

**Damages for Bad Faith Denial of Insurance Claims in Canada:
Continuing a Tradition of Judicial Restraint**

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Introduction

In *State Insurance Ltd. v. Cedenco Foods Ltd.*ⁱ, the New Zealand Court of Appeal expressly declined to decide whether damages can be awarded for a breach by an insurer of its duty of good faith. So, in New Zealand, the question remains unresolved. In contrast, in Canada, recognition of this duty as it applies to the handling of claims and of the availability of damages, particularly aggravated and punitive damages, in the event of its breach has been one of the most significant insurance law developments in recent decades. Thus, when wrongful denial of a customer's claim is attended by treatment deemed by a court to be inappropriate, the remedy is not merely to enforce the insurer's contractual obligation, including pre-judgment interest, but also to require payment of an additional sum.

This paper is devoted, in part, to describing this development. I say "in part" because a bare description would fail to tell the whole story. The more or less sudden imposition by the courts of civil penalties on delinquent insurers without legislative authority might well be regarded with surprise and, by insurers at least, considerable alarm. But when the recent case law is put in context, the picture becomes much less draconian. So, while the first part of the paper is descriptive, the second part provides what I consider to be the appropriate context. This has two facets. First, because imposing an obligation to pay additional money such as punitive damages if a certain standard of

ⁱNew Zealand Court of Appeal, CA 216/97

quality of service is not met alters, perhaps fundamentally, the terms of the contract (the insurer's obligations are increased without providing additional consideration), there are implications in terms of freedom of contract. As it happens, Canadian courts have long enjoyed powers, based variously on statute and case law, to intervene in contractual relations between insurers and their customers in specific circumstances. Examination of powers demonstrates, I believe, that there is a tradition of circumspection in regard to their exercise. The developments with regard to punitive and aggravated damages for bad faith handling of claims are entirely consistent with this tradition.

The second context of relevance is the history, in insurance law, of the concept of good faith generally. While, in the past, most emphasis has been placed on the good faith obligations owed by the insured to the insurer, there has all along been at least theoretical room for a reciprocal duty and recent developments merely give life to that theory.

The Insurer's Duty in Handling Claims

Good Faith and Liability Insurance

The need to create balance between insurer and customer at the claims stage was first apparent in liability insurance cases. This should not be surprising. The insurer's contractual right to control the defence of any litigation or settlement negotiations within the scope of liability coverage gives rise to a triangular relationship involving the third party plaintiff as well as insurer and customer. This creates special tensions concerning claims resolution which do not arise in first party insurance. In its dealings with the third party plaintiff, the insurer may face decisions which place its own interests in conflict with those of its customer. In such a case, the good faith obligation requires that an insurer is bound to afford the customers' interests priority equal to its own.

The prime example of this is where a plaintiff offers to settle for an amount within the policy limits in circumstances where the insurer believes the merits of the case to be weak or the quantum sought exaggerated. The insurer may consider refusal of the offer to be the better tactic. But this course would ignore the customer's interest in avoiding

personal liability for damages in excess of the limits. It is a breach of good faith to fail to account for the customer's interest and, in the event of a subsequent judgment larger than the policy limits, the insurer is liable to pay the full award.ⁱⁱ It must be said that this is not a fiduciary relationship whereby the fiduciary must subordinate his/her own interest to that of the person owed the duty. Here the duty is merely to give the customer's interest equal consideration to the insurer's own. However, it is a duty nonetheless and it is designed to obviate the customer's vulnerability given the insurer's control of the process.

Thus, the tripartite nature of the liability insurance claims process provides unique justification for a good faith obligation. But a third party insurer also carries the burden of good faith more generally, as any insurer does. That is, the customer is entitled to be dealt with fairly and in a timely way even in matters not directly connected to dealings with the third party.ⁱⁱⁱ

First-Party Insurance

This more general form of the duty, as acknowledged by Canadian courts, involves two requirements. The first is that the insurer must pay a claim in timely fashion^{iv} if there is no reason to contest it. The second is to treat the customer fairly throughout the process of investigating and assessing the claim. This applies both to the manner of investigation and assessment and the decision whether or not to pay. In particular the insurer is required to refrain from using its economic muscle or the customer's economic weakness to extract a settlement favourable to itself.^v

ⁱⁱ *Dillon v. Guardian Ins. Co.* (1983), 2 CCLI 227 (Ont. HC).

ⁱⁱⁱ See e.g. *Delmonte v. State Farm Fire & Cas.*, 90 Hawaii 39, 975 P.2d 1159 (1999) where the insurer, among other things withheld information about the defence from the insured, and *Snydergeneral v. Century Indem. Co.*, 907 F.Supp.991 (ND Tex. 1995) where the insurer unreasonably delayed its decision on coverage.

^{iv} See e.g. *Amaprop Canada Inc. v. Guardian Ins. Co.* (2000), 23 CCLI 302 (Ont SCJ).

^v *702535 Ontario Ltd. V. Lloyds* (2000), 184 DLR (4th) 687 (Ont. CA). While most cases involving allegations of breaches of good faith are brought against insurance companies, it is possible that successful claims may also be brought against adjusters personally. In *Spiers v. Zurich Insurance Co.*(1999), 45 OR

The concern is with redressing an imbalance; the imbalance of bargaining power that might exist because of the customer's economic disadvantage or emotional vulnerability. If an insurer is sanctioned for taking advantage of its position of relative strength, it will be less likely to do so. Examples of conduct which has attracted sanction for failing to meet the standard of fairness and timeliness are persistence in maintaining a defence of arson by manipulating evidence or refusing to consider it objectively,^{vi} denial or termination of disability benefits without due regard to objective evidence of disability,^{vii} and demanding material, in support of a claim, to which the insurer was not entitled.^{viii}

The leading case, insofar as it is the first of its type to be considered by the Supreme Court of Canada, is *Whiten v. Pilot Insurance Co.*^{ix} The insured claimed after their house was destroyed by fire. On the basis of the facts that the insured was unemployed and had recently filed for bankruptcy, the insurer formed the view that the fire was the result of arson. It held to this view resolutely despite strong evidence to the contrary. The insured and his wife had to escape the fire by fleeing into a freezing night clad only in pyjamas which caused the insured to suffer frostbite so severe that he was confined to a wheelchair for two weeks. His cat was killed and he lost many possessions of sentimental value. Facts such as these are generally not consistent with arson. Moreover, the fire chief who attended

(3d) 726 (SCJ), an Ontario court refused to strike allegations of bad faith against the insurers employees holding that it was possible they owed an independent duty of good faith to the customer.

