NOVA SCOTIA COURT OF APPEAL
Citation: ***Walsh v. Unum Provident***, 2013 NSCA 124

Date: 20131108
Docket: CA 405527
Registry: Halifax

Between:

Douglas Walsh

Appellant

v.

Unum Provident, a body corporate

Respondent

Judges: MacDonald, C.J.N.S.; Saunders and Fichaud, JJ.A.

Appeal Heard: October 15, 2013, in Halifax, Nova Scotia

Held: Appeal dismissed with as agreed $8,000 all inclusive costs on appeal payable to the respondent, per reasons for judgment of MacDonald, C.J.N.S., Saunders and Fichaud, JJ.A. concurring

Counsel: Colin D. Bryson, Q.C., for the appellant
Michelle Awad, Q.C. and Sara Mahaney, for the respondent

Reasons for judgment:

OVERVIEW

[1] The respondent, Unum Provident (now RBC Life Insurance Company) and its predecessors, provided disability coverage to the appellant, Douglas Walsh, dating back to 1993. In 2000, a claim for "major depression disorder" was filed and, for a time, honoured. Then Unum questioned Mr. Walsh's ongoing disability and stopped paying. This prompted the present action.

[2] In preparing for trial, Unum secured and reviewed Mr. Walsh's medical records. It noted a litany of undisclosed health problems that pre-dated the application for coverage. The list included heart problems, headaches, seizures, anxiety, and back problems. Furthermore, Unum concluded that these problems, had they been known, would have affected its decision to offer coverage. Unum ultimately viewed these as fraudulent material misrepresentations prompting it to then challenge the actual coverage. It therefore counterclaimed seeking (a) a declaration that the policy was void from the outset, (b) the return of its money with interest, and (c) legal costs.

[3] Justice Arthur W. D. Pickup of the Supreme Court of Nova Scotia heard the matter and found entirely in Unum's favour (2012 NSSC 86). Specifically, he accepted Unum's counterclaim in its entirety including the return of all benefits paid plus interest. Alternatively, the judge also found that Mr. Walsh was not disabled under the policy, thereby affording Unum a full defence to the claim proper. Mr. Walsh now appeals to this Court.

[4] I would dismiss the appeal, essentially, by adopting the judge's reasoning on the fraudulent material misrepresentation issue. As I will explain, this result flows from a correct articulation of the law upon which unassailable factual findings were applied.

ANALYSIS

The Decision Under Appeal

[5] My analysis will primarily involve a careful review of the judge's decision and why I feel it ought not be disturbed. Following that, I will, however, attempt to address the main thrust of the appellant's case on appeal.

[6] At the outset, the judge accurately explained Mr. Walsh's statutory duty to disclose information that would be material to the insurer's decision to offer coverage:

> ¶7 It is not in dispute that an applicant for insurance has an obligation to disclose facts within his knowledge that are material to the insurance. Part IV of the *Insurance Act*, R.S.N.S. 1989, c. 231, governs accident and sickness insurance, including disability policies. The following provisions govern the plaintiff's duty to disclose material facts, and set out the consequences of a breach:
>
> > Duty to Disclose
> >
> > 82 (1) An applicant for insurance on his own behalf and on behalf of each person to be insured, and each person to be insured, shall disclose to the insurer in any application, on a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within his knowledge that is material to the insurance and is not so disclosed by the other.
> >
> > (2) Subject to Sections 83 and 86, a failure to disclose, or a misrepresentation of, such a fact renders a contract voidable by the insurer.
>
> ¶8 I am satisfied that the plaintiff had a duty to disclose to the defendant all material facts within his knowledge when he applied for the policy on May 28, 1993.
>
> . . .
>
> ¶10 In Schjerning and Norwood, *Disability Insurance Law in Canada* (Carswell, 2010), the duty to disclose is explained at p. 28:
>
> > Because the insurer has no knowledge of an applicant's health, income or other required history when an application is made for a policy, insurance

> contracts are *uberrimae fidei*, imposing a duty on applicants to make full and true representations of facts which are material to the insurance risk ....

[7] At the same time, the judge recognized that it remains the insurer's obligation to prove both the misrepresentation and the fact that it would have been material to its decision to offer coverage at the specified rate:

> ¶13 The question of materiality is a question of fact for the court and the burden is on the insurer. It is also a question of fact for the court to determine whether, if the matters misrepresented had been truly disclosed, they would have influenced a reasonable insurer to decline a risk or to have stipulated for a higher premium.
>
> ¶14 The burden on a defendant in determining whether material misrepresentations and/or omissions were made, is explained in Schjerning and Norwood, *Disability Insurance Law in Canada* at p. 31:
>
>> It is important to point out that the test of materiality is an objective one, and not a subjective one peculiar to the insurer which is involved. Otherwise, this would leave it open to an insurer to assert, after the event, that it would not have accepted the risk. Accordingly, a particular insurer cannot repudiate the contract merely by claiming that the fact misrepresented would not have satisfied its own private internal underwriting considerations. The insurer's underwriting rules must be shown to be in reasonable conformity with the ordinary standards for measuring insurable risks applied by insurers in general. Materiality, therefore, must be tested in the context of a "reasonable" insurer.
>>
>> Whether or not the insurer's underwriting rules and standards will be considered to be those of a "reasonable" insurer will fall to be determined by the court. Evidence brought by the particular insurer involved of its own underwriting rules and practices is, of course, required and will be accorded some weight, but it is not conclusive. **Independent outside expert underwriters are of necessity called as expert witnesses by insurers to establish that their underwriting denial was reasonable**.
>>
>> Since, to be material, a fact must be one which would influence a reasonable insurer to decline the risk or set a higher premium, it follows that only significant matters will be considered to be material misrepresentations. Minor indispositions of health, or minor discrepancies in respect of the insured's family health history, or past occupation are examples of misrepresentations which are generally immaterial.

