

Insurance Act Regulations

Discussion Paper

February 2010



Ministry
of Finance

Introduction and Request for Comments

The British Columbia *Insurance Act* sets out statutory requirements that apply to contracts of insurance, including required contents of insurance policies and procedures for making claims and payments. The Act does not deal with automobile insurance or the regulation of insurance companies and brokers.

In October 2009, amendments to the *Insurance Act* were passed by the Legislative Assembly of British Columbia as Bill 6, the *Insurance Amendment Act, 2009*.

The amendments respond to frequent criticisms by the courts respecting confusion about how to apply various parts of the Act. There will now be one set of provisions applicable to all property contracts, thereby avoiding the need to classify the insurance contract as a fire contract or a multi-peril contract.

The amendments also enhance consumer protection in many ways, for example, by ensuring coverage for “innocent co-insureds” and lengthening limitation periods. As well, they respond to industry’s needs, by recognizing new products and ways of doing business.

In certain areas, the amendments allow for further details to be set out in the regulations. In some cases, the regulation-making power is there to deal with issues that may arise at a later stage, and no regulations are proposed at this time. However, in many cases, regulations are needed to fully implement, or to refine the application of, the amendments.

This policy paper is intended to provide interested parties with the opportunity to comment on the policy direction for the regulations under the *Insurance Act*. The proposals contained in this paper do not represent government policy; rather, the paper is intended to elicit discussion and input.

Throughout the development of the amending legislation, staff worked closely with their counterparts in the province of Alberta to maximize harmonization between the provinces. As a result, each province’s insurance law is substantively very similar to the other’s.

Alberta began consultations on its *Insurance Act* regulations in 2009 with the publication of the paper “Consultation on Proposed Regulations for the Amended Insurance Act”. The Alberta proposals, and the submissions received on them, can be viewed at:

http://www.finance.alberta.ca/publications/insurance/2009_0615_consultation_insurance_regs.pdf

We have greatly benefitted from Alberta’s initiation of consultations in this area.

For the most part, the proposals now under consideration by British Columbia are consistent with those initially proposed by Alberta. However, there are differences with respect to the use of electronic communications for beneficiary designation and ownership transfer, and the timing of notification of limitation periods, as well as some additional regulations, proposed in this paper, respecting telephonic communications and creditor's group enrolment. As well, there are a number of other issues, such as procedural requirements for innocent co-insureds and restrictions on settlement practices for group insurance claims, about which British Columbia is specifically seeking further input.

Additional differences between British Columbia and Alberta may arise as a result of further policy development in both provinces, although harmonization continues to be a goal in finalizing the regulations.

The regulations proposed in this paper are of general application. Although it may be necessary to exclude special types of insurers and insurance (such as captive insurers, reciprocals and home warranty insurance) from certain provisions, as noted in places in the paper, other refinements will be developed at a later stage.

It is anticipated that the regulations will be drafted by the Fall of 2010, thus allowing for finalization of all of the *Insurance Act* reforms at that time. However, there will be a transitional period provided to allow all parties to become familiar with the new regime, and to make any necessary changes to their procedures and policy wordings, before the amendments and the regulations actually take effect. Ideally, implementation will be co-ordinated with Alberta.

Please direct your comments, by **April 16, 2010**, in electronic form to: fcsp@gov.bc.ca. If you wish to send comments in paper format, please direct them to:

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Please note that the Ministry of Finance will be sharing comments it receives with its counterpart in the government of Alberta, and others. Even where confidentiality is requested, freedom of information legislation may require that responses be made available to those requesting such access.

Thank you for your participation in this review.



Proposed Regulations

PART 1: Regulations applicable to all contracts

The following regulations will apply to all insurance contracts, including property and casualty (P&C) insurance, and life and accident & sickness (LAS) insurance, except as noted.

A. Electronic transactions

New section 2.5 of the *Insurance Act* clarifies the application of the *Electronic Transactions Act* (ETA) to insurance contracts by stating that insurance records may be provided electronically in accordance with the requirements of the ETA (e.g., with the recipient's consent). The provision recognizes that e-communications are an effective, efficient and enviro-friendly mode of conducting business that can benefit both industry and consumers in terms of cost, speed and accessibility.

However, the *Insurance Act* also allows for regulations to specify certain types of insurance documents to be excluded from the application of the ETA – that is, such documents would have to be provided in paper form. In this regard, it has been suggested that electronic transmittal is not appropriate for two types of communication in particular – terminations of coverage and designations of beneficiaries.

With respect to terminations by the insurer, it is proposed that these be excluded from the application of the ETA, and continue to be sent in paper form. The use of electronic communications in the insurance context raises serious concerns about actual receipt by the insured. Notifications terminating a person's insurance coverage are simply too important to be subject to any uncertainty.

Other documents required to be sent by registered mail, including proofs of claim and general notifications to the insurer and insured, could be sent electronically, if both parties have consented to that form of transmittal under the terms of the ETA.

However, it is proposed to allow designations of beneficiaries and transfers of ownership to be made in accordance with the ETA. If, as required, the parties have already agreed to communicate electronically, it would be inefficient and inconvenient to require paper filings for these transactions.

Concerns have been raised about the need to verify the identity of the insured. The initial designation of a beneficiary on electronic formation of a contract raises no particular verification concerns, because the designation is being made by the person forming the contract. Allowing beneficiary changes or transfers to be made electronically could raise issues about the verification of the identity of the sender of new instructions. However, these concerns are not unique to electronic communications, and insurers must safeguard

against fraud even when dealing with paper-based instructions. Electronic communications could actually be more secure than paper if on-line passwords and other sophisticated verification tools are used.

