Personal Injury Motor Vehicle Litigation: SABS and Tort

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The purpose of this paper is to provide a general overview of the tort and the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] ("SABS") systems that apply to personal injury motor vehicle litigation. It must be kept in mind that each personal injury case is unique and circumstances or scenarios may arise that have special considerations which are beyond the scope of this paper. It is recommended that in each new case, a careful review of both the SABS and the *Insurance Act*[2] be undertaken by the plaintiff's lawyer.

Background

When a lawyer is retained by a person who has been injured in a motor vehicle accident, a paramount concern for the client is what sources of compensation are available to them. This is because motor vehicle accident injuries can have a serious and debilitating effect on a client's ability to remain in the workforce and earn an income. The client may also be faced with treatment, rehabilitation and care needs that are not funded through the Ontario Health Insurance Plan. Additionally, the plaintiff's family members may have incurred pecuniary losses for services provided to the injured family member, including lost wages from work and out-of-pocket expenses.

In light of the above, it is important for the plaintiff's lawyer to be familiar with the compensation schemes that are available to a claimant who has been injured in a motor vehicle accident. The three main sources of compensation are as follows:

1. Statutory Accident Benefits ("SABS")

2. Tort Claims

3. Collateral Benefits

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[1] O.Reg. 34/10 to the *Insurance Act*, R.S.O. 1990, c.I.8 as amended
[2] R.S.O. 1990, c.I.8, as amended.

SABS are benefits that are available to all individuals who have been involved in motor vehicle accidents in Ontario, regardless of whether the claimant was the driver, passenger or a pedestrian, and regardless of who caused the accident. The SABS system is often referred to as a "no fault" system, and provides for a basic benefit scheme that includes, among other things, medical, rehabilitation, and income replacement benefits. There are limits on the benefits that are available, both by quantum and duration of claim.

Tort claims are available to litigants who are either not at fault for the motor vehicle accident or are only partially at fault. The heads of damages that can be claimed in tort litigation include non-pecuniary general damages ("pain and suffering"), past and future loss of income and/or loss of competitive advantage, and past and future care cost claims. Tort claims are limited by a statutory threshold and a monetary deductible.

The third type of potential compensation – collateral benefits – may be available to your client depending on their individual circumstances and must always be considered by a plaintiff's lawyer. These can include Ontario Disability Support Program, Canada Pension Plan ("CPP") disability benefits, and/or long-term and short-term disability benefits with a group health insurer through the client's employment. Although it is beyond the scope of this paper to discuss collateral benefits in any detail, it is important for plaintiff's counsel to understand that collateral benefits can affect the value of the tort or SABS claims, as collateral benefits are often deducted from the accident benefits received and/or the damages in tort. A plaintiff's lawyer should always consider collateral benefits at the time a file is being opened and the client needs to be advised to pursue any applicable benefits in order to maximize their entitlement to same.

Statutory Accident Benefits Schedule ("SABS")

The *Statutory Accident Benefits Schedule – effective September 1, 2010* is a schedule to the *Insurance Act* that allows injured persons to claim for benefits to compensate for losses that an individual may incur as a result of a motor vehicle accident. Importantly, the claim for benefits is to be made to the claimant's <u>own</u> motor vehicle insurer.[3] Additionally, as noted above, it is inconsequential whether the claimant caused the motor vehicle accident or was blameless in the accident. The entitlement is triggered by the fact that the claimant was involved in a motor

[3] If the claimant does not have their own motor vehicle insurance coverage, then there are provisions that allow for the SABS claim to be advanced against other insurers, such as the issuer of an insurance policy on which the party is a listed driver; the insurer of a company vehicle that has been supplied to the client for regular use; the insurer of the vehicle in which the client was a passenger; or the insurer for any motor vehicle involved in the accident.

vehicle accident and sustained injury. In this respect, the SABS is a safety net of benefits, however minimal, that are available to all claimants irrespective of liability considerations.

The SABS recently underwent a series of legislative changes that came into force as of September 1, 2010, following the five-year review of automobile insurance in Ontario. The summary below outlines the types of benefits currently available to claimants (i.e. for accidents after September 1, 2010). It is important to keep in mind that historically, changes have been made to the SABS every few years. The benefits that are applicable will be based on the date of the accident. It is therefore important for plaintiff's counsel to confirm the date of the accident and apply the correct legislation.