> The onus lies upon the insurer to demonstrate the undisclosed facts which were within the insured's knowledge, and certainly to prove materiality when it is advancing its case for material misrepresentation.
>
> [emphasis added]

[8] Then, relying on Unum's insurance industry expert, the judge concluded that the alleged misrepresentation would indeed have been material to the coverage issue:

> ¶18 The defendant called Robert Blake Tufford, to provide evidence of a reasonable insurer's response had the plaintiff disclosed an accurate medical history. Mr. Tufford was qualified as an expert in life and disability insurance underwriting, qualified to give opinion evidence in the area of life and disability insurance underwriting, including the assessment of risks, insurers' options when asked to underwrite risks and reasonable insurers' decisions with respect to specific underwriting risks. The materiality test refers to the objective standard of the "reasonable insurer". Mr. Tufford was of the opinion that a reasonable insurer would have declined the plaintiff's application had there been full disclosure of medical information.
>
> ¶19 The plaintiff did not provide expert evidence on the issue of how a reasonable insurer would have handled the claim, but did challenge Mr. Tufford's testimony based on alleged material errors in his report, as well as alleged bias. The absence of an expert opinion from the plaintiff creates an evidentiary gap, as there is no opinion, other than Mr. Tufford's, as to what a reasonable insurer would have done in the circumstances. Likewise, there is no other expert opinion evidence as to whether or not the misrepresentations or omissions by the plaintiff were material. The plaintiff's failure to offer contrary opinion evidence means he cannot offer any evidence to displace the defendant's experts' views. As with any expert opinion, those witnesses must be scrutinized by the court; the court need not automatically accept that evidence. Moreover, the absence of any contrary expert evidence weakens any criticism the plaintiff might offer.
>
> ¶20 In general, Mr. Tufford concluded that the medical histories of heart, headache and anxiety, as evidenced in the plaintiff's medical records, would have caused a reasonable insurer to decline the plaintiff's application. Mr. Tufford testified that there were other parts of the plaintiff's medical history that would not have resulted in a decline of the plaintiff's application had they been disclosed, but rather would have generated other underwriting responses. For example, the plaintiff's history of back troubles (in addition to what was

> disclosed) would have caused an exclusion rider to be added to the policy, and the information on seizures and epilepsy would have caused a reasonable insurer to charge a higher premium. Further, while the histories of heart, headache and/or anxiety on their own would have caused the insurer to decline the disability policy, the other non-disclosed medical conditions when viewed in their entirety would also have caused the defendant to decline to write a policy. Mr. Tufford stated at p. 16 of his report:
>
> > 4. The ratings suggested for each impairment above are on a stand alone basis. It is my opinion that with the combination of conditions and histories a prudent underwriter at a reasonable insurer would have considered Mr. Walsh ineligible for disability coverage on any basis [in] 1993.
>
> . . .
>
> ¶47 In summary, Mr. Tufford concluded that the non-disclosure regarding the plaintiff's medical history of headaches, diseases of the heart and anxiety and stress, would each, on their own, have caused a reasonable insurer to decline. I accept Mr. Tufford's opinion in this regard.

[9] With this backdrop, the judge then, in considerable detail, assessed each alleged misrepresentation. He began with Mr. Walsh's history with seizures, finding that they should have been reported:

> ¶22 The plaintiff testified that he was diagnosed with epilepsy by an emergency room physician after a 1983 incident which led to him being hospitalized for several days. There was also some reference in the medical evidence to further seizures suffered by the plaintiff after that time. The relevant application question asked of the plaintiff was:
>
> > 2. Have You ever had any known indication of or been treated for:
> >
> > ...
> >
> > e. Headaches, fainting spells, epilepsy, paralysis or other disease of the brain or nervous system?
>
> ¶23 The "no" box was checked for this question.
>
> ¶24 Despite being told by the emergency physician that he had epilepsy, the plaintiff testified that he was subsequently seen by a specialist, Dr. David King, who told him he was not an epileptic. Therefore, he answered "no" to this question. The defendant's position is that even if the plaintiff's recollection of Dr.

> King's opinion was correct, it still would not justify the "no" answer on the application.
>
> ¶25 In Schjerning and Norwood, *Disability Insurance Law in Canada*, the authors make the following remarks at p. 29:
>
> > 29 The insured may not know exactly what their symptoms indicate, but, if aware of certain symptoms and if asked for on the application, the insured must disclose them. The insured may genuinely feel that their surgical operation was successful, that a diagnostic prognosis was reassuring, or be quite unaware of or troubled by the results, but the insured certainly knows they had surgery and that they undertook the diagnostic test. While the insured may not know what their doctor knows, and it may be that the doctor chose not to disclose fully the state of health to the insured, this does not alter the fact that the insured *did* consult a doctor or was treated by a doctor. Essentially, therefore, the insured's duty is to disclose to the insurer the *fact* of all other symptoms, consultations, and medical treatments or tests, regardless of the insured's own belief as to their importance or significance or that they feel they are free of health problems.
>
> ¶26 The fact the question was asked and the wording of the question required disclosure by the plaintiff; by his own admission the plaintiff had been told by an emergency room physician that he had epilepsy.

