of Appeal decision of *CE Design Ltd. v*

Saskatchewan Mutual Insurance Company, 2021 SKCA 14, 455 DLR (4th) 417:

> [151] In very general terms, a claim for indemnity on a policy of insurance may prove unsuccessful where the insured has breached a term of the policy. Failure to comply with the terms of an insurance policy can result in loss of coverage. That said, where there has been imperfect compliance with a condition by an insured, a court may relieve against forfeiture where it considers it appropriate to do so. The Supreme Court discussed this concept in *Falk* [*Falk Bros. Industries Ltd. v Elance Steel Fabricating Co. Ltd.*, [1989] 2 SCR 778] in these terms (at 783):
>
> > The purpose of allowing relief from forfeiture in insurance cases is to prevent hardship to beneficiaries where there has been a failure to comply with a condition for receipt of insurance proceeds and where leniency in respect of strict compliance with the condition will not result in prejudice to the insurer. This purpose is consistent with interpreting s. 109 [of *The Saskatchewan Insurance Act*, RSS 1978, c. S-26 (repealed)] as permitting the court to grant relief from contractual as well as statutory conditions
>
> [152] Relief from forfeiture is an equitable, discretionary remedy: see, for example, *Saskatchewan River Bungalows Ltd. v Maritime Life Assurance Company*, [1994] 2 SCR 490 at 504 [*SK Bungalows*], and *Kozel v The Personal Insurance Company*, 2014 ONCA 130 at para 29, 372 DLR (4th) 265. It calls for a court to determine, first, whether it has the authority to grant this form of relief and, second, whether the circumstances warrant granting relief (*Falk* at 781). The following three factors influence the exercise of the court's discretion in this regard: (a) the conduct of the insured, (b) "the gravity of the breach", and (c) "the disparity between the value of the property forfeited and the damage caused by the breach" (*SK Bungalows* at 504, quoting *Liscumb v Provenzano* (1985), 51 OR (2d) 129 (Ont H Ct J) at para 30).
>
> [153] It is evident from a reading of the *Summary Judgment* [*Saskatchewan Mutual Insurance Company v Homegrown Advertising Inc.* (5 April 2019) Saskatoon, QB 171 of 2008 (Sask)] that the above factors were not analyzed by the Chambers judge. However, it is equally evident from the briefs of law filed by the parties at the time of the summary judgment application that counsel did not turn their minds to the nuances of this issue; and, more importantly, CE Design did not seek relief from forfeiture. Where does that leave this Court?
>
> [154] In the end result, I see no reversible error on the part of the Chambers judge. He found numerous breaches of the policy. While he may have misunderstood or overstated the evidence in relation to the

> first two breaches, he appropriately identified two other breaches: i.e., no consent had been obtained for the settlement agreement or the assignment. If CE Design wanted to obtain relief from non-compliance with the terms of the insurance policy, it had to place that issue before the Chambers judge and establish the necessary evidentiary foundation for it. It failed to do so.
>
> [155] Next, as a corollary to the waiver argument, CE Design argues the Chambers judge erred in principle in finding that the Defendants had waived their rights under the insurance policy by voluntarily assuming an obligation (settlement agreement) without SMI's consent. This argument springs from the Chambers judge's comment, "Not only did they not advise SMI in an expeditious manner, they proceeded to make a settlement agreement and had the agreement approved by the Illinois Court without any notice to SMI" (*Summary Judgment* [*Saskatchewan Mutual Insurance Company v Homegrown Advertising Inc.* (5 April 2019) Saskatoon, QB 171 of 2008 (Sask)] at para 16).

[43] I deal firstly with the conduct of the insured. The plaintiff was approximately one year beyond the latest timeframe in the Plan for submission of her application. She provided no explanation for such a lengthy delay nor did she attempt to support her inaction by arguing the delay should have no effect on the availability of coverage for her. Rather, it appears the plaintiff just wants the court to take no notice of the limitation period in the Plan and ignore that particular section.

