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Report on Taxi Claims Review

Presented to

The Board of Commissioners of Public Utilities of Newfoundland and Labrador

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1. Executive Summary

Cameron and Associates (Cameron) were retained to conduct a claims file review involving taxi cab losses occurring in the years 2010 to 2016. Our qualitative review was to analyze the handling of the claims files by adjusters and lawyers and to determine factors, if any, affecting loss experience and factors that could improve the loss experience.

In excess of 100 open and closed claims from the three companies writing taxi business in Newfoundland and Labrador for the time period were audited. All policies for claims audited were placed through the Facility Association (FA).

Cameron did not identify any issues with the claims handling by the insurance companies, adjusters, and lawyers that would adversely influence outcomes or increase loss costs. The files reviewed were generally well handled, with escalation to management when files were above the authority of the adjuster. Legal opinions were properly obtained for complicated coverage issues. There was no evidence that the interests of the insureds were not adequately protected. FA complied with all legal requirements in delivering the claims service. Claims settlements were provident, fair and expeditiously handled.

The factor identified by Cameron as having the biggest impact on loss experience was the manner in which taxi companies reported claims. There were many incidents of late reporting and, in fact, often no reporting by the taxi companies. This led to investigation issues due to delay. To specifically calculate the increased loss costs is impossible, however, prompt notice permits prompt investigation and early recognition of liability which provides opportunities to resolve the claim sooner and may result in a lesser overall payout. The only way to address the issue of poor claims reporting is through risk management and education, training and careful selection of drivers by taxi cab owners.

A second factor that may impact loss experience was non identification of drivers on a policy. Despite the fact that often numerous drivers were listed, sometimes up to 11 on one vehicle, there were still many drivers involved in accidents that were not listed on the policy. No premium was being collected for the unlisted drivers.

The review also identified that the majority of the accident benefits claims were for injuries to the drivers of the taxi cabs. The majority of the claims and the payouts (of all claims) occurred in rating Territory 1, primarily in the St. John's area.

Taxi rate increases have been attributed to continuously escalating loss costs. Cameron's review concluded that the increase in loss costs could not be attributed to the manner in which the claims were handled within the existing legislation. Cameron further concludes that without some major changes to the product, such as increased deductibles, minor injury caps, verbal thresholds or prescribed framework for treatment of minor injuries, the loss experience is highly unlikely to improve.

2. Introduction And Background

On August 9, 2017 the Government of Newfoundland and Labrador ("NL") issued the "Terms of Reference for the Public Utilities Board Review into Automobile Insurance" directing the Board of Commissioners of Public Utilities (the "Board") to review and report on numerous issues with respect to automobile insurance in the Province. As part of the Terms of Reference for the review the Board has been directed:

> "To conduct an audit of taxi closed claims to determine the causes of poor claims experience, including details regarding the underlying causes of loss and high claim costs incurred, and provide any recommendations to reduce claim costs and reduce rates."

Cameron & Associates were engaged by the Board to perform an audit of taxi claims for accidents in the Province occurring in the years 2010 to 2016. Over this time period, incurred losses were in excess of earned premiums in each year as shown in the table below.

Table 1- NL Taxi Industry Loss Experience 2010 -2016

Year of Loss	Earned Premium	Incurred Losses Including Expenses	Earned Incurred Loss Ratio
2010	$1,631,735	$3,833,157	235%
2011	$1,660,712	$4,155,489	250%
2012	$1,761,578	$5,987,580	340%
2013	$1,951,492	$3,955,976	203%
2014	$2,510,338	$4,210,612	168%
2015	$2,558,367	$5,625,398	220%
2016	$2,882,376	$5,061,885	176%

Source: GISA Exhibit AUTO1101-ATL

2.1 Mandate

The parameters of our mandate were as follows:

1. Select 100 closed claims for review;
2. Make our selection from open and closed claims lists and bordereau provided by the Insurers;
3. Review statistical data for closed claims files;
4. Create a file review worksheet to capture data;
5. Attend the offices of the insurers to conduct our review, or to review closed claims files online through an access portal provided by the insurer;
6. Complete a file review worksheet for each file reviewed;
7. Analyze the handling of the claim files by independent adjusters to determine:
    a. Compliance with adjuster ethics and the Insurance Act
    b. If their handling adversely influenced the outcomes in a negative way
    c. If (b) is correct, the increased loss costs flowing from such handling
    d. Analyze findings and prepare narrative report which would include our assessment of:
        i. Factors affecting the loss experience

ii. Factors that may improve loss experience

e. Whether there is sufficient evidence that there may have been a breach of the standard of care in claims handling.

8. Analyze the handling of litigation by law firms to determine:
   a. Reasonableness of legal fees
   b. Adequacy of instructions
   c. Adequacy of direction and follow up
   d. Efficiency in reporting
   e. Predictability of Outcomes

Approximately 95% of taxi business written in NL is placed through the Facility Association (FA). [1] It was confirmed that three insurance companies wrote taxi business through FA within the review period:

- Unifund Assurance Company (owned by Royal Sun Alliance Insurance Company andhereafter referred to as Unifund);
- AXA Insurance (owned by Intact Insurance Company and hereafter referred to as AXA); and
- The Co-operators Insurance Group, (hereafter referred to as Co-operators).

All companies are hereafter collectively referred to as "Insurers".

2.2 Method

2.2.1 Auditing Team

Sharon Cameron, Manager Liability and Risk Management, led and participated in the audit. Consultants Len Bondi and Susan Saksida were the assigned auditors and James Cameron, President of Cameron & Associates, also reviewed a selection of bodily injury and accident benefit files. Their profiles are attached to this report as **Appendix A.**

2.2.2 Closed Claims Data

Facility provided closed file lists for all Insurers. At our request the individual companies provided a breakdown of the file lists by type of claims and open claim lists. As shown in the table below, the vast majority of all policies issued and claims recorded for the years selected were with Unifund. AXA and Co-operators had very few claims.

Unifund was an insurer for all years covered by our audit while AXA and Co-operators were insurers only for the years indicated in Table 2.

[1] http://www.facilityassociation.com/
The Facility Association is an entity established by the automobile insurance industry to ensure that automobile insurance is available to all owners and licensed drivers of motor vehicles where such owners or drivers are unable to obtain automobile insurance through the voluntary insurance market. The Facility Association is an unincorporated non-profit organization of all automobile insurers serving the following Provinces and Territories: Alberta, New Brunswick, Newfoundland & Labrador, Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Yukon.
Every insurer licensed to write automobile liability insurance in any jurisdiction Facility Association serves is required to become a member and remain a member of the Association. All members of the Facility Association must abide by the Plan of Operation.