Proposal 1A: Electronic transactions

It is proposed that notices provided by the insurer that terminate the contract under the following sections continue to be required to be in paper form:

P&C Insurance:

- **Section 17 Effect of unpaid cheque or note for premium**
- **Section 27.1 Statutory conditions: Condition 5**

Accident & Sickness Insurance:

- **Section 89 Statutory conditions: Condition 4**
- **Section 92 Termination for non-payment**

B. Telephonic communications

In this modern age of communications, many insurance transactions occur over the telephone. In particular, insurance clients may be solicited by phone, and important information concerning their eligibility (for example, medical history) obtained through this medium. The use of oral communication raises the risk that information may be misheard or copied down incorrectly. This problem has arisen largely in connection with health information sought to determine eligibility for LAS insurance coverage. The *Insurance Amendment Act, 2009* allows the government to adopt regulations respecting telephonic communications to address these concerns.

The proposed regulation would require that application information gathered over the telephone, and other important information obtained telephonically, be provided in writing to the applicant for confirmation. This will help eliminate or resolve subsequent misunderstandings about the information provided, and more importantly, give the applicant the opportunity to ensure that there has been full disclosure.

It has been suggested that an exemption be provided where the contract is entered into by a licensed person acting on behalf of the insurer. Licensed agents are already extensively regulated, and the misunderstandings have, for the most part, arisen in the context of insurance sold under exemptions from licensing.

Proposal 1B: Telephonic communications

It is proposed that an insurer that accepts an application for insurance, or other information that may be material to a contract, by telephone (or other means of communication that does not produce a concurrent written record) must provide to the insured, as soon as practicable after the communication, a written record of the information obtained to enable the insured to verify its accuracy.

Further input is specifically sought on whether an exemption from this requirement should be provided for licensed agents.

C. Notification of expiring limitation period

The *Insurance Amendment Act, 2009* changes the limitation periods within which a consumer must take legal action against an insurer to enforce a claim under an insurance contract. Generally, the limitation period has been increased from one to two years, and the triggering event, upon which that period begins to run, has been clarified.

However, consumers may still be caught unawares by the expiry of a limitation period, especially if they are still engaged in negotiations with the insurance company. To help remedy this problem, the *Insurance Amendment Act, 2009* authorizes regulations to require insurance companies to inform claimants about the applicable limitation period.

The proposal under consideration would require an insurer to make reasonable efforts to provide written notification of the date upon which, to the best knowledge of the insurer, the claimant's right to sue the insurer will expire. Failure to provide the required notification could postpone the running of the limitation period. Although insurers have raised concerns that these notification requirements will increase administrative costs, timely notification of limitation periods is necessary to protect consumers' rights.

Notification would potentially be required at two stages. First, notification would be required to be given upon denial of any claim. The purpose of this early notification is to alert the insured to their rights and responsibilities, which is particularly important given that limitation periods in insurance claims often run from the time of loss or injury (and not from the making of or denial of the claim).

The second notification would have to be provided at least 60 days, but no more than 120 days, prior to the last day of the applicable limitation period. This second notification would not be required where a previous notice had already been provided upon denial of a "minor" claim. As well, no notification at any stage would be required if the insurer has resolved the claim fully to the written satisfaction of the claimant.

It is not proposed to require that a preliminary notification be sent to a claimant immediately upon the insurer's receipt of the claim. Since most claims will be settled without legal action, it would not be particularly effective or conducive to good relations to inform claimants at this stage of their expiring legal rights to sue the insurer.

Proposal 1C: Notification of expiring limitation period

It is proposed that

- 1. insurers must make reasonable efforts to notify a claimant of the date on which, to the insurer's best knowledge and belief, the limitation period applicable to the claim will expire.**
- 2. this notification must be made at 2 point in time:**
 - if a claim is denied, at the time of denial, and**
 - at least 60 but no more than 120 days before the expiry of the limitation period.**

3. **no notification under 2b is required if both of the following conditions are met:**
 - **notification has already been made under 2a, and**
 - **the insurance claim is a “minor” claim.**
4. **no notification is required if the insurer has settled the claim before the notification period described in 2b has ended and has obtained written confirmation of settlement from the insured. No written confirmation would be required for “minor” claims.**
5. **the notification must state that the period will expire regardless of any continuing discussions with the insurer in respect of the claim.**
6. **failure to comply with the requirement will suspend the running of the limitation period, at the discretion of the court, or allow the court to order other appropriate relief.**

Further input is specifically sought on what should constitute a “minor” claim – that is, on what types of claim should be exempt from the final notification requirement (see proposal 3) or from the requirement for written confirmation of settlement (proposal 4). One option would be to exempt claims which, even if successful, could not exceed a prescribed amount (e.g. \$10,000).

D. Consumer complaints against insurers

The *Insurance Amendment Act, 2009* amends the *Financial Institutions Act* to require insurers to develop their own internal processes for the resolution of consumer complaints and to publicize these processes. The regulations will exempt insurers that provide only vehicle insurance from the requirement to establish internal complaints procedures (on the basis that they have their own processes already in place under other legislation), as well as reinsurers (which do not deal with the public) and self-insurers (such as captives, reciprocals and mutual insurance companies).

