S.C.A. 01616

IN THE SUPREME COURT OF NOVA SCOTIA

APPEAL DIVISION

Hart, Jones and Matthews, JJ.A.

BETWEEN:

LONDON LIFE INSURANCE COMPANY Appellant	E. J. Flinn, Q.C., for appellant
- and -	
JAMES WAYNE BAKER Respondent	A. Lawrence Graham for respondent
	Appeal heard: December 11, 1986
	Judgment delivered: January 28, 1987

THE COURT: Appeal dismissed with costs as per reasons for judgment of Matthews, J.A.; Hart and Jones, JJ.A., concurring

MATTHEWS, J.A.:

The issues here are whether the respondent was at the pertinent times insured by the appellant and totally disabled within the meaning of the provisions of the Policy.

Engineered Roof Truss Limited (the "Company") is a manufacturer of prefabricated roof trusses, walls and homes, and commenced work in April 1981. The operation was seasonal in nature. Mr. and Mrs. Bruce Haines were the officers, principal shareholders, and also employees of the Company. The original employee group included Mr. and Mrs. Haines and two others. A fifth employee was added shortly after business commenced.

In October 1981 discussions were held between Mr. and Mrs. Haines and representatives of the appellant. Agreement was reached to establish a Group Insurance Program for the employees of the Company, effective October 22, 1981. The Insurance Plan which included long-term disability insurance was to cover a minimum of five employees who had to be employed by the Company for at least three months. I will say more later respecting the discussions leading to the insurance coverage.

The appellant provided the Company with a copy of the Policy, a Group Administrative Manual and several types of forms, including an Employee Application Form. The Company was named as the Employer in the Policy. The Company carried

out certain duties which included distributing the Application Forms to the employees, forwarding those forms to the appellant and collection of the employees' portion of the premiums and some administration. Both employer and employee shared the cost of the premiums. The employees were not given a copy of the Policy, but only a Group Insurance Certificate, approximately three inches by two inches in size, usually called a wallet certificate. An employee applied for insurance through his employer and not by direct application to the appellant.

The respondent was not included in the original group of insured employees of the Company. His employment commenced August 31, 1981. Due to work slow-down in November 1981, the respondent, who had the least seniority, was laid off. Other employees were subsequently laid-off during the slack season. The respondent resumed employment on May 13, 1982.

Upon the respondent's resumption of employment, and after discussions with his employer on June 24, 1982, the respondent applied for coverage under the Group Policy. The application showed his "Date of Employment" as May 14, 1982.

The respondent was laid-off work on August 20, 1982. On September 1, 1982, he suffered a problem with his health, which was incorrectly diagnosed as gastro-intestinal in nature. He began part-time employment with the Nova Scotia Liquor

Commission on September 2, 1982. On October 12, 1982, he was hospitalized due to a heart attack, following which a cardiologist diagnosed the instance of September 1 as a heart attack. While in the hospital he received his Certificate of Insurance effective August 14, 1982, that is, three months after the stated date of employment on his application.

On October 18, 1982, the respondent applied for payment of disability benefits under the Policy. The Application noted the "Date last worked" as August 20, 1982. The second page of the Application, Attending Physician's Statement, sets out that the respondent "has been Totally Disabled (Unable to work)" from October 12, 1982.

The appellant denied coverage taking the position that the respondent was not insured under the Policy by virtue of the provisions of s. 20:

> "**TERMINATION OF INSURANCE.** - The insurance on any employee shall terminate on the earlier of the date on which that employee ceases to be in the active full-time employment of the Employer for full pay and the date on which he attains 65 years of age. If an employee is granted leave of absence by the Employer, the insurance on that employee may be continued for a period of not more than 31 days following termination of active full-time employment for full pay with the Employer but in no event beyond the date the employee attains 65 years of age.
>
> "If an insured employee shall cease to be in the active full-time employment of the Employer for full pay by reason of temporary layoff, the insurance on that employee shall be continued until termination

by written notice to the Company from the Employer but in no event beyond 31 days from the date of termination of active full-time employment for full pay. If an insured employee shall cease to be in the active full-time employment of the Employer for full pay by reason of sickness or injury, without being entitled to any benefit hereunder, the insurance on that employee shall be continued until terminated by written notice to the Company from the Employer. The insurance on any employee whose insurance has been terminated in accordance with the provisions of this paragraph may, if the employee is otherwise eligible, be reinstated without evidence of insurability when the employee returns to the active full-time employment of the Employer for full pay, provided that a request for reinstatement be received by the Company within 31 days after the date the employee returns to work."

Initially, the appellant claimed that the disability commencing on October 12, 1982, was more than 31 days after the respondent was laid-off, that is, 31 days after August 20, 1982. To rebut this the respondent at trial called the cardiologist who testified that the respondent was medically totally disabled as of September 1, 1982, and that he should have been hospitalized as of that date. The fact is that the respondent did work at the Liquor Commission from September 2 to October 12, 1982. Total disability is defined in s. 4 of the Policy as:

"DEFINITIONS. -

"When used in this Policy, the meaning of each of the following terms is limited to the definition shown.

(a) **Total Disability.** - An employee shall be totally disabled, or total disability shall exist, when the employee is suffering from a state of bodily

> or mental incapacity resulting from injury or disease as would wholly prevent the employee from, for compensation or profit, engaging in any occupation or performing any work for which the Company considers the employee to be reasonably qualified by education, training or experience; provided that an employee shall not be totally disabled and total disability shall not exist if the employee is, for compensation or profit, engaged in any occupation or performing any work.
>
> ..."

Subsequently, after checking the respondent's employment record, the appellant denied liability alleging that the respondent was never eligible for coverage in the first place, as he did not work a 30-hour week until June 1982, and thus had not completed "three months of continuous active full-time employment with the Employer for full pay" prior to his Application, as required by s. 1 of the Policy:

> "**FORMULA. - ELIGIBILITY.** - Of the classes of employees set forth in the Schedule of Insurance below, the following are eligible for insurance hereunder:
>
> (a) Those who on the Effective Date of this Policy have completed three months of continuous active full-time employment for full pay with the Employer and who are in the active full-time employment of the Employer for full pay on such date. Those excluded under this provision on account of not being actively at work in the full-time employment of the Employer for full pay on the Effective Date shall be eligible on their return to the active full-time employment of the Employer for full pay. However, if this Policy replaces a Group Long Term Disability Insurance Policy issued by any other Insurance Company, within 31 days of the termination of such Policy, any employee of an eligible class hereunder who was insured under such previous Policy immediately prior to the termination of such Policy,

> but has no continuing coverage under such previous Policy, and not at work on the Effective Date of this Policy, shall be eligible for insurance on the Effective Date of this Policy, and for the purposes of Clause 14 shall be considered to be in the active full-time employment of the Employer for full pay.
>
> (b) Those who after the Effective Date have completed three months of continuous active full-time employment with the Employer for full pay.
>
> ...
>
> "An employee shall not be considered to be in active full-time employment with the Employer unless such employee is performing in the customary manner for at least 30 hours per week all the regular duties of his employment either at his customary place of employment or at some other location where the Employer's business requires him to be.
>
> ..."