The key benefits in the SABS are income replacement benefits (or alternatively, non-earner benefits); medical and rehabilitation benefits; attendant care benefits and housekeeping/handyman benefits. What is important to know however is that the monetary limits of the benefits payable and the duration of entitlement are dramatically impacted upon by whether the impairments sustained by the claimant are characterized as a catastrophic ("CAT") impairment, non-catastrophic impairment or as falling within the Minor Injury Guideline ("MIG"). It is important to consider the nature of your client's injuries and impairments and where they fall on this continuum. It is also important for plaintiff's counsel to revisit this issue from time to time, as a client's impairments may initially be deemed non-catastrophic but with the passage of time and deterioration of condition, may qualify as catastrophic. Similarly, what may first appear to be a MIG injury may develop a level of chronicity and impairment that takes your client outside of the MIG classification and moves him/her into the coverages afforded to non-catastrophic injury cases.

Catastrophic Impairment: Catastrophic impairment is defined within the SABS[4] as paraplegia or quadriplegia; total loss of one limb; blindness; a brain injury of a defined severity; an impairment or combination of impairment that results in 55 per cent or more impairment of the whole person; or an impairment that is classified as a marked impairment or extreme impairment due to mental or behavioural disorder. There is a significant body of jurisprudence that addresses the circumstances by which a claimant can be classified as having sustained a catastrophic injury which plaintiff's counsel needs to be familiar with in order to effectively represent their client. The most recent case law confirms that with respect to the 55%

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[4] *Supra,* note 1, Section 3(2)

impairment, the physical and psychological impairments can be relied on in combination to establish the impairment.[5]

Non-catastrophic Impairment: Although not specifically defined within the SABS, a non-catastrophic impairment is that which is not serious enough to be defined as catastrophic, but is of sufficient severity that it is not captured by the definition of a minor injury.

Minor Injury: Means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury.[6] Minor injuries are subject to the Minor Injury Guideline that establishes a treatment framework in respect of one or more minor injuries.

As outlined below, the benefits payable pursuant to the SABS vary widely depending on the characterization of the impairment. A general description of the benefits are as follows:

1. **Income Replacement Benefit**. Pursuant to this section of the SABS[7], if a claimant is employed or self-employed at the time of the motor vehicle accident, or was employed in 26 of the preceding 52 weeks, and suffers a substantial inability to perform the essential tasks of their employment, an income replacement benefit is payable. The benefit is calculated at 70% of gross income to a maximum of $400.00 per week.

   Entitlement eligibility for an income replacement benefit is the same for catastrophic, non-catastrophic and MIG injuries. The benefit is available up to the two year anniversary of the accident, after which time the claimant must demonstrate that he/she is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience.[8] This is commonly referred to as the "post-104 test". If the claimant meets this test, then the income replacement benefit is payable past the two year mark and for as long as the claimant continues to meet the definition.

2. **Non-Earner Benefit:** In the event that a claimant does not qualify for an income replacement benefit, application can be made for a non-earner benefit if the claimant suffers a complete inability to carry on a normal life and was enrolled in school on a full-

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[5] *Kusnierz v. Economical Mutual Insurance Company*, 2011 ONCA 833.
[6] *supra,* note 1*,* s. 3(1)
[7] supra, note 1, s.4 and s.5
[8] supra, note 1, s.6(1)(b)

time basis at the time of the accident, or was a recent graduate who was not yet working in the area in which they had been trained, or does not otherwise qualify for an income replacement benefit.[9] The amount of the benefit is $185 per week but is not payable until the 6 month mark following the motor vehicle accident. At the two year mark, the benefit increases to $320 per week in certain defined situations.

Entitlement eligibility for a non-earner benefit is the same for catastrophic, non-catastrophic and MIG injuries.