[44] The plaintiff's failure in this regard was significant. From the evidence, it appears to have occurred without any involvement of the defendant. There may be no suggestion here that the defendant either took steps, or failed to take steps, which contributed to or encouraged the plaintiff's failure to comply with the application period. The evidence establishes that the defendant was not aware of the plaintiff's potential claim until it physically received the application form.

[45] Why the plaintiff did not pursue her claim against the defendant earlier is not known from the evidence tendered at trial. It would be speculation for the court to surmise that this failure was somehow connected to a complaint the plaintiff had with her employer's actions at this time. But, again, the employer and the defendant are two

separate bodies and accordingly whatever complaint the plaintiff had with the actions of her employer cannot transfer to the defendant in this action.

[46] I next discuss the gravity of the breach. Mr. Jaworski testified as to the rationale behind the filing requirement in the Plan. He indicated that the timeline permits the disability insurer an opportunity to be involved in the initial assessment and management of the file. In particular with low back injury claims, the experience of the defendant has been that their claimants achieve a higher success rate with returning to work if the defendant can be involved in the management of any return to work programs. A delay in application means that management of injury and ability to design return to work programs disappears.

[47] Furthermore, the timeline in the Plan allows the defendant to evaluate the applicant's willingness to comply with treatment requirements and to appropriately deal with any failures in this regard. In this case, the evidence led was that the plaintiff had been non-compliant with the directions of the WCB. This would have an impact on her ability to deal with her injury due to that non-compliance.

[48] The plaintiff provided little in the way of explanation for the delay in applying. Again, it was intimated that her employer had been less than cooperative in providing the application document and then in completing their required documentation correctly. There is little evidence showing when the plaintiff requested the application document nor what efforts she took, if any, to get the application going even if the employer was being uncooperative. The actions of the employer do not impact on the defendant in this action.

[49] There was no evidence presented to show whether the plaintiff attempted to contact the disability insurer directly or obtain the application forms from any other means to allow her to complete her application. Rather, the evidence presented was to the effect that the plaintiff took no steps to deal directly with the defendant prior to the

late submission of her application form nor did she make any inquiries concerning the Plan.

[50] As a result of the foregoing, I conclude, based on the evidence principally of Mr. Jaworski, that the time requirement of the Plan is of considerable importance to the defendant to allow it to assess, manage, and determine claims for disability coverage. The inability of the defendant here to do that, from the evidence of Mr. Jaworski, impacted directly on whether or not coverage could be provided to the plaintiff. Dr. Sommer also testified as to the need to cause injured workers to get back to work to aid in their recovery. This evidence echoes the concerns of the defendant in receiving late notice resulting in an inability to effectively manage an injury claim.

[51] Finally, I consider the disparity between the value of the property forfeited and the damaged caused by the breach. The plaintiff's claim is for disability payments until the age of 65. She seeks to receive these benefits as a result of an incident which occurred at work. The initial assessments completed by the WCB and the healthcare providers were that the plaintiff should be able to return to work and should be managed through a return to work program. She did not comply with the return to work requirements and she declined to participate in that which was directed of her. It appears she made these decisions on her own without medical input and, apparently, without solid justification for such cessation.

[52] The defendant has been denied the opportunity to be involved with the management of the plaintiff's injury from the earliest opportunity following that injury. As a result, the defendant has been denied the opportunity to provide guidance and assistance in getting the plaintiff back to work. I consider this to be a considerable loss to the defendant. While the plaintiff has lost her ability to have her claim considered by the defendant, the defendant has been exposed to a considerable claim without the ability to attempt to limit both its exposure and the plaintiff's time away from work.

[53] The burden of proof to obtain relief from forfeiture resides with the plaintiff. She provided little information concerning why the application was made late. She provided no information explaining what actions she took in this regard. She provided no indication she even attempted to contact the defendant earlier than the December 2010 application. There is nothing in the evidence to allow the court to conclude that the plaintiff made any efforts in this regard.