[10] The judge then addressed Mr. Walsh's history with headaches, finding his reasons for non-disclosure "not credible":

> ¶27 Question 2e of the medical questionnaire referred to headaches. The plaintiff indicated that he had never been treated for headaches, nor had there been any known indication of headaches by checking "no" to this box. On direct examination the plaintiff testified that he had only had a few migraines, but on cross-examination confirmed that he had been having migraines for years, including when he lived in Cape Breton and worked on oil rigs. He confirmed that Dr. Wu, his general practitioner in Sydney prior to 1990, had prescribed a migraine medication, Ergomar. Later, the plaintiff was seen in Halifax by Dr. Fraser, his family physician, who referred him to Dr. Stephen Bedwell, a neurologist. Dr. Fraser described the plaintiff's headache history in his December 5, 1991 referral letter to Dr. Bedwell:
>
> > Over the past five years Mr. Walsh has had rather frequent headaches involving the frontal and parietal areas of the skull ... The headache is much more common in the early morning and is beginning to cause him some concern.

> He also gives a history of some form of migraine headaches, his vision problems and for this he takes Ergomar, with effect.

> ¶28 Although the plaintiff answered "no" to question 2e, the evidence is that less than two years before his May 28, 1993 application, his family doctor was describing a five year history of headaches. This information likely came from the self-reporting of the plaintiff to Dr. Fraser. After reviewing this information, Mr. Tufford concluded at p. 15 of his report that "a prudent underwriter at a reasonable insurer would consider the history and treatment as now known necessitated declining in 1993."

> ¶29 When he was asked why he answered "no" to this question, the plaintiff said that he had not been asked the question and if he had been he would have answered "yes". With respect, I accept the evidence of Ted Fraser, the insurance agent who filled out the application that he asked this question of the plaintiff.

> ¶30 The plaintiff gave no other credible explanation for answering "no". He did suggest that if the question was structured differently he would have answered differently. Generally, the plaintiff suggests that the questions posed on the application were vague, yet offered no evidence to support this position. The suggestion that if the question respecting headaches had been structured differently, the plaintiff would have answered differently, implies very specific comprehension, understanding and listening to the question as asked by Mr. Fraser in 1993. This position is at odds with the plaintiff's allegation that Mr. Fraser read the questions quickly and with the suggestion that the questions were vague and that he may not have understood them. The plaintiff's history of headaches was recent. His reasons for not disclosing this information are not credible.

[11] Then the judge found Mr. Walsh's answers regarding his back problems to be incomplete:

> ¶31 The application question concerning back problems was found at 2n:
>
> > 2. Have **You** ever had any known indication of or been treated for:
> >
> > ...
> >
> > n. Any type of back or spinal trouble including sprain, strain, or disc disease?
>
> ¶32 The plaintiff checked the "yes" box and, as a result, was asked to complete a back pain questionnaire. On this questionnaire he disclosed an incident in 1984 when he was working on an oil rig where he slipped and fell while lifting a pump. Mr. Tufford testified there are a number of other references in Dr. Ashton's file (including Dr. Fraser's files that Dr. Ashton was in possession of) as to ongoing

back problems. A report of March 3, 1987 by an orthopaedic surgeon, Dr. A.M. Mirza, referred to back pain problems after the 1984 incident on the oil rig, including a reference to further back pain caused by driving long distances while working for Shell. Mr. Tufford's conclusion as to these omissions was as follows:

> The history as now known was chronic and recurrent over a number of years. Even though the last known history was in 1987, I feel a prudent underwriter at a reasonable insurer would feel that an exclusion rider involving the lumbar spine and spina bifida occulta was indicated in 1993.

¶33 Mr. Tufford testified that this particular withholding of information would not have resulted in the policy being declined but was another example of misrepresentation or omission, which, when considered with other examples of non-disclosure, would result in an insurer declining to issue a policy.

¶34 While the incident on the oil rig was approximately 9 years before the signing of the application, the reference to the back problems suffered while he was a Shell employee would have been more recent, and would be material and should have been disclosed.

[12] The judge then turned to Mr. Walsh's "chest pain", highlighting several concerns:

¶35 In addition to the 1983 indication of epilepsy, the emergency room doctor at that time also told the plaintiff that he had "a hole in his heart". The relevant application question is 2c and is as follows:

> 2. Have **You** ever had any known indication of or been treated for:
>
> ...
>
> c. Chest pain, heart murmur, high blood pressure, or any disease of the heart, blood vessels, or blood?

¶36 The plaintiff checked "no" in the relevant box. I am satisfied that although the plaintiff had received information from his doctor that he did not have heart problems, he was required to disclose this information. An insured is obliged to disclose to the insurer the fact of all of their symptoms, consultations and medical treatments or tests, regardless of their own belief as to the state of their health.

¶37 More significantly, the plaintiff had EKG tests in September 1990 and February 1991, close to the time he completed the 1993 application for insurance. The first EKG/ECG Report Form indicated the following under interpretation:

> Abnormal sinus bradycardia at 55 per minute. There are ST segment changes in 2, 3 and AVF with ST segment depression, particularly in 3 and AVF - compatible with inferior wall aschemia.

¶38 The second EKG dated February 12, 1991 stated as follows under "interpretation":

> Sinus bradycardia at 55 per minute, intraventricular conduction delay. The ST segment and T-WAVE changes in 11, 111 and AVF noted on the previous tracing are still present and unchanged.

¶39 Mr. Tufford made the following comments about this information at p. 14 of his report:

> The finding of left ventricular hypertrophy in 1983, chest pain in 1985, further chest pain in 1990 (age 32) and 1991 when ECG changes were noted as indicative of inferior wall ischemia would be of concern to any underwriter, and would require referral to the Medical Director.
>
> Without a more extensive cardiovascular work-up I feel a prudent underwriter at a reasonable insurer would have declined in 1993.