Life insurance by definition includes disability insurance by s. 2(n)(vi) of the Insurance Act of Nova Scotia, R.S.N.S. 1967, c. 148, as amended.

Subject to the provisions of the Insurance Act and the fact that a policy of insurance is one of *uberrima fides*, the ordinary rules respecting interpretation of contracts generally apply to the interpretation of an insurance policy. The intention of the parties is to be gathered from the words of the contract and the general rules respecting the exclusion of extrinsic evidence apply. However, many group policies, including that before us, have an anomaly in that the employer is named in the policy and performs certain duties, but is not an insured.

I now return to the narrative. It was several months after commencement of the Company's business that Mrs. Haines had a discussion with Mr. G. D. Organ, an agent of the appellant, respecting her personal insurance. Mr. Organ was well-known to Mr. and Mrs. Haines as he and Mr. Haines had each worked for some years for A. R. Hemming Building Systems, a business much larger but similar in nature to the Company, both as to items manufactured and the seasonal nature of the employment. The matter of Group Insurance for the Company's employees was raised. Mr. Organ arranged two meetings with Mr. and Mrs. Haines to discuss whether a Group Disability Policy could be effected for the Company. As he was a relatively new insurance agent and not familiar with group plans, at each meeting one of Mr. Organ's superiors was present; at the first Mr. Carl Rodrigues, and at the second Mr. Brian Moors. Mr. Rodrigues did not testify at trial.

It is clear from the evidence and the trial judge's decision that Mr. and Mrs. Haines knew little of group insurance in general and the Group Policy in particular. Mr. Organ was called as a witness by the respondent and Mr. Moors by the appellant. The trial judge commented:

> "At the first meeting, Mr. Organ was accompanied by a Mr. Rodrigues who was familiar with the type of policy which was available for a small company such as the Employer Company. At the second meeting he was accompanied by another experienced employee of London Life, Mr. Brian Morris [sic]. Of the

> two experienced representatives of the Insurer attending these meetings, only Mr. Morris [sic] gave evidence at the hearing. Some conflicting evidence occurred regarding the matters discussed at these meetings. Where it is inconsistent with other testimony, I find Mr. Organ's recall of these meetings to be the most acceptable. He is still an agent of the Insurer, was an acquaintance of Mr. and Mrs. Haines at the time of the meeting, was totally acquainted with their business operation, and gave evidence in a clear, forthright, and credible manner. The policy required a minimum of five employees and Mr. Haines was concerned, with normal layoffs occurring during slack periods, if the policy would be affected in the event of his number of employees being reduced to less than five. There was a discussion regarding the seasonal nature of the business and the fact that layoffs could occur. The Haines' were assured that they were qualified for the group policy in spite of their type of erratic business workload and employee numbers and were also assured the employees would be covered during layoffs for 'a reasonable period of time'.
>
> "In reviewing the evidence of the participants who gave evidence about these meetings, I find that the Haines' were not advised that the maximum period of layoff under the policy would be thirty-one days and I reject the testimony of Mr. Morris [sic] to that effect. Mr. Organ indicated that, at the time of the signing of the application form by the Employer Company for coverage, the matter of the layoffs were again discussed briefly. The Haines indicated that their major concern regarding layoffs was whether or not their employees would be covered during such periods and they felt satisfied from the information received that their employees would be so covered. Neither of them read the details of the policy when it was subsequently received which limited the periods of layoff to thirty-one days."

Upon his return to employment with the Company the respondent approached Mrs. Haines in June 1982 concerning insurance, having learned from other employees that the Company had Group Insurance. The respondent, at one time, also had

been employed by the Hemming Company. Mrs. Haines had little first-hand knowledge of the insurance so she again contacted Mr. Organ to arrange a meeting between him and the respondent. The trial judge found that Mr. Organ not only discussed the Group Insurance Plan with the respondent but "recommended that an inexpensive life insurance was available under the group policy". Mr. Organ was also present when the Application Form supplied by the appellant was completed by Mrs. Haines and signed by the respondent. The trial judge noted that the evidence was that the respondent had "a very limited education and could not read". He said that Mr. Organ "believed he had indicated to the parties at the meeting that Mr. Baker would be covered immediately and that he had advised Mrs. Haines to start the premium payment immediately. He noted that the life insurance coverage would go into effect immediately." That meeting was held on June 24, 1982. Parenthetically, it should be noted that after the appellant denied liability to the respondent, the premiums paid by the respondent were credited by the appellant to the account of the employer.

The trial judge also found that, in respect to eligibility, "None of the parties at either of the meetings with Mr. Baker appeared to have referred to the requirements of this section.", that is, s. 1, which I have previously set out. Mr. Baker apparently ignored the prerequisite for

eligibility that the respondent be required to "have completed three months of continuous active full-time employment with the Employer for full pay".

At the time of the respondent's lay-off on August 20, 1982, he enquired of his employer and was informed that insurance coverage would be continued during the lay-off period if his premiums were paid. Mr. Haines testified that the source of that information was Messrs. Organ, Moors and Rodrigues. At the respondent's request, Mrs. Haines then deducted from his pay cheque an amount sufficient to cover the premiums in full for the following two-month period. Apparently neither Mr. or Mrs. Haines bothered to read the Policy. At the time of that lay-off Mr. Haines informed the respondent that he would be recalled when sufficient work required his presence, which was anticipated to occur before Christmas. Thus, the respondent obtained part-time employment with the Liquor Commission to supplement his income during that time.

On a strict interpretation of the Policy, there is much to be said for the appellant's position that the respondent was not eligible for insurance at the time of his Application nor totally disabled within 31 days from the date of termination of active full-time employment, as so defined by the provisions of the Policy. The Policy here is one of indemnity intended to insure against lost wages.