^{vi}*Whiten v. Pilot Ins. Co.* (1999), 42 OR (3d) 641 (CA) currently under appeal to the SCC; *Kogan v. Chubb Ins. Co.* [2001] OJ No. 1697 (SCJ). See also *Bullock v. Trafalgar Ins. Co.* (1996), 9 OTC 245 (Ont. GD); *Yasinski v. Wawanesa Mut. Ins. Co.* (1999), 15 CCLI (3d) 95 (Sask. QB) and *Labelle v. Guardian Ins. Co.* (1989), 38 CCLI 274 (Ont. HC).

^{vii}*Adams v. Confederation Life Ins Co.* (1994), 25 CCLI (2d) 180 (Alta QB); *Ferguson v. Nat. Assur. Co.* (1997), 102 OAC 239 (Ont. CA); *Warrington v. Great West Life Assur. Co.* (1996), 24 BCLR (3d) 1 (BCCA), additional reasons (1997), 39 CCLI (2d) 116n; and *Clarfield v. Crown Life Ins Co.* (2000), 23 CCLI (3d) 266 (Ont SCJ).

^{viii}*Beninger v. Kingsway Gen. Ins. Co.* (2000), 99 ACWS (3d) 842 (Alta Prov. Ct).

^{ix}Supra, note 6.

the fire detected nothing to suggest he should refer the case to the Fire Marshall. The independent adjuster retained by the insurer reported that the fire was “accidental” and that there was no basis on which to deny the claim. The adjuster was asked to reconsider which he did without changing his view. The adjuster was fired. The insurer consulted the Insurance Crimes Investigation Bureau, an insurance industry-sponsored body. That body concluded that if the insurer was to deny the claim on the ground of arson, it “wouldn’t have a leg to stand on.” Still not persuaded, the insurer hired an engineer to investigate. He found the fire to be “accidental”. Under pressure from the insurer’s lawyer, the engineer changed his report to admit of the possibility of arson. All the while the insured cooperated fully with the investigation, even volunteering to undergo a polygraph test under the insurer’s supervision, an offer refused by the insurer. It was not until the case reached the Court of Appeal that the insurer finally admitted that the evidence unequivocally demonstrated that the fire was accidental.

Meanwhile the insured was subjected to considerable hardship both pecuniary and non-pecuniary. Although the insurer initially paid for alternative accommodation it cut off rent payments without notice to the insured. He also suffered the stigma of being a crime suspect, of particular acuity given the small community in which he lived. At all levels, the courts have had little trouble characterising this treatment as bad faith.

But not all refusals to pay amount to breaches of good faith merely because the insurer ultimately changes its mind or is required to pay by a court. The test is one of reasonableness. A denial of coverage must be based on a reasonable interpretation of its rights and obligations under the policy and that there is a “genuine issue” pertaining to coverage.^x In some U.S. jurisdictions there can also be a breach of good faith if the insurer denies coverage without determining whether or not a genuine issue exists.^{xi} This is probably the position in Canada too. In a recent case, an Ontario court

^x10. 702535 *Ontario Inc.*, supra, note 5; *Palmer v. Royal Ins. Co.* (1995), 27 CCLI (2d) 249 (Ont. GD); *D’Onofrio v. ICBC* (2000), 18 CCLI (3d) 252 (BCSC). Cf. *Guebara v. Allstate Ins. Co.* (Cal. CA, Jan. 12, 2001). See also *Radcliffe v. Western Gen. Mutual Ins. Co.* [1991] ILR 1-2773 (Ont. GD) where the court found sufficient evidence to justify the insurer’s initial suspicion of arson which was ultimately proved not to have occurred and *Nelitz v. Dyck* (2001), 52 OR (3d) 458(CA) in which the bad faith claim was dismissed given a context of respectful dealings overall.

^{xi}See e.g. *Viles v. Security Nat. Ins. Co.*, 788 SW 2d 566, 567 (Tex.1990).

found lack of good faith in a disability insurer's apparently standard practice of refusing or delaying claims on the basis of their amount or the insured's employment status regardless of the terms of the policy.^{xii}

In yet other U.S. jurisdictions insurers have been found in bad faith even where they can raise a reasonably debatable argument in support of its denial of coverage if the manner of that denial or accompanying investigation is sufficiently objectionable in terms of delay and unfairness.^{xiii}

A Separate Wrong

The last point is related to the question of the relationship between bad faith claims and the existence of coverage. If an insurer's conduct falls short of the requirements of good faith, it is guilty of more than a mere breach of contract. In the words of the Ontario Court of Appeal, "breach of an insurer's obligation to act in good faith is a separate or independent wrong from the wrong for which compensation is paid."^{xiv} But the extent of this separation is unclear. It has been held, by the Ontario Court of Appeal in another case,^{xv} that the duty arises even before determination of the insurer's obligation to pay the loss under the terms of the insurance contract. As the court stated, "the duty to act promptly and in good faith arises the day the insurer receives the claim." More recently, however, the same court has denied a claim for punitive damages based on the insurer's bad faith because, owing to the customer's breach of a condition contained in the insurance contract, there was no coverage.^{xvi}

In the latter case the court made no reference to the former and dealt with the relationship between coverage and good

^{xii} *Clarfield v. Crown Life Ins. Co.*, supra, note 7.

^{xiii} See e.g. *State Farm Mutual Auto Ins. Co. V. Shrader*, 882 P.2d 813 (Wyoming, 1994). See also Maus & Rawls "Bad Faith Findings in th Absence of Coverage" (2000), For the Defense 18.

^{xiv} *Whiten v. Pilot Ins. Co.* Supra, note 6, at 650.

^{xv} *Maschke Estate v. Gleeson* (1986), 54 OR (2d) 753 (CA).

^{xvi} *Barker v. Zurich Ins. Co.* (2001) OCA

faith in a few lines. It may also have been influenced by its clear finding that there was no bad faith anyway and by its barely disguised suspicions about the customer's conduct. The insured vehicle was reported stolen, found abandoned, taken to the customer's property and repairs commenced before the insurer had a chance to inspect it. Nonetheless, uncertainty remains.

