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The buzz around blockchain is growing louder. An almost consensus-like agreement that it could benefit the insurance industry, though, must be balanced by what can only be described as an incomplete understanding of its workings and potential. That said, both understanding and openness to exploring blockchain are growing.

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Profile
Laura Van Vliet, recipient of the CIP Society’s 2016 Emerging Leader Award, understands how effort and education can build a career. For the assistant vice president of ALIGNED Insurance Inc., Van Vliet’s career to date has been like assembling building blocks to make a solid foundation for the future.

By Angela Stelmakowich

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**EDITORIAL**

**Buzz Kill**

The federal government and its partners are hopeful a new pilot project will help curb incidents involving drug-impaired driving.

Long a stumbling block to prevention efforts, the project will allow police to use a device capable of helping them assess and measure impairment, something that, if given the green light, would provide an immediate means to get drug-impaired drivers off the road.

The hope is that hurdle can soon be cleared, and the human toll and losses associated with related collisions dramatically reduced.

Public Safety Canada, in collaboration with the RCMP and the Canadian Council of Motor Transport Administrators, announced in December that it was launching the pilot project to test use of the roadside screening devices. Select police services across the country will be trained to use the two types of drug-screening (oral fluid) devices in operational settings with drivers and passengers who volunteer to anonymously provide a sample.

Results will help establish possible future operating procedures and, in parallel, Canadian standards for oral fluid devices will need to be established before a government procurement process for the device can be launched, it adds.

The pilot project will unfold as consideration is being given to findings in the recently released Report from the Task Force on Cannabis Legalization and Regulation.

The task force was charged with providing its best advice on how to legalize and strictly regulate cannabis.

“There will be several opportunities to consult Canadians as the government proceeds to legalize, and strictly regulate, cannabis,” Ottawa noted at the time.

If drug-impaired driving is to be reduced, though, assessment devices and laws will need to catch up, and attitudes will need to change.

A recent survey shows some convincing is in order.

More than four in 10 polled Canadians, 44%, who have driven under the influence of marijuana report they do not think doing so has an impact on their ability to drive safely, say survey results this past May from State Farm Canada.

Add to this worrisome finding that 53% note they do not believe police have the tools and resources to identify marijuana-impaired drivers.

Asked what would change their behaviour behind the wheel, 20% of respondents said at the time nothing would make them stop driving while under the influence. About four out of 10 report they think stiffer penalties would deter them, followed by more public awareness.

The “no-affect-on-me” belief was also reflected in survey findings last November from the Canadian Automobile Association (CAA). The poll found 26% of respondents aged 18 to 34 believe a driver is either the same or better on the road under the influence of marijuana.

The CAA survey results further illustrate that 63% of respondents voiced concern that road safety will decline when marijuana is legalized.

“There need to be significant resources devoted to educating the public in the run-up to — and after — marijuana is legalized,” says Jeff Walker, vice president of public affairs for CAA National.

MADD Canada would, no doubt, agree. It reported last spring that there were 614 road fatalities in 2012 where a driver had drugs present in his or her system compared to 476 where a driver had alcohol in his or her system.

Emphasizing better tools and education are required to deter drug-impaired driving, "that is why it is critical that effective drug-impaired driving detection tools be put in place now," MADD Canada chief executive officer Andrew Murie said.

Though no hard date has been set, Ottawa could table legislation to legalize marijuana this spring.

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If drug-impaired driving is to be reduced, though, assessment devices and laws will need to catch up, and attitudes will need to change.

Angela Stelmakowich
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Technology

26% OF POLLED CANADIANS LOOKING FORWARD TO DRIVERLESS CARS: KANETIX

About a quarter (26%) of polled Canadians taking part in a Kanetix.ca survey report they “couldn’t wait” for the day when driverless cars become a reality.

The findings are in line with the previous year’s results, which found 25% of respondents were looking forward to autonomous vehicles, the online comparison site reports.

The online survey, done in December, involved a nationally representative sample of 1,000 Canadians.

Perhaps not surprisingly, the younger demographic (age 18 to 34) is the most excited about driverless cars, with 36% saying that they cannot wait for the day.

But many drivers remain neutral on the idea of driverless vehicles, with 56% of respondents saying it would depend on the technology and how well it works, and 18% reporting “no thanks, they love driving too much.”

SEVEN OF 10 GLOBAL CONSUMERS WOULD WELCOME ROBO-ADVICE

Seven in 10 surveyed consumers around the world would welcome robo-advisory services — computer-generated advice and services independent of a human advisor — for their insurance, banking and retirement planning, Accenture reports.

The survey involved 9,987 financial advisory responses from individuals using banking, insurance and wealth management services across 18 countries and regions, including Canada.

That said, “a large number of consumers still want human interaction for their more complex needs, leaving firms challenged with blending a physical presence with an advanced digital user experience, as they look to integrate robot and human services,” Accenture notes.

Overall, 57% of those polled report they would share more data with insurers in return for new benefits, although the percentage was 55% in Canada and 66% in the United States.

CANADIAN INSTITUTE FOR CYBER SECURITY OPENS

The University of New Brunswick (UNB) has announced that the Canadian Institute for Cybersecurity (CIC) has opened at the university.

With more than $4.5 million in funding and the establishment of a research partnership with global technology firm IBM, the CIC will “train highly skilled cyber security professionals and provide leading-edge research into one of the most pressing issues facing society today.”

CIC “allows us to forge an even more crucial role in developing security measures necessary to protect modern critical infrastructure in Canada and beyond,” says UNB president and vice-chancellor Dr. Eddy Campbell.

U.S. CUSTOMERS WOULD SWITCH CARRIERS TO GET DISCOUNTS

Two-thirds of surveyed homeowner insurance customers in the United States would be willing to change insurance companies to get policy discounts for using smart home devices, NTT DATA reports.

Respondents were asked their opinions on changing insurers for discounts on smart home devices such as smart thermostats, smoke/carbon monoxide detectors and garage door openers.

Canadian Market

BERKSHIRE HATHAWAY ENTERS MARINE INSURANCE MARKET IN CANADA

Berkshire Hathaway Specialty Insurance (BHSI) is introducing inland and ocean marine insurance in Canada.

“BHSI in Canada has launched ocean marine products — including ocean cargo, stock throughput and project cargo insurance — as well as a full line of inland marine products,” reports John Evans, vice president of marine with BHSI.

In July, BHSI noted it planned to introduce four new executive and professional lines in Canada.

CMW INSURANCE SERVICES, CAPRI INSURANCE SERVICES MERGE

The merger of CMW Insurance Services Ltd. and Capri Insurance Services Ltd. has created one of the largest independent, employee-owned insurance brokerages and risk management firms in Western Canada.

As of January 1, “the merger leverages the strength and stability of a combined 63 years of insurance and risk management experience, adding new expertise, products and services to better support clients’ insurance and risk management needs.”

With 14 offices in British Columbia and Ontario, the combined company is “well-positioned to grow.”

Risk

BUSINESS INTERRUPTION TOP BUSINESS RISK FOR CANADIAN RESPONDENTS

The risk of cyber incidents was replaced by business interruption (BI) among Canadian respondents to
Allianz Global Corporate & Specialty SE’s 2017 Allianz Risk Barometer.

Based on a survey of Allianz corporate clients and brokers, risk consultants, underwriters, senior managers and claims experts, 37% of respondents globally named BI as one of the most important risks, with market development risks second. BI topped the list for Canada, with 42% of respondents identifying that risk, up from second place in 2016, when it was identified by 37%.

At fifth, cyber incidents were cited by 20% of respondents, up compared to 17% reported in 2016. At second place was BI’s relationship with Canada, with 42% of respondents identifying Canada as BI’s most important risk.

The group’s view is based on information from publicly available sources and a review of disclosures from 52 companies (39 companies in the TSX Energy sub-index and 13 companies in the TSX Utilities sub-index).

“The sparse disclosure on physical and stranded asset risks is striking when contrasted with a growing body of research predicting wide-ranging, climate-related risks to carbon-intensive sectors such as utilities and energy.”

Regulation

RULE-MAKING AUTHORITY ESSENTIAL FOR ONTARIO’S NEW FSRA: COOKE

Equipping Ontario’s new Financial Services Regulatory Authority (FSRA) with rule-making authority is critically important to ensuring its effectiveness, argues George Cooke, chair of the Board of Directors of OMERS Administration Corporation.

“If rule-making authority is not part of the new FSRA, then it won’t succeed,” Cooke said during a panel discussion hosted by the Insurance Institute of Canada.

“Rule-making authority is absolutely critical and it is one of the major recommendations that allows this entity to be able to adapt to changing circumstances over time” on a timely and relevant basis, Cooke said.

OWNER ADDRESSES TO BE REMOVED FROM MANITOBA REGISTRATION CARDS

Manitoba Public Insurance (MPI) plans to implement a system change to remove the printing of registered owner addresses on non-commercial vehicle registration cards.

The change seeks to protect the privacy and security of Manitobans, MPI notes.

The change will be introduced starting with renewals and new vehicle registrations effective March 1 and later. The cards will be automatically introduced at no cost as policyholders renew or make vehicle or insurance changes that trigger printing of new registration documents.

Claims

SEVERE WEATHER, NAT-CATS CAUSE RECORD INSURABLE DAMAGE

Severe weather in 2016 exacted a heavy toll in terms of insured losses in Canada, with the $4.9 billion hit dwarfing the previous annual record of $3.2 billion in 2013, Insurance Bureau of Canada (IBC) reports.

The latest estimate from Catastrophe Indices and Quantification (CatIQ) indicates insured losses related to the Fort McMurray wildfire amount to just shy of $3.6 billion. This is more than twice the amount of the previous costliest natural disaster on record.

Reinsurance

CANADIAN RISK STARTING TO FEATURE IN CAT BOND MARKET: PCS

Canadian risk has begun to feature “fairly prominently” in the catastrophe bond market, with three Cat bonds issued last year, Property Claim Services notes in its 2016 full-year Cat bond report.

The three Cat bonds last year covering risks in Canada brought $1.4 billion in capital to market (including non-Canadian risks).

Sponsors completed almost US$2 billion in issuance and three of 2016 Q4’s four transactions exceeded US$200 million.
Master Builder

Angela Stelmakowich
Editor

Laura Van Vliet, recipient of the CIP Society’s 2016 Emerging Leader Award, understands how effort, heart and education can build a career. For Laura Van Vliet, her insurance career so far might be likened to what can be achieved by choosing the right building blocks to create a solid foundation for the future.

“So far, it’s been really interesting working,” says Van Vliet, assistant vice president of ALIGNED Insurance Inc. in Waterloo, Ontario.

It has been about “discovering new opportunities that were almost a building block into something else into something else. It was just always a new area of interest that kept coming up and building upon the foundation of insurance,” says the recipient of the 2016 Emerging Leader National Leadership Award.

Van Vliet is honoured and humbled by the award from the CIP Society, the graduate division of the Insurance Institute of Canada (IIC).

“It is a heady honour given that, like so many before her, a career in insurance was not initially in Van Vliet’s sights. Having never considered the option, she had neither knowledge of insurance’s scope nor its particulars.

What she did have was the drive to learn, the will to work and a few industry contacts, although that may not have been readily apparent at the time.

Van Vliet further had an interest in business. That appeal led her to a two-year, general business diploma program at Kitchener’s Conestoga College.

While in her second year, Van Vliet was speaking to her sales professor — who was also involved in the college’s insurance program — when a building block came into view. “We were just talking one day and he said, ‘You know, what about insurance?’ I was like, ‘I don’t really know much about it.’ He said, ‘I feel like it would be a really good fit for you,’” she recalls.

Advising her to do her own research, she did just that. She remembered that, years earlier, she baby sat for a family and the father was the owner of a brokerage.

Van Vliet reached out to him to get a better feel for the industry and an understanding of what it was that he did. “Not being in the industry, it’s pretty overwhelming,” she says. That initial conversation done, the next building block fell into place as she secured a summer job doing data entry at Ned Insurance Agency in London, Ontario.

The position afforded Van Vliet her first real-world view of the insurance industry and it was then that things clicked. “I was like, ‘You know what? I like this.’”

“Trying to do my CIPs, do the diploma and work, it definitely was a lot, but it gave me so many different areas of knowledge.”