Table 2 - Taxi Policy Information 2010 to 2016

Company	Total Policies With Claims	Total Paid Claims	Total Paid 2010 To 2016	Years Policies Were In Force
Unifund	317	933	$ 17,531,611	2010 - 2017
AXA	13	17	$ 128,897	2010 and 2011
Co-operators	12	15	$ 86,811	2016 and 2017
Total	**342**	**965**	**$ 17,747,319**	

2.2.3 Selection

The Unifund closed claim file list was sorted by claims type and then by total paid. A random sampling was taken. A small sample of Open Claims from Unifund were also reviewed. All closed Bodily Injury and Accident Benefit claims for AXA were reviewed as well as all closed Accident Benefit claims and open Bodily Injury Claims for Cooperators.

The following table illustrates the breakdown of the files reviewed:

Table 3 – Files Reviewed Open and Closed By Insurer and Type

	Closed	Open
Unifund Accident Benefits	24	8
Unifund Bodily Injury	47	8
Unifund Property Damage	13	0
AXA Accident Benefits	5	0
AXA Bodily Injury	4	0
AXA Property Damage	2	0
Cooperators Accident Benefits	4	1
Cooperators Bodily Injury	0	4
Cooperators Property Damage	1	1
	100	**22**

2.2.4 Closed Claims Selection With Consideration For Paid And Unpaid Claims

The claims data received from insurers included the following information:

- Insured Name
- Policy Number and Claim Number
- Location of Loss
- Date of Loss, Date Reported and Date Closed
- Fault Assessment as a Yes or No and percentage assigned
- Payments made

The claims files included claims closed with *no payment* issued as well as files with *paid claims*. Cameron's selection of files to review was made from closed files with paid claims only. However, as 259 of the 1224 reported claims were closed without payment, it was deemed important to determine if the unpaid claims may have contributed to the increase in taxi premiums.

This issue was discussed with underwriters who confirmed that only files with paid claims are considered in the premium calculation, and claims reported but not paid are excluded.

2.2.5 Auditing Process

Access to Unifund electronic files was provided at RSA Toronto and to Co-operators electronic files in Guelph, Ontario. A paper file review was conducted of AXA files in St. John's, Newfoundland and Labrador. In addition to closed files, a small sample of open claims files at Unifund and Cooperators were reviewed to determine if there was a difference in claims handling approach on files still open (not settled). AXA did not have any open files.

The categories of claims selected for audit included the following:

- Bodily Injury claims by third parties who were occupants in other vehicles, pedestrians or cyclists, made against the taxicab driver/owner;
- Passenger Hazard[2] claims involving injuries to passengers in the taxicab;
- Accident Benefits claims made by taxicab drivers, other occupants of the taxicab and pedestrians or cyclists;
- Property Damage claims for damages to automobiles and other property made by third-parties against the taxicab driver/owner.

Claim files were reviewed and examined for specific aspects of handling and compared to best practices in the industry. Best practices are not prescribed by law but are the reviewers' opinions, based on our experience reviewing claims at various insurance companies, of what practices and procedures, when consistently applied, positively impact the outcome of claims. Best practices optimize the goal of responding to the Insurer's obligations to Insured persons under their policy. Documented activities reviewed in the files were scored as our estimates of a benchmark to industry best practices.

3. Insurance Coverage In Newfoundland And Labrador

The policy wordings are mandated under the Insurance Act of Newfoundland and Labrador as Newfoundland Standard Automobile Policy S.P.F. No 1 and provide the following coverages:

Section A — Third Party Liability.
- Bodily Injuries and Damage to Other People's Property
- Additional Agreements of Insurer
- Agreements of Insured

Section B — Accident Benefits
- Subsection 1 — Medical, Rehabilitation and Funeral Expenses
- Subsection 2 — Death Benefits and Loss of Income Payments
- Special Provisions, Definitions and Exclusions of Section B

Section C — Loss of or Damage to Insured Automobile
- Subsection 1 — All Perils Coverage

[2] Passenger Hazard claims are from occupants of the Insured automobile. Absolute legal liability is imposed on the operator for injuries to any passengers.

- Subsection 2 — Collision or Upset Coverage
- Subsection 3 — Comprehensive Coverage
- Subsection 4 — Specified Perils Coverage
- Deductible Clause
- Additional Agreements of Insurer

Section D — Uninsured Automobile and Unidentified Automobile Coverage

We have segregated our report into 3 components: Accident Benefits, Bodily Injury, and Property Damage. Most insurance companies assign different adjusters for each of these components of the claim. For example, adjusters handling Accident Benefits are not privy to the bodily injury claim details;[3] these are handled by a different adjuster or in a different department. Each of these components attracts its own premium and is tracked separately. Each also have specific protocols and best practices in claim handling.

4. Audit Results – Accident Benefits

4.1 Description

Persons injured in an automobile accident in Newfoundland and Labrador are entitled to claim Accident Benefits from an insurer.[4] These benefits consist of reimbursement of expenses incurred for hospitalization, medical treatment, and rehabilitation of injuries sustained as a direct result of the motor vehicle accident. The entitlement to such benefits is prescribed by law in the jurisdiction where the accident occurred and is payable on proof of incurred losses without regard to establishing fault (often called no fault insurance). This is typically a first party coverage because the insured (and other specified persons) claims against his own insurer. The purpose of Accident Benefits is to facilitate the prompt treatment, rehabilitation, and recovery of injured victims or to provide death benefits to the family of victims.

4.2 Coverages

Newfoundland and Labrador is the only Canadian province where Accident Benefits coverage is not mandatory.

Accident Benefits, if purchased, includes the following coverages.

4.2.1 Medical and Rehabilitation Benefits

- Medical and Rehabilitation Benefits up to a maximum of $25,000 incurred within 4 years from the accident date.
- Funeral Benefits incurred up to $1,000.
- Death Benefit payable to family members and dependants who meet the definitions in the auto policy. The amounts payable are $10,000 for the death of the head of the

[3] And, in fact, are prohibited from sharing the information provided voluntarily in the first party claim with the adjuster handling the third party claim who may ask for medical reports.

[4] For detailed provisions of the Section B -Accident Benefits coverages, refer to the Newfoundland Standard Automobile Policy - S.P.F. No. 1

household or their spouse, an additional $1,000 is payable to additional survivors of the head of the household, and $2,000 is payable for the death of a dependant.

4.2.2 Disability

- A Weekly Income Benefit of up to $140 per week is payable for 104 weeks if the claimant is disabled from their own occupation. In addition, a lifetime weekly benefit of up to $140 per week is payable after the initial 104 weeks if the claimant remains incapacitated from engaging in any occupation that the person is reasonably suited to.
- There is no reduction or scale down of benefits at age 65. They continue for life.
- A weekly benefit of $70 per week is payable for an unemployed homemaker who meets the disability test; this benefit is payable for a maximum of 12 weeks.
- Accident Benefits are payable to the driver/occupant/pedestrian struck by the vehicle regardless of fault.