3. **Caregiver Benefit:** A caregiver benefit is payable if a claimant suffers a substantial inability to engage in the caregiving activities in which he or she was engaged at the time of the accident and the claimant lived with the person in need of care, was the primary caregiver, and did not receive any remuneration for the caregiving activities.[10] The quantum of the benefit is $250 per week for the first person in need of care and $50 per week for each additional person in need of care. A caregiving benefit is not payable if the claimant elects to receive either an income replacement benefit or a non-earner benefit. At the two year mark, the caregiving benefit is only paid if the claimant suffers a complete inability to carry on a normal life. *Importantly, the caregiver benefit is only available to claimants who have sustained a catastrophic impairment.*

4. **Medical and Rehabilitation Benefits:** Medical benefits are defined as various medical, surgical, hospital, and therapeutic services, including chiropractic, massage and other therapies, in addition to medication, assistive devices, and transportation to services.[11] Rehabilitation benefits are expenses incurred in relation to activities and measures designed to reduce the impact of a disability and reintegrate the claimant with his/her family, society and the labour market.[12] Rehabilitation benefits therefore cover such expenses as vocational training or counselling, workplace modifications, home modifications, social rehabilitation counselling etc., these benefits are not payable unless it is demonstrated that the expense is "reasonable and necessary" and oftentimes, disputes arise with the insurer in relation to what is a reasonable and necessary expense.

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[9] supra, note 1, s.12(1)
[10] supra, note 1, s.13(1)
[11] supra, note 1, s.15(1)
[12] supra, note 1, s.16

It is important to note that in catastrophic cases, the medical and rehabilitation benefits available to a claimant are $1 million with no limit on the period of time in which they can be claimed (i.e. can be claimed over a lifetime). In contrast, in non-catastrophic cases, the medical and rehabilitation benefits available are limited to $50,000 and are only payable for a period of 10 years. In MIG cases, medical and rehabilitation benefits are capped at $3,500. Accordingly, there is a significant difference in the quantum and duration of medical/rehabilitation benefits that are available under the SABS depending on the type of injury. If your client's injuries and impairments are such that they are deemed to have been 'caught' in the MIG, plaintiff's counsel must consider what arguments can be advanced to have their client placed outside of the MIG.[13] *Recent case law has provided plaintiff's case law with some additional arsenal in making these arguments.*[14]

5. **Attendant care benefits**: These benefits are meant to compensate for expenses that are incurred by or on behalf of the claimant as a result of the accident for services provided by an aide or attendant or by a long-term care facility.[15] It is notable that with the recent amendments to the SABS, there is a new definition of "incurred expense" that requires the aide to demonstrate that he/she provided the care in the course of their regular occupation *or* he/she has sustained an economic loss as a result of providing the care.[16] This new provision has made it more difficult for family members to be compensated through this benefit if they can not demonstrate that a pecuniary loss has been sustained when providing care.

In the case of catastrophic impairment, the attendant care benefits available to a claimant are $6,000 per month up to a limit of $1 million with no restriction on the duration of time in which they can be claimed (i.e. over a lifetime). In non-catastrophic cases, the attendant care benefits available to a claimant are $3,000 per month up to a

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[13] For example, the $3,500 limit does not apply to the claimant if their health practitioner determines and provides compelling evidence that the claimant has a pre-existing medical condition that will prevent them from achieving maximal recovery from the minor injury if they are subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline, as per section 38(3) of the SABS.

[14] *Scarlett v. Belair Insurance Company Inc.*, FSCO A12-001079, presently under appeal.

[15] supra, note 1, section 19(1)

[16] supra, note 1, section 3(7)(e)

limit of $36,000, with no ability to claim for the benefit after the 2 year anniversary of the accident.[17]

6. **Housekeeping and Home Maintenance Benefit**. In the event that the claimant sustains an impairment that results in a substantial inability to perform the housekeeping and home maintenance services that they performed prior to the accident, the insurer shall pay up to $100 per week towards expenses incurred. *The housekeeping/home maintenance benefit is only available in catastrophic cases. There is no time limit on the benefit.*

7. **Death and Funeral Benefits**. In the event of a fatality, the insurer will pay a $25,000 death benefit to a spouse, and $10,000 to each dependant. Additionally, a $6,000 funeral benefit is payable.[18]

8. **Optional Benefits.** There are enhanced benefit limits available to a claimant who purchased optional benefit coverage on their automobile insurance policy before an accident occurs. It is therefore important for a plaintiff's lawyer to make inquiries of their client as to whether they purchased optional benefits as this will increase the coverage available.

Procedure for Claiming for Benefits

It is important to know that the procedure for claiming for SABS is quite document-intensive. There are prescribed Statutory Accident Benefits Claims Forms that must be completed by your client before the benefits will be payable. The initial benefits application has various subcomponents, including a Disability Certificate that is required to be completed by a health professional, confirming that the claimant is injured and unable to work and/or requires assistance. Additionally, the Employer's Confirmation of Income form requires a claimant's employer to confirm various income information before an income replacement benefit will be payable.