That being the case, she enrolled in Conestoga College’s Business of Insurance program, worked part-time at McFarlan Rowlands Insurance Brokers and began her Chartered Insurance Professional (CIP) courses, working toward her CIP designation.

In her first semester, Van Vliet completed four or five CIP course exams; in her second semester, she did the same.

“Trying to do my CIPs, do the diploma and work, it definitely was a lot, but it gave me so many different areas of knowledge,” she relays, adding the experience fuelled her interest and enthusiasm.

That interest found its way to work, where she would ask co-workers all manner of questions. She would say, “‘Hey, I’m learning about this. What does this actually mean? How does this apply to the workplace?’ So, it gave me an all-encompassing vision of how insurance works.”

Her second semester done and her CIP completed, Van Vliet remained with McFarlan Rowlands as a data entry clerk for a time before moving over to Cowan Insurance Group in Cambridge, Ontario.

There, more building blocks were assembled. “I started there as a commercial account administrator and it got me into the commercial side, which I found very interesting. I liked that it wasn’t quite black and white, a little more colour to it, and it just kind of drew me into a new level of interest,” she says.

Van Vliet held the position for almost two years before moving into an associate account executive role, focusing on construction accounts. “I was doing insurance as well as surety, so taking it another step further to another interesting area.”

A year later, she made the switch to ALIGNED Insurance. In an advocate role for almost a year, Van Vliet has since become assistant vice president.
EDUCATION KEY
It is a role she relishes given her focus on, and interest in, commercial insurance. It is also a position that has allowed Van Vliet to take yet another step towards enhancing her education.

“I want (clients) to look at me and say, ‘You’re a part of our team. You’re the risk management side of our team,’” says Van Vliet, who earned her Canadian Risk Management (CRM) designation a few years ago and recently finished her Canadian Professional Insurance Broker program.

“Our job is to make sure their (clients’) assets are protected and that, in itself, is so important, so why not make sure you do everything you can to stay educated and continue your education,” she says. Coming to the table and saying, ‘I’ve taken the time to educate myself to make sure I can help you better,’ speaks for itself.”

Van Vliet’s CIP designation, for example, “really provided me with a well-rounded knowledge of the insurance industry,” she notes.

But beyond knowledge, it afforded her an opportunity to meet people through the CIP Society and gain access to great resources and contacts. “The foundation there is getting the designation and then moving forward,” says Van Vliet, a licensed broker in Ontario, Alberta and British Columbia.

RIGHT CHOICE
Van Vliet’s interest in business and her growing understanding of insurance certainly played a role in her decision to make insurance a career. But that decision was made easier by the industry’s natural link to helping people.

“I’ve always loved to do volunteer work and to help others,” Van Vliet says. “Getting an understanding of insurance and how it can help people, that definitely drew me into it.”

Van Vliet’s volunteerism and mentorship efforts have been many. She is involved in the IIC’s Conestoga chapter, has taken part in panels at Conestoga College for new students in the General Insurance Program, serves as an ambassador for IIC’s Career Connections program, has launched and co-ordinates a memorial baseball tournament for a friend who passed away from cancer, and has travelled to Thailand for Habitat for Humanity.

“It’s important to stay connected on issues and trends,” Van Vliet notes.

“The biggest thing for me with education is that knowledge is power. It’s so important to stay informed,” particularly in such an ever-changing industry, she adds.

“Change is inevitable, change is ongoing and we have to be adaptable,” Van Vliet points out. “If we’re not willing to change, then we’re going to be left behind. But I think that’s the cool part of our industry: we develop products to make sure that innovation can keep going and that it can be productive.”

Innovative thinking could also be helpful with building for the future and attracting young people to the industry.

Van Vliet wholeheartedly supports developing “mentor/mentee relationships to make sure the knowledge they (veteran insurance professionals) have is shared and is passed down,” she says.

“The really awesome part of insurance is that there are so many different areas of it that it can be appealing to a number of different personalities, skills sets, experience and strengths,” Van Vliet says.

“There’s a place for everyone in insurance,” she suggests. “That’s my story so far,” says Van Vliet. “The rest is still being written.”

Photo: Peter Tym
Planning Ahead

Global connectedness means companies, including those in Canada, need a robust data recovery plan to protect data critical to their business operations. Still, many companies do not even have such plans in place.

With the number of threats to data security growing, disaster recovery (DR) planning should be a top priority for businesses to ensure rapid recovery and minimal downtime. Yet, many companies do not even have a plan in place and, of those that do, most are not testing or managing those plans to industry standards.

With data security being a top concern for most organizations, TeraGo partnered with IDC Canada to conduct an evaluation of Canadian businesses and their responses to DR processes.

The survey involved more than 200 Canadian companies representing 20-plus industry aggregations, including business/professional services, manufacturing, financial services, government, retail, communications, healthcare and utilities. No single industry aggregate represented more than 13% of the survey base.

The study found that polled Canadian businesses are not prioritizing DR, and of those that do have a strategy in place, 81% are not testing them to industry standards. For example, ISO/IEC 27031, from the International Organization for Standardization and the International Electrotechnical Commission, is the primary international standard for DR and business continuity of IT and communications systems.

COST-BENEFIT ANALYSIS OF DR PLANNING

The Federal Emergency Management Agency (FEMA) in the United States reports that more than 40% of businesses do not reopen after a disaster, and another 25% fail within one year. Not having or properly testing a DR plan can have critical fallout, including likely resulting in financial loss from the following:

- **Downtime**: Inefficient DR planning leaves businesses at risk of losing mission-critical data and can cost a company hundreds of thousands of dollars per hour of downtime. This could include confidential financial data or sensitive customer data, the loss of which could poten-
tially have an impact on brand reputation as well.

- **Re-allocation of resources**: Beyond losing access to data systems and the ability to transact business, resources are diverted from normal business operations to manage the crisis situation.

- **Damage to reputation**: Businesses that suffer from a disaster — especially one that involves a data breach — often see a drop in both customer and employee confidence.

- **Impacted stock price**: For publicly traded companies, damage to the brand can result in stock prices being affected.

- **Legal issues**: Non-compliance by those in the insurance industry could have significant implications as a result of actions by the Canadian Council of Insurance Regulators and provincial or federal insurance regulatory bodies.

With the volume of data growing every year, now more than ever, it is critical for companies of all types to implement a robust DR plan.

### EFFECTIVE DR PLANNING

There are eight essential steps to building, implementing and managing a DR plan.

1. **DR planning begins with a comprehensive assessment of the threats and dependencies that could have an impact on business operations and data security, including the following different types of failures.**
   - **Operational**: Often a company’s IT infrastructure is not equipped to handle the heavy workloads under which it is used. Put under major stress, systems can exceed back-up battery capacity, resulting in circuit breaker failure and breakdown of other IT equipment.
   - **Human-induced**: Internally, careless, uninformed or disgruntled employees can cause harm to the security and integrity of a company’s data, while hacking, terrorism and vandalism from outside sources are also very real threats that companies are facing today.
   - **Natural disasters**: Unpredictable environmental catastrophes, such as floods, extreme temperatures and power outages, can interrupt operations for hours, days or even weeks before regular business can resume.
   - **Dependencies**: Third-party partners, suppliers and service providers that face a disaster can have just as much of an impact on a business’ operations.

2. **Conduct a risk assessment and a business impact analysis (BIA) to fully understand what IT services are necessary to support the company’s critical business activities.**

3. **Define the recovery time objective (RTO), the amount of time a company can effectively operate with systems down, and recovery point objective (RPO), a company’s loss tolerance to data, for all critical applications. RTOs and RPOs both play a critical part in creating a comprehensive BIA for the DR plan.**

4. **Identify key infrastructure and assess gaps, especially for mission-critical applications, and prioritize their failover, as well as plan for duplication of critical skills.**

5. **Define policies and establish which tools are necessary to have on site, off site or with a vendor that can validate the outlined DR procedures.**

6. **Develop an easy-to-use, repeatable process that covers off each step for recovering damaged IT assets and clearly outlines the procedures necessary to recover them and return to their normal operation as soon as possible.**

7. **Test frequently and simulate various disasters, implementing the plan for all contingencies, including the training of relevant staff members on the processes and procedures in DR scenarios, and outlining who does what, when and how.**

8. **Document time-to-remediation for all elements of IT infrastructure so that the potential impact of downtime can be mitigated at all times.**

### TESTING THE DR PLAN

Just as important as having a DR plan is testing it regularly to determine its efficiency and effectiveness. The aforementioned study found that 81% of polled Canadian businesses are not testing their DR plan to industry standards.

Among ISO/IEC 27031’s testing objectives is to build confidence throughout the organization that the DR plan will satisfy business requirements; demonstrate that the critical
systems can be recovered/restored to agreed service levels; provide staff with an opportunity to exercise the DR plan and its execution, including hands-on training; and verify that DR plans and the DR environment are properly synchronized with the production environment and the business.

In line with the aforementioned testing objectives, there are three recommended approaches to testing:

• **Walkthrough:** Individuals involved in the DR planning have an initial walkthrough meeting to discuss objectives, roles, responsibilities and dependencies to ensure that the process is fully understood.

• **Simulated recovery — system subset test:** A critical subset of the environment is scoped and test performed (for example, failover and failback of critical servers and network components) to ensure the DR plan is effective for the subset.

• **Operational test:** This is a wider-scale recovery test that is inherently more complex and introduces additional risk to the normal functioning of systems running the business.

The test scenarios should be exercised at different intervals and are ideally introduced randomly to obtain a more accurate sense of the organization’s state of readiness and preparedness.

DR TESTING CHALLENGES AND SOLUTIONS

Regular DR testing requires a significant amount of resources, which many companies are hesitant to commit. Not only is there a time commitment, there is the logistical cost of organizing and executing DR testing, as well as the productivity cost from diverting staff time and effort away from other priority projects.

A lack of human resources is often where organizations fall short. In fact, 36% of surveyed businesses admitted that they do not have enough qualified staff to implement a DR plan successfully.

To overcome these challenges, organizations should first define their risk profile by conducting a full audit and cost-benefit analysis. This will determine the organization’s risk appetite and the most effective and efficient plan based on that assessment.

Next, breaking down the testing will eliminate the difficulty of testing the whole set of DR plan elements and processes in one test exercise. Finally, consider using a managed service provider to outsource the test to a third party, thereby allowing the core business team to concentrate on operating the business while the provider deals with any technical difficulties.

DR PLANNING FOR THE INSURANCE INDUSTRY

For insurance companies that are in the business of helping people through disasters, having a robust DR plan is paramount. Insurance companies have an obligation to their clients to be available when disaster strikes, so they must be fully functioning regardless of extenuating circumstances.

The implications of downed systems, data loss or being unable to service customers in their time of need could not only damage their reputations, it could also impede their responses to policyholders and the ability to satisfy regulatory requirements of provincial and federal regulatory bodies.

A robust DR strategy, though perhaps not explicitly regulated, is a critical adjunct to an insurance company’s overall risk management and governance strategy.

THE BOTTOM LINE

Disaster recovery planning is critical in this globally connected environment. Canadian companies need a robust data recovery plan to protect data critical to their business operations, including their customer’s private personal data, or risk financial loss.

When developing a DR strategy that will hold up against internal and external threats, a company needs to consider budgets, senior management’s tolerance to risk and industry-specific regulatory obligations.

An advisor can help to strategize, develop, test, manage and execute the plan, while also assisting in minimizing business disruption.
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Claims in Action

The scale and complexity of the Fort McMurray wildfire sparked a multitude of claims issues for the insurance industry as a whole. But a concerted effort by all stakeholders helped insurers address the many and unique challenges in the aftermath of the record loss.

The Fort McMurray wildfire raged for 65 days, igniting May 1 and not fully contained until July 5. During that period, the fire devastated an area of 589,552 hectares, claimed some 2,400 buildings, most of those residential properties, and forced 88,000 inhabitants from in and around the city to evacuate.

As has been well-documented, the wildfire constituted the largest insured loss event in Canada’s history, with Catastrophe Indices and Quantification Inc. reporting last summer a total estimated insured loss of about $3.6 billion. While the majority related to personal lines claims — 58% for personal lines, 38% for commercial lines and 4% for automotive — some 5,000 commercial claims were also received, amounting to more than $1 billion.

All these facts have been extensively documented; what has not are the many claims challenges faced by the insurance industry as a result of the unique catastrophic event.