[54] There is similarly nothing in the evidence to show that the defendant did anything other than assess this claim in accordance with its usually conducted procedure. Mr. Jaworski presented as a thoughtful and meticulous administrator of the Plan. He reviewed the complete file with a view to determine if a waiver of the time frame was warranted. In light of the issues raised above, he was unable to provide such a waiver.

[55] In all of the circumstances, I am unable to reasonably exercise my discretion to grant relief from forfeiture in these circumstances. As a result, the plaintiff's claim must be dismissed on the basis that she failed to comply with the notice provisions in the Plan.

3. Was the plaintiff disabled either from her own occupation or from any occupation in accordance with the terms of the Plan?

[56] The defendant did not rest its defence of this claim on the failure of the plaintiff to apply for benefits in accordance with the terms of the Plan. In this regard, it conducted a full review of the medical information on file and the parties agreed to the retainer of Dr. Sommer to complete an independent medical examination of the plaintiff.

[57] Dr. Sommer testified at the trial. He indicated that he regards himself as an independent witness and is not an advocate for either party. Rather, his function is

to thoroughly review the medical information, physically examine the plaintiff, and provide his unbiased opinion based on the information gathered, to the court.

[58] Dr. Sommer is a physician and physiatrist. He has additional training and qualification in the area of physical medicine and rehabilitation. He has training as a medical evaluator for injuries involving insurance claims. In addition to his independent medical examinations, he also carries on his own medical practice and teaches at the medical school in Manitoba.

[59] In arriving at his conclusions, he attempts to give evidence-based answers to the questions that are asked and to what he finds with respect to any particular individual. As indicated, he reviewed some 218 individual reports, comprising hundreds of pages of material, and provided comment on each of them in his report. He conducted a thorough examination of the plaintiff.

[60] Dr. Sommer presented at trial as an expert who was extremely knowledgeable in his field of expertise and who endeavoured to be complete, thorough, and neutral, in his evaluation of the case. I found his evidence to be extremely persuasive and accordingly I accept his conclusions. I note that his conclusions were not challenged in any way by the plaintiff nor were they questioned through any of the material filed in his report.

[61] Dr. Sommer commented on the finding by the plaintiff's family physician, Dr. Campbell, as to disability. Dr. Sommer opined that such conclusions by Dr. Campbell were of no assistance as it appeared no complete physical examination had been completed to allow for any such conclusions. I accept this rational as it appears the family physicians were merely attempting to assist the plaintiff in managing her self-described levels of discomfort. In this regard they were prescribing ever increasing levels of pain medication and were not working to discover the underlying problem or any treatment which might assist with that underlying problem. They were accepting

of the descriptions of symptoms provided by the plaintiff and were not performing their own independent physical examination of her.

[62] Dr. Sommer concluded that from his examination of the plaintiff and from his review of the medical information, she was not disabled from her own occupation following the initially eight week period when she was off work. He further concluded that as of September, 2011, the applicable two year period in the Plan, she was not disabled from any and all occupations for which she was reasonably suited by virtue of her education, training, and experience. He opined that she is able to work at some occupation in accordance with her education, training and experience. I accept that conclusion also.

[63] It is noted that Dr. Sommer's opinion is confirmed by his independent physical examination of the plaintiff. She had a range of motion in her spine that would allow her to perform her regular activities.

[64] As a result of all of the foregoing, I determine that the plaintiff has failed to establish that she was either disabled from her own occupation or from any and all occupations within the terms of the Plan. As a result, the claim must also be dismissed on that basis.

Conclusion

[65] I determine that the plaintiff's claim must be dismissed. The defendant had also advanced a denial of coverage due to the plaintiff's failure to complete recommended treatment in accordance with s. 8.3 of the Plan. In light of the conclusions reached in this decision, I decline to provide comment on this aspect. It is clear that the plaintiff declined to follow the WCB program, but the evidence is either absent, or unclear as to the reasons for that occurring. As a result, I am unable to be satisfied, on a balance of probabilities, that the plaintiff was in violation of this provision of the Plan.

Costs

[66] The parties have leave to speak to the issue of costs, and arrangements in this regard should be made through the office of the local registrar.

J.
M.T. MEGAW