¶40 As well, question 4c is relevant:

> 4. Within the past 5 years, other than the preceding have **You**:
>
> ...
>
> c. Had an X-ray, ECG, blood or urine test, or other lab tests?

¶41 The plaintiff answered "no". I am satisfied that the plaintiff should have answered "yes" to both question 2c and question 4c.

¶42 At trial the plaintiff said that he did not recall undergoing these EKGs. Forgetting about two EKG tests completed within six months of one another and within three years of the application date is not reasonable nor credible. The plaintiff also suggested that his chest pain related to periodic indigestion. If that were the case, question 2p is relevant which is as follows:

> 2. Have **You** ever had any known indication of or being treated for:
>
> ...
>
> p. Any type of peptic ulcer, indigestion, or any disease of the stomach, intestines, gall bladder or liver?

¶43 The plaintiff answered "no". The plaintiff did not disclose this relevant material medical information to the defendant.

[13] Finally, the judge addressed Mr. Walsh's "anxiety and stress" problems:

¶44 The relevant question regarding anxiety and stress was 2f:

> 2. Have **You** ever had any known indication of or been treated for:

> ...
>
> f. Anxiety, depression, nervousness, stress, burnout, or other emotional disorder?
>
> ¶45 The "no" box was checked. The defendant alleges that the plaintiff failed to disclose a history of anxiety and stress. Mr. Tufford testified that Lectopam is a sedative for anxiety disorders and it had been prescribed to the plaintiff in 1983.
>
> ¶46 Closer to the date of the application was a reference in a letter of December 12, 1991 to Dr. Fraser from Dr. Bedwell, that the plaintiff admitted that he was "under considerable stress". Further, Dr. Bedwell in a February 20, 1992 letter to Dr. Fraser indicated "all this is in fact secondary to stress and I think a mild relaxant would be reasonable". After reviewing this information, and noting the "recurring episodes", Mr. Tufford concluded at p. 15 of his report, that "a prudent underwriter at a reasonable insurer would have declined in 1993." I am satisfied that the plaintiff's treatment for stress was recent and should have been disclosed.

[14] The judge then turned to Mr. Walsh's excuses for answering the questions as he did. He rejected all explanations:

> ¶52 The plaintiff made a number of allegations about the circumstances surrounding the signing of the application for insurance. The plaintiff alleges that the questions posed were confusing and/or vague, and that there was information inserted in the application after it was completed and signed.
>
> ¶53 The circumstances surrounding the signing of the application for insurance were described in the evidence of the plaintiff, Ted Fraser and Greg Flack. There is no dispute that the application was completed on May 28, 1993, nor is it disputed that the application was signed by the plaintiff in the presence of Mr. Fraser. Mr. Fraser could only recall part of his dealings with the plaintiff on that day, but did testify as to his general practice when completing a disability insurance application. His practice was to read each question to the applicant and to record the answers. He said he typically advised applicants to provide accurate and complete answers to the application questions. He recalled that the plaintiff made no comment which would lead him to believe that he did not understand the questions he was being asked.
>
> ¶54 The plaintiff testified that Mr. Fraser told him that it was not necessary to review the completed application. Under cross-examination, Mr. Fraser said he passed the completed application to the plaintiff and asked him to review it before signing. He denied advising the plaintiff that the application need not be reviewed. I accept the evidence of Mr. Fraser in this regard.

¶55 Mr. Fraser said his memory of the events surrounding the signing of the application was not very sharp, as the event was 18 years ago. While he did not recall asking specific questions, he testified that he would have asked the questions and written down the answers provided by the plaintiff. I accept the evidence of Mr. Fraser on this issue.

¶56 Generally the plaintiff questions Mr. Fraser's evidence because during cross-examination it became apparent that Mr. Fraser had made some errors in his direct evidence as to what portion of the application was in his handwriting. While I am satisfied his evidence on direct examination was incorrect in part, I am not satisfied that this would be sufficient reason to consider Mr. Fraser's testimony not credible or to excuse the plaintiff from his non-disclosure of his prior medical history.

¶57 A good deal of cross-examination of the defendant's witnesses was directed at the circumstances of the application and, in particular, who had completed the various sections. Ted Fraser identified his handwriting and Greg Flack, who worked in the Halifax brokerage office of Paul Revere in 1993, identified his handwriting.

¶58 While there were inconsistencies in the evidence as to who wrote what, I am satisfied that between those two individuals virtually all of the entries were identified. Mr. Flack testified that it was not uncommon for him to fill in the income portion of the application either through information gathered from Mr. Fraser or other external sources such as an accountant.

¶59 I am satisfied on the evidence that the section dealing with the plaintiff's health related information was completed by Mr. Fraser. I accept the evidence of Mr. Fraser as to the circumstances surrounding the signing of the application of May 28, 1993. I am satisfied that he read over the questions to Mr. Walsh (other than for question 2g) and recorded the plaintiff's response. I also accept his testimony that the plaintiff appeared to understand the questions. As to question 2g, Mr. Fraser testified that he had no explanation for that question not being answered, other than to say that he must have neglected to ask this question. I accept his evidence on that point.

¶60 Mr. Fraser presented as helpful and forthright, both on direct and cross-examination. He answered questions posed by both counsel earnestly and seriously.

¶61 There was also some question by the plaintiff about who filled in some financial information in the application. I am not satisfied that this is relevant to my determination as it does not concern the medical evidence that allegedly had not been disclosed. In any event, among the four men involved in the application process, namely Charles Nauss, Ted Fraser, Greg Flack and the plaintiff, only Charles Nauss and the plaintiff would know the net annual income amounts which

were required to complete section 1d. In other words, whether it was Ted Fraser or Mr. Flack who wrote in the income figures, the information would have had to come from the plaintiff or Mr. Nauss.