FIGHTING THE FLAMES

Just days into the fire, BMO Capital Markets reported on May 5 it estimated the rapidly growing fire could result in insurable damage of as much as $9 billion if Fort McMurray had to be rebuilt.

Within the first couple of weeks, the insurance industry was already on full alert; first notice of loss (FNOL) notifications were flooding in; the Insurance Bureau of Canada (IBC) had set up the Fort McMurray Working Group to act as a conduit among government, the insurance industry and affected residents; for the first time, IBC created the role of insurance industry claims liaison officer to deal on site with any insurance-related issues affected community members had; and insurance command centres were established in evacuation areas, with proof of policy often the only requirement for payment in those early stages.
Despite the response, the complexity and scale of the loss created a multitude of coverage issues.

In the initial weeks, insurers were tackling claims notifications with virtually no information to support their decision-making process (insurer access on a controlled basis was only granted on May 29; a small number of adjusters had been granted access earlier). Even when the fire was under control and the true level of devastation could be assessed, claims handling remained challenging.

**COVERAGE CHALLENGES**

Given the nature of the event, it was inevitable that potential disputes would arise. One of the most challenging aspects of establishing the cause of loss was deciphering if it was smoke-related damage or normal dust accumulation.

Most residents were given the benefit of the doubt on the existence of smoke damage, which triggered the broader policy coverages that were not available for mass evacuation circumstances only. This created a contentious issue about how much of the home and contents actually required professional cleaning as a result of damage.

Insurers also had to address the issue of “proof of loss.” With approximately 1,900 residential properties and their contents completely destroyed, it was virtually impossible for many insureds to provide evidence of the range and quality of items that had been lost, making replacement values difficult to set.

Even claims settled on an actual cash value (ACV) basis required an assessment of replacement value. Without evidence of what was in the home originally, it was impossible to validate for either the homeowner or the insurer, with many claims simply getting determined by policy limits.

The duration of the mass evacuation period also proved problematic. The evacuation was ordered on May 3, four weeks before the phased re-entry of residents commencing on June 1, and five weeks after resident access to the most severely impacted areas of Beacon Hill, Waterways and Abasand on June 8.

In some cases, the duration of the evacuation breached the time limits for civil authority/mass evacuation cover for additional living expenses (ALE) incurred where people were evacuated, but there was no damage to their respective properties.

In most cases, however, insurers were flexible on this, recognizing the uniqueness of the situation being faced.

Unsurprisingly, losses related to business interruption (BI) and contingent BI (CBI) have formed a significant component of the commercial claims received. For example, the Globe and Mail reported last May that oil and gas producers, upon which the local economy is heavily reliant, saw production disrupted, with 10 operators temporarily halting activity at a cost of $65 million per day.
Insurers have also been faced with controlling the spread of “neighbouritis,” a situation in which insureds demand that their insurers provide the same calibre of treatment received by their neighbours even if their policy does not provide the same level of cover.

One dynamic that is having a significant bearing on the value of BI and CBI claims is the fact that prior to the fire, the economy was experiencing a localized recession. For those businesses able to re-open, however, high demand for limited goods and services has effectively rebooted the regional economy.

This, of course, raises challenges for establishing BI claims settlement figures, as those companies unable to re-open have not been able to capitalize on this financial windfall.

While demand has been high, availability of staff and stock has meant many businesses have been unable to respond.

A further impacting factor is that in some badly affected areas, the populations that supported the local economy have simply not returned. So while businesses may have been able to resume operations, income has been significantly reduced.

Insurers have also been faced with controlling the spread of “neighbouritis,” a situation in which insureds demand that their insurers provide the same calibre of treatment received by their neighbours even if their policies do not provide the same level of cover.

This was a common issue following the southern Alberta floods of 2013, where insureds took to publicly “naming and shaming” their insurers.

SCALE OF THE REBUILD

Rebuild capacity is proving a major challenge in Fort McMurray. Local reports have indicated that in 2017, only 24 new builds had been scheduled for the area. With 1,900 residential properties destroyed by the blaze, the local construction industry simply does not have the capacity to meet demand. Even during the town’s boom period, it was said firms were only able to construct a maximum of 600 residences a year.

Northern Alberta and the remote location of Fort McMurray also pose a number of logistical challenges. For example, severe winters in the region significantly curtail the period during which construction is feasible. Further, the region is only served by a small airport, and a single highway provides the main route into the area, limiting the ability to quickly transport materials and resources.

More than a third of Fort McMurray residents constitute a “shadow population,” where the town is not their primary residence.

Add to those challenges that a number of recent cost increases have needed to be factored into rebuild figures. Changes to the National Energy Code of Canada, effective November 1, 2016, are likely to result in higher insulation costs, while a recently introduced tariff by Canada Border Services Agency on drywall materials entering Western Canada from the United States has seen costs increase by 276%.

The particular characteristics of the Fort McMurray loss created a number of clause-related issues, particularly concerning guaranteed replacement and reinstatement stipulations. Many policies, for example, require that the location of the rebuild be either on the same site or adjacent to it, which, in many cases, is not possible.

Also, more than a third of Fort McMurray residents constitute a “shadow population” working for the oil producers, where the town is not their primary residence. With the fire having significantly affected work opportunities, many are looking to rebuild elsewhere.

In response to these issues, a number of insurers have chosen to extend the rebuild zone — some within provincial boundaries; others anywhere in Canada.

The decision as to whether or not to rebuild in Fort McMurray has also raised issues for multi-family dwellings where owners of adjoining properties do not agree on rebuilding. If the adjacent neighbour has chosen not to rebuild, the remaining insured is only able to recoup 50% of the cost of the wall.

This also creates zoning problems, as the particular site would have been designated for a multi-family property with a shared wall. Local authorities are currently reassessing any zoning restricting to help tackle this problem, the Regional Municipality of Wood Buffalo has reported.

CONCERTED RESPONSE

That a loss of Fort McMurray’s magnitude should create such a raft of claims-related issues is to be expected. The uniqueness of the event demanded that insurers respond to a series of highly challenging claims scenarios.

Insurers, however, proved responsive and flexible — often waiving or amending particular policy clauses to best serve the interests of policyholders.

The flexibility meant that, within weeks, the majority of claims issues had been resolved, a noteworthy achievement given the extreme nature of the event.

And while it is clear that some claims situations will take longer to reach a satisfactory resolution, Fort McMurray has provided a clear example of what can be achieved when communities, government and the insurance industry work together.
What if information about a specific claim, stored in the cloud as part of a company’s new cloud-based system, goes missing? What are the ethical responsibilities of the company, the claims adjuster, the manager and other employees who may have handled the file in past?

A long-standing employee of an insurance company retires after 40 years of service as a claims adjuster. A young professional is hired to take over this position, with some changes to the job description. There is no overlap between the retired employee and the new employee, and the new employee is trained by a far less experienced claims adjuster who started with the organization just a year prior when it transitioned from storing its files as physical documents to a cloud-based system.

The new employee is trained for digital note-taking and within a few weeks of training, she is ready to take on new cases and take over the cases of the retired employee. One afternoon, while reviewing one of the older cases that resurfaced a number of years ago, the new employee discovers that vital documents related to the claim are missing from cloud storage. She searches through all the possible digital folders, but is unable to find the missing information.

Since this missing information is an imperative part of the case, the employee discusses the matter with her manager, who then places a request for archives to search for the physical files. Unfortunately, none are found.

Another long-standing employee overhears the conversations about the file and recalls that when he was an underwriter, he had occasion to consider the same client. He relayed that there were very unique and peculiar risks in the file that required special consideration and costing.

Given it was no longer his file, however, it was not his problem. He warned his employer about the perils of transferring paper files to the cloud, and for this and other reasons, he had not been happy at his job lately, but would soon be retiring, anyway.

In what ways does the long-standing employee have an ethical duty to enlighten his colleagues about some of the nuances of this file based on his recollection of facts? In what ways does the new employee have an ethical responsibility to track down the missing information? And what can the insurance company do to provide an ethical outcome for the client?

Mark MacDonald, B. Comm, FCIP, CRM
Vice President and Broker
Atlantic Public Sector Broking
Aon Risk Solutions
This is a scenario that will, unfortunately, no doubt, arise (or already has) for a number of insurers as the transition takes place from paper files to paperless file storage. This scenario also highlights the importance of ensuring that all file...
documentation is uploaded digitally as this transition takes place.

While the long-term underwriter is no longer handling this file and is retiring soon, he has an ethical obligation to put aside his views on digital storage and inform his colleague of the peculiar nuances of the client to the best of his recollection. He may be the only one who can give the claims adjuster better context around the client and the claim in question.

This long-term employee may also be aware of other avenues to locate the missing documents. For example, he may be aware of an old email server that could be accessed and searched.

The new claims adjuster certainly has an obligation to do everything within her ability to track down any documents that may be missing from the digital file and which may affect the outcome of the claim. These actions may include attempting to retrieve the original paper files (which could not be found in this case), as well as seeking out employees (including, perhaps, the retired employee), who may have been involved at an earlier stage and may have knowledge of where this documentation can be found.

Should all of these efforts fail, and the adjuster is unable to locate these documents, the insurer has an obligation to pay the claim — even if all of the anecdotal evidence suggests that the files existed and would support a denial of coverage. Not only is this the ethical solution, but failure to do so could also put the insurer in an awkward legal position should a denial of coverage be challenged by the client, and the documents relied on by the insurer for their denial cannot be produced.

**Mike Tolan, BSc, FCIP, CRM**

**Director**

Privacy, Quality & Professional Standards
Crawford & Company (Canada) Inc.

Claim departments, both insurer and independent, are well-stocked with seasoned technicians. Many in the industry probably have colleagues who prefer to print an email and attach it to their paper files instead of saving a soft copy PDF document to their claim management systems.

Over coffee, if asked why, there is no guarantee they will know what a PDF document is, never mind the cloud, but they take comfort in the feel and security of a piece of paper. While they are reluctant to change, they are tremendously valued for what they bring on a day-to-day basis.

At the same time, claims organizations are looking for young talent who are IT-savvy and extremely comfortable with new technologies, and who choose insurance claims as their career path. These young people are rare and the industry needs more of them.

In the end, it is about the client’s claim and the onus is on the insurer to adjudicate in good faith. While the aforementioned scenario may highlight the challenges of moving to a paperless world, similar challenges were faced when trying to recall an old paper file from storage, only to discover that it had been destroyed.

Whether the material documentation is stored in a warehouse or in a digital world, the new claims adjuster, along with her manager, are obligated to try and recreate as much of the file as possible.

The seasoned underwriter is under the same obligation. He may not embrace change and he is free to choose whether he wants to learn and remain current, or retire and move on, but in the aforementioned scenario, he is still actively employed by the insurance company.

As the underwriter who was originally involved in reviewing and binding this risk, he has special insight that may assist the adjuster and her manager with recreating this file, and he should step up and help the insurer in responsibly discharging the duty to its client.

**Darrell Mack, FCIP**

**Director,**

Saskatoon Injury Claims
Saskatchewan Government Insurance

The first item for this company to address is the reliability of the cloud storage system provider. While the physical files are usually destroyed, there should be a digital record of every piece of information that was uploaded into the digital storage system.

This is also an important time to review the organization’s policies around confidentiality and its codes of ethics and conduct. An employee has an obligation to the organization’s standards of business and to protect the personal information entrusted to him or her, as this is one way to earn a client’s trust.

If the former adjuster properly attached the vital documents to the claim file, he has done nothing to cause the loss of the information. The new adjuster has a duty to find this documentation and make all attempts to replicate it.

The new adjuster also has a duty to
disclose to the client that records have been destroyed or lost, similar to when reporting a breach of privacy involving personal information.

Assuming these documents are important and essential to the adjudication of the claim, the new adjuster could ask for the assistance of the insured to produce the documentation from years ago. The new adjuster can also liaise with the underwriting department and ask if it can share any relevant information from the file, even if this requires an authorization signed by the client.

The long-standing employee with prior information has a duty to keep documents in strict confidence and only disclose for the benefit of the company. When an employee ends his employment, he is required, by policy and ethically, to return all documents and information, and this includes knowledge of the client. Employee knowledge, which includes data and information, is the property of the employer and is used to conduct business.

