Supreme Court of Canada Examines: What is a *Claim?*

By Lovel Vining

Introduction

When reporting a liability loss to an insurance company, the difference between "occurrence" and "claims-made" policy forms is a crucial issue. Occurrence forms cover claims for negligent *acts that take place during the policy term*, regardless of when the claim is subsequently filed. A claims-made form, however, covers only those negligent acts that have both *taken place and materialized into an actual demand for compensation during the coverage term*. The coverage term of a claims-made form is typically extended at each renewal so that contiguously renewed annual policies constitute a multi-year coverage period. Most claims-made policies also provide an extended reporting period beyond the expiration date of the current coverage term. Likewise, an insurer writing a new claims-made policy will often provide a "tail" period that will cover claims for losses that were incurred but not reported during a defined period before the new policy was in place.

The effectiveness of an insurance policy always depends upon that policy's definition of a "claim." In many instances, the policy language will specify that oral or written demands for monetary or non-monetary damages are the claim "triggers." In some instances, however, policies can be less specific.

A recent decision by the Supreme Court of Canada in the matter of the *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, [2006] SCC 21, has provided clarity as to what constitutes a claim in the absence of a specific definition within a policy. The case focused on the application of an occurrence form Comprehensive General Liability (CGL) policy obtained by the Jesuit Fathers. In addition to its usual coverage grant, the policy extended additional coverage for professional services and incorporated certain language typically found in a stand-alone claims-made Errors and Omissions policy. Unfortunately for the Jesuit Fathers, the amended form did not define the term "claim."

Background

The case involved a number of abuse claims that stemmed from the Jesuit Fathers' operation of a residential school in northern Ontario. In 1991, when the Jesuit Fathers were made aware of an alleged abuse of a former student at the hands of a Jesuit teacher, investigations were undertaken by the Ontario Provincial Police and by the Jesuit Fathers. The results of the internal review, first delivered to the Jesuits in October 1993, revealed at least ten potential victims of abuse. The CGL insurance policy purchased by the Jesuit Fathers in 1988 was continually renewed until September 30, 1994, when due to the revelations of abuse and potential abuse, the insurer declined to renew the policy.

In January 1994 a lawyer retained on behalf of Peter Cooper, an individual previously identified by the Jesuit Fathers in their internal review as a potential claimant, sent a letter to the Jesuit Fathers outlining his allegations and seeking to settle the matter without litigation. The Jesuit Fathers wrote to the Guardian Insurance Company in March 1994 to alert them to Mr. Cooper's claim and to the possibility that nine other claims could develop. The notice identified the alleged perpetrators, the dates and locations of the alleged abuse, and the names of the nine additional victims discovered during their internal investigation. Mr. Cooper eventually filed suit in 1995. Although Guardian acknowledged an obligation to provide coverage for the Cooper claim, they subsequently denied coverage for all of the other claims on the basis that they were not "first made" during the policy period. A coverage dispute between the Jesuit Fathers and Guardian ensued and the Court was ultimately asked to address the issue of what constituted a "claim" under Guardian's policy, in the absence of a specific definition in their policy.

Supreme Court Decision

The Supreme Court ruled that while the Guardian policy did require the Jesuit Fathers to report "occurrences," the coverage it provided was on a true claims-made form. Citing previous Supreme Court case law, the Court reiterated the common law requirements for a "claim" to be made under an insurance policy:

> *"The authorities establish that as a general rule, for a "claim" to be made there must be some form of communication of a demand for compensation or other form of reparation by a third party upon the insured, or at least communication by the third party to the insured of a clear intention to hold the insured responsible for the damages in question."*

The Court held that the claim of Mr. Cooper was sufficient to attract coverage under the policy. His claim was clearly "first made" (by virtue of a letter from his legal counsel seeking damages and early resolution of the matter) during the policy period and therefore triggered coverage under the Guardian policy. However, given the absence of a definition for "claim" in the policy, the circumstances of the nine other potential victims did not meet the common law requirements of a claim. More specifically, the information regarding the nine claimants did not arise from a demand by the victims or their appointed representatives, but rather came to light following an internal investigation.

Impact for Insureds

The outcome of this case highlights several important issues that need to be considered and addressed by a buyer of Errors & Omissions coverage.

Firstly, the policy at issue was essentially a hybrid that expanded a standard Comprehensive General Liability form to include coverage for Errors and Omissions. Caution must be exercised in constructing policies. While amending an existing policy form to expand coverage may be an efficient and cost-effective way to manage risk, doing so without the appropriate guidance and due diligence to tailor an insurance program to specific needs can create significant problems, including potential gaps in coverage. In its decision, the Supreme Court observed that alternative insurance products were available in the market at the time Guardian's policy was first purchased and that such alternatives could have provided the Jesuit Fathers with more effective and complete protection.

Second, in re-examining the legal doctrine of *contra proferentum*—in which ambiguities in contract language are typically construed against the drafter—the Supreme Court suggested that, in the context of an insurance policy, the drafter may not always be the insurance company. The process of constructing a comprehensive insurance program will often require engaging unique and specialized expertise. It is of the utmost importance for companies who call on specialists such as insurance brokers for help in negotiating and drafting complex policy wordings, to be confident in that specialist's knowledge and experience. Companies also need to be aware of the impact that suggested language may have on the interpretation of policies; otherwise, ambiguities in manuscripted policy language could be interpreted in favor of the insurer.

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