There can be no doubt, if the respondent's condition had been properly diagnosed on September 1, 1982, he would have been hospitalized and would not have worked for the Liquor Commission. The fact is, he did. However, the trial judge found that, on the particular facts of this case, the respondent was entitled to disability benefits under the Policy. He commented:

> "It is to be noted that the contra preferentes [sic] principle of interpretation applies in that contracts drafted by an insurer are to be strictly construed against the insurer and any ambiguity in the contract is to be resolved against the insurer. In **Hutton** v. **Watling**, **[1948] 1 All E.R. 803**, Lord Greene, M.R., stated at page 803 [805]:
>
> > **'The true construction of a document means no more than that the court puts on it the true meaning, and the true meaning is the meaning which the party to whom the document was handed or who is relying on it would put on it as an ordinary intelligent person construing the words in a proper way in the light of the relevant circumstances.'**
>
> Thus this group policy should be construed in the light of the manner in which it was to be applied to the employees of the Employer Company involved and their circumstances. I find that the Insurer, through some of its employees, had clear knowledge of the special nature of the Employer Company's business, that is that it was seasonal and somewhat erratic and that its employees were subject to layoff.
>
> "I cannot, however, accept that the Insurer was entitled to rely on the Employer Company to make a determination of Mr. Baker's eligibility to enter the plan. At most, the Insurer was entitled to rely on either the applicant employee or the Employer Company to accurately provide to the Insurer the information requested by it in order to make a determination of eligibility. In this case, the Insurer requested information via the application

> form which asked the 'date of employment', which information was accurately provided (with the slight inconsequential error of one day). In fact, the Haines' and Mr. Organ, in error, thought that Mr. Baker's coverage commenced immediately and deducted premiums on that basis. Mr. Baker was their first employee to be added to the group plan and they had not read the material provided by the Insurer relating to such an addition."

And further:

> "Having accepted Mr. Baker as eligible under the policy and after accepting his premiums from the date he applied for coverage (not only from the date he was accepted) the Insurer now denies Mr. Baker coverage under the policy. I find that they are bound by their acceptance of Mr. Baker's application in these circumstances.
>
> "I would also hold that Mr. Baker, having no notice of the policy provisions requiring a three month waiting period before the policy was effective, should be covered after the passage of a reasonable waiting period. In my opinion the time covered until his layoff actually would be such a reasonable period of time.
>
> "Neither the Employer Company or Mr. Baker made a false statement or a misrepresentation and do not have a positive duty to the Insurer to draw to its attention everything which might influence its judgment. The Employer Company, as a party to the policy, is required to act in the utmost good faith and here there was no evidence that it did not do so."

With deference to the trial judge, the contra proferentes principle is not applicable here. That principle is not applicable to vary the terms of a written contract because of prior oral representations where, as here, there is no ambiguity in the contract.

It is clear from the evidence that the respondent during his two meetings with Mr. Organ, in effect, put himself in

Mr. Organ's hands. Both he and the employer relied upon Mr. Organ to inform the respondent of the details of the Application for Insurance and the insurance itself. Mr. Organ knew that the respondent could not read. It was then incumbant upon Mr. Organ to determine if the respondent was eligible and Mr. Organ had full opportunity to do so. Mrs. Haines was present during those two meetings; she provided some details for the Application. Mr. Organ informed the respondent that he was covered "immediately", and the respondent's portion of the premium was deducted from his salary as of June 25, 1982. If there were any errors in determining eligibility in accord with the provisions of the policy, and there were, then these were errors made by the agent of the insurer, Mr. Organ. The appellant is bound by the acts of its agent. The appellant should not succeed on the issue of eligibility.

As to the issue whether the respondent was totally disabled within the meaning of those words in the Policy, the trial judge referred to ss. 4(a) and 20 and then said:

> "I accept that if the proviso of section 4 creates the situation where Mr. Baker lost his classification of total disability, he subsequently became qualified to benefits under section 6 of the policy and I therefore determine that he is entitled to the disability benefits provided under the policy."

Section 6 of the Policy reads:

> "**CESSATION AND RECURRENCE OF TOTAL DISABILITY.** - If an employee ceases to be totally disabled no further benefits, other than those paid during

> Rehabilitative Employment, shall be payable under this Policy, until the employee shall again become totally disabled, in which event the benefits herein provided will be granted subject to all the conditions hereof as if no prior total disability had existed. However, if within six months of the termination of any total disability on account of which an employee has received benefits hereunder such employee again becomes totally disabled due to the same or related cause or causes, such later disability shall be treated as a continuation of the previous disability and, where the employee has returned to active full-time employment for less than 60 days, benefits shall be payable at the same level as the previous disability, but in no case shall benefits commence under this Policy if the employee is receiving income disability benefits under any Group Policy with the Company or any other Insurance Company."

I am of the opinion that, with due respect to the trial judge, s. 6 of the Policy is of no assistance to the respondent. The respondent was not totally disabled within the meaning of s. 4 of the Policy until the heart attack of October 12, 1982. There was not a recurrence of total disability within the meaning of s. 6.

The trial judge made findings of fact and credibility that the agents of the appellant had discussions with Mr. and Mrs. Haines prior to entering into the agreement for group insurance and accepted the version of those discussions as stated by Mr. and Mrs. Haines and Mr. Organ. During those discussions Mr. and Mrs. Haines made it clear that a Group Insurance Policy was only of use to them if it were to take into consideration the erratic nature of the employment with the Company and that an employee would be insured during lay-off

if the premiums were paid. The trial judge found that Mr. and Mrs. Haines were "assured the employees would be covered during layoffs for 'a reasonable period of time'". Such an assurance was not definitive. However, the terms of the contract are clear on point. By virtue of s. 20 of the Policy, the insurance terminated 31 days after the August 20, 1982, lay-off, that is, it terminated prior to the heart attack of October 12, 1982.

The respondent urged before us that due to the fact that prior to entering into the contract the employer had made it clear that because of the seasonal nature of the work group insurance would only be of use to the employees if they were covered during lay-offs and because the agents of the appellant had stated there would be such coverage and there was reliance upon that statement, thus the appellant is estopped from denying coverage. The principle of estoppel is not applicable to this issue. The provisions of s. 20 of the Policy are clear and unambiguous in respect to temporary lay-off, insurance shall be continued "in no event beyond 31 days from the date of termination of active full-time employment for full pay".