Given that the concept of bad faith claims treatment by insurers is in its relative infancy in Canada, it is not surprising that issues such as this are yet to be fully flushed out. It is instructive that in the U.S., where these matters have been litigated over a longer period, while there continues to be a divergence of approach depending on jurisdiction, almost everywhere there is recognition of a good faith duty independent of coverage. True, it has been held in Texas that "there can be no claim for bad faith when an insurer has promptly denied a claim that is not covered"^{xvii} and in Alabama and Mississippi that the law "precludes a first party bad faith claim if the insured does not establish coverage."^{xviii} However, in other jurisdictions the key factor is the manner of the insurer's conduct whether there turns out to be coverage or not.^{xix} Even in Texas and Alabama there are exceptions to the narrower approach. In Texas there may be a successful action for bad faith in the absence of coverage if the insurer is guilty of extreme conduct causing injury independent of the insurance claim. In Alabama there is actionable bad faith where the insurer intentionally or recklessly fails to investigate the insurance claim or invents reasons to deny it - even if, with the exercise of reasonable consideration, it could have resisted the claim successfully.^{xx}

The key to this issue is the harm-causation nexus. If there turns out ultimately to be coverage, establishing a causal link between the insurer's wrongful conduct and the customer's loss is straightforward. Denial of coverage is loss in itself. As we shall see, this may be redressed by requiring payment of the insurance money and, in appropriate cases, aggravated damages. In some circumstances, delay in payment, even for unjustified reasons, may not cause any loss,

^{xvii}*Lemke Concrete Constr. v. Employers Mutual Casualty Co.* 1997 Westlaw 78917. See also Maus & Rawls, *supra*, note 13.

^{xviii}Maus & Rawls, *ibid.* at 20.

^{xix}E.g. Wyoming. See *supra*, note 13.

^{xx}Maus & Rawls, *supra*, note 13.

aggravated or otherwise. In *702535 Ontario Inc. v. Lloyds Underwriters*,^{xxi} the Ontario Court of Appeal declined to overturn a judgment in which damages for bad faith had been refused because the evidence failed to show the delay in payment (eventually made voluntarily by the insurer) caused any loss to the customer. But this situation is likely to be rare. More problematic is the case where ultimately there is no legitimate basis on which the claim can stand, either as a matter of interpretation of the coverage provisions (including exclusions) in the policy or because of a breach of condition by the customer, but where the insurer has been guilty of conduct amounting to bad faith. Examples are an unreasonable refusal to investigate or deny liability promptly or unnecessarily heavy handed tactics in addressing the claim. This conduct may cause harm, even if there is no coverage. A customer may delay having repairs done to damaged property pending a decision from the insurer owing, among other things, to a concern not to breach a policy condition precluding unauthorised repairs. S/he may defer medical treatment while insurance coverage is clarified. The point here is that if the plaintiff can show (a) conduct amounting to bad faith and, (b) loss or harm resulting from that conduct, that should be sufficient to establish the cause of action even if, in the end, there is no liability under the policy.

It is also unclear in Canada whether this separate wrong is a category of tort or something else.^{xxii} There have been strong hints from the courts that it would be recognised as a tort if this be necessary to found an award of punitive damages.^{xxiii} Nonetheless, courts have regularly awarded both punitive and aggravated damages against insurers adjudged to have breached their duty of good faith without benefit of a final categorisation.

Damages

^{xxi}Supra, note 10.

^{xxii}Note that the duty is not a fiduciary duty. It does not oblige the insurer to place the customer's interest above its own, merely to accord that interest equal consideration. See *Whiten*, supra, note 6, at 650.

^{xxiii}*Whiten v. Pilot Ins. Co.*, supra, note 6; *Adams v. Confederation Life.*, supra, note 7.

Punitive damages have been awarded where the court has determined the insurer's conduct to be so harsh, vindictive, reprehensible or malicious as to offend its sense of decency. For example, in *Whiten v. Pilot Insurance Co.*^{xxiv}, discussed above, a jury awarded punitive damages in the amount of \$1 million although this was reduced on appeal to \$100,000. In *Adams v. Confederation Life Insurance Co.*^{xxv} the insurer terminated the customer's disability benefits on the basis of its unilateral determination of entitlement made in defiance of medical reports contrary to its view and without exercising its right to an independent medical examination. The insurer terminated benefits without giving the customer an opportunity to respond. The court awarded punitive damages in the amount of \$7,500.

On the other hand, in *Bullock v. Trafalgar Insurance Co.*^{xxvi}, persistence in alleging arson without benefit of convincing evidence led merely to aggravated damages being awarded against the insurer.^{xxvii} The distinction between punitive and aggravated damages was considered in *Warrington v. Great West Life Assurance Co.*^{xxviii} The British Columbia Court of Appeal deemed the insurer's "hard-nosed and burdensome tactics" together with its refusal to pay benefits justified an award of aggravated damages to compensate the customer for the distress and humiliation suffered as a result but that the conduct was not sufficiently "harsh, vindictive, reprehensible or malicious" to justify punitive damages.^{xxix}

A useful case for understanding the courts' approach to aggravated and punitive damages is *Clarfield v. Crown Life Insurance Co.*^{xxx} The court awarded both to a plaintiff whose claim for disability benefits had not been dealt with by

^{xxiv}Ibid.

^{xxv}Supra., note 7.

^{xxvi}(1996), 9 OTC 245 (OGD). See also *Ferguson v. Nat. Assur. Co.* (1996), 36 CCLI (2d) 95 (OGD).

^{xxvii}The goals of punishment and deterrence were addressed in this case by a prosecution under the Ontario *Insurance Act* for unfair and deceptive business practices (see Part XVIII of that act). The insurer was fined \$25,000.

^{xxviii}(1996), 24 BCLR (3d) 1 (CA), additional reasons (1997), 39 CCLI (2d) 116n.

^{xxix}See also *Clarfield*, supra, note 7.

^{xxx}Supra, note 7.

the insurer with sufficient promptness or fairness. \$75,000 was assessed for aggravated damages to compensate the plaintiff for “the increased anxiety, stress and financial pressure both from the rejection of his claim and from the delay in dealing with it...at a time when he was particularly vulnerable to stress because of the nature of his illness.”^{xxxii} The financial uncertainty resulting from his treatment by the insurer caused him to sell his house, only to buy it back when the insurance money was finally forthcoming. The humiliation attending this process and the disruption involved in two moves added to the non-pecuniary component of his loss and were taken into account in the assessment, as was an amount to cover the needless transaction costs involved.

Whereas aggravated damages are about compensating the plaintiff for harm suffered in addition to the denial of insurance itself, punitive damages are focused on the defendant insurer. Their purpose is to punish the insurer for inappropriate conduct and to deter it and other insurers from repeating such conduct^{xxxii}. In *Clarfield*, the court utilised seven criteria for assessing the proper amount in a given case^{xxxiii}. These are: the reasonableness of the relationship between the quantum of punitive damages and the degree of past, present and future harm; the reprehensibility of the conduct, including its duration, the defendant’s awareness of it, any concealment and the existence of a past pattern of similar conduct; any profitability to the insurer of the conduct; the financial position of the insurer; the costs of litigation; any criminal penalties imposed for the same conduct; and the existence of other civil awards for that conduct.