Each person in this scenario has a duty to conduct themselves using a framework of ethical principles for the success of the employee and the company. In the absence of the documentation, the ethical outcome for the client is to pay the claim as if the documentation in question never existed.

THE FINAL WORD

The insurance industry depends on accurate, relevant, reliable information and the ability to retrieve it at the right time in order to do its business. In the scenario described, important information pertaining to a claim has gone missing.

While the way in which it has gone missing might be new — it disappeared from the cloud — the industry has had to deal with similar scenarios in the pre-digital world.

The new claims adjuster is already doing her part to try to locate the missing documents, but the long-standing underwriter needs to disclose what he knows in order for the company to move forward. While the underwriter may not have all the missing information, any additional information can help fill in the blanks and may even reveal new sources of information.

At the same time, the client should be notified that the documents are missing and kept abreast of what is being done to remedy the situation. This includes how the client’s missing information is being pieced together, but also how the company will prevent such oversights in the future by reviewing its file digitization and storage processes.

While the loss of information appears to be the result of a simple mistake, now that the company is aware, it has an ethical responsibility to figure out its scope and to prevent it from happening again.

Lastly, in resolving the claim file, the company must ensure the missing documents are considered and any uncertainty as a result of the missing information is dealt with in favour of the client.
Mainframes have proved essential over the decades for insurers needing to run core applications. But are these once-reliable units becoming a hindrance to innovation? Is modernization of mainframes essential for the global insurance industry?

The insurance industry is undergoing transformative change. Traditional insurance practices are being challenged by evolving customer expectations and cost control demands spurred by new technology, disruptive competitors and an evolving insurance business model.

It seems that many insurance organizations are feeling the pressure to innovate and differentiate themselves in a bid to remain both relevant and profitable.

Those efforts are unfolding as insurance IT budgets look to have flatlined. Statistica, a statistics portal that includes stats and studies from more than 18,000 sources, includes information on the average IT spending ratio of insurance companies as a percentage of premium from 2011 to 2016.

“In 2014, the insurance companies spent about 3.5% of their direct written premium on information technology,” the portal reports.

Most of the spending was dedicated to running and maintaining day-to-day systems and far less earmarked for transformation and growth.

Over the last 25 years, the insurance industry has relied on mainframes as they have been considered a good investment in terms of reliability, performance and security.

It has been reported that research conducted by Gartner in 2015 revealed more than half of surveyed global insurers still had more than 50% of their core applications running on a mainframe, while one-third still had between 10% to 50% still running on the mainframe.

MODERNIZATION IS ESSENTIAL

However, some argue that these once reliable and secure mainframes are quickly becoming antiquated, expensive and a hindrance to innovation. Modernizing mainframe applications has become a business imperative for several reasons.

Mainframes do not support innovation

Big data and analytics are driving innovation and competitive differentiation for insurance companies. Older mainframe applications tend to use more file-based data storage, limiting flexibility and analytics.
It is anticipated that organizations will need to make their mainframe data more available and compatible to support today’s digital businesses, develop new products and services and offer competitive information and insights.

Risk of losing market share to more agile competitors

More and more companies appear open to moving to the cloud for increased capacity, higher return on investment and the agility required for digital businesses. The results of a legacy infrastructure that incorporates the best of both worlds: business-defining intellectual property with demonstrated business logic.

Processes that have been refined over many years are reinvigorated by moving from a one-tier approach to more agile capabilities, including better scaling, higher reliability and improved integration with big data analytics being delivered on a platform that is less expensive to acquire and maintain.

Expense of mainframes

Today’s mainframes run on COBOL, PL/1 or other languages difficult to support, which cannot be expanded or quickly adapted to respond to new market demands. Maintenance can be an issue as many users may employ mainframe hardware, software, and tools from vendors who have retired, gone out of business or no longer exist.

In addition, mainframes require considerable space, and have associated power and cooling costs that, ultimately, can have an impact on the bottom line.

Mainframe expertise is limited

The mainframe workforce is slowly retiring and a very small percentage of younger employees are being trained on them. Companies face a great challenge when looking for the right talent to support and maintain their mainframes.

A recent Compuware Corporation study of 350 global chief information officers (CIOs) found that while 88% agreed the mainframe will continue to be a key business asset over the next decade, 75% of polled CIOs said today’s crop of distributed application developers have little understanding of the importance of the mainframe.

The talent challenge is exacerbated by findings of another Compuware survey released last December. Conducted by Forrester Consulting, the survey involved 182 input and output, IT and app development professionals in the United States and the European Union responsible for application development teams at organizations with mainframe systems of record. In all, 90% of respondents reported challenges in delivering and delivering applications that involve the mainframe.

Modernizing core insurance applications like claims management, policy administration, underwriting, commissions management and actuarial systems offer an opportunity to help reduce the day-to-day spend.

The survey further found the biggest challenges include unacceptably slow delivery, expensive workarounds, development teams saddled with changing priorities, and compliance and security risks. Despite mainframe application delivery challenges stifling innovation and speed to market, 57% of respondents reported new business initiatives involve the mainframe and 39% said it is involved with at least some new initiatives.

With the majority of annual IT spend going towards running day-to-day business, legacy modernization is quickly becoming a critical priority.

Modernizing core insurance applications like claims management, policy administration, underwriting, commissions management and actuarial systems offer an opportunity to help reduce the day-to-day spend.

There is increasing awareness that legacy modernization can free up resources, making it possible to focus on high-priority investments that have the potential to help grow and transform the business.

Although there are tangible benefits to modernizing core policy systems, including improved security, mergers and acquisitions simplification and lower maintenance costs, a large-scale modernization project does come with some risk. There must be acceptance that modernization takes time and cannot be completed overnight.

Decommissioning mainframes requires planning and the implementation of formalized processes, as well as the support and buy-in from internal stakeholders across the organization.

One of the first and most critical steps is evaluating the organization’s application portfolio to better understand how the mainframe is being utilized. This is necessary for a modernization road map to be completed, thereby allowing an IT decision-maker to dive into his or her application portfolio and decide which applications need to be modernized.

Regardless of their size and scale, insurance IT decision-makers will find a number of options for modernization, including developing custom software, investing in commercial off-the-shelf software, and layering and leveraging an existing platform. Each option, of course, offers a varying level of risk, cost and customization.

Mainframe re-hosting is one option to help mitigate the risks on a less expensive and open architecture, without a complete code rewrite. Automated modernization and re-hosting solutions can bring pre-structured query language (SQL), single-tier mainframe applications to an SQL database in a multi-tier cloud environment — without any change to applications.

The option allows those in the insurance industry to move mainframe applications unchanged to a modern open system, either on site or in the cloud.

Savings realized from re-hosting can be channeled into projects that impact transformation and innovation initiatives, with the idea being to enable insurance companies to grow the bottom line and increase the market share.
ANNOUNCEMENT

As the President of IFS, Jai has focused his first year meeting with IFS brokers and identifying areas where they could help support their growth. Recent major changes; simplifying the endorsement process and introducing credit card and online payment option with our new partner KixPay as well as the addition of new sales team members are evident of their commitment to the broker.

When asked about how he felt about his first year at IFS he said the following:

“I am thrilled with our 2016 results. It was a great year for IFS and our partners. We are on the right track and the progressive changes we’ve made are reflected in the positive momentum. Maintaining an exceptional customer service level has been the true secret to our success. The personal touch we give to our brokers and clients is second to none. As we transition into 2017 we will continue our efforts to meet the growing expectations of our brokers across Canada and look forward to strengthening our current relationships and building new ones.”

IFS are excited to introduce its growing sales team and its newest member, Kathy Walters. Kathy will represent IFS as the Director of Sales for Ontario, effective January 2017. As IFS continues to grow, we felt it was important to have a presence in Ontario to support our growing partners. Kathy brings 15 years of Insurance experience, and a passion for building relationships. Please contact Kathy directly to set up an appointment to discuss how IFS can support your Insurance financial needs.

We are also excited to welcome Lynne Gerhardt as Director of Sales, Atlantic. Lynne joined IFS September of 2016 with 12 years of experience in the insurance industry. She has built exceptional relationships with the Atlantic Brokers and is looking forward to making new relationships in her role with IFS.

Our Western region continues to be supported by Brenda Brells who brings her past experience as a Broker to better understand our partner’s needs. Brenda has a strong connection with our partners in the region, and is always looking to expand our Western presence and welcomes the opportunity to introduce herself and the IFS proposition to new Brokers.

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The buzz around blockchain is growing louder. An almost consensus-like agreement that it could benefit the insurance industry, though, must be balanced by what can only be described as an incomplete understanding of its workings and potential. That said, understanding is growing in step with an apparent openness to partner and explore.

BY ANGELA STELMAKOWICH
When it comes to blockchain, is the property and casualty insurance industry ready to burst from the blocks or is a more deliberate start in order?

Whatever the approach taken, blockchain looks to be here to stay. Implementation in some form or another appears inevitable (and advisable), with time frames likely to be set as stakeholders enhance their understanding of the needs of their organizations, customers, partners and fellow blockchain participants.

For the uninitiated, or the still-trying-to-figure-it-outers, what exactly is blockchain?

Some define it as a distributed ledger, some call it an open-source distributed database and others, still, define it as a distributed data identification technology. At its simplest, blockchain is a database that can be used to record transactions and is copied to the computers of those taking part in the network. It contains the complete history of all instructions associated with that particular blockchain.

“As the number of participants grows, it becomes harder for malicious actors to overcome the verification activities of the majority. Therefore, the network becomes increasingly robust and secure,” notes a post from Deloitte in the United Kingdom.

Blockchain touts transparency and offers fraud-combating characteristics. However, what needs to be done before everyone included in the insurance value chain — and their customers — see promise transform to reality?
**BLOCKCHAIN DEFINED**

In a report released last December, market intelligence firm Tractica noted the expectation is that blockchain for the enterprise applications market will reach US$19.9 billion by 2025. Fundamentally, blockchain “provides the ability to exchange information or money directly between any two parties without the need for a trusted party as an intermediary,” states Blockchain in Insurance: Insurer Progress and Plans, a report issued this past November by Strategy Meets Action (SMA). “It provides a universal source of truth with full transparency and security, and no need for clearinghouses or institutions to conduct transactions,” it states, adding that information currently exchanged via unsecured or semi-secured methods — such as fax, email or overnight delivery — can be exchanged in a highly secure manner.

“Blockchain uses cryptography, an advance form of encryption that ensures that information cannot be accessed or understood by anyone for whom it was unintended,” says Manav Gupta, North American cloud technical leader for IBM Cloud Canada. It “is a peer-to-peer distributed ledger and can provide increased transparency throughout many — if not all — functions within insurance.”

Blockchain automates the process where “two bodies are getting involved in a contractual financial agreement. That’s a real opportunity for insurers to take advantage of and try to build better customer relationships with their policyholders,” says Jeff Goldberg, senior vice president of research and consulting for Novarica.

So what does all of this ultimately mean for P&C insurance?

**OPPORTUNITIES GALORE**

Joel So, a partner and financial services technology strategy practice leader and Canadian blockchain lead for PwC, suggests that “at the heart of blockchain, it is an enabling technology.”

Blockchain presents an enormous opportunity, says Veronica Scotti, president and chief executive officer of Swiss Re Canada. “It has the potential to bring significant efficiency improvements to some of our back-end processes, and more importantly, it facilitates the creation of new products with very low operational costs,” Scotti notes.

“All parties that are involved in providing, reviewing and accepting/declining an insurance claim can benefit from the transparency and trust that blockchain provides,” Gupta says.

Fei Zhang, lead of blockchain projects at Allianz Group, suggests that “blockchain is, first, an opportunity to rethink about lots of our business processes along the lines of how automatic can the processes be, how much can we embed trust into the smart contract systems, etc.”

The first opportunities of blockchain in insurance, Zhang expects, “will probably be in improving the business process and customer experience.”

Mary Trussell, global insurance change lead partner for KPMG in Canada, says blockchain “will allow the industry to build a peer-to-peer network to establish smart contracts without the need for an intermediary or administrator.”

Capgemini Consulting defines smart contracts as programmable contracts capable of automatically enforcing themselves when pre-defined conditions are met. Potential annual savings in the personal motor insurance industry alone could amount to US$21 billion globally from automation and reduced processing overheads in claims handling, the firm argues.