The amendments also provide authority to pass regulations requiring insurers to become members of a dispute-resolution organization. These organizations provide a second line of recourse for unsatisfied consumers, by offering free “ombudservices” to help resolve insurance disagreements.

The proposed regulation would require membership in one of two named independent ombudservices. The OmbudService for Life and Health Insurance (OLHI) would assist consumers with concerns and complaints about life and health insurance products and services, while the General Insurance OmbudService (GIO) would provide similar services for consumers of home and business insurance (again, companies that offer only vehicle insurance, reinsurance or self-insurance will be exempt, as will federally-regulated companies that are already members of other dispute-resolution organizations in compliance with federal requirements).

GIO and OLHI are the two major consumer complaint programs currently operating in Canada. They already provide independent ombudservices, cost free for consumers, for almost all federally-regulated insurance companies, and both organizations have good track records at resolving disputes. Requiring membership in these organizations will help ensure that people dealing with provincially-regulated insurance companies enjoy a consistent and effective process for dispute resolution. To ensure that consumers are aware of the options for dispute resolution, it is also proposed that insurers be required to notify their clients about the availability of these services.

The regulation-making powers also allow for regulations to require mediation of certain disputes and to prescribe appropriate procedures. This would enable a more formal mediation process to be mandated should the ombudservices approach discussed above prove ineffective. No regulations in this area are proposed at this time.

Proposal 1D: Consumer complaints against insurers

It is proposed that

- 1. insurers that provide only vehicle insurance, reinsurance, or self-insurance be exempted from the requirement to establish internal complaints.**
- 2. insurers offering P&C insurance be required to be members of GIO.**
- 3. insurers offering LAS insurance be required to be members of OLHI.**
- 4. membership in these organizations would not be required for insurers offering only vehicle insurance, reinsurance or self-insurance, or federally-regulated companies that are members of another ombudservice organization.**
- 5. on becoming aware of a dispute, an insurer would be required to notify the consumer of the availability of the service provided by the ombudservice organization.**



PART 2: Regulations applicable to P&C contracts

A. Applicability of statutory conditions

Generally, the statutory conditions set out in the *Insurance Act* must be printed word-for-word on every property and casualty (P&C) contract, and cannot be added to or changed. Section 27.1 (2) allows for regulations to specify classes of insurance to which the Statutory Conditions do not apply.

The proposal under consideration would exempt a number of classes of insurance (based on the new classes of insurance to be adopted for *Insurance Act* purposes – see Proposal 4A) from the requirement to include the statutory conditions in the contract. In some cases (e.g., aircraft insurance, mortgage insurance, credit insurance), the exemption stems from the relative sophistication of the insurance consumer and/or the straightforward nature of the insurance product, which reduce the need to provide detailed regulatory protection. In other cases (title, fidelity, warranty), the statutory conditions appear inappropriate and inapplicable to the particular type of insurance product.

Hail insurance will be excluded to allow for harmonization of British Columbia policies with hail policies in Alberta (where separate statutory conditions apply). As well, statutory conditions will not be required to be printed on the baggage insurance component of a travel insurance product that is predominately life or accident & sickness (LAS) insurance, or on other products that are regulated predominately as LAS (e.g., credit protection insurance).

Proposal 2A: Applicability of statutory conditions

It is proposed that the Statutory Conditions set out in section 27.1 of the *Insurance Act* not apply to the following classes of insurance:

- **aircraft insurance**
- **boiler and machinery insurance**
- **credit insurance**
- **credit protection insurance**
- **fidelity insurance (Surety insurance is already excluded by s. 27.1 (3) of the *Insurance Act*)**
- **hail insurance**
- **mortgage insurance**
- **product warranty insurance**
- **title insurance**
- **vehicle warranty insurance**
- **baggage or trip cancellation insurance in a predominately LAS contract.**

B. Fire coverage

The provisions of the *Insurance Act* state that fire insurance contracts cover all fires, no matter how caused – however, the insurer may exclude fires that result from certain causes, so long as those exclusions are set out under the regulations. This is similar to the current Act, which itself lists the named causes for which fire coverage can be excluded.

It is proposed that the same list of named events that currently applies be carried forward into the regulation. Specifically, all fire insurance contracts would be deemed to cover the insured property against fire, whether resulting from explosion or otherwise, so long as the fire was not caused by certain named events (matters along the lines of riot, war and invasion).

It has been suggested that insurers should also be allowed to exclude fires following earthquake and terrorist acts. However, consistent with the Alberta proposals, it is not proposed to expand the list of permitted exclusions at this time. Fire losses often entail significant financial loss for individuals and businesses, and limits in fire coverage may result in unexpected and unfair consequences. As discussed below, allowing fire following earthquake and/or terrorism to be excluded could seriously limit consumer coverage in the event of catastrophic loss.

Fire following earthquake: Some insurance industry participants have advocated the separation of fire from earthquake insurance. It has been suggested there would be greater clarity for consumers and efficiencies for industry if all earthquake coverage (fire and shake) were provided in one separate earthquake policy, rather than having fire following earthquake coverage as a mandatory coverage in a fire/multi-peril policy and offering shake coverage separately.

However, removing earthquake fires from ordinary fire coverage raises serious consumer protection concerns. Consumers now covered for fire following earthquake as part of their basic fire coverage would have no protection from losses arising from fire following earthquakes unless they purchased additional coverage. Even those who purchased additional coverage could find their fire loss coverage significantly reduced due to higher deductibles that apply to earthquake coverage.