There remains the question of agency. Was the employer acting as the agent of the appellant at the time the respondent was laid off, August 20, 1982, when the employer informed

the respondent that he would be covered by insurance during lay-off provided he paid the premiums?

Counsel informed this Court that there was paucity of authority on point in Canada.

In the instant case, the contract does not insure the Company, but names it as the Employer. The insureds are the eligible employees:

> "In consideration of the payment of premiums London Life Insurance Company (herein called the Company) hereby insures the eligible employees of the above-named Employer in accordance with the terms and conditions of the contract as set out in this Policy."

There is nothing in the Policy stating that the Employer is the agent of the appellant. See for example:

> "2. **EVIDENCE OF INSURABILITY.** - The Company [appellant] reserves the right to require evidence of the insurability of any employee applying for new or increased insurance hereunder.
>
> "If there is any misrepresentation or failure to disclose any fact which is material to the contract in the evidence of insurability, the insurance to which the evidence of insurability pertains shall be voidable by the Company, except as provided in the Incontestability clause."
>
> "11. **PREMIUM ADJUSTMENT.** - Premium adjustment shall be made on account of changes in the insurance under this Policy, as follows:
>
> "There shall be refunded to the Employer any unearned premium paid on account of any insured employee whose benefit has been cancelled or decreased. If the Employer does not give notice to the Company [appellant] that the benefit shall be cancelled or decreased within thirty-one days

following the date the benefit terminates or decreases, the Company shall not be required to make a refund in respect of any period prior to the date the Employer gives such notice to the Company.

"There shall be charged to the Employer the premium for new benefits granted to employees becoming insured or for any increases in benefits.

"Any fractional portion of a Policy-month shall be ignored in calculating premium adjustments."

"17. **CERTIFICATE OF INSURANCE.** - The Company [appellant] will issue to the Employer individual certificates for delivery to each insured employee. A certificate issued to an employee not entitled to insurance under this Policy shall be of no effect."

"19. **INSURANCE ON NEW ENTRANTS.** -

(a) Employees not insured on the Effective Date of this Policy must within thirty-one days after the date they become eligible make application on forms furnished by the Company [appellant]. The insurance shall be effective on the later of the date of eligibility and the date of application, except that if evidence of insurability is required by the Company the insurance with respect to the employee shall be effective from the date of approval by the Company of the evidence of insurability;

(b) Employees making application for insurance after the expiration of 31 days after the date they become eligible or reapplying after terminating their insurance for any reason other than termination of employment, must, except as otherwise provided in the clause concerning Termination of Insurance, furnish evidence of insurability satisfactory to the Company. Insurance in these cases shall become effective from the date of approval by the Company of the evidence of insurability.

"If there is any misrepresentation or failure to disclose any fact which is material to the contract in the evidence of insurability, the insurance with respect to that employee shall be voidable by the Company, except as provided in the Incontestability clause.

> "The Employer agrees to furnish to the Company the individual applications of the employees that make application for insurance, together with the data necessary for the purposes of determining the amount of the insurance. The name of each employee becoming insured, together with the amount of insurance issued, shall be entered by the Company in the Register as of the effective date of the insurance."

As with group life insurance plans, group disability insurance plans have, in general, two methods of administration; the one where the plan is administered by the insurer with the employer performing some administrative duties, and the other a self-administered plan where the insurer essentially delegates to the group policyholder most of the administrative functions.

Lorne Wilson, an employee of the appellant for 36 years and at the time of trial Manager of Field Plans, testified:

> "Q. Mr. Wilson, is there a difference in the way London Life's various group plans or policies are administered?
>
> "A. Yes. London Life markets two broad definitions of administration. The most common administration is what we term regular administration where London Life with information fed to London Life, London Life completes all administrative functions such as determining eligibility of employee to be insured, determining when he becomes insured, processing applications, calculating premiums, billing premiums, collecting premiums, reviewing claims that are fed to London Life, determining eligibility for payment of claims, actually paying the claims, sending cheques, doing the other details of administrative work, and that is a regular administration, a regular

accounting basis, and the vast majority of the group policies that we sell have regular administration. In addition to that, London Life does market what we term self administration or self accounting basis of administration of the group policy. And the difference there is that the employer assumes more responsibility for determining when employees become eligible in accordance with the terms of the group policy. They actually take the applications, they themselves process the applications, add the employees to the list of insured people. They actually issue wallet certificates. They terminate employees when they should be terminated in accordance with the policy. They establish records such as a register of insured employees. They determine the amounts to which the employee is entitled or the amount of benefit to which they are entitled. They actually bill themselves, if you will, for the premiums that are due. They collect the premiums and then they remit the premiums to London Life in a bulk basis. In effect under a self accounting group, the employer in effect does all the administration work, maintains the details of coverage, who is insured, in what amounts, collecting premiums, terminating insurance, and doing all of the administrative work. But as far as London Life is concerned, under those circumstances we would have no record of who is insured or the amounts that are insured, and would depend upon the records of the particular employer in determining that. The only thing we would be involved in is processing the premiums and mostly in that type of administration London Life would be actually a claim adjudicator, we would actually be involved in the payment of claims, but depending upon records of coverage, etc. that would be provided by the employer. There are two types of administrative plans, maybe I should clarify here for yourself and the court. We are talking of a small group package, a group plan, and that would be a regular administration where London Life would determine eligibility based upon information that is fed to us from the employer.

"Q. That is Engineered Roof Truss Ltd plan?

"A. Engineered Roof Truss Ltd., yes.

"Q. If I can clarify that and just take a typical example of how insurance is applied for in this particular plan and distinguish that from how it would be done in a self administered plan? Page 13 has been spoken to as the employee's application form group life insurance in the particular plan which is the subject of this action?

"A. Yes.

"Q. Now could you just take us through the procedure as to how the employee gets on this particular plan as distinguished from how he would get on the plan in a self administered fund?