Benefits will accrue from technology, process redesign and “fundamental changes in operating models, as they require a group of firms to share a common view of the contract between trading parties,” the company adds.

“Considering the scale of this digital upheaval, it will be at least three years before smart contracts enter the mainstream,” it predicts. “Smart contracts that do not require distributed ledgers could be viable by the end of 2017.”

Scotti’s take is blockchain will “enable new models for sharing, distributing and funding risk — which may be disruptive to our industry, but can also be opportunities for insurers who understand the implications and start experimenting with new business models early.”

Gupta maintains that “blockchain for insurance is a transformative technology with the potential to change technology the same way the Internet changed communication in the 1990s.”

The value chain in the insurance market is transforming rapidly, Juniper Research reports. This will force traditional providers to improve their offerings and customer service to fend off the threat posed by fintech suppliers.

Given that insurers are not “always quick to adopt new technologies,” says Goldberg, blockchain is “a way for outsiders or smaller companies to provide a value proposition that incumbents are not, and bring customers their way.”

Blockchain’s ability to send, receive and store data, as well as to enable transaction flow across multiple layers of counterparties “can potentially redefine the new standard for digital transaction processing,” Scotti expects.
What is Craftsmanship℠?

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GET IT?
This all sounds great, but are organizations ready to move forward? Is their understanding of blockchain sufficient?

In November, SMA reported that just 33% of surveyed P&C insurers “are now starting to understand” blockchain, 27% are “slightly familiar with the concepts of blockchain, but don’t understand its implications and/or potential for insurance,” 20% are “aware of specific insurance use cases or are experimenting with the technology,” and 20% are “not at all aware of blockchain.”

Pointing out it is “early days for blockchain,” Trussell says “while a number of financial institutions are investigating it, including insurance companies, insurers have not yet developed a full-scale blockchain capability, nor yet explored the end-to-end opportunities.”

Scotti would likely agree. “Most insurers are still in the exploration phase — attempting to understand the implications of the technology, while experimenting with limited proofs of concepts (PoCs),” she reports.

“In our view, the lack of understanding of blockchain technology and its potential for disruption poses significant risks to existing business models and the firms that do not take the time to understand the impact will underestimate the opportunities and threats that blockchain can provide,” Haskell Garfinkell, PwC’s U.S. fintech co-leader, suggested in a statement last March.

BENEFITS NEAR AND FAR
Despite the need to beef up blockchain understanding, Gupta sees things moving forward in the coming year. “Around the world and even here in Canada, we’re seeing insurance companies explore how they can integrate blockchain technology and best determine which products or use cases will provide tangible value and better business results,” he reports.

“Imagine you are parking a car and it goes from manual to the self-parking mode. At some point, it bumps the next car. How do we determine who is responsible: the driver, the insurance company, the manufacturer?” he asks.

Blockchain will record each transaction, Gupta explains. “This becomes a permanent record of what happened that can’t be changed. You don’t need a witness, you don’t need a third-party report to validate the accident,” he says.

“What we believe — and what IBM predicts — is that blockchain will be a huge trend for 2017, so we should expect to see more companies realize the potential for blockchain and how it can improve business,” Gupta says.

Scotti expects larger-scale implementations of blockchain will begin “in two to three years from now.”

Trussell says “insurers could use digital ledgers to digitize and validate customer data and improve compliance. Also, real-time data flows and claims determination could speed up inputs into reserve calculation impacting support processes.”

Looking forward, says Scotti, “as a start, we’ll begin to see blockchain-enabled parametric and metric products, where the entire value chain is completely automated by blockchain-resident smart contracts and premium, and claims payments are conducted across the blockchain.”

Citing blockchain’s impact on the insurance value chain, Zhang says “there we might see changes to the roles different stakeholders play in the value chain. But again, that’s the role of innovation: to shift and transform value chains.”

His expectation is “the change will be gradual and long term. Migration of data from legacy systems could be a potential issue, but that’s a valid concern for any kind of technology upgrade.”

IN WHOLE OR PART?
“Even though there are different fabrics of blockchain, no business can operate in isolation,” Gupta emphasizes. “What we’re seeing in the industry is a need and a desire for one blockchain fabric to integrate with another.”

Zhang, whose company is one of the founding members of the Blockchain Insurance Industry Initiative, B3i, also sees openness to working together. The initiative was launched last October jointly by Aegon, Allianz, Munich Re, Swiss Re and Zurich.

“Blockchain technology shows most of its potential only if it’s applied in a network of peers,” Harald Rosenberger, head of innovation at Munich Re, said in a statement announcing B3i.

As with all financial institutions, So says, “ultimately they are in competition.”

But there are “certain aspects about their business where there are synergies for them to share data and some processes where it’s actually not part of a competitive advantage,” he explains. “When it comes to, for example, adjudicating risk of certain policyholders, I think it behooves all of the insurers to have a shared understanding that enriches their actuarial model of a particular policyholder or business risk.”

Trussell notes there are already those setting up incubators and joint ventures aimed at developing new concepts, those investing in emerging technologies to buy in skills outside of their core competencies and capabilities, and those investing resources and capital into pilot projects and PoCs.

With blockchain, “benefits are directly proportional to the level of collaboration and the industry’s ability to...
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“IBM views blockchain as an opportunity for business to work more closely with regulators, and, in fact, regulation will be one of the key drivers that will make blockchain successful,” says IBM Cloud Canada’s Manav Gupta.

come together to drive standards for wider blockchain adoption,” Elizabeth Wesson, director of digital strategy for Swiss Re, says. “Ultimately, deep collaboration between incumbents, innovators and regulators is the key to success.”

Though the insurance industry is at the very early stages of blockchain development, Zhang says that PoCs are very appropriate ways of exploring this technology. “The expectation is that some of the PoCs will graduate into cases with tangible business value with real support from the operating business,” he says.

CLEARING HURDLES

“As we think about larger-scale blockchain implementations, there are numerous technical, regulatory and business-related challenges ahead,” says Wesson.

“Technical challenges include the ongoing instability of blockchain platforms as they continue to be developed, issues around transaction confidentiality and privacy, and questions about the scalability of blockchain solutions,” she says.

“Due to blockchain technology’s immutability, proper data governance and data quality is a necessary prerequisite,” Wesson comments. “Combined innovations of blockchain, artificial intelligence, Internet of Things (IoT) and other technologies will form the foundation of next-generation financial services infrastructure,” she adds.

PERVERSIVE INFLUENCE

“The impact of blockchain has the potential to span the insurance cycle end-to-end,” Trussell says, including potential applications for claims management, underwriting, reinsurancce, fraud detection and prevention, and risk determination and reserve calculation. “It will also have impacts for policy sales and incident management,” she adds.

Wesson would likely agree. “When we think about coupling blockchain with smart contracts, and then even taking it a step further to incorporate IoT, we really have the power to transform the entire insurance value chain,” she says.

“We can create low-cost, automated, trigger-based parametric or metric products where blockchain and smart contract infrastructure take care of everything from identifying the user, validating information in the underwriting process, triggering a claim, and making a payment,” Wesson reports.

It is also important to remember that blockchain can be used effectively within organizations. “The real promise of blockchain is to enable trust in a trustless environment,” So says, explaining that trust in this context is not necessarily adversarial in nature.

“Sometimes, trust means that certain parties have different views of data, have different timeliness of data,” he says. “So if you redefine the notion of trust that way, you can start to imagine there are certain business problems inside of an organization, which may span... less than a half-dozen participants,” each an individual user or whole groups.

This is all well and good, but insurance is a highly regulated industry. Are regulators showing signs of being open or closed to how blockchain might potentially be used?

“IBM views blockchain as an opportunity for business to work more closely with regulators, and, in fact, regulation will be one of the key drivers that will make blockchain successful,” Gupta predicts. “Regulators are interested in finding out the truth, and the easiest way to share truth is to ensure everyone is looking at the same information.”

Zhang says regulators appear “open to new experiments,” expecting that industry players will come up with something tangible about the pros and cons of a new solution that can then be presented to the regulators.

“Regulators are, by nature, cautious and tend to focus on potential risks and protecting consumers. That’s natural,” says Trussell. Still, they recognize that the world is changing, she notes.

“Some of the inherent qualities of blockchain, particularly transparency and auditability, as well as blockchain’s ability to lower operating costs of insurance to, ultimately, provide better value to the consumer, will be looked on favourably by regulators,” says Wesson.

“I think blockchain definitely will take advantage of the savvy customer bases’s desire for faster, more touchless interactions and communication,” Goldberg says. “But blockchain itself, really, is bigger than that and is more about building this kind of distributed ledger of communication across people without a central governing body.”
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Now that 2016 has come to an end, it is time to start planning for 2017. This includes keeping a watch on appeals in the coming year.

Three such appeals to track include Gill v. Ivanhoe Cambridge I Inc., to be heard before British Columbia’s Court of Appeal, and two appeals to the Court of Appeal for Ontario, namely Mason Homes Limited v. Lombard General Insurance Company of Canada, and Routh Chovaz Insurance Brokers Inc. v. Aviva Insurance Company of Canada.

**INTERPRETATION OF THE “FAMILY MEMBER EXCLUSION”**

Gill v. Ivanhoe Cambridge I Inc. required the court to consider the application of the “family member exclusion” in circumstances where third-party proceedings were commenced against a parent, alleging negligent supervision of the infant plaintiff.

The infant plaintiff, who was under his father’s care and supervision at the time, had been injured at a shopping mall when he found his way through a gap in the glass adjacent to an escalator, resulting in a fall to the level below.

The plaintiff brought a claim against a number of defendants, including the mall owner and elevator company. Three of the defendants, in turn, filed third-party notices against the plaintiff’s father, Kirpal Singh Gill, alleging negligent supervision. Gill sought coverage under his homeowner’s policy with Economical Insurance.

Economical Insurance relied, in part, on the 2013 decision of the Court of Appeal for Ontario in Bawden v. Wawanesa Mutual Insurance Company. The circumstances were similar, except that the exclusion in the Wawanesa Mutual Insurance policy re-
moved coverage for liability in relation to “claims for” as opposed to the broader wording, “claims arising out of.” The court found that the exclusion did not apply.

Since the Economical Insurance policy used the words, “claims arising from,” it was argued that the wording of the exclusion was clear and unambiguous. However, the court noted the wording did not state that it barred claims arising “directly or indirectly, in whole or in part,” which would have accorded with language used in other parts of the policy. This created an ambiguity that the trial judge resolved in favour of Gill.

Economical Insurance has filed an appeal of the decision and it is expected that the appeal will challenge the trial judge’s ruling that the wording of the exclusion is ambiguous. The insurer will likely argue that the words of the exclusion are clear and unambiguous, and that the court erred in permitting a strained and unrealistic interpretation of the exclusion to find ambiguity.

A reversal of the trial judge’s decision would bring the British Columbia law in line with Court of Appeal for Ontario authorities so as to provide consistency in the interpretative approach to this exclusion nation-wide. This will be a case of interest to Canadian underwriters, as an affirmation of the trial court decision might necessitate alterations in wording of the exclusion in order to give effect to its intent.

ANOTHER RUN AT COVERAGE FOR CONSTRUCTION FAILURES

Construction claims have dominated insurance coverage litigation over the last number of years. Following that trend is the 2016 decision by Ontario’s Superior Court of Justice, Mason Homes Limited v. Lombard General Insurance Company of Canada, which represented a rare win for the insurer.

The underlying litigation involved a claim against a property developer, Mason Homes, by the purchasers of a home developed by the company. The plaintiffs alleged their property was improperly graded, thereby rendering the property unsafe and not usable.

Mason Homes sought coverage from its insurer, Lombard General Insurance Company, under a commercial general liability (CGL) policy. Lombard General Insurance denied coverage on a number of bases, including the following:
- the loss was not caused by an “occurrence” or “accident”;
- the loss was expected or intended from the standpoint of the insured;
- there was an exclusion for property damage to real property on which the insured was performing operations where the property damage arose out of those operations; and
- there was an exclusion for property damage to impaired property or property that had not been physically injured arising out of a defect, a deficiency, inadequacy or dangerous condition in the insured’s product or work.

Further, Lombard General Insurance argued that the claim was framed in breach of contract and intentional conduct, which are not covered by an insuring agreement.