Modern predictive tools have made it possible for the industry to appropriately price, and obtain reinsurance to cover, the risk of fire following earthquake. Industry analysis indicates that it adds very little to the cost of insurance to include fire-following earthquake with the ordinary fire coverage in a multi-peril contract. This approach is an effective, and efficient, mechanism for spreading the risk.

Some insurance contracts currently exclude fire following earthquake. As a transitional matter, these policies will be “grandparented” to allow them to continue despite the new prohibition on excluding fire following earthquake.

Fire following terrorism: There appear to be greater concerns about pricing and reinsurance with respect to fire following terrorism, where the risk is much more unpredictable. Insurers indicate that uncertainty regarding the extent of possible losses following a terrorist attack, and the difficulty of finding reinsurance in this area, could lead to solvency issues in the event of a major terrorist event. Being forced to cover catastrophic risks that cannot be properly priced or re-insured against may lead insurers to withdraw from the marketplace, thus ultimately hurting consumers by reducing competition.

These concerns are valid. However, the risk of loss to consumers and to society from lack of insurance coverage is also significant. As well, there are difficulties in defining “terrorism” and distinguishing it from, for example, politically motivated acts of vandalism.

We propose to maintain the integrity of broad fire insurance coverage by not providing an exclusion for fire following terrorism at this time. Generally, the proposal to not allow exclusion of fire following terrorism, like the similar proposal for fire following earthquake, is rooted in consumer protection concerns. A consumer who believes that buying a fire insurance policy will provide coverage for fire, whatever the cause, would be unfairly surprised to find that it does not cover fire losses in these circumstances.

Other countries have resolved this issue through the use of government back-stops. We acknowledge that mandating fire following terrorism coverage in the absence of such back-stops could pose significant problems for insurers that are unable to obtain appropriate reinsurance. Therefore, we are specifically inviting input on how this issue may be addressed in order to, at least partially, meet the needs of both insurers and consumers. One suggestion might be to allow fire following terrorism to be excluded, but only where the terrorist event causes truly catastrophic, widespread loss (e.g. losses in excess of \$100 million). A monetary limit such as this could protect individual consumers from isolated events (precluding the need to distinguish terrorism from vandalism), while still protecting insurers from catastrophic losses and insolvency.

Fire during vacancy: The amendments allow for regulations to prescribe circumstances which may not be excluded by an insurer providing fire coverage. The main issue that has been raised with government in this area arises where property is vacated (that is, where a person has moved out of the premises with no intention to return). Theoretically, an insurer could exclude any fire damage that occurs if a property is left vacant, even for a relatively short period of time. This can be problematic, especially in the case of newly purchased real estate that is not immediately occupied by the buyer.

The regulation would prescribe the circumstance of “vacancy of 30 days or less”, and prohibit an insurer from excluding fire coverage for this reason during this period. If insured property is vacant for a period of more than 30 days, the insurer would be able to exclude coverage (except where the insurer has issued a vacancy permit), as now occurs in most policies.

This regulation is needed to ensure that insurance coverage reflects what the average consumer understands and expects it to be.

Proposal 2B: Fire Coverage

It is proposed that a contract that includes coverage for loss or damage by fire

- 1. may exclude fire caused by**
 - in the case of goods, their undergoing any process involving the application of heat, and**
 - riot, civil commotion, war, invasion, act of foreign enemy, hostilities, whether war be declared or not, civil war, rebellion, revolution, insurrection or military power.**
- 2. may not exclude coverage by reason of a vacancy of 30 days or less.**

Further input is specifically sought on methods by which insurers' exposure for fire following terrorism could be limited while still maintaining broad fire protection for consumers.

C. Notification of dispute resolution processes

Under the *Insurance Act* amendments, the old "appraisal" remedy in section 9 has been replaced by a more comprehensive dispute resolution process for certain P&C disputes (principally about the extent of losses and damage). Although the new process is substantively similar to what was there before, a number of enhancements are included, such as setting out time frames for appointing a representative, and enabling the Superintendent of Financial Institutions to appoint an umpire if representatives are unable to agree on one.

The regulation-making powers allow for regulations respecting the dispute resolution process, including requiring an insurer to give notice to the insured.

Timely notification of the right to pursue this statutory remedy is essential to enable consumers to protect their interests. The proposed notice requirement would state that an insurer must give notice in writing to an insured advising of the dispute resolution process, and including a copy of section 9 of the Act (which sets out the substance of the process). This obligation must be fulfilled by the insurer

- within 10 days of the insurer becoming aware of a disagreement to which the dispute resolution process applies, or
- in any event, no later than 60 days after proof of loss is received by the insurer.

These new time limits better protect consumers by requiring faster notice to consumers (compared to the current requirement of 21 days after the insurer becomes aware of an applicable dispute). No notification would be required if the claim is resolved to the written satisfaction of the claimant, or if the claim is denied for reasons other than those to which the dispute resolution process applies.