After the initial application for benefits is submitted, a claimant can advance ongoing claims for benefits. The disability test that governs income replacement benefits has been described above and from time to time, the insurer will request updated Disability Certificates from a health practitioner to confirm whether the claimant continues to satisfy the definition of disability. With

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[17] supra, note 1, section 19(2) and 20(1)
[18] supra, note 1, section 26 and 27.

respect to treatment, the claimant can submit for approval of therapy (for example, physiotherapy or chiropractic therapy) which will be subject to the "reasonable and necessary" criteria. Treatment plans (OCF-18s) must be completed by the therapy provider and set out the cost, duration and anticipated goals of the requested treatment. All of the forms can be accessed on the website of the Financial Services Commission of Ontario ("FSCO").[19]

It is important that the SABS application be submitted in a timely way. The Schedule provides that a claimant provide notice of the motor vehicle accident and his/her intention to claim for SABS within 7 days of the accident.[20] The Schedule also provides that the completed application must be submitted within 30 days after receiving the application forms from the insurer.[21] It is also important to keep in mind that all of the forms that are completed, including the claimant's description of the accident and their injuries, will be producible in any lawsuit and therefore must be accurate. Defence counsel will comb through the accident benefits file to identify any discrepancies in reports of injury or conflicting evidence in order to cast doubt on your client's credibility.

Procedure When a Benefit is Denied

When a benefit is denied by an insurer, formal written notification is provided by the insurer to the claimant. If the claimant then wishes to challenge the denial of benefit, he/she is subject to section 280 of the *Insurance Act* which provides that the parties must participate in a mandatory mediation with a mediator from the Financial Services Commission of Ontario ("FSCO"), in an attempt to resolve the dispute. Assuming the mediation is unsuccessful, a Report of Mediator is issued to the parties and then it is open to the claimant to either sue the insurer for failing to pay the benefit or, alternatively, apply for arbitration with FSCO.[22] Arbitration proceedings are subject to the *Dispute Resolution Practice Code*.

Summary of SABS

SABS are an important part of the compensation scheme available to injured parties so it is important for plaintiff's counsel to be familiar with the various types of benefits and classifications of injury in order to maximize their client's entitlement to same. SABS are critical because they can be applied for immediately and can provide a compensation stream to an

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[19] http://www.fsco.gov.on.ca/english/forms/autoforms/claims/default.asp
[20] supra, note 1, section 32
[21] supra, note 1, section 32(5)
[22] as per sections 279-282 of the *Insurance Act, supra*

injured party while the party's tort claim is making its way through the Courts. It is important to remember however that SABS interface with tort claims in significant ways, both in terms of disclosure/discovery obligations and credits and set-offs against tort awards. It is therefore important for plaintiff's counsel to have a good working knowledge of the SABS system.

Tort Claims

Due to the caps and restrictive definitions that apply to SABS claims, a party will not be wholly compensated for having sustained injury in an accident if their claim is only limited to the SABS. Accordingly, if liability for the motor vehicle accident rests solely or partially with another party, then your client can advance a claim in tort against the defendant driver and/or other defendants. Not only can a lawsuit be brought against an at-fault driver, there may also be claims against a municipality for failing to salt or sand or keeping the roads in a proper state of repair, or a tavern for over-serving an intoxicated driver.

In reference to the tort claims, the *Insurance Act* contains an expansive set of provisions relating to motor vehicle accidents and liability provisions. The *Insurance Act* addresses many matters of which a lawyer must be aware, including who a plaintiff can claim against, what notice must be provided, and what limitations will apply to the claims.

In a typical motor vehicle accident claim, the automobile insurance policy of the at-fault driver, or the automobile insurance policy of the owner of the vehicle that the at-fault driver was operating, will respond to the claim, with any judgment or settlement of the action being paid up to the limits of the policy. It is important to be aware however that there may be more unique situations where automobile insurance coverage is available beyond a typical motor vehicle collision and will respond to a plaintiff's claim. Section 239(1) of the *Insurance Act* provides that coverage is available in circumstances where the defendant's liability is "arising from the ownership or directly or indirectly from the use or operation of" an automobile. This provision has been the subject of much comment and analysis in the jurisprudence, such that if the plaintiff can establish that the automobile was involved in a manner that was more than "merely incidental or fortuitous", than coverage will be afforded.[23] Accordingly, automobile insurance may be available in more unique circumstances such as a plaintiff assisting the owner of the vehicle in loading equipment on to the vehicle and being injured in the process. A detailed discussion of these cases is beyond the scope of this paper, but a lawyer must be aware that

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[23] *Vytlingham v. Farmer*, 2007 Carswell Ont 6626 at para 29 (S.C.C.).

auto insurance coverage can extend beyond the classic scenario of a multi-vehicle collision on the roadway.