Some unique features of NL Accident Benefits are**:**

4.2.3 Priority of Coverage

- In NL, Accident Benefits coverage applies to the insured vehicle. The driver, occupants of the vehicle, or a pedestrian who is struck by the insured vehicle can claim Accident Benefits under the policy insuring that vehicle, if that coverage was purchased by the policyholder. In other words, Accident Benefits coverages follow the vehicle. This differs from other common law provinces where coverage follows the insured person.[5]

4.2.4 Subrogation

- Since Accident Benefits coverages are optional, in vehicle to vehicle accidents where the driver/owner of the at-fault vehicle does not carry Accident Benefits coverage or is uninsured, the insurer paying the benefits can subrogate for the full amount of Accident Benefits they paid.[6]

4.3 Accident Benefits Loss Experience

The following table shows the Accident Benefits loss experience from 2010 to 2016 for taxis in NL. The earned to incurred loss ratio represents, for example, that in 2010 at 547% insurers paid out in claims and claims expenses approximately 5.5 times the total premiums collected for this coverage. Any year where the loss ratio is over 1.0 demonstrates a loss for the Insurers.

[5] For example, in Ontario, Accident Benefits are available to Insured Persons under the Policy whether they are injured in the insured vehicle or in another vehicle or when struck by another vehicle. These benefits are paid to the Insured person with very limited specific subrogation rights only against heavy commercial vehicles.
[6] This differs from other jurisdictions. See footnote 7

Table 4 - Incurred Loss Ratio for Accident Benefits Coverage

Year	Earned Premium	Number of Claims	Incurred Losses Including Expenses	Average Cost Per Claim	Earned Incurred Loss Ratio
2010	$26,908	35	$147,187	$4,205	547%
2011	$29,150	50	$290,027	$5,801	995%
2012	$31,318	42	$639,591	$15,228	2,042%
2013	$37,588	43	$199,745	$4,645	531%
2014	$58,439	45	$174,807	$3,917	299%
2015	$66,231	57	$693,497	$12,120	1,047%
2016	$120,369	37	$235,061	$6,308	195%

Source: GISA Exhibit AUTO1101-ATL

4.4 Audit Finding Benchmark Results

Claim files were reviewed and examined for specific aspects of handling and compared to best practices in the industry. The results were compiled and scores calculated as follows:

Table 5- Accident Benefits Benchmark Score

Accident Benefits	
Claims Handling Issues	**Score**
Was coverage handled correctly?	88%
Were the appropriate Med Rehab benefits paid in accordance with the policy?	90%
Were the appropriate Disability benefits paid in accordance with the policy?	90%
Was investigation appropriate in all the circumstances?	88%
Was litigation handled appropriately?	80%
Was subrogation identified and investigated?	85%
Was leakage avoided?	80%
Was subrogation handled correctly?	88%
Overall Score	86%

An overall score of 86% is indicative of above average claims handling of all aspects of a claim. This score would suggest that while the handling was not perfect or best in class, in our opinion the loss results are not adversely impacted in a meaningful way by the claims handling.

4.4.1 Was Coverage Handled Correctly? Score 88%

The first step in any claim process is identification of coverage and determination that the liability of the insurance company under the policy to respond to or on behalf of the policyholder is engaged. During such process, some underwriting issues become apparent, such as whether the driver of the insured vehicle was named or listed on the policy. The following observations were made:

- On any file where coverage issues were apparent, coverage opinions were obtained from legal counsel and the insurer followed the legal advice provided.

- A significant proportion of third party uninsured drivers were noted.[7] This observation has also been noted in a report by the IBC[8] and can be a by-product of increased costs of insurance leading to decreased affordability. It was not within the mandate of the review to investigate this matter further.

A note was sent to underwriting each time the driver and/or the involved taxicab was not listed on the policy. The named insured responded to questions by the underwriters who were informed it was either a one-off situation and the driver was not added (or paid for) or the driver was added after the loss. For some claims the unlisted drivers reported an injury and claimed Accident Benefits. To the extent that a premium must be paid for every driver, we identified this as leakage.[9] Even when the driver was not listed on the policy, consent to drive the vehicle was always advised as given, therefore the policy had to respond to the claims to indemnify.[10]

In all of the claims reviewed the insured had purchased Accident Benefits coverage.

4.4.2 Medical and Rehabilitation Benefits Score 90%

Benefits paid were appropriate within the legislative provisions in all claims reviewed. Collateral sources[11] of benefits were identified and pursued with few exceptions.

4.4.3 Disability Benefits Score 90%

Disability claims were generally of a duration of several weeks. In a few cases this benefit was payable for approximately one year and, in a minority of cases, up to the two year (104 week) limit for own occupation.

In two of the closed claims reviewed, the claimants suffered serious injuries which led to the settlement of their claims for lifetime weekly benefits. In both of these cases, settlement was based on a structured settlement annuity quote, which is the industry norm. Commutation of long term claims is generally considered the optimum outcome of such cases as it adds certainty to the results as a paid claim, and does not expose the insurer to further handling expenses.

Each insurer paid appropriate sums for medical, treatment and income benefits. Each insurer also consistently investigated and factored in deductions for collateral source payments where appropriate.

4.4.4 Investigation Score 88%

Claimants are dispersed in the Province amongst numerous remote areas. Not all areas are serviced by IME (insurer medical evaluation) assessors, rehabilitation and health care providers,

[7] An investigation of this situation was not within our mandate. It could be argued that a higher proportion of uninsured drivers exposes the insured drivers to greater losses on BI claims and, with respect to Newfoundland, unrecoverable Accident Benefit subrogation claims (Even where the uninsured driver is identified, recovery of funds is unlikely where the driver is impecunious.) .
[8] Available at **http://www.ibc.ca/nl/auto/nlautoinsurance/premium-problems-in-nl**
[9] The misclassification of drivers or the failure to identify drivers may result in substantial premium leakage over the long term.
[10] Each driver of the vehicle who has the consent of the owner to drive is an insured, whether listed or not.
[11] Recovery of expenses from government or other providers is deducted from any auto accident benefit payment under s. 34 of the Insurance Act.

and investigative services. Claim expenses can be high in some cases where these services are needed or in cases where the claimant has to travel to an IME or for rehab.

Additional observations include the following:

- Generally medical claims remained open for no more than a few months, however some claims continued for up to the 4 year limitation period.
- In most cases appropriate use of an IME or assigning rehab services was observed. In a few cases these services could have been obtained/assigned earlier in the life of the claims. On balance, this was generally well handled.

4.4.5 Litigation Score 80%

Some Accident Benefit claimants had legal representation, but this generally seemed to be ancillary to Bodily Injury tort claim representation. In a minority of cases, claimants were represented for Accident Benefits only. One claim reviewed involved litigation relating to stoppage of the Weekly Income Replacement. It was appropriate for the insurer to challenge entitlement on cases where the evidentiary proof of entitlement is not convincing. The litigation was being handled appropriately with proactive instructions to defence counsel and use of litigation budgets to control expenses.