Proposal 2C: Notification of dispute resolution processes

It is proposed that

- 1. insurers be required to give written notice to claimants of the dispute resolution process, including a copy of section 9 of the *Insurance Act*, no later than the earlier of:**
 - a. 10 days after the insurer becomes aware of a disagreement to which the dispute resolution period applies, and**
 - b. 60 days after proof of loss is received by the insurer.**
- 2. no notification under 1b would be required if, before the expiry of that 60 day period,**
 - the insurer has settled the claim to the written satisfaction of the claimant, or**
 - the insurer does not dispute the estimate of the loss or damage on the proof of loss, but has denied the claim for reasons other than those to which the dispute resolution process applies.**

D. Innocent co-insured claims procedures

New section 28.6 of the *Insurance Act* is a significant consumer protection measure. The section provides that, if a contract excludes losses caused by the wrongful acts of an insured person, the exclusion applies only to defeat the claims of that wrongdoer, and cannot be used against an “innocent co-insured”, who will still be able to recover for losses proportionate to their share of the property. The amendment is intended to increase protection for non-culpable parties, who may otherwise be denied insurance coverage because of the wrongdoing of another. It would not allow the claim of a person who has abetted or colluded in the wrongful acts or consented to them being done.

Because this provision is new and unique, broad regulation-making powers have been provided to allow its application to be fine-tuned. At least initially, it is proposed that the protection apply only to natural persons, and not to claimants that are corporations. Although the principle of fairness that underlies the policy of allowing recovery is the same for corporations as for individuals, the primary purpose of the new provision is the protection of individuals in abusive relationships.

In response to industry concerns about the need for special procedures to control the possibility of fraudulent claims in this area, the proposed regulation would require a person whose claim would otherwise be barred by the wrongful acts of their co-insured to submit to an examination under oath on request of the insurer. Input is sought on whether the regulation should also specifically require that the claimant co-operate with the insurer in its investigation of the loss and provide all relevant information and documents in addition to those required by the contract. Since these duties may apply to other insurance claims as well, setting them out here could raise the implication that they apply only in these circumstances. As well, there are concerns that concepts like “cooperate” might be too general and vague to be effectively, and fairly, administered.

Proposal 2D: Innocent co-insured claims procedures

It is proposed that

- 1. “corporations” be prescribed for the purposes of section 28.6 (1)(d), so that only individuals could be “innocent co-insureds” for the purposes of this protection.**
- 2. persons relying on section 28.6 of the *Insurance Act* be required to submit to an examination under oath on request of the insurer.**

Further input is specifically sought on the appropriateness of expressly requiring that the innocent co-insured fully co-operate with the insurer.



PART 3: Regulations applicable to LAS contracts

A. Right to rescind insurance coverage

The *Insurance Act* amendments provided regulation-making authority to allow a “cooling off” period in which a purchaser of a life or accident & sickness (LAS) insurance contract can rescind that contract without penalty. This complements, in part, the new statutory provisions that require policies to contain conspicuous notice of certain unusual terms, and mirrors the powers under Alberta legislation.

The proposed regulation would allow a purchaser of an individual LAS insurance contract, or a person whose life and/or health are insured under a contract of creditor’s group insurance, to cancel the contract or coverage within 10 days after receiving the insurance policy or certificate, and obtain a refund of any premium already paid.

The cooling off period would not apply to the purchase of group insurance contracts. Since these are generally arranged by parties (such as employers) on behalf, and in the best interests, of the persons whose lives are insured, the latter do not need the protection of rescission rights. As well, given the nature of the product, it would not be appropriate to give rescission rights to purchasers of blanket insurance covering specified risks for short periods of time or to investment products such as segregated funds and annuities, which are subject to an industry standard 2 day cooling off period, consistent with securities law. In the case of travel insurance, the rescission period would end on the expiry of the 10 days, or on the departure date, whichever comes first.

Proposal 3A: Right to rescind contracts

It is proposed that

- 1. a person who buys a contract of life insurance or accident & sickness insurance has the right to rescind the contract (or in the case of creditor’s group insurance, to cancel their coverage) within 10 days after receiving the insurance policy or certificate (or within any longer period specified in the contract).**

2. a person who rescinds coverage is entitled to receive from the insurer a refund of the whole premium that has been paid.
3. the right to rescind coverage will not apply to the following contracts:
 - group insurance contracts
 - blanket insurance as defined in the *Insurance Act*¹
 - segregated funds and annuities.
4. in the case of travel insurance, the 10 day right to rescind will only apply until the day prior to the date of departure.

B. Access to group insurance contracts

The *Insurance Act* amendments provide, for the first time, a right for persons insured under a group product (such as employees insured under a group contract entered into by their employer) to obtain, upon request, a copy of the contract. As well, a claimant under a group policy (e.g., a beneficiary) has the right to obtain certain information. This access is important to enable group insureds and their beneficiaries to exercise their contractual rights and determine their legal positions.

To protect privacy, the legislative framework already contains some exceptions to this right to access information. Specifically,

- there is never any access to personal information about other insured persons contained in group contracts,
- a claimant's access is limited to information relevant to their claim, and
- a regulation-making power to restrict access to prescribed information is provided.

Some insurers have argued that the access provided by the amendments is too broad, in that it would allow a person insured under a group product (a "group insured") to inspect parts of the contract that contain confidential information about benefits payable to other classes of individuals or about the commercial interests of the insurer or the insured (the policy holder), such as trade secrets or financial information. Restricting access to information about other classes of members is reasonable. However, further details about the practical risks of commercial information disclosure would be required before these concerns would automatically outweigh the group insured's right to not be unreasonably denied access to the policy.