On the facts before it the court awarded \$200,000 in punitive damages. In terms of the listed criteria, the court noted first that the plaintiff had suffered considerable harm in the form of denial of economic security and peace of mind. It also found that the insurer’s conduct failed to meet the appropriate standards of timeliness and fairness. In particular its tactic of pressuring the customer to accept a small *ex gratia* payment in place of benefits amounted to “a

^{xxxii}Ibid, at p.285.

^{xxxiii}See *Whiten v. Pilot Ins.*, supra, note 6.

^{xxxiii}Taken from *Pacific Mutual Life Ins. Co. V. Haslip*, 499 US 1 (US Ala, 1991).

condemnable form of negotiating with a disabled person.”^{xxxiv} Moreover, evidence suggested such conduct was a matter of company policy in dealing with large disability claims involving unemployed claimants thus underlining the need for a deterrent award. The court also found that the insurer stood to profit from this conduct in that denial of claims represented “exceedingly large” savings. The financial position of the insurer (\$10 billion in assets) was such that “an immense award would be required to make an economic impact on the company.”^{xxxv} While the court realised that other factors mitigated the size of the award^{xxxvi}, the financial means of the insurer clearly encouraged the court in awarding what, by Canadian standards in these cases, is a substantial amount^{xxxvii}. The “risk and expense of a 12-day trial in order to gain this entitlement under his insurance policy”^{xxxviii} was also considered to be relevant as were the facts that there were no criminal sanctions or other civil awards arising out of the insurer’s conduct in this case.

Bad Faith by the Customer

^{xxxiv}*Clarfield*, supra note 7, at p.289.

^{xxxv}*Ibid* p.291.

^{xxxvi} In a recent case in New Brunswick, *Cloutier v. Canada Life Ins. Co.*(2000), 24 CCLI (3d) 51 (QB), the court held that an insurer’s size, worth or profitability were all irrelevant and that the only criterion was relationship to harm as measured by compensatory damages. The court applied a rule of thumb that punitive damages should constitute approximately 35% of total damages. Contrast *Friese v. Citadel Life Assur. Co.*(2000), 19 CCLI (3d) 178 (Ont. Master) affirmed SCJ, June 12, 2000, where the insurer was compelled to produce financial statements to establish quantum of punitive damages.

^{xxxvii}But see also *Khazzaka v. Commercial Union Assur. Co.* [1999] OJ No.3583 (GD).

^{xxxviii}*Ibid* p.292.

An insured also owes a duty of good faith to the insurer, particularly at the contract negotiation stage. While it has often been said that this duty is owed through the life of the contract, including the claims stage, only recently has this become an issue of any practical significance. Conduct amounting to bad faith is usually dealt with as fraud which entitles the insurer to deny coverage^{xxxix} and the issue has not usually been couched in terms of the duty of good faith. Courts in the U.S. have resisted the notion that conduct that amounts to bad faith should afford the insurer an affirmative right to a remedy beyond merely denying payment of the insurance money.^{xl} But, in a recent Alberta case^{xli}, the Court of Queen's Bench expressly characterised the insured's "deliberate course of conduct to misrepresent facts to the Defendant in order to continue to collect disability benefits" as bad faith. The court said that, if loss of benefits was the only sanction, the insured would be no worse off than if he had been honest. The court considered it appropriate to impose an award of \$20,000 in punitive damages as a deterrent. The court described the good faith principle as a "two-way street ... arising from the very nature of the contract." Apart from this, bad faith by the customer does have one clear consequence. It can be seized upon by the court to offset, entirely or in part, any bad faith on the part of the insurer. This is referred to as comparative bad faith and operates like contributory negligence in the sense that any damages attributable to the insurer's bad faith are reduced in proportion to the customer's bad faith.^{xlii} In Canada the only case raising issues of this type saw a Manitoba court denying a claim for punitive damages despite conduct by the insurer similar to that which had attracted punitive damages in other cases because the customer had exaggerated symptoms to support the claim.^{xliii} Presumably, it would have been open to the court, if it so chose, to have awarded some punitive damages, but at a reduced rate.

^{xxxix}See e.g. *Ontario Insurance Act*, s.148, statutory condition 7 which provides that "any fraud or wilfully false statement...vitiates the claim."

^{xl}See *Maus & Rawls*, *supra*, note 50, at p.23 citing *inter alia*, *Tokles & Son Inc. v. Midwestern Indem. Co.* 65 Ohio St. 3d 621 (1992).

^{xli}*Andrusiw v. Aetna Life Ins. Co.* [2001] AJ No.789 (QB).

^{xlii}See e.g. *California Casualty Gen. Ins. Co. V. Superior Court (Gorgei)*, 173 Cal. App.3d 274 (1985). However, this does not apply to liability insurers in respect of their duty to settle third party claims within policy limits. See *Kransco v. Amer. Empire Surplus Lines Ins. Co.* (Cal SC, file No. S062139, June 22 2000).

^{xliii}*Wachal v. Crown Life Ins. Co.* [1999] MJ No. 366 (Man. QB).

The Duty of Good Faith and Freedom of Contract

The purpose of contract law generally is to give effect to bargains freely entered into. Whether or not one of the parties to a bargain got the better of the deal is usually not for a court to question. Accordingly, the courts have traditionally been reluctant to intervene to alter the obligations assumed. The threat of enforcement of the bargain as negotiated is generally thought to be sufficient to deter breach of contract. Exceptions are made where the imbalance of bargaining power is extreme or where legislation protects consumers in specific types of transactions, such as door-to-door sales. But they are just that; exceptions; and they are based on factual findings or assumptions that the contract was not freely bargained from the point of view of one of the parties.

When, in rare cases, courts in Canada have awarded aggravated or punitive damages in breach of contract cases (outside the insurance context), they have reconciled these remedies to the freedom of contract ideal. Aggravated damages are given only for harm which, while beyond the mere loss of bargain, was within the reasonable contemplation of the defendant, if not at the time of contracting^{xliv}, at least at the time of the breach.^{xlv} In other words the original bargain is taken to have included the promise not to breach the contract in a way which would cause additional foreseeable harm such as mental distress. In punitive damages cases, the courts insist that there be a wrong committed separate from the mere breach of contract. This separate wrong is the manner of the breach which, because of its outrageous nature, “assumes the character of a wilful tort, calculated rather than inadvertent and in wanton and reckless disregard for contractual rights of others.”^{xlvi} The two requirements for punitive damages, commission of a

^{xliv}1. In which case the damages would be within the scope of remoteness as defined in *Hadley v. Baxendale* (1854), 9 Exch. 341.

