DOES MY MEMBER HAVE A DISABILITY CLAIM?

A union representative's guide to determining if a member may have a long-term disability claim or other financial or social assistance claims

To assist you to assist others

This guide was prepared with union representatives in mind who might not be familiar with disability insurance, in response to their common questions regarding their members' eligibility for long-term disability benefits and other public and private income replacement or social assistance benefits and in determining whether legal representation might assist their members.

MK Disability Lawyers understands the unique issues union members face with respect to disputing the denial or termination of their LTD claims. Together, our senior partners have over 50 years combined experience representing union members, (including Teachers) from various unions across Ontario, in their LTD benefit disputes. MK Disability Lawyers has the experience, insight, dedication and compassion to effectively represent union members in their LTD appeals and court actions.

If you are a representative of a union (including any of the Teachers' Unions) in Ontario and you have a member who could benefit from our assistance with their LTD denial/termination, please feel free to reach out to us on behalf of your member or encourage your member to contact us directly.

MK Disability Lawyers are experienced disability lawyers dedicated *exclusively* to the practice of disability insurance litigation. We would be happy to provide you and/or your member with a free consultation.

This booklet is meant to be a guide only and not to replace independent legal advice or the services provided by an experienced disability insurance lawyer.

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Introduction

Disabled members often have difficulty expressing what their legal issues are and how they need your assistance. They are aware that they have serious medical problems, as well as financial problems, as a result of their inability to work, but they may not know what questions to ask you or what information is relevant to getting the legal assistance they require. To complicate matters, often their cognitive functioning may be impaired by stress, pain or mental illness and they may find it difficult to remember important facts, to focus or concentrate in your meeting and to follow through with your recommendations.

While identifying these members' legal issues can be extremely challenging, given their financial and medical vulnerability, union representatives who come in contact with these members have a unique opportunity to make an immediate and long-term difference in their lives. Therefore, it is critical we understand the potential issues that these members typically encounter; the facts relevant to these issues; and the financial resources and legal claims that may be available to assist these members.

Obtaining the Relevant Facts

Members may come to you first, knowing only that they are not well and not able to work. They may have some documentation or they may have none. They may believe that they have an issue with their employer or their doctor, when in fact, the issue is with social services or an insurance company. Therefore, the objective is to gather as many details as possible to clarify the issues identified by the member, identify other potential issues and determine the best course of action for the member.

Below is a list of questions that may be helpful in extracting the relevant facts necessary to identify the real issues with which the member requires your assistance.

- **Was the member working? If so, at what job, for what employer and for how long? Was he/she unionized? Is he/she still employed?**
- **When was the last day worked?**
- **What were all of the reasons the members stopped working? (For example: employment terminated, resignation, workplace harassment, an injury, accident or illness, etc.)**
- **Has the member received any income from any sources since going off work? What are the details of that income?**
- **If the member stopped working due to a workplace issue or termination or resignation, what happened and did his/her disability play a role?**
- **If the member stopped working due to a medical condition, what caused the condition? (For example, injury, accident, motor vehicle accident, illness, etc.)**
- **Ask the member to list all the reasons, symptoms or conditions that prevent him/her from working. It may be helpful to ask that he/she make a list going from head to toe, listing the physical conditions and then list any mental or cognitive conditions.**
- **When did these conditions/symptoms start and how do they prevent him/her from working? Has he/she attempted to return to work at his/her job or at some other job?**
- **What sort of treatment is he/she receiving and how is he/she paying for that treatment?**
- **What do the doctors say about his/her prognosis for recovery or for returning to work?**
- **Financially, how is he/she managing? What financial resources does the member have available to him/her? Has he/she declared bankruptcy?**
- **If any claims have been made for benefits, when were they denied? Did the member appeal the denials? What is the current status of the claims?**

Identifying the Potential Issues

Based on the information disclosed by the member regarding his/her employment, medical condition and financial circumstances, a number of potential legal issues/claims may be identified or eliminated. By narrowing the issues, you will be better able to advise and direct the members.