4.4.6 Leakage Identified Score 80%

The term leakage is used to identify practices, procedures or decisions that had or may have had a negative impact on the outcome of the claim. Where leakage is identified, the reviewer makes an assumption that the claim would have developed in a different direction. The outcome of each case is dependent on the merits of that case.

More definable leakage occurs when a benefit is paid without proper documentation, where payments are late resulting in interest being incurred, and improper stoppage, commencement, or amount of benefits.[12]

Some examples of leakage observed in the reviewed files were:

- Drivers not listed on policies.
- In one medical claim, open for 36 months, the claimant's doctors, not the insurer, managed the medical direction and the claimant was not referred to an IME.
- In one case, subrogation had been abandoned because the insurer missed the limitation period for bringing an action.

Overall the leakage was within industry standards. In a perfect world, each file would score 100% when reviewed with the benefit of hindsight; however, this is not the case in practice. Any leakage identified in this coverage area did not, in our view, significantly increase the loss cost experience.

[12] For example, where an adjuster misses the claimants entitlement to collateral source benefits which may have been deducted from the claim.

4.4.7 Subrogation Score 85%

We reviewed all of the closed Accident Benefits claims to see how optional accident benefit coverage affected subrogation.

Subrogation involves significant work for the insurer's claim examiner. They have to contact the third party insurer to find out if they carry accident benefit insurance. Often this was done when discussing the liability situation. In most cases the insurer did a good job of asking whether the at fault third party insurer carried accident benefits coverage to enable Accident Benefits subrogation. There were only 12 files where there was subrogation involving approximately $74,000 owed. Recovery on all of the subrogation sums owed was not observed however due to various reasons such as it being applied to the wrong file, paid as part of a Bodily Injury settlement, etc.

4.5 To Whom Are The Accident Benefits Being Paid?

The following chart details the amounts paid in Accident Benefits by type of claimant:

Table 6 - Accident Benefits Injury Claimant Analysis

Closed Claims					
	No: Of Claimants	**No: Of Files**	**Med**	**Disability**	**Expenses**
Driver only claim	86	86	$ 330,734	$ 139,976	$ 75,515
Drivers where passenger also hurt	12	12	$ 48,452	$ 26,203	$ 20,494
Driver Claims	**98**	**98**	**$ 379,186**	**$ 166,179**	**$ 96,009**
Pedestrian/cyclist	9	9	$ 50,117	$ 5,386	$ 22,471
Passengers only	36	27	$ 69,890	$ 9,734	$ 15,743
Passengers where driver also hurt	12	12	$ 49,557	$ 308,796	$ 18,027
Other than Driver	**57**	**48**	**$ 169,564**	**$ 323,916**	**$ 56,241**
All Accident Benefits Claims	**155**	**146**	**$ 548,750**	**$ 490,095**	**$ 152,250**
Total			**$**		**1,191,095**

Over the time frame of our audit, $549,721, or 46.2%, was paid in Accident Benefits to 57 claimants who were passengers, cyclists or pedestrians. A total of $641,374, or 53.8%, of the Accident Benefit claims and expenses were for injuries to drivers of the insured taxi.

Cameron reiterates that in NL, Accident Benefits coverage is optional and it follows the vehicle. In other jurisdictions where Accident Benefits is mandatory and follows the insured, it could be argued that some of the loss experience burden is shifted to personal lines auto results. In most cases, the Bodily Injury claim is reduced by the amount of Accident Benefits paid and the Insurer does not have to pay the Accident Benefits if the occupant or person struck has their own auto

insurance. In other words, an Insurer can benefit from Accident Benefits paid by another Insurer (in the tort claim).[13]

4.6 Claims Paid to Unlisted Drivers

As previously noted, one of the areas of leakage identified was with respect to drivers not listed on policies. Although fleet polices do not always have to list their drivers, individual rated polices do. Cameron found that nearly 30% of the claims made and 38% of the claims paid were with drivers who were not listed on the individually rated policy at the time of the claim.

Table 7 Accident Benefit Claims with Drivers Listed or Unlisted

	No: Of Files	Medical	Disability	Expense	Total
All listed drivers and not listed fleet drivers	79	$296,315	$48,451	$67,621	$412,387
Not listed-individually rated	31	$106,452	$117,638	$27,131	$251,221
Total Driver Claims	**110**	**$402,767**	**$166,089**	**$94,752**	**$663,608**

4.7 Overall Conclusions on Accident Benefits

Cameron's overall conclusion is that the Accident Benefits files were handled by the Insurers' claims staff with the same care and attention to detail paid to all automobile claims. The handling of the claims was within industry standards and generally reflective of best practices. The manner of claims handling cannot be said, in our opinion, to be a cause of the poor loss experience. However, the leakage identified with respect to unlisted drivers may have negatively impacted the lost costs experienced.

5. Third Party Liability

Third Party Liability coverage is the portion of the automobile insurance policy that pays for the costs associated with bodily injuries to third parties (other people involved) or for the costs of property damaged by you when you are found legally responsible for a car accident. We examined Bodily Injury and Property Damage separately. This coverage also provides a legal defense in the event that you are sued for damages.

The NL loss ratios for this coverage include the figures from third party property damage claims but the property damage numbers are not significant. The following chart demonstrates the loss experience for this coverage line.

[13] For example, a passenger in a taxicab is injured. The taxi driver is at fault. In other jurisdictions, the taxi would not have to pay Accident Benefits if the passenger had a vehicle or was named on an insurance policy. If for example, those benefits are $50,000, the taxi would be able to reduce the tort BI claim by the $50,000 accident benefits paid by the other insurer. This would be a saving of $ 50,000 in theory (had they paid the AB they would still be able to deduct the income benefits from the tort BI claim.) The impact of spreading the AB losses in this fashion would factor in the loss experience and premiums calculations for all personal lines. It also probably could only work where AB coverage was mandatory.

Table 8 - Earned To Incurred Loss Ratio for Bodily Injury/ Third Party Liability Coverage

Year	Earned Premium	Number of Claims	Incurred Losses Including Expenses	Average Cost Per Claim	Earned Incurred Loss Ratio
2010	$1,488,716	131	$3,621,948	$27,648	243%
2011	$1,525,674	164	$3,628,770	$22,127	238%
2012	$1,604,258	156	$5,207,261	$33,380	325%
2013	$1,764,904	142	$3,484,578	$24,564	197%
2014	$2,277,427	176	$3,606,051	$20,541	158%
2015	$2,317,918	183	$4,732,183	$25,892	204%
2016	$2,557,852	158	$4,386,706	$27,731	171%

Source: GISA Exhibit AUTO1101-ATL

6. Audit Results - Bodily Injury

A total of 50 closed and 16 open Bodily Injury files from the three insurance companies were selected for review. The focus was on overall handling and the specific handling of coverage, investigation, liability assessment, litigation management and settlement. Cameron examined aspects of the handling evident in the files and compared these to best practices in the industry. The results were compiled and scores calculated as follows:

Table 9 – Audit Finding BI Benchmark Score

Bodily Injury	
Claim Handling Issues	**Score**
Coverage	85%
Was investigation timely and appropriate?	76%
Liability assessment correct?	80%
Litigation handled appropriately?	86%
Settlement proactivity	96%
Overall Score	**86.6%**

An overall score of 86.6% is indicative of above average claims handling of all aspects of a claim.