"A. On a regular administered group, Engineered Roof Truss, when a group policy is issued by London Life and placed with Engineered Roof Truss, the supply of employee application cards would be included in an administration kit along with other details, but in this particular case there would be a supply of application cards given to Engineered Roof Truss in what we term an administration kit. Then Engineered Roof Truss would assuming in the future after the group is issued, after the group is issued, an employee is hired, Engineered Roof Truss would then arrange to have an employee complete an application and in accordance with the contract an employee who had been with the company for three months on a continuous full time basis, they would give the employee an application card and if he wished to participate in the group plan he would complete the application, the application would then be processed by the employer to London Life, and then London Life would determine if the employee is eligible for coverage and if the employee is eligible for coverage and everything is acceptable, then the application would be processed, the calculation would be done by London

> Life of the amount of the premium, the application would have an effective date on it, which is determined by London Life in accordance with the policy. A registered card would be produced and the registered card is a card which indicates the effective date of the coverage and the details of the coverage that is being insured. In addition to that, London Life would produce what we term, is a wallet certificate.
>
> ...
>
> This wallet certificate is a group insurance certificate which is prepared for the employee who has become a member of the group plan. Again this would identify the certificate number that had been allocate, the person's name, and would also indicate the benefits that had been issued to that person."

As explained by David Norwood, Life Insurance Law In Canada at pp. 109-113:

> "Whether the group plan is administered by the insurer, or self-administered by the group policyholder, the individual group lives insured deal only with the group policyholder and not directly with the insurer. When an individual applies for group coverage or designated a beneficiary, he files the documents with the group policyholder and not the insurer. If there are contributions towards group coverage to be made by the individuals, this is a matter exclusively between the individuals and the group policyholder, not involving the insurer. Certificates or booklets are received by the individual from the group policyholder and not from the insurer.
>
> **ERRORS IN ADMINISTRATION**
>
> "From the perspective of the group life insured, or a claimant for the group insurance proceeds on his life, it will be seen that his understanding of his group insurance coverage will depend upon the certificate or booklet he has received, perhaps related to the amount of contributions which the group life insured has made, so that a problem arises

if the details of his coverage, as he understands them, are not in accord with the coverage which should have been available to him pursuant to the terms and conditions of the master group contract. Despite the terms of the certificate, etc., the individual may in fact be a non-eligible member, or he may qualify for a lesser amount of insurance, or insurance may not have taken effect at all in accordance with the group policy if he did not meet the actively-at-work condition appropriate to the circumstances of the situation.

"In resolving these problems as between the interests of the individual group life insured, the group policyholder and the insurer, regard must be had to the method of administration of the group plan. There has been relatively little case law on this subject in the Canadian context, but it is perhaps safe to say that Canadian courts will be likely to follow the trend of the U.S. law where group plans operate in the same manner, and where the issues have been extensively considered under the same basic principles of insurance contract law [Association of Life Insurance Counsel, Legal Section Proceedings, 1965, page 148].

"If the insurer has administered the group relying upon reports in respect of the individual members received from the group policyholder, it may be said, generally, that the insurer may be held free from responsibility for the discrepancy which has occurred [Boseman v. Connecticut General Life Insce. Co. (1937), 301 U.S. 196. Duval v. Metropolitan Life Insce. Co. (1927), 82 N.H. 543. Keane v. Aetna Life Insce. Co. (1952), 22 N.J. Super. 296]. If, however, the group is a self-administered group, it may be said, generally, that the insurer may be held responsible for the discrepancy on the grounds that the group policyholder, who brought about the discrepancy, acted as the agent of the insurer in the implementation of the master group contract [Elfstrom v. New York Life Insce. Co., 7 U.S. Life Cases (2d) 514. Exstrum v. Union Casualty and Life Insce. Co. (1957), 86 N.W. 2d 568, 78 A.L.C. 95].

"Where the insurer administers the group plan, so that it has to rely upon information received from the group policyholder, it would appear that

the group policyholder will not be held to be the agent of the insurer, and that the insurer will not be held liable if, on the basis of inaccurate information, the group coverage indicated to the individual is not in accord with the terms of the master group contract. As has been stated in a leading U.S. case [Boseman v. Connecticut General Life, supra]:

> 'When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums and generally in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer but for their employees or for themselves.'

"So if the group policyholder reports that a particular individual is actively at work, when in fact he is not, the insurer may rely upon the actively-at-work provisions of the group policy. The fact that the individual received a certificate, etc., from the group policyholder will not prevail as evidence of coverage and, in this context, it should be noted that the insurer usually instructs the group policyholder not to deliver a certificate to any member of the group who is not actively at work on the purported effective date, so that if the group policyholder handed the certificate over, this would be a violation of the insurer's instructions rather than an act which could readily be construed as an action on the insurer's behalf. However, where the factual background is uncertain or ambiguous, so that it is not completely clear whether the person was or was not actively at work, the insurer may be held liable on the basis of the group policyholder's judgment of the situation. In a case [Kriluck v. Imperial Life Assce. Co., [1965] I.L.R. 1-141, 1 O.R. 640, 49 D.L.R. (2d) 196], previously referred to, where an executive was in hospital upon the purported effective date, but carried out some of his duties there, it was held that this qualified him as being actively at work within the meaning of the group policy.

"Similarly, if the group policyholder allows a non-eligible person to enter the plan, this does not bind the insurer to coverage, although that

person may have received a certificate, etc., and made contributions in respect of coverage under the group. But again, it should be noted that where the status of the individual is such that a judgment must be made as to whether his particular job category qualifies him as an eligible member, the insurer may be held liable.

"Similarly, if the group policyholder makes an inaccurate report to the insurer about the ranking of an eligible member of the group, or his rate of earnings, etc., so that the insurer issues a certificate showing an amount of insurance which does not correspond to the amount to which the individual would have been entitled under the classification schedule in the group policy, the insurer will not be liable for other than the correct amount of insurance which would have been applicable if the facts had been reported accurately to it. It may be said that discrepancies of this nature fall into the cagegory of clerical error and that, since the group policyholder is not the agent of the insurer, the group policyholder's knowledge of the true facts will not be imputed to it. However, as discussed, if the nature of the error is subjective, involving assessment of the group life insured's job category (e.g. supervisory or non-supervisory), or where the nature of the report was such that the insurer could reasonably have recognized the error in the reporting, it may be held that the insurer will be bound to the higher amount of insurance.