^{xlv}See e.g. *Pilon v. Peugeot Can. Ltd.* (1980), 29 OR (2d) 711 (HC).

^{xlvi}*Thompson v. Zurich Ins. Co.* (1984), 45 OR (2d) 744 (HC).

wrong separate from mere breach of contract and “harsh, vindictive, reprehensible and malicious”^{xlvii} conduct are merged. In contrast, in insurance cases, these two elements are more obviously distinct. The wrong committed is a breach of good faith^{xlviii} which may or may not be done in a manner sufficiently reprehensible to attract punitive damages.

Whether or not the complaint is about conduct distinct from the breach of contract, it remains true that awards of punitive damages or, indeed, aggravated damages (if based not on loss reasonably contemplated at the time of the contract but merely at the time of the breach), constitute payments not contemplated as part of the bargain.

If there is a problem with this, it is inefficiency. Elsewhere^{xlix} (with Bruce Feldthusen), I have argued against a judicial power to impose warranties in respect of non-dangerous defects in property where the warranties are not bargained for or required by legislation. That argument was in the context of the debate about tort liability for pure economic loss resulting from negligently caused shoddiness in products or buildings but one of the key points has relevance here. That point is that a judicial warranty has the effect of adding to the cost of the good in question. This added cost was not in contemplation when the bargain was made. For future costing, the seller will have to take the warranty into account and increase the price. Consumer choice embraces both higher priced items with superior warranties and lower priced ones with inferior or no warranties. Sometimes a consumer wishes to take the cheaper option. For him/her, it represents the most efficient use of available funds. If all goods have to be priced to include a superior warranty, that choice is taken away. Inefficiency results.

These arguments also apply to insurance. The judicially imposed good faith obligation equates to a warranty of

^{xlvii}*Vorvis v. ICBC* (1989), 58 DLR (4th) 193 (SCC).

^{xlviii}It remains unclear whether a duty of good faith attends the performance of non-insurance contracts. See *Peel Condominium Corp. No. 505 v. Cam-Valley Homes Ltd* (2001) 196 DLR (4th) 621 (Ont. CA).

^{xlix}Brown and Feldthusen, “Pure Economic Loss: Who Should Pay, When and How?” in *Negligence After Murphy v. Brentwood DC* (Legal Research Foundation, Auckland, 1991) 39.

quality of service some customers may choose to forgo. These are customers who, in exchange for a lower premium, would be prepared to accept a remedy restricted to the limits of insurance provided in the contract. It is not that they necessarily accept in advance dilatory and shabby treatment in the event of claims. Rather, like buyers of cars without extended warranties, they are willing to gamble that they will not have a problem. To them that is the efficient choice. Because the obligation to pay aggravated or punitive damages is extra-contractual^l, this choice is practically difficult to accommodate. Theoretically customers could waive in advance their rights to aggravated or punitive damages^{li} but this would involve a declaration that shabby treatment is possible, hardly an attractive marketing ploy. Absent the use of waivers, insurers would have to apply this “warranty”, and spread its cost to all their customers.

But the evidence so far suggests that the good faith obligation imposed by the courts has negligible, if any, effect on pricing of insurance products.^{lii} As will emerge from a more detailed discussion later, this is attributable to a circumspect approach by the courts which, despite making some accommodation for extra-contractual remedies, pays due obeisance to the sanctity of contract. In *Vorvis v. Insurance Corporation Of British Columbia*^{liii}, a seminal case on aggravated and punitive damages in breach of contract cases, McIntyre J. said:

In an action based on a breach of contract, the only link between the parties for the purpose of defining their rights and obligations is the contract. Where the defendant has breached the contract, the remedies open to the plaintiff must arise from that contractual relationship, that “private law”, which the parties agreed to accept.

The injured plaintiff then is not entitled to be made whole; he is entitled to have that which the contract provided for him for compensation for his loss. This distinction [between contract and tort] will not

^lRecall aggravated damages, by definition, relate to losses not contemplated at the time of contracting. If they were, there would be no need of this separate category of damages as they would be covered by the *Hadley v. Baxendale* principle.

^{li}In *Central & Eastern Trust v. Rafuse* [1986] 2 SCR 147, the Supreme Court of Canada affirmed that parties to a contract may limit their liability to one another for torts related to performance of the contract. It is unclear whether this applies to liability for punitive, as opposed to compensatory damages.

^{lii}Letter to the author from Ron Miller, Baron Actuaries, Toronto, dated 1 June, 2001.

^{liii}Supra, note 47, at 208.

completely eliminate the award of punitive damages but it will make it very rare in contract cases.

None of this should come as a surprise. Among the things which set insurance law apart from the law of contracts generally is the possibility it provides for judicial intervention. Several rules other than those related to the good faith obligation, some legislated, some judge-made, allow a court to impose upon one or other party obligations beyond those negotiated or erase rights which were seemingly part of the bargain. For example, in recent years, courts have embraced a new approach to the interpretation of contracts under the rubric of “reasonable expectation”. At least potentially, this could sanction the rewriting of key terms. Another example is a section in the *Insurance Acts* in force in most Canadian provinces and territories provides that a customer is not bound by any stipulation, condition or warranty in a fire insurance contract if a court finds it to be unjust or unreasonable. And another section in most *Insurance Acts* allows a court to grant a customer relief from forfeiture for failure to comply with certain provisions of the contract if the court considers it inequitable that coverage should be forfeited on that ground. As the following examination of these rules demonstrates, there is in each case, a tradition of judicial restraint and deference to private bargains; a tradition later to be seen in the cases on punitive and aggravated damages.

Reasonable Expectations

A judicial device having the potential to impose extra-contractual obligations on the parties, particularly the insurer, is the approach to policy interpretation which is based on “reasonable expectations”. The adoption of this approach in Canada no doubt was cause for concern among insurers because some courts in the United States had used it to justify rewriting insurance contracts even in the face of clear exclusionary language in the policy.^{liv} But, so far, any such fears have proved to be unfounded. In the first Canadian case of consequence to examine reasonable expectation as a guide to interpretation,^{lv} the Ontario Court of Appeal gave it effect merely to resolve an ambiguity in the policy in favour of

^{liv}For a review of American approaches see *Wigle v. Allstate Ins. Co.* (1984), 10 CCLI 1 (Ont. CA) and the dissenting judgment of Cory J. in *Brisette v. Westbury Life Ins. Co.* (1992), 13 CCLI (2d) 1 (SCC). See also Abraham, “Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured.” (1981), 67 Virginia LR 1151.