¶62 The plaintiff also highlighted the speed at which Mr. Fraser read a question from the application on direct examination. The plaintiff suggests that this is indicative of the speed at which Mr. Fraser would have read the questions to the plaintiff at the time he signed the application, the implication being that this led to the plaintiff's confusion and is somehow a reason for not having disclosed his past medical history.

¶63 Mr. Fraser explained on cross-examination that the speed of his reading during his trial evidence could be contrasted with the circumstances of his meeting with the plaintiff to complete the application. It must be remembered that Mr. Fraser testified that the plaintiff appeared to understand the questions. In response to the questions about back pain, the plaintiff related the incident where he hurt his back when he worked on an oil rig in the early 1980's. It can be inferred from this that the plaintiff understood the question. I am not satisfied that the speed at which Mr. Fraser read a question in direct examination was indicative, in any way, of how he would have asked the questions at the time the application was completed.

¶64 The plaintiff suggested that the questions asked on the application were ambiguous. No evidence was provided that this was the case. Moreover, the application contained what I would consider a catch-all question, namely question 4 which asked:

> 4. Within the past 5 years, other than the preceding have **You**:
>
> a. Been examined by or consulted a physician, chiropractor, psychologist, physiotherapist or other practitioner?
>
> b. Been under observation, or treatment in any hospital, sanitarium, or institution?
>
> c. Had an X-ray, ECG, blood or urine test, or other lab tests?
>
> d. Had any surgical operation, treatment, special diet, or any illness, ailment, abnormality or injury?
>
> e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?

¶65 The plaintiff answered "no" to each of these questions. Even if he did not understand the preceding questions, he should have answered "yes" to c, at least, because of the EKG tests, and to 4a and b based on the medical evidence.

> ¶66 I am satisfied that none of the issues raised by the plaintiff surrounding the signing of the application explain the reason for, or excuse, the non-disclosure or misrepresentation of his medical history as required by the *Insurance Act*. Nor am I satisfied that the circumstances surrounding the signing of the application are such that Mr. Fraser's evidence should be considered "with a great deal of caution" as suggested by the plaintiff.

[15] However, because the contract was in effect for over two years, a finding of material misrepresentation would not be enough to void the policy. Instead, Unum would have to go further and establish that the representations were fraudulent. As the judge explained, this could be established by Unum proving either intent or recklessness:

> ¶67 The plaintiff was under a duty to disclose to the defendant all material facts within his knowledge at the time he applied for the policy. I have found that there were material non-disclosures. If the material non-disclosures were made fraudulently, the plaintiff's claim must fail and the defendant's counterclaim must succeed. The onus is on the defendant to establish on a balance of probabilities that the non-disclosures were made fraudulently.
>
> ¶68 The relevant provision of Part IV of the *Insurance Act* provides as follows:
>
> > 83(1) Subject to Section 86 and except as provided in subsection (2),
> >
> > > (a) where a contract, including renewals thereof, except a contract of group insurance, has been in effect continuously for two years with respect to a person insured, a failure to disclose or a misrepresentation of a fact with respect to that person required by Section 82 to be disclosed does not, except in the case of fraud, render the contract voidable;
>
> ¶69 On the issue of incontestibility the plaintiff suggests that the threshold for enforceability under the policy is higher than the threshold of the Act. I am not satisfied that this is the case. On a review of s. 9.2(a) of the policy and s. 83(1) of the *Insurance Act*, *supra*, I see no substantive difference between the two.
>
> ¶70 The defendant does not dispute that the incontestibility provisions apply and that it has the burden of proving fraud. I am satisfied actual fraud must be established. That is, the defendant must establish something more than an innocent or negligent material misrepresentation.
>
> ¶71 The test for fraud was considered in *Kruska v. Manufacturers Life Insurance Company* (1984), 54 B.C.L.R. 343, 1984 CanLII 888 (B.C. S.C.) affirmed at 1985 CanLII 464 (B.C.C.A.)), at paras. 37 and 38:

> 37. The accepted test of actual fraud in a civil case derives from Derry v. Peek (1889), 14 A.C. 337 (H.L.). There must be a false representation, made knowingly, without belief in its truth, or recklessly, without care whether it is true or false. Nothing less than this will suffice for the defendant to succeed in this case. Conduct without fraudulent intent which, before the statute, might have been characterized as fraud will no longer so qualify. The effect of the statute is that the insured is still bound by her duty of utmost good faith until the incontestability clause takes effect. After that time she will be held covered if her material misrepresentation or non-disclosures were made innocently, or negligently. The incontestability clause protects her from false representations of that kind. But it will not protect her if she has the fraudulent mind described in *Derry v. Peek*. Then the law will deprive her, or her beneficiaries, of the proceeds of the contract.
>
> [emphasis added]
>
> 38. Fraud, as defined for these purposes, must be proven by the defendant insurer on the balance of probabilities, the ordinary civil standard of proof: *Hanes v. Wawanesa Mut. Ins. Co.*, [1963] S.C.R. 154. However, the seriousness of the conduct alleged is a circumstance to be considered in determining whether the matter has been sufficiently proven: *Smith v. Smith*, [1952] 2 S.C.R. 312 at 331.

[16] On the facts as he found them, the judge found the misrepresentations to be intentional, or alternatively reckless:

> ¶72 The insurance agent Ted Fraser met with the plaintiff, read the questions to him and recorded his responses. Other than an indication of previous back pain in 1983 all of the other questions were answered in the negative. Contrary to the arguments of the plaintiff, I do not find the questions confusing. Each of the questions asked whether the plaintiff had "any known indication of or been treated for" the listed conditions. There is no indication that the plaintiff did not understand the questions. At the time he filled out the questionnaire he was a busy contractor with a successful company. There was no indication in 1993 that he was suffering from any condition that would affect his comprehension of the questions and his answers. On p. 6 of the application, above his signature was the following:
>
> > **It is understood and agreed as follows:**
> >
> > (1) I have read the statements and answers recorded in Parts 1, 2 and 3. They are, to the best of my knowledge and belief, true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued on it.