6.1 Coverage Score 85%

We observed coverage being analyzed and verified for each Bodily Injury claim reviewed. There were very few files for which coverage was questionable. Drivers were not always listed, but this was referred to underwriting to be addressed and coverage was accepted, provided the driver had permission to operate the vehicle.

Of the limited Bodily Injury coverage issues identified, one involved an impaired driver (for which coverage did not apply). Another involved whether a Bodily Injury claim was payable under this section of policy or under Section D (Uninsured Motorist) in the case of theft of a vehicle. A coverage opinion was obtained and the insurer went to a summary judgment on the issue.

6.2 Initial Claim Reporting Not rated

Since the reporting of claims was beyond the control of the insurer it was not scored. Of the 790 Bodily Injury claims listed, only 174 claims were reported within one day of the accident; for 65 claims the reporting period exceeded 100 days. Any delay in reporting may severely impact the thoroughness of the investigation that follows, particularly when serious injuries have occurred.

In Cameron's experience, poor claims reporting is a problem in the taxi industry throughout the country. The only way to address it is through risk management and education, training and careful selection of drivers by taxi cab owners

The Third Party Insurer or lawyer or the Insured's broker reported many of the claims. This was true of claims reviewed for all companies.

6.3 Was Investigation Timely And Appropriate? Score 76%

For many of the claims reviewed the accident details were straight forward and the driver and/or their passenger and/or the third-party agreed on what happened.

When there was a dispute in versions of the facts there was an attempt to obtain witness statements. This did not always help as the witnesses were usually the passengers in one of the two vehicles and/or the independent witnesses could not be found or had poor recall. There was also real difficulty in obtaining information due to late reporting.

It was often difficult to obtain a statement from the driver. Independent adjusters were hired to take statements and do other task assignments.[14] We observed lengthy delays on some of these files due to workload pressures on the independent adjusters.[15] Sometimes they were unable to obtain statements from the drivers for months.

We did not see surveillance used often but it was controlled with proper budgets when initiated.

[14] We had expected that the vast majority of the claims would be outsourced to independent insurance adjusters. Our field work revealed that this was not the case. Adjusters were used for task assignments only (to obtain a statement from a driver or occupant or witness) and the claims were handled in house by examiners or staff adjusters. There was no issue with the quality of work of the independent adjusters or in house staff.

[15] When a major weather event strikes the Province, claim adjusters are immersed in work assessing damage and handling the catastrophe claims.

6.4 Was Liability Assessed Correctly? Score 80%

With poor investigations caused by late reporting and lack of drivers statements it was often difficult to dispute liability. Where statements were available, often the drivers provided very different accounts of the facts leading up to the accident and at times their evidence was not as credible as the other parties involved. Ultimately, liability was assessed correctly although it was often a long winding path.

6.5 Was Litigation Managed Appropriately? Score 86%

There was no indication these files were handled differently than any other claims.

One of the most significant costs of an insurer is the management of litigation expenses for defence of the Insureds. From our review, we observed that there were adequate controls on defence costs. Tools such as litigation budgets were consistently applied and monitored. In respect to management of the litigation process, we observed proper utilization of summary judgment motions, consistent proactive negotiations and offers to settle, consistent use of settlement conferences, and generally excellent control of defence expenses.

6.6 Settlement Proactivity Score 96%

The claims reviewed were predominantly soft tissue injuries and Whiplash Associated Disorders ("WAD") which in other jurisdictions would fall within Minor Injury Guidelines or caps[16].

Smaller claims were settled on an expedient basis for low amounts exceeding the deductible. In fact, the deductible did not appear to be a consideration at all as each negotiation would start "in excess of the deductible." In Cameron's opinion, at $2,500, the deductible was simply so low as to be meaningless and damages paid were higher overall as a result. Minor soft tissue injuries were generally overcompensated. We observed that claims handlers frequently checked jurisprudence on damages before setting reserves and discussing settlements. Adjusters always checked seatbelt use (The Insurance Act mandates a 25% reduction for contributory negligence if a claimant injured was not wearing a seatbelt[17]). Appropriate deductions were always made.

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[16] It is difficult to calculate the impact of these regulated caps in every case. Where limits or thresholds are implemented, it becomes a challenge for plaintiffs to prove they are an exception and this can impact how much documentation or examination they go through to prove this.

[17] Then Newfoundland and Labrador Insurance Act provides

28.1 (1) Where a person who is required by section 178 of the *Highway Traffic Act* to wear a seat belt assembly sustains bodily injury or dies in an accident while the person is not wearing a seat belt assembly, the amount recoverable by the person, or, in the event of the death of the person, the administrator or a beneficiary of the estate of the deceased person, as damages for bodily injury or death in an action arising out of the accident shall be reduced by 25%, unless the person or the administrator or the beneficiary establishes that the failure to wear the seat belt assembly did not contribute to the bodily injury or death.

(2) Where a person to whom subsection (1) applies contributed to his or her bodily injury or death by other acts or omissions in addition to the failure to wear a seat belt assembly, and the person, or, in the event of the death of the person, the administrator or a beneficiary of the estate of the deceased person, does not establish that the failure to wear a seat belt assembly did not contribute to the bodily injury or death, the reduction in the amount of damages shall be determined with regard to all circumstances but shall not be less than 25%.

(3) Subsection (1) does not apply to a person who sustains bodily injury or dies in an accident while the person is wearing a seat belt assembly but is not wearing it in a properly adjusted and securely fastened manner as required under section 178 of the *Highway Traffic Act* 2004 c27 s7

For the majority of files reviewed, defence counsel was not retained and the claims were settled without a lengthy litigation process ensuing.[18] The settlements were handled as much as possible by the examiner and there was excellent use of settlement conferences consistently keeping pressure on plaintiff's counsel to settle. This should have had a moderating impact on claims expenses and, arguably, ultimate loss settlements.

Cameron found a real delay by plaintiff's counsel in getting medical and wage loss reports. There are many who reportedly will not even discuss settlement until 1 to 2 years post-accident. This is usual for all provinces.

The soft tissue injury settlements seemed high for cases with a few medical treatments or a few rounds of physiotherapy, when compared to other common law jurisdictions. The claims presented were supported with case law in NL on damage awards.

6.7 Large Losses

There were only 25 Bodily Injury closed claims with total payout over $100,000 but these accounted cumulatively for one third of the total of Bodily Injury payments. There was only one payout exceeding $ 1 Million.