The following is a list of the most common types of issues/claims that disabled members have:

- **Long-Term or Short-Term Disability Claim**
- **Creditor Disability Claim**
- **Wrongful Dismissal**
- **Human Rights Complaint**
- **Workplace Safety Insurance Board (WSIB) Claim**
- **Employment Insurance (EI) Sickness**
- **Canadian Pension Plan (CPP) Disability**
- **Ontario Disability Support Plan (ODSP)**
- **Personal Injury Claim**
- **Accident Benefits Claim**
- **Tort Claim**
- **Extended Health Care**
- **Critical Illness Claim**

If the client has applied and been denied for any of these benefits, it is important to review all documentation explaining the basis for the denial and the client's right to appeal. This information would normally be found in the denial letter. The denial letter may also set out the limitation period for appealing the decision and for commencing an action. It may be that the client has limited time to appeal the denial, based on legislation or the insurance policy/program or based on the wording of the denial letter. It is also important that the client is made aware of the limitation periods (contractual or statutory) for commencing an action or filing a grievance.

A number of these claims can quickly be eliminated based on the facts provided by the member. For example, if the member's medical condition did not arise out of a workplace injury/illness, there would be no claim for WSIB. If the employer did not terminate the member's employment and he/she does not have any concerns regarding how the employer treated him/her, you can eliminate Wrongful Dismissal or Human Rights claims. If the person's disability or injury did not result from a motor vehicle accident, a tort, or a critical illness, claims for accident benefits, critical illness insurance benefits, and personal injury would obviously not be at issue.

If however, a member was working and was forced to stop working due to an illness or injury, he/she may have disability insurance coverage through a number of sources, including: group disability insurance through their employer, individual disability insurance, creditor disability insurance tied to their mortgage or credit cards, EI Sickness, ODSP and/or CPP Disability. It is important that the member is made aware of these potential sources of income and apply for these benefits as soon as possible, in order to maximize their entitlement and minimize their financial stress.

What are Long-Term Disability Benefits?

While long-term disability benefit litigation can be complex, it is important to understand the basic principles in order to be confident that you have properly identified the member's legal issues and are able to assist him/her yourself or refer the member to lawyers who specialize in this area of law.

The two most common types of disability insurance coverage are individual and group. **Individual insurance** is purchased by the individual and he/she pays premiums for a specified level of coverage. The individual will usually need to answer a medical questionnaire and undergo a paramedical examination, in order for the insurer to underwrite the policy and agree to provide the coverage. Usually, professionals, such as lawyers, dentists, doctors, and veterinarians, as well as self-employed people, will self-insure against loss of income due to disability using this type of policy. In addition to denials based on the member not satisfying the definition of disability in the policy, individual disability insurance claims may also be denied based on a pre-existing condition exclusion or on the basis of a material misrepresentation on the initial application for coverage.

The more common form of disability coverage is group. **Group disability insurance** is typically offered to employees by an employer or by a professional/trade organization. Members of the group qualify for the coverage by virtue of being a member of the group (without any medical disclosure) and premiums may be paid by the employee, the employer or by a combination of both. Most employers offer group disability insurance coverage to their permanent employees. Claims under these policies are typically denied based on the insurer's opinion that the person is not disabled according to the definition of disability in the policy or that they have not satisfied other policy requirements.

With respect to group disability policies, the employee may be entitled to short-term and long-term disability benefits. Usually, these benefits are insured by the insurance company, meaning that the insurance company assesses and pays claims. However, sometimes and more often with respect to short-term disability benefits, the benefit is assessed by an insurance company but paid out by the employer. This arrangement is referred to as an **Administrative Services Only (ASO)** arrangement and may require the employee to sue the employer for payment of benefits, in addition to the insurance company who assessed and denied their claim. If the member is unionized, the Collective Agreement will give some clue as to whether the benefit is paid by the employer or an insurance company and whether the employee must pursue a dispute over benefits by way of grievance or if they have the option to commence a court action.

Generally, the definition of disability in a short-term benefit plan requires a claimant to provide medical evidence to demonstrate that he/she is **not able to perform the duties of his/her own job**. After the short-term period, which is usually 180 days, the person may apply for long-term disability benefits. Usually, the definition of disability in a long-term disability policy requires a person to be **disabled from performing the essential duties of his/her own occupation for the first 24 months and thereafter, to be disabled from performing the essential duties of any gainful occupation for which he/she the requisite education, training and work experience**. Benefits are typically payable to age 65 and are generally 66.6% of the person's pre-disability income. While these are common terms in group policies, it is important to review the member's policy or, at least, their benefit booklet (a document which is given to the employee and that summarizes the Policy) to determine the exact wording that applies. If the member is a member of a union, the Collective Agreement may be the governing document, which sets out the terms of the disability benefit.