It is proposed that the regulation-making power be used to restrict access only to information that is not relevant to the contractual rights of the group insured, and only in certain limited circumstances. As well, to address industry concerns, it is proposed that

¹ "blanket insurance" means group insurance that covers loss

(a) arising from specific hazards incidental to or defined by reference to a particular activity or activities, and
(b) occurring during a limited or specified period not exceeding 30 days [6 months for A&S contracts] in duration.

an insurer may, with court approval, deny access to other aspects of the contract on the basis that disclosure could harm commercial interests. This will balance the group insured's need to understand the nature of their coverage with the commercial interests of insurers and policy holders.

Proposal 3B: Access to group insurance contracts

It is proposed that access to the policy of group insurance referred to in section 32 or 84 of the *Insurance Act* not extend to the following information, if and to the extent that such information has no relevance to the rights or obligations of the group insured under that policy:

- **information about a benefit class to which the group insured is not a member;**
- **other information that a court determines, in an application by the insurer (or policy holder) brought within 30 days of the claimant's request for access, should be withheld on the basis that its disclosure could reasonably be expected to harm significantly the competitive position, or interfere significantly with the commercial interests, of the policy holder or the insurer.**

C. Insured's rights where beneficiary is irrevocable

The *Insurance Act* (sections 55 and 107.1) provides that an insured may assign or otherwise deal with the insurance contract. However, if there is an irrevocable beneficiary, no dealings can occur unless the beneficiary consents.

Concerns were raised that these restrictions were overly broad and prevented legitimate transactions that did not reduce a beneficiary's rights. Therefore, the amendments provide that an insured who has not obtained the irrevocable beneficiary's consent can still deal with the contract in the ways set out in the regulations. Regulations are now proposed to allow the insured to make certain changes, such as increasing coverage and providing for payment of other benefits under the contract. This will provide the insured with some flexibility, without impairing the beneficiary's interests.

The Act clearly establishes that the person who takes an interest under a contract does so subject to the rights of an irrevocable beneficiary. Given this, it has been suggested that the insured should also be permitted to deal with the contract in broader circumstances, including using it as collateral for loans. However, there are concerns that such dealings could result in the contract being owned by someone whose interests are not entirely aligned with the irrevocable beneficiary, which could affect the maintenance of the contract. Therefore, at this time, it is proposed that the only transfers or assignments allowed would be those made to a parent of the irrevocable beneficiary, whose interests can be presumed to coincide with the beneficiary. This would address a common situation by allowing assignment of a policy benefitting children to be made to an ex-spouse on marital breakup.

Proposal 3C: Insured's rights where beneficiary is irrevocable

It is proposed to allow the following transactions where there is an irrevocable beneficiary:

- **increases to the amount of insurance coverage**
- **the naming of a beneficiary with respect to the portion of any benefit to which the irrevocable beneficiary is not named**
- **the naming of a beneficiary to receive any proceeds payable if the irrevocable beneficiary predeceases the person whose life is insured**
- **the transfer or assignation of ownership of the contract to a person who is the parent of the irrevocable beneficiary.**

D. Regulation of group insurance

The *Insurance Amendment Act, 2009* amended the *Financial Institutions Act* to give broad regulation-making powers respecting group and creditor's group insurance products. These products continue to raise regulatory and consumer protection problems, especially with point of sale disclosure and certainty of coverage. Specifically, consumer advocates have raised concerns that some consumers may unwittingly misrepresent their health history and status in response to unclear or general questions used in the sign-up process. As well, there are concerns about conflict of interest in contract formation and claims settlement.

It is therefore proposed to require an insurer who pays compensation (such as commission) to a group policyholder to disclose, in writing, to the group life insured or group person insured, the amount of that payment. For example, in the case of group insurance covering employees, if an insurer makes a payment to the employer for placing the contract or administering it, this compensation would have to be disclosed to the employees, putting them in better position to assess the value of the insurance benefit. Similarly, if a financial institution that sells creditor's group insurance receives an enrolment fee from the insurer, the amount of that fee would have to be disclosed to the customer.

This regulation could reveal potential conflicts of interest and help protect consumers of group products. Further input is sought on whether the disclosure obligation should apply to compensation payable to an administrator, where the potential for conflict is not as clear cut.

Another regulation under consideration would prohibit an insurance company from using a group policyholder (e.g. the employer or financial institution) or administrator to negotiate and settle claims on behalf of the insurance company for group and creditor's group insurance. This practice may create a conflict of interest -- for example, where the policy holder has an interest in minimizing claim costs. Furthermore, the policyholder

may not have the expertise and experience necessary to settle claims, especially given the technical issues sometimes raised by insurance claims. Despite these concerns, however, there may also be circumstances in which such claims settlement practices are actually in the best interests of the insured. Further input from stakeholders is sought on what approach should be adopted.

The above-noted proposals do not directly address the issue of the misunderstandings respecting medical history and health status that may result in a denial of coverage, particularly in the area of creditor's group insurance. Full disclosure by consumers of all health issues is clearly needed so that insurers can determine eligibility; however, that disclosure must be prompted by clear, unequivocal questions about specific health issues.

Therefore, we are proposing to require that the questions asked during enrolment in creditor's group insurance target specific conditions or diseases (e.g. have you had tuberculosis?), rather than asking open-ended general questions (e.g. have you had respiratory problems?), in order to avoid the possibility of misunderstandings that could lead to non-disclosure of pertinent information. As well, persons conducting the enrolment would be required to advise the applicant that a failure to disclose information could result in loss of coverage. Failure to comply with these requirements would bar the insurer from using the answers to deny a claim (unless, perhaps, in circumstances of fraud).