¶73 Also, the following caution was in bold letters immediately above the signature space:

> **This application will form part of any insurance contract issued. The contract will be of utmost good faith, based upon the statements contained in this application. You are responsible for the accuracy of the statements. Before signing, please verify that all answers are correct and complete and that you have initialled any changes to those answers. Inaccurate answers to any questions may affect your eligibility for coverage and/or benefits.**

¶74 Ted Fraser was also required to sign the application. Immediately above the signature space for his name was the following caution:

> **I certify that I have truly and accurately recorded on this Application the information supplied by the Applicant in my presence.**

¶75 An insured is bound by their signature on an application for insurance. They are especially so bound where the document they sign has a clear caution that the insured applicant is responsible for the accuracy of the statements and should inaccurate answers be provided to any questions, it may affect eligibility for coverage and/or benefits. In *Disability Insurance Law in Canada*, the learned authors state at p. 32:

> Because alleged cases of misrepresentation often turn into a contest of he said/she said where an insured claims to have told the agent of their health condition but the agent advised that it was not serious enough to disclose or that the agent forgot to record the insured's answer, the law has developed that an insured is bound by their signature to any false declaration contained in an application.

¶76 The defendant says that given the extent of the plaintiff's misrepresentations and omissions, it is open for this court to conclude they were fraudulent; either deliberately misleading or because the plaintiff was so reckless as to the truth of his answers and, the consequences of his giving them, that his actions were dishonest. The plaintiff says that the defendant has not met its burden of proving fraud.

¶77 While it is understandable that an individual may forget medical complaints and conditions identified many years previously, in this instance it stretches credibility to suggest the plaintiff would not at least have disclosed some of the many conditions that the medical evidence reveals he was treated for. I accept the evidence of Mr. Tufford, which is uncontradicted, that these misrepresentations or omissions were material and, as a result, a reasonable insurer would have declined to issue a policy had they been aware of the many medical conditions

> subsequently disclosed. I am satisfied there is ample factual basis to support Mr. Tufford's opinion.
>
> ¶78 It is not believable that the plaintiff in 1993 (who was only in his early 30's) forgot all of the medical history that was missing from his application. The reason he most often gave is that he forgot, and his counsel argues that the plaintiff could not be expected to provide information which he could not recall. With respect, this is not credible and I can come to no other conclusion than that the plaintiff consciously withheld the medical information called for on the application. This was a false representation made and knowingly without belief in its truth. Alternatively, I conclude that he was reckless, as it stretches the imagination to believe that he would not recall these numerous medical conditions, tests and attendance at specialists. There was no evidence as to why this information would not have been disclosed other than that the plaintiff had forgotten. It would be understandable if there were one or two isolated omissions of information from many years previously, however, here the evidence shows a significant number of omissions, many of them recent.

[17] All this prompted the judge to grant Unum the relief it sought:

> ¶79 There will be a declaration that the insurance policy in question is void *ab initio* and the plaintiff's action is, therefore, dismissed.
>
> ¶80 The parties have agreed that the plaintiff has been paid benefits in the amount of $125,119.20. The plaintiff shall reimburse the defendant in the amount $125,119.20, plus pre-judgment interest. I will leave it to the parties to calculate the total amount repayable by the plaintiff and submit it in a draft order to the court.

[18] In my view, this thorough analysis leaves little left to be said. It is sound in law. Furthermore, the judge made significant factual findings, many of which went directly to Mr. Walsh's credibility. These findings are solidly supported by the evidence and fall completely within the judge's discretion. They do not come close to reflecting the palpable and overriding error that would have to exist for us to interfere. See **Housen v. Nikolaisen**, 2002 SCC 33, at ¶ 4 and 18; **Fleet v. Federated Life Insurance Co. of Canada**, 2009 NSCA 7; at ¶ 18.

The Alleged Errors

[19] However, I will attempt to address what I perceive to be the thrust of the argument on the coverage issue.

[20] Essentially, Mr. Walsh insists that Unum's health questions were ambiguous and that the judge should have realized this. In other words, instead of determining what he (the judge) thought the questions meant, he should have asked what the questions *could* have meant to a prospective insured. Had he done so, he would have realized that many of the so-called misrepresentations were not misrepresentations at all. And, of course, without misrepresentations, there could be no fraud. He explains it this way in his factum:

> 54. …In his pre-trial brief (Appeal Book, Volume 6, Tab 2, Pages 38 to 39), Mr. Walsh argued that the questions on the insurance application form were ambiguous and that it was important to consider the nature and context of the questions, specifically referencing this Court's decision in *Fleet v. Federated Life Insurance Co. of Canada*, 2009 N.S.C.A. 76 (Appellant's Book of Authorities, Tab 4). The trial judge's decision does reflect any consideration of the *Fleet* decision or the cases referenced in it. The trial judge's legal analysis was limited to the following at paragraph 25 (Appellant's Book of Authorities, Tab 13):
>
> > 25 In Schjerning and Norwood, *Disability Insurance Law in Canada*, the authors make the following remarks at p. 29:
> >
> > > 29 The insured may not know exactly what their symptoms indicate, but, if aware of certain symptoms and if asked for on the application, the insured must disclose them. The insured may genuinely feel that their surgical operation was successful, that a diagnostic prognosis was reassuring, or be quite unaware of or troubled by the results, but the insured certainly knows they had surgery and that they undertook the diagnostic test. While the insured may not know what their doctor knows, and it may be that the doctor chose not to disclose fully the state of health to the insured, this does not alter the fact that the insured did consult a doctor or was treated by a doctor. Essentially, therefore, the insured's duty is to disclose to the insurer the fact of all other symptoms, consultations, and medical treatments or tests, regardless of the insured's own belief as to their importance or significance or that they feel they are free of health problems.
>
> 55. It is submitted that the above reference to *Disability Insurance Law in Canada* is an incomplete statement of the law, and if the concluding sentence is