"In contrast, where the plan is operated as a self-administered group and the group policyholder has been delegated to perform the administrative functions which the insurer could carry out, it is safe to say that the courts will be more likely to hold that the group policyholder was acting as agent of the insurer, so that its knowledge and conduct will be attributed to the insurer, and the insurer estopped from relying upon the terms of the master group contract which the group policyholder has failed to follow in matters affecting an individual group life insured [Elfstrom v. New York Life, supra; Exstrum v. Union Casualty and Life, supra. In one leading case [Bohl v. Great-West Life Insce. Co., [1974] I.L.R. 1-601 (Sask. C.A.)], the eligibility provisions of the policy included only full-time employees who had completed three

> months of full-time employment, and the amount of insurance depended upon the amount of earnings within a given period. The insurer argued that the individual employee was a part-time employee who was ineligible for coverage, but the court held that the group policyholder was the insurer's agent for the purposes of determining eligibility. The insurer further argued that the individual's earnings did not qualify him for the amount of insurance claimed, but the court similarly held that the insurer was liable for the ministerial error in respect of the amount of coverage made by the group policyholder as its agent.
>
> "It should be noted, however, that the court indicated that its decision did not lay down any 'general rule' which would be applicable to all group policies, thereby leaving the way clear, it is submitted, for different results to follow in situations where the insurer itself administers the group plan relying upon information supplied to it by the group policyholder. The court drew attention to the nature of the administration of the plan as a self-administered group, and observed that the insurer had had the opportunity, if it wanted to take it, to audit the operation of the plan as carried out by the group policyholder.
>
> ...
>
> "In disputes affecting negotiations for the group contract itself, or policy amendments in respect of benefits, it is clear that the group policyholder cannot be the agent of the insurer, since, otherwise, the insurer would be bound to negotiations with itself (through its agent). Similarly, the group policyholder cannot be the insurer's agent in disputes about premium payments between the insurer and the group policyholder, since this would make non-performance tantamount to performance binding upon the insurer. In the same way, it is suggested that the group policyholder should not be considered as the agent of the insurer in matters affecting the essential conditions of the risk, such as the implementation of the actively-at-work condition in respect of individual members of the group."

The plan in effect here was not a "self-administered" plan, but a small group plan. The appellant administered

the plan, made the decisions, and the employer carried out a few administrative functions.

The trial judge had this to say:

> "The type of policy in question is issued in the name of an employer who collects the payments of premiums and performs some administrative duties. The extent of those duties depend upon the type of group policy in question. The administrative duties may be very extensive and include most of the duties normally performed by an insurer, but in the matter before us the duties of the Employer Company were extremely limited and involved essentially the collection of the premiums, the completion of forms, and the forwarding of the forms and premiums to the Insurer. Here, as in most cases, the Employer Company collected part of the premium by a deduction from wages and paid the balance of the premium itself. Such premiums are lower than rates on individual policies. All parties, the Employer Company, James Wayne Baker, (the 'Employee') and the Insurer benefit to some extent by these group policies. The Employer Company, by the security provided to his employees and their families; the Employee, by obtaining coverage at a reduced cost and with little formality; and the Insurer, by a reduction of administrative and sales costs because of providing coverage to several persons with one policy.
>
> ...
>
> "The Employer Company, if an agent for the Insurer in any respect, was only so for the limited purpose of taking the specific action of having the application card completed and forwarded to the Insurer. The insurer clearly retained the right to determine if the Employee applicant was qualified or eligible to be accepted into the group plan.
>
> "The evidence of the Insurer was that there are two methods of administration of group plans - those administered by the Insurer and, in the case of some larger plans, those administered by an employer, or self-administered. In this small group policy, the administration was largely done by the Insurer who requested the Employer Company to perform specific functions. These functions included the collection

> of premiums and the forwarding of forms to the Insurer. It was clear that the Employer Company was not expected to become an expert on all the various terms and conditions of the policy and its administration, and indeed Mr. and Mrs. Haines did not have much knowledge of this plan. They relied on the Administration Guide provided by the Insurer and on telephone calls to the Insurer's agent, Mr. Organ, if they needed assistance or clarification.
>
> "One of the Employer Company's functions was to have new applicants complete the application form already referred to and which was provided by the Insurer. There were no special instructions as to how this form was to be completed.
>
> ...
>
> "The Employer Company was not the agent of the Insurer for the purpose of determining eligibility. In my opinion, the Employer Company here fulfilled any duty it had to the Employee in processing the application and, as well, complied with any duty it may have had as an agent of the Insurer by providing in good faith the information requested by the Insurer."

The appellant urges that we apply the reasoning of Taschereau, J., in <u>The Provident Savings Life Assurance Society of New York</u> v. <u>Mowat et al.</u>, [1901-02] 32 S.C.R. 147 at pp. 154-56:

> "However, assuming that the material facts are as alleged by the respondent, and that he did not get the policy he, at one time, might have expected from the company, I do not think that he can succeed in this action.
>
> "It is not disputed that he had ample opportunity, several times during several days, to read his policy before paying the first premium. Neither can it be contended that the company did anything whatever, when delivering the policy, or at any time during the seven years, to mislead him or to put him off his guard, or to induce him not to read it. They had no reason whatever to believe that he would not read it. And, if he did not read it he has

no one but himself to blame. As an inference of fact, from the facts proved, I find that he acted with gross carelessness. And a court of equity will not, it is trite to say, any more than a court of law, relieve anyone from the consequences of his own carelessness. Mackenzie v. Coulson [L.R. 8 Eq. 368]; Grymes v. Sanders [93 U.S.R. 55]; Pope v. Hoopes [90 Fed. Rep. 451]. 'Vigilantibus non dormientibus subvenit lex.' By the judgment a quo, he has benefited from his careless act. He has been insured gratis for seven years. If he had died during that period his wife would have got $3,000 from the company. Yet the company is ordered to return him the premiums.

"His contention that he was justified in trusting that it was what he had previously bargained for that the company handed him is met by the most salutary rule, that parol negotiations leading up to a written contract are merged in the subsequent written instrument, which is conclusively presumed, in the absence of fraud (and none is found here), to contain the entire engagements of the parties, and by which alone their intentions are to be ascertained. Carroll v. The Provincial Natural Gas and Fuel Company of Ontario [26 Can. S.C.R. 181], and the cases there cited; Inglis v. Buttery [3 App.Cas. 552].

"And if, in the course of making a contract, one party delivers to another a written document, and the party receiving the paper knows that the other party hands him the document as the contract between them, then the party accepting the document and keeping it assents to the conditions it contains, and agrees that the contract is as expressed therein, although he does not read it and does not know what they are. Van Toll v. The South Eastern Railway Company [12 C.B.N.S. 75]; Lewis v. McKee [L.R. 4 Ex. 58,61]; Parker v. The South Eastern Railway Company [2 C.P.D. 416,421]; Watkins v. Rymill [10 Q.B.D. 178]; Coombs v. The Queen [26 Can. S.C.R. 13]; Burke v. The South Eastern Railway Company [5 C.P.D.1]."