Many of the payouts over $100,000 involved multiple claimants in one accident with soft tissue injuries but there were some serious injuries. It was also observed that small claims appear to attract higher settlements than other provinces. There was not as much discrepancy for the larger claims.

6.8 Open Bodily Injury Claims

Many of the oldest claims were subrogation only. On other older files there seemed to be large delays in file handling often caused by third party counsel or very litigious plaintiffs drawing out the settlement. The reserves appeared adequate on the few files reviewed and the handling of the files does not appear to be distinguishable from the closed files reviewed.

6.9 Overall Conclusions on Bodily Injury Claims

Cameron's overall conclusion is that the Bodily Injury claim files were handled by the Insurers' claims staff with the same care and attention to detail paid to all automobile claims. The handling of the claims was within industry standards and generally reflective of best practices. Proactive measures to try and drive settlements were successful in closing files. Settlements were within the ranges of jurisprudence developed on damages awarded in the Courts of Newfoundland. Judicial inflation continuously presents challenges to Insurers to contain loss costs. The manner of claims handling cannot be said, in our opinion, to be a cause of the poor loss experience.

Cameron concludes that the significant delays in reporting by taxi companies may have had a negative impact on the loss experience as prompt reporting and investigation provides opportunities to resolve the claim sooner which may result in a lesser overall payment.

[18] Best practices dictate that all attempts at settlement of claims where liability is engaged can be handled more expeditiously by the adjuster without incurring unnecessary legal fees.

7. Property Damage

Between 2010 and 2016 a total of 311 claims classified solely as Property Damage were opened and closed. This category included both Property Damage claims made by third-parties and Collision Damage claims made by the insured. We did not differentiate between the two as for the vast majority of claims, payment was made to third-parties[19].

7.1 Property Damage Audit Finding Benchmark Score

Table 10 -Property Damage Audit Score

Property Damage	
Claim Handling Issues	**Score**
Was Coverage Confirmed?	100%
Was the Inter-Company Settlement Agreement Applied Appropriately?	83%
Repairs and Loss of Use Handled correctly?	84%
Subrogation Identified	88%
Was Leakage Identified	100%
Overall Score	**91%**

As indicated earlier in this report the overall score in this range is excellent and not far from best in class when benchmarked to the industry as a whole.

7.2 Was Coverage Confirmed? Score 100%

For all files, coverage was verified and recorded in notes. In some cases the insured driver was unlisted, but the claim was still accepted. The information was recorded in the file and passed on to underwriters where we presume this was raised as an underwriting matter, possibly to charge additional premium as warranted.

7.3 Was the Inter-Company Settlement Agreement Applied? Score 83%

The Inter-Company Settlement Agreement between signatory insurance companies applies to fault determination for collisions between two or more persons. The Fault Determination Rules (FDR) set out the most commonly occurring accidents, and designate fault based on the configuration of the vehicles at the time of impact, irrespective of what led up to impact. These rules only apply to the damage paid by insurers and are not binding on the drivers involved, who may seek remedy under tort for any portion of their damages not paid by insurers. For example, FDR does not apply to deductibles unless waived, or to rental expenses not covered under loss of use coverage.

For the majority of claims, fault was assigned at 100% under FDR, or 50% when there was a dispute in versions and the point of impact within the lane could not be established. Rarely was the taxi driver found to be less than 50% at fault.

[19] On many of the policies the physical damage coverage for damage to the taxi was not purchased

7.4 Repairs And Loss Of Use Handled Correctly? Score 84%

7.4.1 First Party Repairs Completed?

We identified no issues with first-party repairs although the time to complete did take longer in some cases due to unavailability of parts. We found this to be the case with third-party repairs as well when the claims were adjusted by the third-party insurer.

7.4.2 Timely Repairs for Purpose of Rental

For the majority of claims, it was the third-party's insurer that controlled this aspect of the claim. One claim reviewed involved another cab driver as the third-party. The notes in file indicated that it took 3 days to complete repairs but 17 days of down-time were paid. The right passenger door and door handle were damaged, but it was not clear why the vehicle was off the road for such a lengthy period.

7.5 Subrogation Identified Score 83%

For the majority of claims it was the third-party subrogating against the insured. We identified one claim where the insured lost control on an icy road, striking a fire hydrant where the flooding damaged adjacent houses. Liability was accepted on a 100% basis, and all damages paid. We questioned this finding as no investigation was undertaken to determine when the roads were last salted and sanded given the icy conditions or why there was such a delay in responding to the leaking hydrant.

7.6 Leakage Identified Score 100%

Leakage was not identified as an issue in the Property Damage files reviewed.

7.7 Overall Conclusions on Property Damage

The results of the Property Damage review did not indicate any critical issues in the adjustment of the claim. These were non-complex claims where for almost all claims, fault was decided correctly by applying the Fault Determination Rules, with damages paid as presented.

The cost of physical damage repairs are increasing significantly and are blamed for rate increases for many of the major insurers across the country[20]. This is attributed predominantly to the cost of replacing parts in newer vehicles with partially automated driving features. We did not observe evidence of this in the taxi files reviewed.

[20] Why driving safety tech doesn't cut claims costs –yet; Canadian Underwriter February 19, 2019 https://www.canadianunderwriter.ca/insurance/driving-safety-tech-doesnt-cut-claims-costs-yet-1004127511/

8. Additional Considerations

8.1 Tort Deductible on Bodily Injury

NL has, as previously discussed, a $2,500 deductible applicable to general damages on Bodily Injury claims. From our observations, the $2,500 deductible on Bodily Injury claims had absolutely no impact on the outcomes but was merely given passing reference by the parties.

The deductible in Ontario, to name one jurisdiction, is $37,385,[21] indexed annually. This is coupled with a verbal threshold that the injury must result in serious permanent impairment of an important bodily function. This seems to discourage actions in soft tissue injury cases. Both have had an effect on reduction of loss cost escalation in Ontario.

Another factor in Ontario is the disappearing monetary threshold. The deductible is waived if the injury claim for general non-pecuniary damages exceeds $ 124,616[22]. It appeared from the NL files reviewed that the smaller cases were attracting much higher payouts but moderate injuries were lower.

8.2 Accident Benefits Restrictions and Priority

Similarly, in Ontario where the Accident Benefits are more robust in most cases, there is a Minor Injury Guideline cap of $3,500 for accident benefits medical or rehabilitation in soft tissue WAD I or WAD II cases that is consistently applied. Certain benefits such as housekeeping are not available for Minor Injuries. From the files reviewed, it was unclear whether this type of cap would significantly impact the results. The average cost per Accident Benefit claim (see Table 4) of $$6,308 in 2016 is still less than Ontario.

NL Accident Benefits coverage, where purchased, follows the vehicle. Pedestrians struck by taxis or taxi passengers often do not have their own insurance so it is difficult to tell how much of these losses would actually be avoided in the overall taxi loss experience if the priority was different. Changing priority to individual insureds appears to work better where Accident Benefits coverage is mandatory so that the risk is spread evenly.