> focused on, as the trial judge did at paragraph 36 of the decision, an incorrect statement of law. It is submitted that to properly analyse the alleged misrepresentations, the *Fleet* decision and the cases referenced in the *Fleet* decision needs to be considered and that the trial judge erred in failing to do so. …

[21] At the outset, I should note a basic disagreement between the parties regarding the standard upon which we should review this aspect of the judge's decision. The appellant insists that whether Unum's questions are ambiguous involves an issue of law that would therefore be ultimately left for us to decide on the correctness standard. In other words, we would offer the judge no deference. After all, says Mr. Walsh, we can read a document as easily as a trial judge.

[22] However, Unum insists that the judge's interpretation of the questions is inextricably tied to his factual findings about how the document was completed. Thus, says Unum, the judge was engaged in an exercise of mixed fact and law which would command deference so that, as with factual findings, we would interfere only in the face of palpable and overriding error. In advancing this position, it relies on the Manitoba Court of Appeal decision of **Badenhorst v. Great-West Life Assurance Co.**, 2013 MCBA 5 (leave to appeal dismissed in 2013 SCCA 118), where Scott C.J.M. observed:

> ¶50 Materiality, in the context of insurance, is ordinarily a question of fact, but a trial judge must apply the correct legal standard to those facts. In this instance, the trial judge applied the wrong test by considering the subjective opinion of the respondent as to the interpretation of the questions, thereby ignoring the issue of their materiality. In my opinion, this is an extricable point of law and an error in law was clearly made by the trial judge, with the result that no deference is owed. Applying the correctness test, the trial judge erred in his approach and in his conclusion and thereby committed reversible error.
>
> ¶51 Furthermore, the trial judge improperly considered irrelevant evidence in reaching his decision and, therefore, no deference should be afforded to the trial judge's tainted factual findings.
>
> ¶52 In any event, there is overwhelming evidence, as we have seen, from both GWL's and the respondent's experts that the critical questions were clear, unambiguous and material. In the result, if required, I would have had no hesitation in concluding that the trial judge's findings of ambiguity in the questions constituted palpable and overriding error.
>
> ¶53 This conclusion makes it unnecessary to comment on the quantum of the mental distress damages awarded in this instance.

[23] However, Mr. Walsh denies that **Badenhorst** stands for the proposition attributed to it by the Respondent. He explains in his post hearing submission (October 21, 2013):

> The Court [in *Badenhorst*] focussed on materiality and ambiguity. With respect to materiality, the Court held that materiality was to be determined from the point of view of a reasonable insurer and that the applicant's or reasonable person's view of materiality was irrelevant. With respect to ambiguity, responding to the Respondent's argument that ambiguity was a question of mixed fact and law requiring review a standard of palpable and overriding error, the Court, at paragraphs 44 to 46, cited *Housen* (and other cases) for the proposition that what may appear to be a question of mixed fact and law is really a matter of law when an extricable point of law can be isolated from the factual findings and conclusions. However, after stating this, the Court did not proceed to examine whether there was an extricable point of law in this case. Rather, it said as follows at paragraph 52:
>
> > "In any event, there is overwhelming evidence, as we have seen, from both G.W.L's and the Respondent's experts that the critical questions were clear, unambiguous and material. In the result, if required, I would have no hesitation in concluding that the trial judge's findings of ambiguity in the questions constituted palpable and overriding error."
>
> It is submitted that this conclusion is not a statement that an extricable point of law did not exist and that palpable and overriding error was the standard of review. In effect, the Court found that resolution of that issue was unnecessary given "the trial judge's findings of ambiguity in the questions constituted palpable and overriding error."

[24] Here, I need not resolve this standard of review issue because, as I will explain, there would be no basis for us to interfere under either standard.

[25] Turning to the merits of this issue, I agree with Mr. Walsh that an insurer's questions must be carefully examined for ambiguities and that any so found must be interpreted in the insured's favour (the *contra proferentem* rule). We said that very thing recently in **Fleet**, *supra*:

> ¶25 However, the nature and context of an insurer's questions can have a direct impact on the scope of an insured's duty to disclose. Again, in **Ontario Metal Products Co.**, *supra*, like here, the question which confronted the court was whether the deceased had failed to disclose certain treatment he had received from a physician. Prior to taking out the policy, the deceased had, over a period of three

years, occasionally received injections because he was feeling run down. The insurance policy listed four questions which the court considered relevant:

> 17. What illnesses, diseases, injuries or surgical operations have you had since childhood?
>
> 18. State every physician or practitioner who has prescribed for or treated you, or whom you have consulted, in the past five years.
>
> 19. Have you stated in answer to question 17 all illnesses, diseases, injuries or surgical operations which you have had since childhood? (Answer yes or no.)
>
> 20. Have you stated in answer to question 18 every physician and practitioner consulted during the past five years, and dates of consultations? (Answer yes or no.)