If the member has not yet made a claim for disability benefits, it is important he/she do so, as soon as reasonably possible, as most policies provide for a limitation period, within which to submit a claim and most Collective Agreements set out deadlines for filing a grievance, if that is the mandatory process for disputing disability claims. Claims forms (which typically consist of the **Claimant's Statement, Attending Physician's Statement and Employer's Statement**) may be obtained from either the insurer or from the employer and are usually submitted directly to the insurer. Even if the claim is submitted late, the insurance company has the discretion to assess the claim, if it would not be prejudiced by the lateness of the claim. Therefore, the member should still submit a late claim for consideration and in the event that litigation is required, counsel can make arguments as to the reason the claim was late and that there was no prejudice to the insurer.

What types of disputes arise in Long-Term Disability cases?

During the course of a disability insurance claim and in litigation, disputes may arise concerning various terms and conditions in the disability policy, as well as with respect to the member's entitlement to extra-contractual damages, such as punitive and aggravated damages. The issues that most often arise in disability insurance cases, include:

- **Interpretation of the definition of disability**
- **Calculation of the benefit amount**
- **Applicability and calculation of offset provisions**
- **The member's own job or own occupation**
- **The essential duties of the job/occupation**
- **Severity of symptoms (particularly, subjective symptoms such as pain)**
- **Compliance with treatment**
- **Compliance with rehabilitation**
- **Appropriate treatment**
- **Negligent adjudication of the claim**
- **Aggravated damages such as mental and financial distress claims**
- **Credibility based on presentation at discovery, medical records and/or surveillance**
- **Transferable skills to perform any occupation**
- **Efforts to mitigate (attempts to return to work, retrain, exhaust treatment options, etc.)**
- **Coverage issues regarding pre-existing conditions, waiting period or premiums**
- **Waiver of premiums for life insurance**
- **Workplace issues**
- **Limitation period for submitting a claim or for commencing a court action**

Some of these issues may be identified from the denial letter or from other information provided to you by the member. However, in order to appreciate all of the potential issues in a claim, it is necessary to request and thoroughly review the insurance claims file. The claims file provides valuable insight into the basis for the denial as well as any errors or omissions or bad faith in the adjudication of the claim.

How are disability benefit disputes resolved?

Disability benefit claims are identified and disputes over benefits are resolved based on contractual interpretation, medical documentation, credibility of the member, the quality of the claims adjudication, statute, and case law. In terms of resolution, a benefit denial may be overturned on appeal (in-statement or reinstatement) or if the dispute is litigated, the case will likely resolve by way of negotiation. Very few disability insurance cases go to trial.

If a member has been denied benefits, he/she may either **appeal** the decision or commence **litigation** (or arbitration, if required by a collective agreement). Normally, there is no requirement for a member to exhaust all avenues of appeal before commencing a court action. In fact, it may be necessary to commence litigation, rather than continue to appeal, if the limitation period is fast approaching or if the member has been worn down (financially and emotionally) by the insurer and it is unlikely the insurer will change its decision.

If the member chooses to **appeal** to the insurance company, it is important that he/she provide the insurer with new medical information to support his/her claim. This would include clinical notes and records, reports from treating doctors and specialists, test results, and any new and relevant medical documentation. If the information provided is persuasive, the insurer will approve the claim, pay arrears and then pay benefits going forward, on a monthly basis. The member will need to continue to provide medical updates, as requested by the insurer and the insurer may terminate his/her benefits, at any point, if it determines the member is no longer disabled. The insurer may also work aggressively with the member to rehabilitate him/her and implement a gradual return to work plan.

If the member decides to **litigate** the denial of his/her disability claim (either by grievance or court action), he or she will need experienced legal representation. Disability benefit cases are very different from motor vehicle or personal injury cases and often lawyers practicing in those areas may not understand the contractual and common law nuances of disability insurance law. Members should be encouraged to meet with two or three law firms/lawyers to ensure a good “fit”, not only with respect to knowledge and experience but also, with respect to service. Disabled members require counsel who appreciate that the member is suffering emotionally, physically and financially and are able to tailor services to accommodate the member’s physical, cognitive and emotional limitations and restrictions.