[21] Deductible Amounts in Ontario

Section reference in Court Proceedings for Automobile Accidents That Occur on or after November 1, 1996 (O. Reg. 461/96)	Description	Amount 2017	Amount 2018
5.1 (1)	Non-pecuniary loss deductible	$37,385.17	$37,983.33
5.1 (2)	Family Law Act deductible	$18,692.59	$18,991.67

[22] Monetary Thresholds In Ontario

Section reference in the Insurance Act	Description	Amount 2017	Amount 2018
267.5 (8.3)	Non-pecuniary loss	$124,616.21	$126,610.07
267.5 (8.4)	Actions under the Family Law Act	$62,307.59	$63,304.51

8.3 Minor Injury Caps and Thresholds

Minor Injury Caps are prevalent in Atlantic Canada and specify that particular types of soft tissue injuries cannot attract more than the cap amount in General Damages for bodily injury claim. This is an alternative to deductibles.

Over time, the effectiveness of such controls tend to erode with exceptions working their way into the jurisprudence. It takes considerable patience and perseverance on the part of Insurers to enforce these restrictions under constant challenge from claimants seeking exceptions, at least until a body of jurisprudence is established. Most of the Bodily Injury claims we reviewed would arguably have fallen within a precise definition of minor injury similar to those in Ontario or the Atlantic Provinces and would have significantly reduced loss costs.

Verbal Thresholds are another way to control loss costs by restricting entitlement to general damages for bodily injuries by stipulating that no action could be brought against a third party unless the injury results in a permanent, serious impairment of an important bodily function.

How these tools are implemented and how leakage (exceptions to the criteria) is controlled are critical to the success of these as an effective cost containment measure.

8.4 Territorial Differences

When the claims were sorted by territory it was striking how many of the claims were in Territory One (mainly St. John's area).

Table 12 - Claims sorted by Territory (all claims)

Claims Sorted By Territory		
Territory 1		
	Total Gross Paid (includes Expenses)	**# Of Claims**
Accident Benefits	$ 1,907,119.00	211
Bodily Injury	$ 12,446,054.00	308
Physical Damage	$ 1,217,928.00	312
Totals	**$ 15,571,101.00**	**831**
Territory 2		
	Total Gross Paid (includes Expenses)	**# Of Claims**
Accident Benefits	$ 165,829.00	19
Bodily Injury	$ 2,627,592.00	23
Physical Damage	$ 179,277.00	62
Totals	**$ 2,972,698.00**	**104**
Territory 3		
	Total Gross Paid (includes Expenses)	**# Of Claims**
Accident Benefits	$ 115.00	1
Bodily Injury	$ 97,582.53	3
Physical Damage	$ 75,812.00	7
Totals	**$ 173,509.53**	**11**

9. Conclusions

Cameron makes the following overall conclusions as a result of the review:

9.1.1 For the 2010 to 2016 period, the claims reviewed were handled properly by the Insurers.

9.1.2 The manner of claims handling cannot be said to have increased the loss costs significantly.

9.1.3 There were a significant number of drivers of the taxi cabs who were not listed on the policy.

9.1.4 There were significant delays in reporting of claims which hampered proper investigation and may have been a factor in the loss results. The only way to address it is through risk management and education, training and careful selection of drivers by taxi cab owners.

9.1.5 Bodily injury claims were predominantly soft tissue injuries which would have qualified as Whiplash Associated Disorders (WAD) WAD I or WAD II.[23]under minor injury guidelines or definitions in other provinces.

9.1.6 The current deductible had no impact on the loss results.

9.1.7 The majority of claims and payouts were in the St. John's rating territory.

9.1.8 Changing how the claims are handled, without major changes to the product, will not assist in reducing the loss costs.

9.1.9 Changes to the product such as minor injury caps, meaningful tort deductibles, minor injury treatment protocols and verbal and monetary thresholds should have a significant impact on loss costs.

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4753964/WAD I is a designation of a whiplash associated disorder that exhibits one or both of the following: 91) objective, demonstrable , definable and clinically relevant signs;

10. Notice to Reader

Cameron & Associates Insurance Consultants applied the knowledge, experience and judgment of its technical staff to interpret information made available to them at the time of the audit to form conclusions and opinions. Estimates of the probable outcome of any claim were based on the information available on the electronic file at that time and are subject to circumstances beyond our control. We have not anticipated any extraordinary changes to the legal, social, or economic environment that might affect the frequency or severity of claims. Any warranty or guarantee of any particular outcome is expressly denied. This report was prepared for the expressed purpose of assessing the accuracy and efficiency of claims adjudication and recording and for no other purpose.

James I. Cameron, FCIP, CRM, C.Arb
President
Cameron & Associates Insurance Consultants Limited

James Cameron, FCIP, CRM, C. Arb.

President, CAMERON & ASSOCIATES

James (Jim) Cameron founded Cameron & Associates Insurance Consultants Ltd. in 1994, and has grown a company that is recognized for its customized services delivered by highly skilled insurance professionals. Over his almost forty year career, Jim has participated in several regulatory and industry initiatives where he is highly regarded for his extensive insurance knowledge. He is regularly retained by Government, Risk Managers, Insurance and Reinsurance companies, public entities and private industry. Client companies include professional, financial, transportation, manufacturing, technology and property management.

His claims knowledge has been applied to asbestos, environmental liability, sexual abuse, nuclear liability, products liability, and other large or continuing loss scenarios. Recognized for in-depth analysis and unbiased delivery, he is frequently consulted as an Expert Witness and regularly acts as a Mediator, Arbitrator and Umpire in Reinsurance and commercial dispute resolution.

Actively involved in educational initiatives; Jim conducts seminars and leads workshops at Insurance Institutes and for private groups on a variety of industry topics. He has published numerous papers on subjects of interest for insurance professionals and has addressed the Canadian Bar Association Ontario, Law Society of Upper Canada, Canadian Institute of Actuaries and Adjuster and Brokers Associations across Canada.