The Ontario court, ultimately, found for Lombard General Insurance on all fronts. The court confirmed that coverage is only afforded if the property damage is caused by an “occurrence.”

While not specifically stating that there was no “occurrence,” under that analysis, the court found the negligence allegations were merely derivative of the claim of acts done deliberately, knowingly, maliciously and in fundamental breach of the contract. As such, the negligence claim was subsumed in the intentional tort claims and did not trigger a duty to defend.

The court also found that damages for costs of repair do not constitute “property damage” for purposes of the policy and, as such, there was no allegation of “property damage” that triggered the insuring agreement.

In the event that it was wrong and the insuring agreement was triggered, the court also reviewed the exclusions and found that all of them would apply to exclude coverage.

On appeal, it is expected that Mason Homes will attack the trial judge’s finding that the negligence claims are derivative of the intentional act claims.

However, the trial court’s finding that there was no “property damage” may well be the most interesting issue, particularly in light of last year’s Supreme Court of Canada decision in Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Company.

THE INSURER, BROKER AGENT RELATIONSHIP

Routh Chovaz Insurance Brokers Inc. v. Aviva Insurance Company of Canada is of interest, as
it addresses the agency relationship between insurance companies and brokers in circumstances where brokers have the authority to bind the insurer.

The action arises out of an underlying claim brought by Waqar Zaidi against the broker, Routh Chovaz, for incorrectly placing coverage on the wrong model of vehicle.

Zaidi was involved in a motor vehicle accident and his insurer, Aviva Canada, voided coverage on the basis that its policy did not cover the loss.

Zaidi sued the broker on the basis of negligence.

The broker, in turn, brought a claim against Aviva Canada for the property damage it had paid and a declaration that the insurer must defend and indemnify Zaidi for claim for personal injury damages in accordance with the policy.

The court looked at whether there was a sustainable cause of action against Aviva Canada, either in contract or tort. Further, the court addressed whether or not the equitable remedy of recoupment applied.

With respect to the claim in tort, the court found that the insurer’s only obligation is to issue a policy in accordance with the application submitted by the broker. Brokers are regulated and subject to codes of conduct.

If the law imposed a duty on the insurer to determine the insured’s requirements, duplication of effort would result at the expense of the insured. Therefore, the court held that a direct duty should not be imposed on Aviva Canada in these circumstances.

The court then turned to the brokerage agreement, which contained cross-indemnity agreements and determined that the indemnity clause provisions provided a complete defence for Aviva Canada.

Finally, Chovaz relied on the equitable remedy of recoupment, which it argued gave a right to indemnity as a remedy. Previous case law had held that where an agent has been negligent in its dealing with an insured, the insurer will not be entitled to indemnity as against the agent, except for the premium, if the risk would have been accepted in any event.

The trial court, ultimately, found that the brokerage agreement took priority. To find otherwise would ignore the contract between the parties and, ultimately, leaves “little basis or need for [brokers] to have errors and omissions insurance.”

The appeal of this decision will be of value if it addresses in more detail the agency relationship in cases where a broker is acting for the insured while possessing binding authority for the insurer.

There is disparate case law on the agency relationship between the parties involved in making the insurance contract and some clarification from the Court of Appeal for Ontario would be welcome.
Tempering Temporary Risk

Temporary structures, commonplace on construction sites, can bring with them significant high-risk exposures. Understanding the types and inherent risks associated with the design and erection of temporary structures is critically important to avoid damage, disruption and injuries.

Temporary structures such as scaffoldings, platforms and formworks are typically assembled on construction sites in a short period of time to provide an elevated workplace for workers or to support temporary loads. Such structural systems are common on construction sites owing to their versatility and quick assembly that save time for the constructors.

Although using temporary modular systems accelerate the construction process, temporary structures are more prone to collapse in comparison with other types of structures.

There is no unique standard to determine the likely loads applied on all temporary structures given their vast variety. As such, design procedure of such structures is less regulated and some critical assumptions are typically left to the judgment of the constructor.

Furthermore, human error and omission in the assembly of these structures may directly disrupt the load path, potentially resulting in injuries and collapse.

The Infrastructure Health & Safety Association of Ontario reports that scaffold accidents are one of the most serious safety issues leading to casualties on construction sites. This is primarily as a result of the innate vulnerability of scaffolds stemming from their simple geometry, prescriptive design and installation.

While potential construction hazards can be mitigated by following strict safety regimes in conjunction with comprehensive training programs for workers, the safety of temporary structures predominantly depends on structural integrity.

As such, it is critically important that insurers not only understand the types and inherent risks associated with design and erection of temporary structures, but also employ proper pre-emptive measures to minimize the risk exposure on construction sites.
WHAT ARE THE TYPES OF TEMPORARY STRUCTURES?
From a structural prospective, temporary structures can be classified in three different categories in terms of the load bearing mechanism:

• Group (i) structural systems that hold lateral pressures of material (for example, concrete formwork or a trench box);

• Group (ii) structural systems that support an existing building during remediation or alteration (for example, a bracing system or shoring); and

• Group (iii) temporary systems that form an independent and full structure, including all fundamental components (for example, falsework or a platform).

Design and erection of each group is associated with various uncertainties, such as the applied loads, connections and geometry. While some insurers may view the groups identically, underlying risk rises from (i) to (iii) as a result of more complexity.

Consider that for Group (i), a primary input for design of a lateral supporting system, such as a trench box, is the soil condition. Underwriters are likely to request a complete geotechnical report, including soil conditions in various locations and depths.

Careful review of the plans may reveal the earthwork slope and distance from any adjacent buildings, utilities or access roads, all of which should be taken into account when designing a soil supporting system.

A heavy rainfall may saturate the soil and overstress a supporting system. That being the case, duration and timeline of the construction work is a substantial input for the risk evaluation of the group.

For Group (ii), the risk associated with the design and installation of structural components that stabilize a portion of an existing building (for example, a bracing system), is considerable since the designer must make some assumptions with respect to the load-bearing capacity of the existing elements, some of which might not be known at the time.

Quantification of a building’s conditions during the design phase is a common source of error that may impose additional risk on the project.

Typically, the design documents of the existing building, in conjunction with the alteration plan, should be obtained, reviewed and understood by the engineer of record prior to any remedial work being done.

And for Group (iii), falseworks, scaffoldings, platforms and cranes are independent structures that should be designed similarly to a normal structure and according to their specific standards.

Self-stabilization is a key in design and erection of these structures, necessitating that provisions be made to ensure that lateral stability is properly provided. As such, calculation notes and design drawings signed and sealed by professional engineers are imperative for safety assurance.
WHAT ABOUT SAFETY?
The safety of structures closely correlates with the quality of design, erection and communication between the office and site engineering team. A high-rise building is typically designed by a team of experienced engineers employing analytical approaches, while temporary structures oftentimes are installed on site based on either no or simplified calculations.

An inaccurate mindset exists that temporary structures are pre-designed and pre-examined components, and hence, safe. As such, some constructors do not update the analyses and template drawings based on actual site conditions.

For instance, design of a concrete formwork is primarily based on load tables, erection procedures and recommendations provided by the supplier. Unknown site conditions, on-site alterations of initial plans, and a simplified design approach escalate the vulnerability of temporary structures.

WHAT CONSTITUTES A FAILURE?
Unlike temporary structures, failure or injuries on sites for permanent construction are not necessarily the result of structural deficiencies; external factors such as equipment failure, fire and extreme weather conditions are more likely to trigger an incident.

For temporary structures, though, the probability of root causes of failure is typically different and can be ordered in a hierarchy as follows:

1. **Construction deficiencies**: Statistical studies, including the Study of Recent Building Failures in the United States released in 2003, note that failure of temporary structures show that design and erection deficiencies are the most common factors that enable a failure. Improper lateral bracing, shoring, foundation or connection components, as well as poor workmanship and maintenance of the elements, are the most recorded deficiencies. That said, however, most such deficiencies can be prevented through supervisory measures.

2. **Procedural causes**: Inadequate interaction between the design and installation team, on-site alteration and hit-or-miss site inspection are procedural causes that may contribute to an incident. The presence of a design team representative as a site supervisor may resolve possible discrepancy between the plan and build, such as overloading.

3. **External causes**: Vibration, impact and environmental events, including wind gusts, freezing temperature, flood and heavy rainfall beyond the degree prescribed in the design standard, are probable external causes. Adverse weather conditions are the most recorded deficiencies.

With regard to temporary structures, a simplistic design viewpoint, overlooked safety concerns and innate vulnerability of the proprietary systems because of a lack of structural redundancy raises the associated risk of the construction.

WHAT ARE THE PREVENTIVE MEASURES?
Failure of construction, even partial, may result in an economic disaster and, in some events, catastrophic injuries. With regard to temporary structures, a simplistic design viewpoint, overlooked safety concerns and innate vulnerability of the proprietary systems because of a lack of structural redundancy raises the associated risk of the construction. However, this susceptibility to damage can be managed and mitigated through additional quality assurance steps.

Prior to erecting a large temporary structure such as a bridge falsework, an insurer can request technical documents, including updated design plans, calculation notes, site inspector qualifications and duties of the engineer of record to clarify the responsibilities of the involved parties at each stage. For high-profile or high-risk projects, a third engineering party can be involved to peer-review the plans, identify potential human errors, inspect the construction site and monitor the erection.

Offering discounts on premiums can persuade an insurer to take extra precautions on a construction site, especially for facultative policies.

The insurer may also elect to retain an engineering consultant to occasionally monitor the practice of contractors who are regularly engaged in erecting temporary elements on construction sites for the purpose of reviewing the technical and procedural documents. An insurance policy can mandate the presence of a supervisor engineer on sites during installation and removal of the structural components.

Intense competition in the insurance market to underwrite a policy and attract potential clients is, indeed, a challenge for insurers, particularly once competitors take additional risks by offering price breaks on premiums and asking for less paper work from their clients.

Nonetheless, the higher potential risk exposure of temporary structural systems and the number of related incidents necessitate a dynamic risk mitigation plan since a large loss may force an insurer out of the market.

If a bridge falsework under construction collapses, it may result in work injuries, project delays, environmental catastrophe and enormous litigation expenses, perhaps leading to a seven-digit insurance claims.

Therefore, higher premiums are not a remedy; rather implementing supervisory measures and assigning qualified individuals before and during the installation of a temporary structure will help lower the potential risks and bring an added value for insurers.
Concerns have been raised following the release of a decision January 11, in which a Financial Services Commission of Ontario (FSCO) arbitrator ruled in favour of Co-operators General Insurance Company.

The insurer paid Nicole Breadner $2,200, plus tax, for the cost of one neuropsychological assessment. But Breadner, who was injured in a vehicle accident in February 2014, had submitted a treatment and assessment plan recommending a neuropsychological assessment with costs totaling more than $5,000.

On Breadner’s treatment and assessment plan (OCF-18), the breakdown of related costs included $2,000 for a neuropsychological interview and another $2,000 for neuropsychological testing. (The hearing was held in February 2016, before the province transferred responsibility for accident benefits claims disputes to the Licence Appeal Tribunal.)

In agreeing to pay just $2,200, plus tax, for Breadner’s assessment, The Co-operators argued that the work done was actually only one assessment/examination.

Section 25(1) of SABS stipulates that an auto insurer must pay “reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan” for medical and rehabilitation benefits, under certain circumstances. Section 25(5) further stipulates that an insurer “shall not pay...more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.”

The cap has been in place since 2010, when the Ontario government made reforms to auto insurance rules.

FSCO arbitrator Caroline King notes in her decision that in the latter section, the word “report” is plural. “This indicates that the number of reports does not itself trigger entitlement for additional assessment/examination costs,” King writes in the ruling.

“This comes up for us in cases all the time, when assessors are submitting invoices that are more than the $2,000 cap with even just one assessor,” says Shannon Gaudet, a Toronto-based associate for Lerners LLP who practices insurance defence law.

Gaudet suggests that with the Breadner ruling,
when receiving accident benefits claims, “insurers will be taking a closer look at the scope and nature of the work that was done to perform the assessments, and to consider whether or not it constitutes one assessment or two.”

Wendy Moore Mandel, a partner with Thomson Rogers suggests that “as medical experts become expensive, the $2,000 cap can become a problem.”

The $2,000 cap “going to be more of a problem for insurers than for plaintiffs who have tort cases because [defendants’ insurers] will fund it anyway,” says Moore Mandel.