One of the most common misconceptions and perceived deterrents members have with respect to commencing a lawsuit is the belief that they cannot afford a lawyer. Most lawyers practicing in this area will provide members with a complimentary consultation and a **contingency fee based retainer agreement**, that will allow the member access to legal representation without having to pay legal fees until his/her case is resolved. This arrangement allows the members to speak to their lawyer without concern for the cost associated with the lawyer’s time and also,

encourages the lawyer to obtain the best possible settlement for the member, within a reasonable timeframe.

A second misconception is that litigation will be too stressful and therefore, the member would rather "walk away" from the dispute than fight it. While this is a normal **"flight or fight"** response, particularly with members who are under a significant amount of stress, it is important to emphasize that their financial and emotional distress will only worsen if they do not take steps to recover the benefits to which they are entitled. Assuming they are able to retain experienced counsel, their stress and financial situation will improve as a result of litigation. The lawyer will take over the dispute with the insurance company, easing the member's stress and allowing him/her to focus his/her energies and efforts on treatment and recovery and financially, a settlement will assist the member with his/her debt, treatment costs, and living expenses.

Generally, the **member's involvement** in a disability lawsuit is limited to communicating and updating the lawyer; attending his/her examination for discovery; attending mediation; and, possibly, attending an independent medical assessment and/or a defence medical. With respect to discovery and mediation, the lawyer should spend as much time as needed preparing the member for these attendances, in an effort to lessen the member's stress and anxiety. Lastly, the member will be required to make a decision with respect to how to resolve his/her case (how much to settle for, terms of the release, whether to go to trial, etc.). However, with experienced and patient counsel, the member will typically be well-prepared and well-informed in order to feel confident in making decisions concerning the resolution of his/her case.

What information is helpful to a member with a potential disability claim?

Whether or not you will be representing a disabled member in his/her disability appeal or court action or referring him/her to another lawyer, there is some important information that should be provided to the member, as early as possible, ideally at the initial consultation. This information can help ensure that the member does not prejudice his/her claims, inadvertently. The following is a list of **seven important recommendations** that may be helpful to your member.

1. **Continue with treatment.** The member should make every effort to attend all medical appointments, fill prescriptions, follow up and attend specialist appointments, and pursue any and all treatment recommendations. It is important that he/she be candid with all healthcare providers about symptoms, functioning, activities, and effectiveness of treatment. Often members, for a variety of reasons, may not wish to admit the severity of their condition and decline medication or other treatments. This could have an adverse impact on their disability claim/lawsuit. members might also not want to admit to the emotional toll their disability or related financial issues has taken on their mental health and may be suffering from untreated depression, anxiety, and panic. Left untreated, these conditions may exacerbate their existing disability or become a new disabling condition. members should be encouraged to speak to their family physician or any treating doctor about their mental health.

2. **Keep the employer updated, but only to the extent required.** If the member is still employed, but his/her claim for disability benefits has been denied, the employee's status will change to "unapproved leave of absence". The employer may want to know from the member whether or not he/she will be returning to work and when. The employer may also want to know whether it can accommodate the employee's medical restrictions and limitations. The employer may ask for the employee to complete a functional abilities form or to provide a doctor's note, periodically. The member should understand that the employer is not entitled to details of his/her medical condition, but that the employer is entitled to know whether the employee continues to be medically unable to work, whether he/she can be accommodated and whether he/she will be returning to work in the foreseeable future.

   Ignoring these requests may result in the employer terminating the member, claiming the member has abandoned his/her job. In such instance, no termination pay would be owing and extended health care benefits would also terminate. If the employer is not able to accommodate the member or if he/she is not able to work into the foreseeable future, the employer may choose to terminate the member's employment based on frustration and pay what is required by law. Alternatively, the employer may continue to keep the employee on "unapproved leave" indefinitely, such that the employee may still be entitled extended health benefits and a

job to return to once he/she is able to work. The member should be advised, not only to keep the employer updated as required but also to seek legal advice immediately if the employer terminates his/her employment.