Proposal 3D: Regulation of group insurance

It is proposed that

- 1. insurers offering group insurance or creditor's group insurance be required to give written disclosure to the group insured of the amount of any compensation paid to a group policyholder. If the amount of compensation is unknown, the insurer must disclose the likely amount of compensation or the method by which the compensation will be determined.**
- 2. questions used to elicit evidence of insurability at the time of application for creditor's group insurance be required to take the form of questions about specific medical conditions and diseases, with a caution to applicants about the need for full disclosure, if insurers intend to rely on the answers to those questions as evidence of misrepresentation in order to deny a claim.**

Further input is specifically sought on the following issues:

- whether insurers should be required to disclose compensation payable to administrators**
- whether insurers offering group or creditor's group insurance should be prohibited from using a group policyholder or administrator to negotiate and settle claims on behalf of the insurer.**



PART 4: Technical, transitional and other regulations

A. Classes of insurance

Both the *Insurance Act* and the *Financial Institutions Act* (FIA) contemplate that various types of insurance are to be defined by regulation.

The FIA, which regulates the insurance business, currently differentiates between 50 different classes of insurance for regulatory (business authorization) purposes. It is proposed to replace these classes with a more streamlined set of classes based on those recognized by federal legislation, with minor wording adjustments (shown in Appendix A in redline) to accommodate local needs. For example, it is proposed that the definition of “title insurance” in British Columbia continue to refer only to real property – title insurance is a relatively new product, and any expansion of this class requires further analysis. As well, reflecting provincial treatment of warranties as “insurance”, it is proposed to include British Columbia’s existing classes of “product warranty insurance” and “vehicle warranty insurance”.

The federal definition of “fire insurance” is not included, as it is no longer needed for either Act. As well, the federal class of “loss of employment insurance” is not included. In these respects, the proposed classes are consistent with those adopted by Ontario.

The *Insurance Act*, which deals with contracts of insurance, requires definitions for fewer classes, most notably “life insurance” and “accident & sickness insurance”. It is important that the different types of insurance be clearly defined so that the applicable provisions of the *Insurance Act* can be determined. Again, it is proposed to adopt the federal definitions for these and the other classes referred to in the *Insurance Act* (e.g. see Proposal 2A, above).

Proposal 4A: Classes of insurance

It is proposed to adopt streamlined classes generally consistent with federal regulations for the purposes of the FIA and the *Insurance Act* (see Appendix A).

B. Transitional issues

The *Insurance Act* amendments will change business practices and procedures for insurers in a number of significant ways. For example, new requirements for disclosure of various matters, including the existence of limitation periods and any contractual restrictions on beneficiary designations, will now be required to be printed on the face of the contract.

Transitional regulations will be drafted, wherever possible, to ensure that these new requirements apply only to policies issued (either originally or upon renewal) after the provisions come into force. Similarly, to provide continuity and ensure fairness, new rules respecting the settlement of claims (including the longer limitation periods) should only apply to losses which arise after the coming into force of the new provisions.

With respect to the coming into force of the new provisions, it is proposed that there be a lead-time of approximately 12 months after the regulations are finalized and deposited. It is hoped that this will give the industry sufficient opportunity to make any necessary changes to its documents, procedures and systems with confidence and certainty, knowing exactly what is required.

Implementation of the new classes of insurance for FIA purposes (see Proposal 4A, above) will be delayed to allow business authorizations and licences to reflect these new classes to be issued upon renewal.

C. Other regulations

In some areas, regulation-making authority has been adopted as a precautionary measure in case future problems arise. No proposals for regulations for a number of matters are being made at this time, but comments are invited.

No regulations are proposed to:

- to prescribe procedures that must be followed by an umpire in the course of dispute resolution under section 9 (section 192(2)(i))
- to prescribe other perils and any permitted exclusions with respect to those prescribed perils (section 28.4 (1))
- to provide conditions/restrictions on an insurer's ability to limit the right of an insured to designate a beneficiary (sections 48(4) and 102(4))
- to apply accident & sickness provisions to the disability component of life insurance (section 82(3)(a)).



APPENDIX A: Classes of Insurance

It is proposed to adopt the following classes for the purposes of the FIA and the *Insurance Act*. The redlined and struck out text shows differences from the federal classes. The actual wording enacted by British Columbia may differ from that proposed, due to requirements of the province's drafting style.

"accident and sickness insurance" means insurance

- (a) against loss resulting from bodily injury to, or the death of, a person caused by an accident,
- (b) under which an insurer undertakes to pay a sum or sums of money in the event of bodily injury to, or the death of, a person caused by an accident,
- (c) against loss resulting from the sickness or disability of a person not caused by an accident, but excludes loss resulting from the death of the person as a consequence of sickness,
- (d) under which an insurer undertakes to pay a sum or sums of money in the event of the sickness or disability of a person not caused by an accident, or
- (e) under which an insurer undertakes to pay a sum of money in respect of the health care, including dental care and preventative care, of a person.

"aircraft insurance" means insurance against

- (a) liability arising out of bodily injury to, or the death of, a person, or the loss of, or damage to, property, in each case caused by an aircraft or the use of an aircraft, or
- (b) the loss of, the loss of use of, or damage to, an aircraft.

"automobile insurance" means insurance

- (a) against liability arising out of bodily injury to, or the death of, a person, or the loss of, or damage to, property, in each case caused by an automobile or the use or operation of an automobile,
- (b) against the loss of, the loss of use of, or damage to, an automobile, or
- (c) that falls within paragraph (a) or (b) of the class of accident and sickness insurance, if the accident is caused by an automobile or the use or operation of an automobile, whether or not liability exists in respect of the accident, and the policy includes insurance against liability arising out of bodily injury to, or the death of, a person caused by an automobile or the use or operation of an automobile.