^{lv}*Wigle*, *ibid.*

the customer. Note that another well established and non-controversial method, *contra proferentum*, was available to achieve the same result. The significance of the introduction of the concept of reasonableness into the process was that it could potentially *limit* the application of *contra proferentum*. That is, if the resolution of an ambiguity in favour of the insured produced an unreasonable result, the court should strive to find a fair result by using other approaches.

Subsequent Canadian cases have generally accepted the view that reasonable expectation is only applicable to resolve ambiguity; that is, where the court finds it impossible to determine the intention of the parties in choosing the words in dispute.^{lvi} Moreover, Canadian courts also generally require examination of the reasonable expectations of both parties, not just the customer.^{lvii} This is redolent of an earlier seminal case on policy interpretation, *Consolidated Bathurst v. Mutual Boiler & Machinery Insurance Co.*^{lviii} in which the Supreme Court of Canada held that any resolution should be commercially sensible from the point of view of both parties. In the words of Estey J.:

the courts should be loath to support a construction which would either enable the insurer to pocket the premium without risk or the insured to achieve a recovery which can neither be sensibly sought nor anticipated at the time of the contract.

The newer language of the reasonable expectation doctrine has been applied in a way which is entirely consistent with this older approach and which seems to extend it not at all. As with the good faith rule in respect of claims, the courts in Canada have declined to adopt an approach inconsistent with the tenets of freedom of contract. Courts will intervene only when the bargained terms are ambiguous and, even then, the intervention is not automatically in favour of the customer. The imposed result must fit within the (admittedly broad) confines of good business sense from the

^{lvi}See e.g. *Reid Crowther & Partners v. Simcoe & Erie Gen. Ins. Co.* (1993), 13 CCLI (2d) 161 (SCC) and *Chilton v. Cooperators Ins. Co.* (1997), 32 OR (3d) 161 (Ont. CA).

^{lvii}But see remarks by Laforest J. in *National Bank of Greece v. Katsinouris* [1990] 2 SCR 1029 and the comment by McLachlin J. in *Reid Crowther*, *ibid*, that she was giving effect to "settled" law by referring to the reasonable expectations of the parties in the event of ambiguity "*without pronouncing on the reach of the doctrine*".

^{lviii}[1980] 1 SCR 888.

point of view of both parties.

Unjust or Unreasonable Terms in Fire Insurance

The *Insurance Acts* in force in most provinces and territories in Canada contain the following section applicable to fire insurance:

Where a contract...contains any stipulation, condition or warranty that is or may be material to the risk including, but not restricted to, a provision in respect to the use, condition, location or maintenance of the insured property, the ...stipulation, condition or warranty is not binding upon the insured, if it is held to be unjust or unreasonable by the court before which a question relating thereto is tried.^{lix}

This provision appears to give judges the power to refuse to apply terms imposing obligations or restrictions on customers when, according to subjective values, it would seem unfair to do so, even if, objectively, the obligation or restriction is material to the insurance. However, yet again, this apparently wide discretion to intervene has been exercised conservatively.

For the most part, the courts have considered the relevance of the stipulation, condition or warranty to the risk insured to be key in determining whether it is unjust or unreasonable. In *Duddingham v. St. Paul Fire & Marine Insurance Co.*^{lix} a condition that the insured, a jeweller, keep at least half his stock locked in a safe overnight was held not to be unjust or unreasonable because it was related to the premium charged. Significantly, it was a term requested by the insured. In other words, the insured bargained for a lower premium in exchange for a promise to take additional security precautions. He could hardly be heard to complain that the very term he bargained for, in exchange for a

^{lix}Ont., s.151; Alta, s.238 (new Act, yet to be proclaimed, s.552); BC, s.129; Man., s.145; NB, s.130; Nfld, (*Fire Insurance Act*) s.11; NS, s.171; PEI, s.117; Sask, s.131; NWT, s.67; YT, s.71.

^{lx}(1963), 45 WWR 463 (BCCA).

benefit, was unjust or unreasonable. Courts have also held that conditions requiring continual occupancy of buildings, a fact material to fire insurance risk, not to be unjust or unreasonable^{lxi}. But it is different when occupancy is not material to the insurance, such as cracks in a cistern.^{lxii}

The reason terms irrelevant to the risk are more apt to be judged unreasonable (if not unjust) is that they are likely to have had no impact on the premium. They would not be part of a reasonably contemplated bargaining process. Their presence in policies is most often explained by the fact that a boiler plate form is used to cover variations of a particular category of insurance. For instance, the same form may be used by a particular insurer for both homeowners and renters insurance with not all clause being relevant to both. In a case like that the court may either determine, as a matter of interpretation, that some parts of the standard form were intended by the parties to be inoperative or that the application of irrelevant terms to the particular customer to be unreasonable. Either way, the court is doing no more than giving effect to the essence of the bargain. It is not intervening to change it.

In the rare case where an unscrupulous insurer has inserted a term, irrelevant to the risk, to trap an unsuspecting customer and provide an excuse for non-payment of a claim, the court is justified in intervening on grounds of abuse of a dominant bargaining position which, as mentioned above, is a remedy known to contract law generally.

Relief From Forfeiture

Most *Insurance Acts* also contain sections giving courts power to grant relief to a customer who would otherwise face forfeiture of an insurance entitlement because of a breach of an obligation imposed by the contract. Specifically, the section provides:

Where there has been imperfect compliance with a statutory condition as to the proof of loss to be given by the insured or other matter or thing required to be done or omitted by the insured with respect to the loss and a

^{lxi}*Simon v. London & Scottish Assur. Co.*[1969] ILR 1-267 (Nfld CA); *Sturk v. Legal & Gen. Assur. Soc.*[1967] ILR 1-181 (Man. CA).

^{lxii}*Hirst v. Commercial Union Assur. Co.*[1979] ILR 1-1071 (BCSC).

consequent forfeiture or avoidance of the insurance in whole or in part and the court considers it inequitable that the insurance should be forfeited or avoided on that ground, the court may relieve against the forfeiture or avoidance on such terms as it considers just.^{lxiii}

Note that, while this grants courts discretion to disregard contractual provisions and, while its purpose is to counter “unjust advantages” accruing to insurers because of a superior bargaining position,^{lxiv} that discretion is narrowly circumscribed. The section only applies to obligations relating to the claims process and not, for example, to matters arising before loss such as late or non-payment of premiums, breach of warranty, or non-disclosure when the contract was being negotiated. It also applies only to imperfect compliance, rather than non-compliance, with an obligation.^{lxv}

The remaining restriction is that relief may be granted only where forfeiture would be considered inequitable. This means the court should examine both the conduct of the customer (if s/he does not have “clean hands” in the matter, such as where there is fraud, it is usually unlikely that forfeiture be inequitable) and whether there has been prejudice to the insurer.^{lxvi} In this context prejudice means that the basis on which the insurer has undertaken its obligations has been undermined. Its promise to indemnify is based, among other things, on its ability properly to investigate claims. If proof of loss is filed so late, or in such a state of inadequacy, that the reasonable opportunity to investigate is denied, that basic understanding has not been met. The customer’s breach has gone to the root of the bargain. It is only where the basis of the bargain is not threatened, and the breach is a mere technicality, that relief may be granted.