3. **The member should not return to work without medical clearance.** Often a denial of a disability claim will prompt members to return to work before they are medically able. members may feel as though they have no other choice but to return to work. They may be willing to risk aggravating their medical condition, in exchange for the financial security of employment. However, if an employee is not medically ready to return to work, there is a real and substantial risk that his/her condition will be aggravated and any progress that the member made in his/her recovery will be lost. Returning to work before the member is ready may also strain his/her relationship with the employer if the employer's expectations exceed the member's capabilities. members should be advised that there are other disability benefits that may provide them with financial assistance while they are in litigation and before their case settles.

4. **Be aware of the limitation period.** members should be aware of any contractual and/or statutory limitation period with respect to commencing an action for long-term disability benefits. Generally, the statutory two-year limitation period applies. However, the date from which the limitation period begins to run may be difficult to ascertain, particularly if the member appealed the denial or if he/she never submitted the initial claim. There may also be a contractual limitation period in the policy or the denial letter. Irrespective, the member should be advised that a lawsuit should be commenced as soon as reasonably possible. If the limitation period appears to have passed, the member should still be advised to pursue the matter. There are several persuasive arguments that lawyers can make to counter a limitation period defence, depending on the facts and evidence of each case.

5. **The possibility of surveillance.** members are often concerned about surveillance. Providing the member will some information about surveillance may ease some of this anxiety. It may be helpful for them to know that investigators are limited to observing persons from public property or online searches. They may not look over a fence into a person's yard or look in a window or communicate with the subject. They may only take photos and video of the subject if the subject can be viewed from a public location. They may follow the subject on the bus or by car and into stores or in parking lots or coffee shops, etc. However, if the member has been denied, no appeal has been submitted and an action has not commenced, the insurer has no reason to conduct surveillance.

   The member should be encouraged to engage in their regular activities and advise their doctors and the insurance company (if asked) of these activities. So long as they present in public (and online) as they do to their doctors and to the insurance company, surveillance will not be a problem. The member should be encouraged to live his/her life and allow the lawyer to address any arguments the insurance company makes based on surveillance.

6. **Apply for all other potential sources of income.** members may feel discouraged after going through the claims process and being denied. They may not be aware of the various other benefits available to them or their condition may restrict their ability or motivation to apply for other benefits. However, it is important that members understand that just because their disability claim has been denied, claims for other sources of income will not necessarily be denied. The definitions of disability and the requirements for other types of benefits vary greatly, as do approval rates. members should be advised to apply for EI Sickness, ODSP/Ontario Works, and CPP Disability. They should also apply for any disability insurance on their mortgage or credit cards. If they do not have extended health coverage, they should be made aware of the Trillium Prescription Drug Program. Litigation loans are also a possibility, however only as a last resort, as interest rates on these types of loans are extremely high.

7. **Be encouraging.** Disabled members are struggling financially and medically. They are often discouraged and feel hopeless. Therefore, the information and encouragement the lawyer provides at an initial consultation can make a world of difference with respect to the member's outlook. If the member feels he/she has options and feels supported and empowered, he/she will find the strength to pursue their entitlement to disability benefits, which is the first step in improving the member's financial circumstances and all other issues that stem from them.

Other Income or Social Assistance Benefits

In addition to long-term disability benefits, disabled members may be entitled to income from other sources, including the social assistance programs described below. members should be encouraged to apply for all of the benefits to which they believe they could possibly be entitled, and to do so as soon as reasonably possible to ensure that they do not miss deadlines for submitting claims and so that they are able to maximize their potential entitlement. However, it is important for them to understand that some benefits will offset others and there may be obligations (assignments) to repay some/all of certain benefits if others are later approved.

Employment Insurance (EI) Sickness Benefits provide eligible workers with up to a maximum of 15 weeks of benefits if they cannot work because of sickness, injury or quarantine, but would otherwise be available to work. To receive these benefits, members must submit their Record of Employment (ROE) and a medical certificate from the member's doctor. The member will be eligible if their employer deducted premiums for EI; his/her normal weekly earnings have been reduced by more than 40%, and he/she has accumulated at least 600 hours of insurable employment in the 52 weeks prior to their last day worked. members can apply online at Service Canada or at a Service Canada office. EI may require repayment if the member is later approved for long-term disability benefits.