The $2,000 cap “has proven difficult for some more complex assessments, including neuropsychological assessments,” notes a Smitiuch Injury Law blog. “In order to obtain a reliable assessment, the cost is well beyond $2,000,” it states.

“On the tort side, I usually see neuropsych assessments for something in the $10,000 range — maybe a bit more, maybe a bit less — just because the amount of testing is so significant,” says Tara Lemke, an associate with Williams Litigation Lawyers. Noting that neuropsychological assessment reports can be in excess of 30 pages (with 20 of those test results that have been performed), “I can certainly understand why claimants’ counsel are trying to get that broken into multiple assessments,” she says.

“I have seen other instances where they are successful in that regard to help defray some of the costs of these assessments,” she adds.

Lemke, Gaudet and Moore Mandel were not involved in the Breadner case.

Breadner “is extremely relevant to insurers and to claimants, especially in the new age of capped costs for assessments,” Ashleigh Leon, a partner with Miller Thomson LLP, which represented The Co-operators, writes in Lexology.

“There are numerous assessments which appear to be multidisciplinary in nature, such as neurocognitive examinations and psychovocational examinations, just to name a few,” Leon notes.

Since 2010, many plaintiff’s lawyers and insurers “have been getting around” the $2,000 cap on assessment fees “by dividing up the assessment into two distinct assessments,” argues the post from Smitiuch Injury Law.

“For the most part, this has been widely accepted as a way to comply with the statutory limit while getting a fairly reliable assessment report,” the blog states. “There have been a few insurers who have not agreed with this approach.”

Lemke argues that if arbitrators “stick to the fact that it really is only $2,200 for a neuropsychological assessment, I think that is going to make it much harder for both insurers and claimants to actually get those assessments completed because I can’t imagine that the doctors would be willing to do, say, a $10,000 or $12,000 assessment, for $2,200.”

Moore Mandel maintains that a neuropsychological assessment represents “the most glaring example” of a medical assessment that would cost more than $2,000, given its length and different components.

While she does not disagree with the arbitrator’s ruling in Breadner, “the issue I think is going to be a tougher one for insurance companies than for plaintiffs,” Moore Mandel predicts.

“If plaintiffs have a tort case, then they are going to get the full testing and the full reporting done anyway, even if the no-fault insurer’s contribution is limited to $2,000, because we will just pay for it on the tort side of the case,” she says.

“I think in the short term, insurers will see this as a cost savings, because they will go, ‘Great. We don’t have to respond to the higher costs for these neuropsych assessments that are being asked for by insured people,’” she says.

“But in the long term, when they come to realize in those cases where the insurance company needs a neuropsych and can’t afford to get it, their hands are going to be tied,” Moore Mandel adds.

Although Lemke has no quarrel with having a cap on assessment fees, it must “reflect the reality” of neuropsychological assessments, meaning there should “be some very limited, very strict exceptions to the $2,000 rule.”

“On the tort side, I usually see neuropsych assessments for something in the $10,000 range — maybe a bit more, maybe a bit less — just because the amount of testing is so significant.”

Insurers should be “very diligent in examining the costs breakdown on the OCF-18s submitted to determine whether the work to be done constitutes one or more assessments, regardless of the number of reports the assessor(s) intends to complete,” Leon writes.

“I expect that with [the Breadner] decision, insurers are going to use it to say, ‘No it’s one assessment,’” says Gaudet.

A neuropsychological assessment is usually done when an accident victim has a brain injury, Lemke says. “Because there is such an overlap between the effects of a significant psychological disorder versus what could be attributed to a traumatic brain injury, in some cases there is a question of, was there actually a brain injury, and if so, what are the measurable effects and is that due to a brain injury or is that due to a psychological sequela?” she comments.

“Be some very limited, very strict exceptions to the $2,000 rule.”

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Duty Affirmed

The Court of Appeal for Ontario has affirmed the duty to defend in a recent case exploring if consequential or resulting damage attracts commercial general liability coverage. The decision is of interest because it negated the motion judge’s ruling, which seemed to be the first Canadian case to address if application of the “subcontractor exception” in the “your work” exclusion can be constrained by a finding that the subcontractor was engaged only as a supplier, and not a contractor.

In November 2016, in Parkhill Excavating Limited v. Royal & Sunalliance Insurance Company of Canada (RSA Canada), the Court of Appeal for Ontario reversed a motion judge’s finding that there was no duty to defend a construction deficiency claim in respect of the installation of septic systems.

At first instance, Justice Susan Healey of Ontario’s Superior Court of Justice ruled in October 2015 that there was no defence obligation as the subcontractor exception to the “your work” exclusion did not apply because the subcontractor was a supplier and not a contractor. The Court of Appeal held that because consequential damages were alleged, the exclusion could not apply, a defence was owed, and it was unnecessary to go on to consider the “subcontractor exception” to the exclusion.

FACTS
In 2004, BGS Homes Inc. and B.G. Scugog Inc. retained Parkhill Excavating Limited to design, install and supervise the construction of 36 septic systems in homes it had constructed. The work was performed over a six-year period from 2004 to 2010.

In May 2010, the local health unit wrote to 25 of the homeowners warning of potential problems with their septic systems, all of which had been installed by Parkhill Excavating. Subsequently, pursuant to Ontario’s Building Code Act, the health unit issued “orders to comply,” identifying a number of contraventions, to all 36 homeowners. As a result, BGS Homes and Tarion Warranty Corporation replaced all 36 septic systems in August 2011.

In 2012, BGS Homes sued Parkhill Excavating for negligence and breach of contract, alleging that from 2004 to 2010, Parkhill Excavating supplied and installed incorrect and non-compliant filter mediums. In addition, BGS Homes alleged that the calculations and designs used by Parkhill Excavating to obtain the permits for the septic systems in 11 of the homes did not conform to the features of the houses as required under the Building Code Act.

During the period of 2004 to 2010, Parkhill
Excavating had commercial general liability (CGL) policies with three different insurance companies: Economical Mutual Insurance Company from 2003 to 2006; Royal & Sunalliance in 2007; and Northbridge General Insurance Corporation from 2007 to 2010. Parkhill Excavating, in turn, alleged that each of the insurers were at risk for a portion of the relevant period and owed it a duty to defend, which the insurers denied.

Parkhill Excavating subsequently commenced a third-party claim against Robert E. Young Construction Ltd., alleging that the latter supplied deficient filters for the septic systems.

SUPERIOR COURT DECISION

Parkhill Excavating sought a declaration compelling the three insurers to provide a defence on a motion for summary judgment. Justice Healey found that none of the insurers owed the company a duty to defend.

The justice further found that the allegations raised in the claims were within the coverage of the CGLs, as the allegations were for defective or faulty workmanship or materials, and, therefore, constituted property damage caused by an occurrence triggering the duty to defend. In addition, she found that the “your work” exclusion applied to preclude coverage because Parkhill Excavating failed to discharge its burden to demonstrate that Robert E. Young Construction was a subcontractor, rather than a supplier, to oust the exclusion.

ISSUES ON APPEAL

The principal issue on the appeal was whether or not the motion judge erred in not finding that the mere possibility that consequential damages were being claimed thereby triggered a duty to defend, which meant the “your work” exclusion could not apply.

COURT OF APPEAL DECISION

As established in Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada, released by the Supreme Court of Canada in September 2010, all that is required to trigger the duty to defend is a mere possibility that a claim falls within coverage under the subject insurance policy. Pleadings must be given the widest latitude when determining whether or not the mere possibility of a claim under a policy exists.

Citing Progressive Homes, the Court of Appeal for Ontario also noted that when a claim is limited to the direct costs of repairing or replacing the defective work, “your work” exclusions will generally apply. However, if consequential damages are alleged, the exclusion applies only with respect to the cost of repairing an insured’s faulty work, and there is coverage for the consequential damage.

The Court of Appeal for Ontario also noted that when a claim is limited to the direct costs of repairing or replacing the defective work, “your work” exclusions will generally apply. However, if consequential damages are alleged, the exclusion applies only with respect to the cost of repairing an insured’s faulty work, and there is coverage for the consequential damage.

The insurers submitted that the true nature of the action was an attempt to recover the costs the plaintiff incurred to correct the deficiencies in Parkhill Excavating’s work and that there was no allegation of any consequential damage, whether express or implied, in the action.

However, this submission was inconsistent with the motion judge’s findings. In her reasons Justice Healey found that, among other things, “the damages sought in the underlying action are approximately four times what Parkhill was paid to install the septic systems,” it is alleged the “[b]uilder has incurred costs and continues to incur costs performing remedial work necessary to satisfy the orders to comply,” the claim alleges the plaintiffs “are expected to perform further remedial work at their own expense,” and the claim refers to the cost of the remedial work, “including the higher cost of remedying work once the homes had been sold.”

“Accordingly, in addition to the question of whether defective work can be an accident, which has been answered affirmatively by Progressive Homes …, it is not at all clear from the claim that the damages sought are restricted only to the replacement of the allegedly deficient systems due to the work performed by Parkhill.”

Justice Healey had written that the damages claimed might not have been restricted to the cost of replacing the allegedly deficient systems as she noted that the claim makes repeated reference to remedial work. The claim for the increased cost of remedying the work once the homes had been sold implied claims for consequential damages.

Having made that finding, the appeal court found that Justice Healey had erred as she should have concluded there was a mere possibility that claims for consequential damages were being asserted, which should have ended the analysis. This meant the “your work” exclusion did not apply and the “subcontractor exception” did not require consideration.

Accordingly, the Court of Appeal for Ontario reversed her decision. A declaration was granted that the insurers were obliged to provide a defence to the main action except for fraud allegations against one of the defendants, which it was conceded did not attract a defence.

And, in supplementary reasons, the appeal court noted it was subsequently advised RSA Canada had settled the claims made by Parkhill Excavating against it prior to the hearing of the appeal, so the declaration was amended to apply against the other two insurers only.
The insurers withdrew reliance on the “professional services exclusion,” which the court originally declared remained to be determined. Further, the costs award of $15,000 to the insureds was vacated because of an agreement among the parties that if the appellant insureds were successful, they would be entitled to full indemnity costs, which are to be agreed upon or fixed by the panel.

**COMMENTARY**

There are four noteworthy points from the Ontario appeal court decision:

1) The court affirmed that consequential or resulting damage attracts coverage. This is consistent with the comments to this effect recently made by the Supreme Court of Canada in Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co., where the court observed its interpretation of the faulty workmanship exclusion in a builder’s risk policy “as precluding from coverage only the cost of redoing the faulty work breaks no new ground in the world of insurance, as it mirrors the approach courts have adopted when construing similar exclusions to comprehensive general liability insurance policies. These policies cover the risk that the insured’s work might cause bodily injury or property damage. However, they generally contain a ‘work product’ or ‘business risk’ exception, which excludes from coverage the cost of redoing the insured’s work…”.

2) Consistent with the obiter comments in Progressive Homes, the determination as to whether the claims were excluded depended on the allegations and the application of the “your work” exclusion, as there was no dispute that the allegations of defective or faulty workmanship or materials may constitute “property damage caused by an occurrence,” thereby triggering coverage.

3) The motion judge’s decision was of particular note because it appears to have been the first Canadian case that addressed whether or not the application of the “subcontractor exception” can be constrained by a finding that the subcontractor was engaged only as a supplier, and not as a contractor. A determination of this point will have to await another case.

4) The parties agreed that full indemnity costs would be payable to the successful insured. While the trend of the courts is in this direction, there have been cases where if it is shown that there were legitimate questions regarding insurance policy interpretation raised by the insurer requiring adjudication, then partial indemnity costs were ordered. It is unclear whether the court’s original costs award of $15,000 was on a full, substantial or partial indemnity basis.

Many thanks to Leah Dick, student-at-law in Hughes Amys LLP’s Toronto office, for her excellent assistance in the preparation of this article.
# Events and Seminars Calendar

CIP Society Events and Seminars give you the opportunity to learn, to network, to catch up on industry developments and to advance your professional and career development.