"boiler and machinery insurance" means insurance

- (a) against liability arising out of bodily injury to, or the death of, a person, or the loss of, or damage to, property, or against the loss of, or damage to, property, in each case caused by the explosion or rupture of, or accident to, pressure vessels of any kind or pipes, engines and machinery connected to or operated by those pressure vessels, or
- (b) against liability arising out of bodily injury to, or the death of, a person, or the loss of, or damage to, property, or against the loss of, or damage to, property, in each case caused by a breakdown of machinery.

"credit insurance" means insurance against loss to a person who has granted credit if the loss is the result of the insolvency or default of the person to whom the credit was given.

"credit protection insurance" means insurance under which an insurer undertakes to pay off credit balances or debts of an individual, in whole or in part, in the event of an impairment or potential impairment in the individual's income or ability to earn an income.

"fidelity insurance" means

- (a) insurance against loss caused by the theft, the abuse of trust or the unfaithful performance of duties, by a person in a position of trust, and
- (b) insurance under which an insurer undertakes to guarantee the proper fulfilment of the duties of an office.

~~"fire insurance" means insurance against the loss of, or damage to, property caused by fire, lightning, an explosion due to ignition, smoke or the breakage of, or the leakage from, a sprinkler or other fire protection equipment or system.~~

"hail insurance" means insurance against the loss of, or damage to, crops in the field caused by hail.

"home warranty insurance" means a contract of insurance covering defects in the construction of a new home or renovation, and consequential losses or costs incurred by the owner;

"legal expenses insurance" means insurance against the costs incurred by a person or persons for legal services specified in the policy, including any retainer and fees incurred for the services, and other costs incurred in respect of the provision of the services.

"liability insurance" means insurance, other than insurance that falls within another class of insurance,
(a) against liability arising out of bodily injury to, or the disability or death of, a person, including an employee,
(b) against liability arising out of the loss of, or damage to, property, or
(c) if the policy includes the insurance described in paragraph (a), against expenses arising out of bodily injury to a person other than the insured or a member of the insured's family, whether or not liability exists.

"life insurance"

- (a) means any insurance that is payable
 - (i) on death,
 - (ii) on the happening of an event or contingency dependent on human life,
 - (iii) at a fixed or determinable future time, or
 - (iv) for a term dependent on human life, and
- (b) without restricting the generality of paragraph (a), includes insurance under which an insurer
 - (i) undertakes to pay an additional sum of money in the event of the death by accident of the person whose life is insured,
 - (ii) undertakes to pay a sum of money or to provide other benefits in the event that the person whose life is insured becomes disabled as a result of bodily injury or disease, or
 - ~~(iii) undertakes to pay endowment funds at a fixed or determinable future time if the person whose life is insured is then alive, or at the person's death if they die before that time,~~
 - (iii) undertakes to provide an annuity, or what would be an annuity except that the periodic payments may be unequal in amount, for a term dependent solely or partly on a human life.

~~"loss of employment insurance" means insurance against the involuntary loss of employment by a person, the limit of which insurance is all or part of the debt of the person.~~

"marine insurance" means insurance against

- (a) liability arising out of
 - (i) bodily injury to, or the death of, a person, or
 - (ii) the loss of, or damage to, property, or
- (b) the loss of, or damage to, property, occurring during a voyage or marine adventure at sea or on an inland waterway, or during a delay or a transit other than by water that is incidental to a voyage or marine adventure at sea or on an inland waterway.

"mortgage insurance" means insurance against loss caused by default on the part of a borrower under a loan secured by a mortgage or charge on, or other security interest in, real property.

"other approved products insurance" means insurance against risks that do not fall

within another class of insurance, and for the purposes of this class, the commission may specify, in the business authorization of an insurer authorized to do business under this class, the types of insurance business the insurer may carry on within this class.

“product warranty insurance” means insurance, not being insurance included in or incidental to any other class of insurance, against loss of or damage to personal property, other than a motor vehicle, that is contracted between the purchaser of the property and an insurer whereby the insurer undertakes for a specific period to assume the cost of repairs or replacement;

“property insurance” means insurance against the loss of, or damage to, property and includes insurance against loss caused by forgery.

"surety insurance" means insurance under which an insurer undertakes to guarantee the due performance of a contract or undertaking or the payment of a penalty or indemnity for any default.

"title insurance" means insurance against loss or damage caused by

- (a) the existence of a mortgage, charge, lien, encumbrance, servitude or any other restriction on real property,
- ~~(b) the existence of a mortgage, charge, lien, pledge, encumbrance or any other restriction on personal property,~~
- (c) a defect in any document that evidences the creation of any restriction referred to in paragraph (a) ~~or (b),~~
- (d) a defect in the title to real property, or
- (e) any other matter affecting the title to real property or affecting the right to the use and enjoyment of real property.

“vehicle warranty insurance” means insurance, not being insurance included in or incidental to automobile insurance, against loss of or damage to a motor vehicle arising from mechanical failure, that is contracted between the purchaser of the motor vehicle and an insurer whereby the insurer undertakes for a specific period to assume the cost of repairs or replacement, towing fees, car rentals and accommodation as a result of a covered mechanical failure.