^{lxiii}Ont., s.129; Alta, s.205 (new Act, s.515); BC, s.12 (broader language); Man., s.130; NB, s.110; Nfld, s.10, 22; NS, s.33; PEI, s.92; Sask., s.109; NWT, s.33; YT, s.52. This section does not apply to life, marine or accident and sickness insurance. However, another section makes similar provision for accident and sickness insurance. See e.g. Ont., s.328.

^{lxiv}*Prairie City Oil Co. V. Standard Mutual Fire Ins. Co.* (1910), 44 SCR 40, at 59.

^{lxv}For a discussion of cases which examine this distinction, see Brown, Menezes and Cassels, Brock and Blackwell, *Insurance Law in Canada*, Loose-leaf ed. p.9-25.

^{lxvi}*Falk Bros. Industries v. Elance Steel Fabricating* [1989] 2 SCR 778.

In recent times it has been argued, with some success, that these provisions in the *Insurance Acts* are not the sole source giving courts authority to relieve against forfeiture. Other provincial legislation, usually called the *Judicature Act* or *Courts of Justice Act*, contains a section giving courts the authority to grant relief against “penalties and forfeitures” on such terms as they see fit.^{lxvii} In *Saskatchewan River Bungalows v. Maritime Life Assurance Co.*^{lxviii}, a case involving life insurance (excluded from the ambit of the relief provision in the *Insurance Act*), the Supreme Court of Canada, after deciding that the customer’s unreasonable conduct precluded relief in the particular case, added that:

...the existence of a statutory power to grant relief where other types of insurance are forfeited...does not preclude application of the *Judicature Act* to contracts of life insurance. The *Insurance Act* does not “codify” the whole law of insurance; it merely imposes minimum standards on the industry. The appellant’s argument that the “field” of equitable relief is occupied by the *Insurance Act* must therefore be rejected.^{lxix}

This dicta has been applied in subsequent cases.^{lxx} However, the generality of the statement that the restrictions in the *Insurance Act* provision are no longer fatal to an application for relief needs to be qualified. While it is probably true that relief is now available in respect of life insurance, it remains the case that it will only be so where that is the equitable result, meaning that it cannot prejudice the insurer in the sense described above.

It is also unclear whether the more general provision may be applied in cases involving pre-loss breaches or total non-compliance. Recently courts have denied relief where the breach is non-payment of premiums.^{lxxi} The reason is that the effect of a breach of this nature is to bring the contract to an end. There being no contract, there are no rights to be forfeited so there can be no forfeiture and therefore nothing to relieve against. In the words of the Ontario Court of Appeal:

^{lxvii}See e.g. *Ontario Courts of Justice Act*, RSO 1990, c.C.43, s.98.

^{lxviii}(1994), 23 CCLI (2d)161 (SCC).

^{lxix}Ibid at p.175-6.

^{lxx}See e.g. *Feature Foods v. Landau* (1995), 27 CCLI (2d) 179 (Ont.GD).

^{lxxi}*Pluzak v. Gerling Life Ins. Co.*(1999), 44 OR (3d) 49 (CA); *Khan v. Primerica Life Ins. Co.* (1998), 13 CCLI (3d) 171 (Ont. GD).

The premium is the payment for coverage for the next term. ..[T]here is no coverage for that term when a payment is not made and the insurer arranges its commercial affairs accordingly. In these circumstances, the contract terminates on its own terms and not by a breach.^{lxxii}

In another case,^{lxxiii} the Saskatchewan Court of Appeal held that a vehicle's registration was a condition of coverage under an auto insurance policy so that expiry of the registration removed a basis for the existence of the contract. Accordingly, failure to maintain registration was not something against which relief could be given.

In essence, these cases show that the courts will not use the relief provision to create obligations where they do not already exist or where they have expired. Thus there is a distinction between types of condition or stipulation for these purposes. Those that go to the existence of the contract itself, in the sense that their breach terminates the contract, are beyond the reach of even the general provisions contained in the *Judicature or Courts of Justice Acts*. That reach extends only to terms which, when breached, do not destroy the whole contract but merely attract some other adverse, but less serious, outcome, such as forfeiture of a claim or payment of a penalty. Lord Wilberforce, in a case dealing with relief from forfeiture,^{lxxiv} said, "equity expects men to carry out their bargains." It was not an insurance case but it reflects the same attitude these recent Canadian insurance cases reflect; that is reverence for the essential sanctity of a contract freely bargained.

The Good Faith Obligation Historically

Insurance contracts are different from most other commercial transactions in that the parties owe each other obligations of candor and fair dealing in addition to the obligations contained in the terms of the contract itself and

^{lxxii}Pluzak, *ibid* at para. 18.

^{lxxiii}*Chamberlin v. Sask. Govt. Ins.* (1995), 28 CCLI (2d) 157 (Sask.CA).

^{lxxiv}*Shiloh Spinners Ltd. V. Harding* [1973] AC 691, at 723-4 (HL).

have access to remedies beyond those afforded by ordinary contract law.^{lxxv} This special treatment is said to be justified by the particular nature of insurance which, in different ways and at different times throughout the life of a contract, places each party in a position of vulnerability to the other.

Until relatively recently, statements that this duty applied to insurers, as well as customers, were little more than platitudes. In the vast majority of cases the duty was applied to customers in the context of negotiating the contract of insurance. A customer seeking to transfer a risk to an underwriter is obliged, not only to refrain from untrue representations, but also positively to disclose all matters material to the risk even if not asked specifically about them. The objective of this duty of utmost good faith is to place the parties on an “equal footing”^{lxxvi} by canceling the perceived information advantage held by the customer. Without this rule, developed by the courts in the eighteenth century, it was feared insurers would be forced to accept risks different from those they thought they were accepting, thus undermining their viability as underwriters. In other words, underwriters were thought to be vulnerable given the customer’s monopoly on information material to the risk being transferred.^{lxxvii}

But gradually this one-sided view has changed. For one thing, the information-gathering abilities of insurers have become more sophisticated. Accordingly the rule prescribing the customer’s duty of disclosure has been modified in Canada, both by legislation and by the courts, to reflect the shifting balance of advantage from customers to insurers. For fire insurance, legislation has modified the duty to require only that customers not “fraudulently omit” to disclose material information.^{lxxviii} The rule for auto insurance essentially restricts the duty to filling out the application form

^{lxxv}See *supra*, note 48.