Jim was involved in the drafting and presentation of Bill 164 by the Insurance Institute in 1993, and has authored and taught courses for the Insurance Institute to over 1000 students on the changes to the Ontario auto product in 1996, 2003, 2006, 2010. Recently he designed and presented “the new auto” to over 400 insurance professionals dealing with O. Reg 34/10.,

Areas of Expertise

- Property, Casualty, Professional Liability, Environmental and Technology
- Risk management principles
- Reserve adequacy, compliance and due diligence
- Reinsurance agreements
- Insurance archaeology and allocation of loss over coverage years
- Expert Witness, Mediator, Arbitrator and Umpire
- Ontario Automobile SABS and BI auditor and consultant

Professional Experience

Cameron & Associates Insurance Consultants
Founder 1994 to present

Canadian Reinsurance Company
Vice President 1989 to 1994

Symons International Group
Assistant Vice President, Risk Management 1984 to 1989

Phoenix Continental Management Ltd.
Casualty Claims Manager for Canada 1979 to 1984

Associations

Insurance Institute of Ontario
Ontario Insurance Adjusters Association
Society of Fellows of the Insurance Institute
ADR Institute of Canada
Risk Management Consultants of Ontario
Toronto Commercial Arbitration Society

Certifications:

Fellow, Chartered Insurance Professional, Insurance Institute
Canadian Risk Management Diploma, Insurance Institute of Canada
Chartered Arbitrator, ADR Institute of Canada

Awards:

Queen's Diamond Jubilee Medal, 2013
CIP Society National Leadership Award, 2013
CIP Society Fellow of Distinction, 2012
Huntington Society National Award of Merit 2009

Publications:

On auto Insurance:
The History of Automobile Insurance in Ontario, 2010
When will we get it right? (Auto Insurance) 2011 CIP Society Symposium
When the Dam Bursts, (FSCO Mediations) 2012, Canadian Underwriter
The Courts in the Boardroom, 2011, Canadian Underwriter
SABS FSCO Compliance, 2012
Frankly Scarlett, (MIG and BI Problems) May 2013
MIG Schmig, 2012

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Sharon Cameron, BA, FCIP, CRM
Manager, Liability and Risk Management

Sharon Cameron has a 30 year career with the Insurance Industry. In her senior capacity as Director of Claims at Zurich Insurance she managed a department of senior claims examiners with a large volume of complex property, casualty and professional liability claims. Sharon developed customized claims procedures for diverse commercial clients; from international corporations to professional associations such as accountants, lawyers and real estate professionals. As Liability Practice Leader at Royal Sun Alliance Head Office, Sharon conducted audits and implemented enhancements to the claims procedures for Canada. She successfully led a reinsurance recovery plan for the financial benefit of the company.

Sharon joined Cameron & Associates in 2004, where her ability to derive innovative strategies to resolve complex litigation issues is of particular benefit to clients concerned with increased loss costs. As the leader of the Audit Team, Sharon's exceptional organizational skills and her goal oriented focus ensure that clients' objectives are surpassed.

Sharon is active in the insurance industry and lends her time and support to numerous charities and sits on the Insurance Institute Faculty and Seminar committee.

Areas of Expertise

- Audit Standards and Data Analysis
- Coverage Analysis
- Reserve Reconciliation Reviews
- Claims and Litigation Cost Management
- Reinsurance Quantification Audits

Professional Experience

Royal Sun Alliance
Liability Practice Leader

Zurich Insurance
Director of Claims

Zurich Insurance
Claims Supervisor

Associations

Ontario Insurance Adjusters Association
Society of Fellows
Risk Management Consultants of Ontario, past President

Education and Training

Chartered Insurance Professional
Canadian Risk Management
University of Toronto, B.A.

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Susan Saksida, CIP, CRM
Risk Management and Insurance Consultant

Susan Saksida has an over three decade career in the property and casualty insurance industry. As Commercial Claims Manager at Zurich Insurance, she managed an all-lines department of 23 adjusters and examiners. At ACE-INA as Director of Casualty and Directors & Officers' Claims, Susan introduced vendor and litigation management controls which improved indemnity and expense results and accelerated claims resolution. Joining Cunningham Lindsey Claims Management Services she worked closely with clients and adjusters to improve service deliverables. As Senior Vice President and Chief Quality Officer for Marsh Canada, Susan had oversight for broker professional standards and compliance. She worked with Marsh Treasury and Revenue Canada on the issue of Federal Excise Tax and multi-jurisdictional broker licensing.

Susan joined Cameron & Associates in 2006, where she assists private companies and government agencies with their risk management, coverage analysis and claims needs. Her projects have included preparing training manuals and delivering training to; a national policing organization, municipalities, government agencies and private companies. She has worked with the Ontario Power Authority on various insurance matters including participating in the review of insurance placement for hydro-electric projects.

Areas of Expertise

- Documentation and Reserve Reviews
- Developing Standards and Procedures
- Due Diligence Audits
- Coverage Adequacy Analysis
- Error and Omission Identification

Professional Experience

Marsh Canada
Senior Vice President & Chief Quality Officer

Cunningham Lindsey Adjusters
Manager Claims Management Services (CMS)

Ace INA Insurance Company (formerly Cigna)
Director, Casualty Claims & D&O

Zurich Canada
Manager, Commercial Claims

Associations

Insurance Institute of Ontario
Risk Management Consultants of Ontario

Education and Training

Chartered Insurance Professional (CIP)
Canadian Risk Management (CRM)
Negotiation and Mediation Skills, University of Windsor
Defence Research Institute: Environmental, Bad Faith, D&O

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Leonard Bondi, C.I.P.
Insurance Consultant

Leonard Bondi has had a lengthy claims career with a Canadian national insurance company. In his role as Head Office Claims Analyst, he applied his knowledge of property and casualty claims, particularly in the area of automobile bodily injury and accident benefits, to provide technical support to the field. Leonard developed a process by which accident benefit claims with catastrophic potential were identified and monitored and claims determined to be catastrophic were placed on a formalized work plan. He shared his claims expertise by teaching courses at the Insurance Institute of Ontario and in-house.

His responsibilities included compliance audits, participation in internal cross functional initiatives and providing input into the enhancement of the company's claims database. His involvement in special project included Insurance Bureau of Canada ("IBC") projects and automobile insurance initiatives such as Auto Reforms and FSCO Forms Committee.

Leonard joined Cameron & Associates in 2015 as a member of our Audit Team, where he conducts claims and compliance audits for our insurance company clients.

Areas of Expertise

- Claims and Reserve Adequacy Analysis
- Compliance Audits
- Training and Education

Professional Experience

The Dominion of Canada General Insurance Company – Currently Travelers Insurance Company

Positions held:

1992 – 2014 Head Office Claims Analyst
1998 – 1992 Claims Unit Manager – Scarborough, Toronto
1997 – 1998 Claims Unit Manager – Sault St. Marie, Ontario
1985 – 1987 Claims Supervisor – Ottawa, Ontario
1979 – 1985 Resident Claims Adjuster, Cornwall, Ontario
1978 – 1979 Outside Claims Adjuster, Ottawa, Ontario
1976 – 1979 Inside Claims Adjuster, Ottawa, Ontario

Associations

Insurance Institute of Ontario (C.I.P.) Designation with additional courses toward the F.C.I.P designation.
Past Associate Member of the Canadian Defence Lawyers Association.

Education & Training

Chartered Insurance Professional (CIP)
Graduate of St. Lawrence College, Kingston
Automobile insurance seminars including Regulation 34/10, Bill 59/198, Bill 164, the Ontario Motorist Protection Plan and inter-jurisdictional claims issues

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