¶26 In assessing whether there were undisclosed facts material to the risk, Anglin, J., at page 39, applied the *contra proferentem* rule, by finding that any ambiguities with the questions favoured the insured:

> The group of questions --17 to 20 inclusive -- must be read together and effect given to them in the sense in which a layman so reading them would understand them. It is well established law that the preparation of the form of policy and application being in the hands of the insurers, it is but equitable that the questions to which they demand answers should, if their scope and purview be at all dubious, either in themselves or by reason of context, be construed in favour of the insured, especially after his death when we are deprived of the advantage of his version of what occurred upon the medical examination and of any explanation by him of his understanding of the questions and of his reasons for giving the answers to them recorded by the medical examiner. The insurers put such questions and in such form as they please, but they "are bound so to express them as to leave no room for ambiguity." To such a case the rule contra proferentem is eminently applicable. **Thomson v. Weems** [9 App. Cas. 671, 687]; **Life Association of Scotland v. Foster** [[1873] 11 C.S.C. (3rd series) 351, 358, 364]; **Fowkes v. Manchester and London Life Assurance Association** [[1863] 32 L.J. Q.B. 153, 157]; **Joel v. Law Union and Crown Ins. Co.** [[1908] 2 K.B. 863, 886. 159, 160]; **In re Etherington and The Lancashire, etc., Ins. Co.** [[1909] 1 K.B. 591, 596]; **Condogianis v. Guardian Assurance Co.** [[1921] 2 A.C. 125, 130]. [pages 41-42]

¶27 Then after construing the ambiguous terms against the insurer, Anglin, J. found that the nature of the insurer's questions directly impacted the extent of the insured's duty:

> What a reasonable man would regard as material is not necessarily what the assured so regarded, **Joel v. Law Union and Crown Ins. Co.**, [[1908] 2 K.B. 863, 884] See also **Pickersgill, etc. v. London and Provincial, etc. Ins. Co.**, [[1912] 3 K.B. 614, 619]; **Traill v. Baring**, [4 DeG., J. & S., 318, 330]. In the view I have taken, however, that by its requisitions for information the company elected to relieve the insured from any duty to disclose matters in regard to his past health which its questions did not cover (having by an express provision of its policy agreed that only the statements contained in the written application should avail it as matter of defence; **Joel v. Union and Crown Ins. Co.**[supra]; **Ayrey v. British Legal and United Provident Ass. Co.**, [1918] 1 K.B. 136, 141), and that there was in fact no misrepresentation or concealment of anything required to be disclosed by questions nos. 17, 18, 19 and 20 it would seem to be unnecessary to pass upon the question of materiality. [page 49]

¶28 This approach has also been applied by other Canadian courts. For example, in **Caverhill Estate v. Bank of Montreal** (1994), 153 N.B.R. (2d) 195, 392 A.P.R. 195, (sub nom. **Caverhill v. Bank of Montreal**) [1995] I.L.R. 1-3135 aff'd 161 N.B.R. (2d) 78, 1995 CarswellNB 385, 414 A.P.R. 78, [1995] N.B.J. No. 185 (N.B. C.A. Mar 29, 1995), Stevenson, J. not only applied the contra proferentem rule but also added that the nature of an insured's questions may amount to a form of waiver.

> ¶ 25 An applicant's duty to disclose facts within his knowledge may be waived by an insurer or may be limited or restricted by the questions the insurer asks the applicant on an application form. When, as here, the insurer requires answers to only two short questions the applicant is not required to disclose matters which the questions do not cover. See **Taylor v. National Life Assurance Co. of Canada** (1990), 7 C.C.L.I. (2d) 146 at 151-152 (B.C.C.A.).

¶29 See also: **Taylor v. National Life Assurance Co of Canada** (1990), 7 C.C.L.I. (2d) 146; [1990] I.L.R. 10362; 21 A.C.W.S. (3d) 1051 (B.C.C.A.); **Kong v. Manulife Financial Services Inc.**, 2008 BCSC 65 aff'd 2009 BCCA 90; **Stewart v. Canada Life Assurance Co.** (1999), 14 C.C.L.I. (3d) 178; [2000] I.L.R. I-3792 (ON SCJ) aff'd, [2000] O.J. No. 2970 (O.N.C.A)).

[26] However, here the trial judge found no ambiguities. Neither do I. Nor did several other courts who considered the very same questions. See: **Fernandez v. RBC Life Insurance Co.**, [2008] O.J. No. 272; upheld on appeal (2009 ONCA 864); **Hoffart v. Paul Revere Life Insurance Co.**, [1995] S.J. No. 621; and **Belley v. Paul Revere Life Insurance Co.**, [1999] O.J. No. 4856.

[27] Even more telling is the fact that Walsh offered no evidence of being confused by any of the questions posed. Instead, for many of the examples of non-disclosure, he simply blamed the agent, Mr. Ted Fraser, who, says Mr. Walsh, did not ask all the impugned questions or otherwise made him feel rushed. But, as noted in the excerpts cited above, the judge completely rejected Mr. Walsh's evidence on this point. In my view, the judge was correct to find the questions unambiguous (thereby sustaining his decision under either standard of review).

[28] In short, instead of asking us to apply the *contra proferentem* rule to resolve ambiguities, we are invited to use this rule to create ambiguities which do not exist. That, of course, is not how this rule operates. Therefore, despite appellant's counsel's able and thorough argument on this point, it remains, in my view, without merit. The judge's decision, declaring the policy void, stands. Therefore, I see no reason to address the disability question.

DISPOSITION

[29] For all these reasons, I would dismiss the appeal with as agreed $8,000 all inclusive costs on appeal payable to the respondent.

MacDonald, C.J.N.S.

Concurred in:

Saunders, J.A.

Fichaud, J.A.