^{lxxvi}*Greenhill v. Fed. Ins. Co.* [1927] 1 KB 65 at 76 (CA). For detailed arguments supporting an insurer’s duty of good faith in this context, see Boivin, “Wrongful Denial of Insurance Benefits: A Canadian Perspective” (1999), 7 *The Tort Law Review*, 52.

^{lxxvii} In *Rozanes v. Bowen* (1928), 32 Ll. LR 98 at 102, the court wrote, “It has been for centuries in England the law in connection with insurance of all sorts, marine, fire, life, guarantee and every kind of policy that, as the underwriter knows nothing and the man who comes to him to insure knows everything, it is the duty of the assured...to make a full disclosure to the underwriters without being asked of all the material circumstances.”

^{lxxviii}See e.g. in Ontario, *Insurance Act*, s. 148, Statutory condition 1.

fully and accurately.^{lxxix} It has long been the case that the customer's duty extends only to information within his/her personal knowledge (so the customer is not penalised for failing to mention something, however material to the risk it may be, the insurer knows or ought to know).^{lxxx} Now the idea is cast in terms of the insurer's duty.^{lxxxi} It is considered a breach of good faith for the insurer to lure a customer into a contract knowing it, the insurer, would never have to pay out under the contract owing to the defence of non-disclosure. Again, the underlying principle is that the parties be on an "equal footing". Neither party is permitted to hide relevant facts from the other.

More recently still, courts in Canada, taking their lead from the U.S., have given substance to another oft-stated platitude; that the duty of good faith applies not only to the negotiating stage but lasts throughout the life of the contract. For both parties this probably means a general obligation to deal openly and honestly with each other regardless of the specific requirements contained in the contract, particularly in respect of claims^{lxxxii}. The insurer's duty at the claims stage is of more practical significance, not least because that is where the customer, having suffered loss or injury, is economically and, possibly, psychologically vulnerable. Again, it is the "equal footing" rationale in play.

^{lxxix}*Ibid.* s.233.

^{lxxx}*Carter v. Boehm* (1766), 3 Burr. 1905 97 ER 1162 (KB).

^{lxxxi}*Coronation Ins. Co. v. Taku Air Transport* [1991] 3 SCR 622.

^{lxxxii} On example arises in respect of subrogation. Where an indemnity insurer has made only partial payment of a loss, depending on policy terms or relevant legislation, it may not be entitled to exercise subrogation rights. However, the customer remains under a duty to pursue in good faith the full value of any claim against a third party in respect of the same loss and reimburse the insurer once s/he has obtained in total a full indemnity. See *Globe & Rutgers Fire Ins. Co. v. Truedell*(1927), 60 OLR 227 (CA).

Conclusion

The recognition of bad faith as a separate wrong, awards of damages for aggravated harm consequent upon such a wrong and awards of punitive damages all speak to the theme of this paper. Judicial intervention is not about enforcing a contractual remedy, it is about compensating loss and punishing conduct which, while occurring in a relationship born of contract, is outside the scope of that contract. It is not a breach of contract that is the target of this rule, it is the insurer's tortious conduct. The court is not intervening to change the terms of the bargain. It is acting to punish the egregious way in which the insurer has failed to keep its side of the bargain, and to compensate any loss beyond simply loss of the bargain suffered by the customer.

In this light an intervention can hardly be impeached as contrary to freedom of contract. It is an attempt simply to enforce the bargain which had been freely agreed to, especially that part promising "peace of mind"^{lxxxiii}. Nonetheless judgments awarding aggravated and/or punitive damages add to insurers' costs and, like judicial warranties of quality in the case of goods, would be expected to affect prices.

In fact the prospect of paying such damages is not yet a specific factor in setting premiums.^{lxxxiv} In part this is because there are relatively few cases.^{lxxxv} It is also because premium levels also have much to do with the state of competition in the insurance market and the level of investment earnings factors which tend to distort a strict "cost-plus" approach to pricing. To the extent aggravated or punitive damages are considered in a costing framework, it is likely that the risk of having to pay them is regarded as part of the cost of fighting fraud. These cases arise invariably in cases where insurers suspect fraud such as arson or malingering. These suspicions are borne of the often bitter experience of

^{lxxxiii}Ibid.

^{lxxxiv}Letter to the author from Ron Miller, Baron Actuaries, Toronto, dated 1 June, 2001.

^{lxxxv}Recall it is not every denial of an eventually successful claim which attracts these damages. It is only where the insurer is guilty of egregious conduct.

adjusters who develop a sense about when to challenge claims. They may be prepared to back their intuition, gambling that it will flush out more genuine fraud than it will attract sanction for getting it wrong.^{lxxxvi}

As the title of this paper suggests, the principal reason for the negligible impact of the good faith requirement on prices is judicial restraint when it comes to intervening in contracts to an extent which would fundamentally change the assumptions on which prices are based. Perhaps an equally apt word is balance. It can be argued that the purpose of the rules giving substance to the duty of good faith owed by both parties to an insurance contract is to ensure balance in that relationship. The relatively recent development of the duty as applied to insurers upon receipt of claims is consistent with that theme. First, the very existence of a duty imposed on insurers balances the hitherto one-sided emphasis on the duty owed by customers regarding the disclosure of material facts when entering into contracts of insurance. Second, creation of the duty promotes parity of bargaining power in the process of settling claims by providing a strong incentive for insurers not to take advantage of the economic and perhaps emotional vulnerability of those who have suffered disability or property loss. Third, the duty is limited by the notion of reasonableness. Insurers are not deterred from proper investigation of claims or denying them when reasonable grounds (factually or in terms of policy interpretation) exist for doing so. Fourth, bad faith by customers may offset or even cancel the legal effect of bad faith by insurers. Fifth, the measurement of punitive damages, the chief means of deterrence, is governed by criteria designed to promote proportionality to the harm done, the degree of fault financial means of the insurer and the existence of other penalties. In these ways, the insurer's good faith obligation reflects the underlying rationale of all insurance law. In a market place where perfect information is often lacking, insurance law generally is designed to achieve balance between the reasonable expectations of consumers and the need for financial viability of the institution of insurance. In this context, development of the duty is a natural one.

^{lxxxvi}In any case the courts seem willing to give insurers some leeway in investigating suspicious claims, provided they act reasonably.

¹This is a revised version of a paper presented at the 2001 annual conference of the New Zealand Insurance Law Association. My thanks to my colleague, Prof. Mitchell McInnes for his comments which assisted me in its preparation.