There the insured was given a copy of the policy and did not read it. In the instant case, the appellant had carried out all of the initial discussions with the Employer and none

with the respondent; the respondent did not become one of the insureds until almost one year after the effective date of the policy; the appellant delivered but one copy of the policy and that was to the employer, not the respondent; and it was never intended that the respondent would receive a copy of the policy. In that respect, the caution of Taschereau, J., is apt (pp. 152-53):

> "I premise the observation that this is a class of cases where the rule cannot be too often recalled to attention that general expressions in every judicial opinion are to be taken in connection with the facts in reference to which those expressions are used...."

The principle set out in Provident Savings that once the policy is delivered the insured has a duty to read it, and if he continues to pay the premiums, he cannot deny knowledge of its contents and is bound by its terms, has been applied in subsequent cases. See, for example, Ramey v. Maritime Life Assurance Company (1972), 25 D.L.R. (3d) 133 at p. 139. That principle is applicable to contracts of insurance on the life of an insured as in Provident Savings, however, in the instant case the respondent, unlike Mowat, did not receive a copy of the Policy but only a Certificate of Insurance.

In the present case, the Employer carried out the initial discussions with the appellant and made application for the group insurance. Can it then be said that the Employer is

the agent of the appellant at the time the Employer related to the respondent his understanding of the terms of the Policy relating to coverage during lay-offs? Does the fact that the Employer had not read the policy alter the answer?

The Supreme Court of the United States in Boseman v. Connecticut General Life Ins. Co., 57 S.Ct. 686 said:

> "Employers regard group insurance not only as protection at low cost for their employees but also as advantageous to themselves in that it makes for loyalty, lessens turn-over and the like. When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums, and, generally, in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer, but for their employees or for themselves."

And as stated in First National Bank of LaMarque 436 F.Supp. 824 "Boseman has been consistently followed."

Cases such as Bohl v. Great-West Life Assurance Co. (1972), 28 D.L.R. (3d) 191 (Sask.Q.B.), and on appeal (1973), 40 D.L.R. (3d) 584; and International Brotherhood of Teamsters, etc., v. Taylor-Read Enterprises Inc. et al. (1980), 109 D.L.R. (3d) 653 (B.C.S.C.) and the authorities cited therein are not persuasive in resolving the issue here. Here there was not a self-administered group plan; here the issue is not whether the group policyholder was or was not the insurer's agent for the purposes of determining eligibility, nor is the issue the failure of the Employer to forward to the insurer

a Form of Application for life insurance duly completed by an eligible employee, or respecting one of the steps to be taken by the Employer as set out by the insurer, or an understood arrangement between the Employer and the insurer that the Employer would carry out some duty which the Employer neglected to do, or the failure of the Employer to perform any duty in the administration of the group policy; nor are we here considering a clerical error.

McKenzie, J., in International Brotherhood of Teamsters, etc. v. Taylor-Read, supra, commented at pp. 658-660:

> "There have not been many decisions in Canada relating to group insurance and those which have been made have drawn on American authorities. One such case is Elfstrom v. New York Life Ins. Co. (1967), 432 P. 2d 731 at p. 732, which decided that 'An employer administering group insurance policies on its employees is acting as agent of the insurer rather than as agent of the employees.' In that case the insurer provided the employer 'with a manual setting forth in minute detail the steps to be taken by it in performing such tasks as enrolling employees...reinstating and terminating insurance, reporting details of coverage and premiums paid to defendant, and issuing certificates of insurance provided by defendant' [at p. 736]. The amount of involvement by the employer in that case in running the plan was much more extensive than here.
>
> "Another American case is Norby v. Bankers Life Co. (1975), 231 N.W. 2d 665, from the headnote of which the following is taken:
>
> > '...that employer which, under the policy, had the obligation of forwarding application forms was insurer's agent for that purpose; that employee was entitled to recover from the insurer where lack of actual coverage was due to employer's neglect or oversight in failing to forward the application form; and that insurer, having suffered no loss except for unproved lost premiums, was not entitled to indemnity from the employer.'

"In the present case the employer had no express obligation under the policy of forwarding application forms but the inevitable inference to be drawn is that this was an understood arrangement between the employer and the insurer. The insurer gave the forms to the employer. Where else in a bakery would the forms be kept than in the office? Martens supplied a form to Doerksen and undertook to forward it when he was 'qualified'. The whole course of dealing between the insurer and the employer makes it clear that the function of completing, or assisting in the completion, of applications and the forwarding of them was delegated by the insurer to the employer. It is not necessary to decide what further functions, if any, were delegated.

"Elfstrom was followed by the Saskatchewan Court of Appeal in Bohl v. Great-West Life Ass'ce Co. (1973), 40 D.L.R. (3d) 584, [1974] 1 W.W.R. 700, and at p. 590 Brownridge, J.A., said for the Court in referring to Elfstrom:

> 'There the Court held that the employer is an agent of the insurer in performing the duties of administering group insurance policies, and at p. 738 said:
>
> > **"The most persuasive rationale for adopting the view that the employer acts as the agent of the insurer, however, is that the employee has no knowledge of or control over the employer's actions in handling the policy or its administration."**
>
> (Emphasis added)
>
> 'Without attempting to lay down any general rule which may be applicable to all group policies, I am satisfied that in this case the employer was properly held to be the agent of the insurer for the purpose of determining eligibility.'

"It is not necessary to even go as far as did that Court to hold that the relatively minor administration function of completing and forwarding applications was delegated to the employer who became the insurer's agent in that respect. It follows

> that the employer's neglect or oversight as the insurer's agent in forwarding the forms either when completed or, at the latest, immediately after December 1, 1976, must be chargeable to the insurer."

In the instant case, the issue does not concern some "relatively minor administrative function...delegated to the employer" by the insured, it concerns incorrect information given to the respondent by the employer as to the coverage afforded to the respondent while laid-off.