### CIP Society Seminars

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<td>February 21</td>
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<td>Kitchener</td>
<td>Leading Insurance Coverage and Liability Cases</td>
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<td>Ottawa</td>
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<td>Advanced Business Interruption</td>
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<tr>
<td>Toronto</td>
<td>The Art of Persuasive Negotiation</td>
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### CIP Society Events

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<td>Bowling &amp; Networking Night</td>
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<tr>
<td>Toronto</td>
<td>Celebrate, Refresh &amp; Relax</td>
<td>May 9</td>
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Looking for information to advance your career? Visit: [www.insuranceinstitute.ca/mycareer](http://www.insuranceinstitute.ca/mycareer).
1 David Levinson [1a] has been named president and chief agent for Zurich Canada. Zurich Canada’s last chief executive officer and chief agent was Patrick Lundy [1b]. With Zurich Insurance Group for more than two decades, Levinson was formerly regional leader for the west region in the Commercial Markets unit of Zurich North America and a member of the Commercial Markets senior leadership team. Prior to joining the insurer, he was a senior manager in Audit Practice at KPMG in the greater New York City area.

2 Nowell Seaman [2a], director of global risk management for Potash Corporation of Saskatchewan Inc., took on his role as president of Risk and Insurance Management Society Inc. (RIMS) on January 1. A RIMS member for 21 years, Seaman has served on its Board of Directors for nine years, was chair of the RIMS Canada Council from 2003 to 2005, was a director of the RIMS Saskatchewan chapter from 1997 to 2007 and chaired the secretariat responsible for the creation of the William H. McGannon Foundation. Also on the RIMS board for 2017 is vice president Robert Cartwright [2b] of Bridgestone Retail Operations LLC, treasurer Steve Pottle [2c] of York University, and secretary Gloria Brosius [2d] of Pinnacle Agriculture Holdings.

3 Len Copp [3] has been appointed president of Xpera Risk Mitigation & Investigation, SCM Insurance Services Inc. has announced. Previously Xpera’s chief operating officer, Copp also served as president of Forensic Investigations Canada until it merged with CKR Global in 2015 to form Xpera Risk Mitigation & Investigation. He is a licensed private investigator and has been with the SCM group of companies since 2000.


5 Traci Boland [5a], a partner with Ontario West Insurance Brokers, has officially assumed duties as the 2017 president of the Insurance Brokers Association of Ontario (IBAO). Boland takes the reins from Doug Heaman [5b], president of Advocate Insurance Group, who becomes IBAO chair. Before becoming president, she served as second vice president and first vice president. In addition, Boland is a past president and chair of IBAO’s Young Brokers Council.

6 KTX Insurance Brokers Ltd. has launched a new mobile app for iOS and Android that allows policyholders to both access advice from licensed brokers and self-serve their insurance policies online. Clients can chat with licensed brokers, view policy documents, request policy changes and start claims, reports the division of Kanetix Ltd.

7 Co-operators General Insurance Company reports a wholly owned subsidiary has purchased personal and commercial lines brokerage Denny’s Insurance. Current clients of the Acton, Ontario business will be notified of the change in ownership and existing coverage will remain in effect with no changes. As the current term of their policies expire, clients will be offered comparable policies from The Co-operators.

8 John Elliott [8], senior vice president of information technology UPonnen EVENTS: FOR A COMPLETE LIST VISIT www.canadianunderwriter.ca AND CLICK ‘MY EVENTS CALENDAR’ ON THE HOME PAGE
MOVES & VIEWS

and chief information officer at RSA Canada, is now on the Board of Directors of the Centre for Study of Insurance Operations (CSIO). Elliott has 20-plus years of experience overseeing large teams within the financial services and insurance sectors. He has held executive positions at companies, including most recently with Allianz Global Corporate and Specialty.

Vericlaim Canada, a subsidiary of Sedgwick Claims Management Services Inc., has opened an office in Winnipeg and hired Harry Toews [9] as executive general adjuster. Toews, who will lead the Winnipeg office and is licensed in nine provinces, brings more than 30 years of independent adjusting and management experience to his new role, Sedgwick Claims Management notes. He is a past president of the Manitoba Insurance Adjusters Association and past arbitration chair for the Canadian Insurance Claims Managers Association, Manitoba chapter.

Economical Insurance has completed its acquisition of Western Financial Insurance Company (WFIC), which writes pet insurance. WFIC has changed its legal name to Petline Insurance Company. Formerly owned by Desjardins Group, it will remain in Winnipeg.

Gord Rider has been appointed as Boston-based Berkshire Hathaway Specialty Insurance’s (BHSI) senior marine underwriter in Toronto. Rider was formerly senior marine underwriter at Chubb Insurance Company of Canada. BHSI’s coverages in Canada include marine.

CEP Forensic has opened an office in Moncton and hired Charles LeBlanc, former fire chief for Dieppe, New Brunswick, as a fire and explosion investigator. LeBlanc has led extensive improvements in fire and rescue operations, and emergency medical services.

François d’Entremont will also join CEP Forensic’s structural/civil engineering team in Moncton. Among other things, D’Entremont has experience in cost analysis for industrial and commercial construction projects.

Ayman Dabbas [13] is Invista Forensics’ new senior project engineer in its civil/structural division. A professional engineer in Ontario and Alberta, Dabbas’s expertise includes building failures, remediation and condition assessments.

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It was a great party at the Rosewater restaurant in Toronto on November 17, 2016 as guests gathered for the Young Insurance Professionals of Toronto (YIPT) Year-End Celebration. Fine food, great conversation and a good time was had by all at the event celebrating YIPT’s third anniversary and including the presentation of YIPT’s 2016 Young Professional of the Year award to Candace Colquhoun. Colquhoun, regional underwriting manager, financial institutions for AIG Canada, was cited for both her contributions to her company and the insurance community.
With 250-plus in attendance, McCague Borlack LLP hosted its 22nd Annual “Christmas in January” party on January 17 at Roy Thomson Hall in downtown Toronto. McCague Borlack LLP, the Ontario affiliate firm of Canadian Litigation Counsel (CLC), welcomed members of CLC and its sister organization in the United States, The Harmonie Group. The get-together allowed members, clients and guests from all facets of the insurance industry to discuss the latest news and developments.

See all photos from this event at www.canadianunderwriter.ca/gallery
Recent Insurance Press Releases featured on insPRESS.ca

Gary Hirst appointed President and Chief Executive Officer of CHES Special Risk Inc. January 31 — by CHES Special Risk Inc.

Michael Lawrence of Richmond Hill wins 2017 Buick Verano in Select Sweepstakes January 31 — by Economical Insurance

Offering support to the people and businesses impacted by the New Brunswick ice storm January 31 — by FIRST Insurance Funding of Canada

Kernaghan Adjusters expands B.C. operations with two new branches and four additional adjusters! January 30 — by Kernaghan Adjusters

CSIO welcomes Mutual Fire Insurance Company of British Columbia January 30 — by CSIO (Centre for Study of Insurance Operations)

ServiceMaster Restore brings Scotties Trophy to OIAA Claims Conference January 27 — by ServiceMaster of Canada Limited

Everett Porter joins Cunningham Lindsey as District Manager for Atlantic Canada January 25 — by Cunningham Lindsey

Canada's premier claims adjusting firm, DSB Claims, celebrates five-year Anniversary January 25 — by DSB Claims

CSIO appoints John Elliott of RSA Canada to Board of Directors January 24 — by CSIO (Centre for Study of Insurance Operations)

-30- Forensic Engineering’s Joel van Popta to present at the SMART Remediation Conference January 24 — by -30- Forensic Engineering

Envista Forensics announces addition of Ayman Dabbas as Senior Project Engineer January 24 — by Envista Forensics

Vericlaim expands with new Winnipeg office January 23 — by Sedgwick

Blouin Dunn & -30- Forensic Engineering thank 2017 Big Mingle sponsors January 19 — by -30- Forensic Engineering

Grand opening of CEP's Moncton office! January 18 — by CEP Forensic

PT&C|LWG Forensic Consulting announces corporate rebranding, changes name to Envista Forensics January 18 — by Envista Forensics

-30- Forensic Engineering launches Fixed-Fee Fire Investigation Service January 17 — by -30- Forensic Engineering

-30- Forensic Engineering promotes Pablo Robalino to Senior Associate within Civil/Structural Group January 13 — by -30- Forensic Engineering

Yarmouth Mutual Insurance Company effectively implements the Insurance Business Solution (IBS®) for their enterprise insurance back-office solution with their partner, Mutual Concept Computer Group Inc. (MCCG) January 12 — by Mutual Concept Computer Group Inc. (MCCG)

-30- Forensic Engineering strengthens Civil/Structural Group with the appointment of Paul Reinis January 12 — by -30- Forensic Engineering

Len Copp appointed President of Xpera Risk Mitigation & Investigation January 11 — by SCM Insurance Services
Insurance Brokers of Toronto Region held its monthly luncheon January 25 at Le Parc in Markham, Ontario. The guest speaker at the January Luncheon was Jean-François Blais, president of Intact Insurance. During his talk, 2017: Priorities in a Challenging Environment, Blais discussed industry-wide financial performance figures for Canadian property and casualty insurers for the first nine months of 2016. Personal auto insurance and weather catastrophes are two reasons p&c insurers are having difficulty right now, Blais told attendees.

Host Liquor and Hospitality

For over 35 years, GroupOne’s Host Liquor and Hospitality program has offered comprehensive, quality and competitive insurance.
The annual Canadian Collision Industry Forum (CCIF) was held January 27 at the Universal Event Space in Vaughan, Ontario. Repairers, insurers and suppliers representing the insurance claims and collision repair industries gathered for information sessions and a trade show. Hot topics during the information sessions included disruptors in the Canadian collision industry, which will likely be unrecognizable 10 years from now as a result of connected autonomous vehicles and ridesharing. Andrew King, managing partner for DesRosiers Automotive Consultants Inc., said during his presentation. Citing “soft” and “hard” disruptors, King explained that soft disruptors are things that will impact the industry, but are manageable, while hard disruptors will “rip the industry apart and lead to a whole new world.” Also on the speaker list this year was CCIF chairman Joe Carvalho; Annabelle Cormack, president of Cormack Recruitment Ltd.; Patrice Marcil, North American learning and development director for Axalta Coating Systems; Andrew Shepherd, senior director of Automotive Industries Association of Canada (AIA Canada) and executive director of I-CAR Canada; Mike Anderson of Collision Advice; and automotive journalist Zack Spencer.

Ian Portsmouth has been appointed Managing Director of Newcom Business Media’s Insurance Group, effective January 30.

The Insurance Group publishes Canadian Underwriter magazine, Claims Canada, the Ontario Insurance Directory, the Insurance Marketer and the Statistical Issue, as well as a number of other online vehicles for property and casualty insurance professionals in Canada.

Portsmouth was previously Group Publisher, Business & Personal Finance at Rogers Media, where he oversaw Canadian Business, MoneySense and PROFIT.

“Ian will be a strong addition to Newcom’s management group and it’s my opinion that his experience with PROFIT and Canadian Business magazines will translate seamlessly to the insurance market,” said Joe Glionna, President of the Newcom Group of Companies.

Portsmouth brings a diverse skillset and wide range of experience to Newcom. He is best known for his award-winning editorial work and small-business ambassadorship at PROFIT, Canada’s first publication dedicated to entrepreneurs, where he was editor-in-chief from 2002 through 2013. He is also the author of Marketing Masters: The Best Ideas, Tips and Strategies of Canada’s Savviest Marketeers (John Wiley & Sons) and a sought-after commentator and public speaker on the topics of entrepreneurship and business management.

As a publisher, Portsmouth has won several awards for business and marketing innovation, and conceived numerous multiplatform programs for some of Canada’s largest companies in the insurance, banking, accounting and investment industries.

Portsmouth replaces Steve Wilson, who has left Canadian Underwriter after 23 years of service with the Insurance Group.
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The Insurance Institute of Ontario held its 118th Annual Convocation & Awards Night January 26 at the Metro Toronto Convention Centre. Institute president Tom Reikman served as emcee. Jean-François Blais, chair of the Insurance Institute of Canada, addressed 200 General Insurance Essentials, Risk Management Certificate, Chartered Insurance Professional (CIP) and Fellow Chartered Insurance Professional (FCIP) graduates. Natalie Panek, a rocket scientist, adventurer and advocate for women in technology, then inspired the audience with stories of her travels and how she embraces learning while working towards her dream of becoming an astronaut.

see all photos from this event at www.canadianunderwriter.ca/gallery
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Calvin Newman, President, Newman Insurance