The *Insurance Act* provides minimum coverage of $200,000.00. As set out in section 252(1) of the *Insurance Act*, this amount is exclusive of interest and costs. It is important for a lawyer to inquire early in the litigation as to what policy coverages are in place in order to determine whether sufficient funds are available.

With respect to notice, section 258.3 of the *Insurance Act* provides that if a plaintiff intends to bring a claim for loss or damage from bodily injury or death arising from the use or operation of a vehicle, he/she is to provide written notice of the potential claim on the defendant within 120 days of the accident. There are additional steps that a plaintiff is required to take pursuant to this section of the *Insurance Act*, including applying for SABS and providing medical or other information to the defendant, as requested, pursuant to the Regulations. Importantly, failure to provide notice within 120 days of the accident is not fatal to a plaintiff later advancing a tort claim within the 2-year limitation period. Rather, as per section 258(8) of the *Insurance Act*, the penalty is that no prejudgment interest shall be awarded under section 128 of the *Courts of Justice Act* for any period of time before the plaintiff served notice. Additionally, non-compliance with notice shall be a factor that the Court will consider in awarding costs.[24]

Threshold

One very important aspect of the *Insurance Act* is what is known as the "threshold". The statutory threshold is contained in subsections 267.5(3) and (5) of the Act. It provides as follows:

> **Protection from liability; health care expenses**
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> (3) Despite any other Act and subject to subsections (6) and (6.1), the owner of an automobile, the occupants of an automobile and any person present at the incident are not liable in an action in Ontario for damages for expenses that have been incurred or will be incurred for health care resulting from bodily injury arising directly or indirectly from the use or operation of the automobile unless, as a result of the use or operation of the automobile, the injured person has died or has sustained,
>
> (a) permanent serious disfigurement; or

[24] as per section 258.3(9) of the *Insurance Act*, supra.

(b) permanent serious impairment of an important physical, mental or psychological function.

Non-pecuniary loss

Despite any other Act and subject to subsection (6) and (6.1), the owner of an automobile, the occupants of an automobile and any person present at the incident are not liable in an action in Ontario for damages for non-pecuniary loss, including damages for non-pecuniary loss under clause 61(2)(e) of the *Family Law Act*, from bodily injury or death arising directly or indirectly from the use or operation of the automobile, unless as a result of the use or operation of the automobile the injured person has died or has sustained,

(a) permanent serious disfigurement; or

(b) permanent serious impairment of an important physical, mental or psychological function.

As per this section of the legislation, a claimant cannot advance a claim for non-pecuniary general damages or health care expenses unless they meet this "threshold of impairment". In more modest injury cases, the question of whether the plaintiff "meets the threshold" has become a significant battle ground between litigants. In order to successfully prove that a plaintiff meets the threshold, counsel must be aware of Ontario Regulation 461/96 "*Court Proceedings for Automobile Accidents that Occur On or After November 1, 1996*", which provides the definition of a permanent serious impairment. In very general terms, it is defined as either an impairment that substantially interferes with a plaintiff's ability to continue with their usual and regular employment or substantially interferes with most of the plaintiff's usual activities of daily living. The Regulation also provides that evidence shall be adduced from a physician that explains the nature of the claimant's impairment, its permanence and the importance of the function impaired, among other things, in order to successfully demonstrate that the plaintiff meets the threshold.

When advising a plaintiff about the risks of litigation, it is important to outline the application of the threshold and how it may prevent a claimant who has more minor injuries from successfully advancing a lawsuit. Insurers are obviously eager to rely upon the threshold provisions of the *Insurance Act* to deny that any compensation is due to the claimant for non-pecuniary general damages and/or health care expenses. Careful consideration needs to be made of whether the plaintiff will meet the threshold before expensive and protracted litigation is undertaken.