The Supreme Court of California in Elfstrom v. New York Life Ins. Co., Cal. Rptr. 35, considered the distinction between the administration of a group plan by the insurer and by the employer:

> "The administration of a group policy may be handled either by the insurer itself on the basis of information furnished to it by the employer or, as in the present case, by the employer. If the insurer administers the policy, the employer periodically submits to the insurer the names of its employees and other information relevant to coverage. The preparation of accounting records and changes of beneficiary, as well as other details are handled in the insurer's offices. Ordinarily, an employee who becomes eligible for insurance is required to sign an acceptance card authorizing payroll deductions and indicating his choice of beneficiary. The company then sets up an accounting record for the employee and prepares his certificate of insurance. Other duties of administration include the termination of an employee's insurance upon notice from the employer, adjustment of benefits and premiums as the employee's classification changes, and the recording of changes of beneficiaries. (Gregg, An Analysis of Group Life Insurance, op. cit. supra, pp. 115-118).
>
> "Under an employer-administered plan the employer performs these functions, sometimes resulting in

> a saving in premiums. The only records regularly exchanged between the employer and the insurer are those pertaining to the calculation and payment of premiums, usually in terms of the number of lives insured, the amount of insurance in force, and specification of charges. These functions are performed by the employer under the direction of the insurance company, which ordinarily provides service visits by a representative to check on the administration of the plan, examine the employer's records, lend assistance to the employer in improving administrative practices, and promote the enrollment of additional employees in the plan."

In Elfstrom the plan was employer-administered. The court listed a substantial number of cases which had considered the question whether an employer acts as the agent of the employee or of the insurer in administering a group policy and frankly stated "...their holdings are hopelessly in conflict". In the former:

> "The rationale of these cases appears to be that the employer is acting for its own benefit or for its employees in performing these tasks, rather than serving the purposes of the insurer, that the real insured is the employer acting for the employees as a group, that the employer and the employees are allied in their interests, and that these interests are adverse to the insurer."

In the latter:

> "The reasoning underlying these decisions is that the employer carries out the functions which the insurer necessarily would perform in other types of insurance and thereby confers a substantial benefit on the insurer, and that since the individual employee has no knowledge of or control over the administrative acts performed by the employer, it would be inequitable to charge him with the employer's errors."

I have read a number of the United States cases. I am again reminded of the words of Taschereau, J., in The

Provident Savings Life Assurance Society of New York v. Mowat et al., supra, "...this is a class of cases where the rule cannot be too often recalled to attention that general expressions in every judicial opinion are to be taken in connection with the facts in reference to which those expressions are used...." That principle may explain to some extent the conflict in these cases. Each case must stand on its own factual base. Whether an employer is the agent of the insurance company or the agent of the employee in a given circumstance depends upon the factors to be determined, all of the facts and the relevant documents including the group insurance certificate where applicable, and the relevant responsibilities thereunder.

As emphasized by the authorities, and as stated in 1 Appleman Insurance Law and Practice, p. 89:

> "There is a distinct conflict of authority as to whether the employer acts as the agent of the insured or of the insurer in making the contract and keeping it in force...."

It is the appellant's contention that when Mr. Haines informed the respondent that he would be covered by insurance during lay-off if he paid the premiums, Mr. Haines was not carrying out an administrative function on behalf of the appellant, he had no authority from the appellant to interpret the provisions of the policy on behalf of employees in respect to coverage, and was not acting as the agent of the appellant

in so doing, and further had Mr. Haines read the policy in his possession he would have realized that the information he gave to the respondent was not correct, for the relevant provisions of the policy are clear "the insurance on that employee may be continued for a period of not more than 31 days following terminatiuon of active full-time employment for full pay with the Employer".

As earlier mentioned, the appellant supplied a copy of the Policy to the Employer only. As is customary with group insurance, the respondent as an insured employee did not receive a copy of the Policy. He was provided with the wallet size Group Insurance Certificate produced by the appellant. As Lorne Wilson said, it was "prepared for the employee who has become a member of the group plan". That was the respondent's source of information. That Certificate sets out in part:

London Life Insurance Company
Head Office London Canada N6A 4K1

Termination of Insurance

Insurance terminates on termination of employment and on the termination of the Group Policy or Policies. The Life Insurance may be converted within 31 days of termination, in accordance with the terms of the Conversion Privilege set forth in the Group Life Insurance Policy.

London Life Insurance Company hereby certifies that the employee named on the reverse side was insured under the Employer's Group Insurance Plan on the date shown, subject to the provisions of the master Policy or Policies which have been issued to the Employer.

Details of the benefits provided under the Group Insurance Plan are set forth in the master Policy or Policies. Information regarding the benefits will be furnished upon request by the Employer. In the event of conflict between the benefits stated herein and the entitlement under the terms of the Policy, the Policy shall govern

The respondent desired the coverage to continue while he was temporarily laid-off. He, therefore, sought information from his employer. He was assured by the Employer that he would be covered and the premiums for two months were deducted from his pay.

We are here not dealing with a situation as set out in the Certificate, "in the event of conflict between the benefits stated herein..." The respondent did that which insured employees were instructed to do by the appellant in the Certificate. He went to the employer; the employer furnished the information requested; in so doing, the employer on these facts was the agent of the appellant.

In Bareno v. Employers Life Insurance Company of Wausau et al. 103 Cal. Rptr. 865, (although some of the facts differed from the present case) the court said:

> "The certificate itself named the employer as one who could inform the employee as to the terms of the policy; our cases have uniformly recognized that in this situation the employer acts as the agent of the insurer and that the insurer is bound by such agent's acts...."

In the circumstances, with the instruction to the insured employee that "Information regarding the benefits will be furnished upon request by the Employer"..., the respondent had the right to rely upon those words and the appellant the duty to properly instruct the employer as to the methodology

of furnishing such information. The appellant is bound by the words as used in the Certificate and the information furnished to the respondent by the employer.

I would dismiss the appeal with costs.

J.A.

Concurred in -

Hart, J.A.

Jones, J.A.

1983 S.H. No. 45965

FILED
CHARGED
APR 1 1986
ENTERED

IN THE SUPREME COURT OF NOVA SCOTIA

TRIAL DIVISION

BETWEEN:

JAMES WAYNE BAKER

Plaintiff

\- and -

LONDON LIFE INSURANCE COMPANY

Defendant

HEARD: at Halifax, Nova Scotia before the Honourable F. B. William Kelly, Trial Division, on January 28th and 29th, 1986.

DECISION: March 24, 1986

COUNSEL: Mr. A. L. Graham, for the plaintiff

Mr. E. J. Flinn, Q.C., for the defendant