It should be emphasized that even if a claimant does not meet the threshold, they can still sue for pecuniary losses, including income loss and loss of earning capacity. However, it is rare to see a situation where income losses have been incurred because of motor vehicle accident

injuries and impairments but those same impairments would not qualify as meeting the threshold.

Statutory Deductible

The other important aspect of the *Insurance Act* that applies with respect to non-pecuniary general damages is the statutory deductible contained at section 267.5(7)-(8). This section provides that in cases where the non-pecuniary general damages award is less than $100,000, a $30,000 deductible applies. Accordingly, if the plaintiff's pain and suffering award is assessed at $75,000, the net damages awarded are $45,000. Importantly, the deductible is a "vanishing deductible" in that any non-pecuniary general damages award that exceeds $100,000 is not subject to a deductible.

In cases where the plaintiff has very modest impairments, plaintiff's counsel needs to be cognizant of the impact of both the threshold and the deductible that will apply to their client's recovery and advise them accordingly. Even if plaintiff's counsel is able to marshal evidence to establish that their client meets the threshold, the pain and suffering awards for soft tissue injuries can often be assessed at amounts less than $100,000, resulting in a very significant deductible applying to the award.

FLA and Fatality Claims

Family members of a claimant may also advance claims in motor vehicle personal injury litigation pursuant to the *Family Law Act* which provides:

> 61.(1) If a person is injured or killed by the fault or neglect of another under circumstances where the person is entitled to recover damages, or would have been entitled if not killed, the spouse, as defined in Part III (Support Obligations), children, grandchildren, parents, grandparents, brothers and sisters of the person are entitled to recover their pecuniary loss resulting from the injury or death from the person from whom the person injured or killed is entitled to recover or would have been entitled if not killed, and to maintain an action for the purpose in a court of competent jurisdiction. R.S.O. 1990, c. F.3, s. 61(1); 1999, c. 6, s. 25(25); 2005, c. 5, s. 27(28).
>
> **Damages in case of injury**
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> The damages recoverable in a claim under subsection (1) may include,
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> (a) actual expenses reasonably incurred for the benefit of the person injured or killed;
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> (b) actual funeral expenses reasonably incurred;

(c) a reasonable allowance for travel expenses actually incurred in visiting the person during his or her treatment or recovery;

(d) where, as a result of the injury, the claimant provides nursing, housekeeping or other services for the person, a reasonable allowance for loss of income or the value of the services; and

(e) an amount to compensate for the loss of guidance, care and companionship that the claimant might reasonably have expected to receive from the person if the injury or death had not occurred. R.S.O. 1990, c. F.3, s. 61(2).

In addition to the deductible discussed above in relation to the plaintiff's non-pecuniary general damages award, there is a deductible that applies to the family members' claim for loss of care, guidance and companionship in the amount of $15,000.00. However, like the injured plaintiff's claim, if the damages award for loss of care, guidance and companionship exceeds $50,000.00, there is no deductible. It is also important to note that the deductible does not apply to fatalities.

Additional and Special Circumstances

It must be kept in mind that there are numerous exceptional situations that can arise in motor vehicle injury litigation. A lawyer must be alive to these special situations and understand how the *Insurance Act* and the case law apply in any individual case.

One such situation is when a pedestrian has been struck by a vehicle. It is important for counsel to understand that there is a reverse onus that is provided for in the *Highway Traffic Act*[25], which provides that the at-fault Defendant must disprove that he or she was negligent. Therefore, there is a presumption in the law that the driver was negligent.

Other exceptional situations can arise when minors are involved in a motor vehicle accident. An injured minor must be represented by a litigation guardian. Additionally, settlement of any claims that are made on behalf of minors must be approved by the Court.

There are also various considerations at play when an uninsured or unidentified driver is involved in a motor vehicle accident. These are situations where it is important for plaintiff's counsel to closely investigate the circumstances of the accident and review the relevant statutes and case law for guidance.

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[25] R.S.O. 1990, c.H.8, s.193.

Conclusion

This paper is designed to provide a general framework and discussion with respect to more general situations that are encountered in motor vehicle accident litigation and accident benefits claims. Obviously, there is a myriad of situations that can arise in this area of law and a lawyer must ensure that they are familiar with both the Statutory Accident Benefits Schedule and the *Insurance Act* so that their client's rights and remedies are fully realized.