Ontario Disability Support Plan (ODSP) offers financial assistance to help members and their families with essential living expenses; benefits, for the member and his/her family, including prescription drugs and vision care; and help finding and keeping a job, and advancing his/her career. ODSP offers two types of support. The first is income support which is financial assistance provided each month to help with the costs of basic needs, like food, clothing, and shelter. Income support also includes benefits, like drug coverage and vision care, for members and their eligible family members. The second is employment supports which are services and supports to help members with disabilities find and keep a job, and advance their careers. ODSP may require repayment if the member is later approved for long-term disability benefits. If a member requires immediate financial assistance, they should contact their local Ontario Works office (and also still apply for ODSP).

Ontario Works offers two types of assistance. The first is financial assistance, including income support to help with the costs of basic needs, like food, clothing and shelter and health benefits for members and their families. The second is employment assistance to help members find, prepare for and keep a job. This assistance may include: workshops on resume writing and interviewing, job counselling, job-specific training, access to basic education, so members can finish high school or improve their language skills. In most cases, a member must agree to participate in employment assistance activities in order to receive financial assistance. **Emergency assistance** is also available to people who are in a crisis or an emergency situation (e.g. people who have lost their homes, are leaving an abusive relationship and/or are worried about their safety). To be eligible for Ontario Works a member must be in financial need (their household does not have sufficient financial resources to meet basic living expenses) and be willing to make reasonable efforts to find, prepare for and keep a job, unless they have

specific circumstances that temporarily prevent them from doing so, such as an illness or caregiving responsibilities.

Canada Pension Plan Disability (CPP-D) is a federal government-sponsored plan. Eligibility is determined by contributions from employment in Canada. members must demonstrate that their disability is “severe and prolonged”. While some members may assume that they will not qualify because they have been denied other benefits, it is important that they still apply, as they may be approved and any payment for arrears will be based on the date of the initial application. The benefit amount is based on contributions and prior income and increases annually based on the cost of living index. A dependent benefit is also available. Once approved, the claims assessment is less onerous than that of private insurers and members may work, earning an income annually (the maximum is adjusted every year by Service Canada), without termination or reduction of their benefit. CPP-D reduces any entitlement to long-term disability benefits. (For more information about CPP-D, please find a link to our “CPP Disability Benefit Guide” on our website: www.mkdisabilitylawyers.com.)

Workplace Safety and Insurance Board (WSIB) Benefits may provide financial assistance if the member is injured or became ill because of his/her job. WSIB provides income replacement benefits, as well as other support, such as return to work assistance. To be eligible for WSIB insurance benefits, the member must have a worker-employer relationship with an employer covered by the WSIB; have an injury or illness directly related to your work; promptly file a claim with the WSIB; provide all relevant information requested by the WSIB to help them determine entitlement to benefits; and consent to the release of functional abilities information to their employer by the health care professional treating them. WSIB claims regarding mental illness due to workplace harassment or claims regarding repetitive strain injuries are very difficult to prove. members may wish to find a lawyer/paralegal to assist them with their WSIB if they are faced with a complicated and difficult to prove claim. WSIB income benefits often offset long-term disability benefits, entirely. However, even if the member is receiving WSIB, he/she should still pursue long-term disability for a declaration of disability, in the event that WSIB terminates at some time in the future.

Related Claims

In addition to social assistance and long-term disability benefits, members may have other claims related to their disability. It is important when speaking with the member to keep these other potential claims in mind to ensure that the member does not miss a limitation period and to ensure the member pursues all possible sources of income. members should be advised that they will likely require legal representation to pursue these other claims but to reassure them that many lawyers will agree to payment of legal fees out of a settlement, allowing members access to representation despite their limited financial resources. It is also important to note that some of these settlements can be used to reduce other settlements and that evidence from one claim may be used to argue/defend another. Whenever there is potential for multiple claims arising from some of the same facts, the member should seek the guidance of experienced legal counsel.

a) Claims Against the Employer

Disabled members may have been treated poorly by their employer and/or have been terminated from their employment. Therefore, they could have a wrongful or constructive dismissal claim or a human rights complaint. Sometimes the facts/evidence supporting these claims overlap with those in a long-term disability claim. For example, the member may have been harassed at work, resulting in anxiety, panic, and depression, which conditions form the basis of the member's long-term disability claim. Similarly, if there was some form of discrimination, that too may have contributed to the member's mental health condition. The risk, however, is that if there is a wrongful/constructive dismissal or human rights complaint, arguments supporting those claims may contradict arguments in the long-term disability action. For example, if the member argues that the employer failed to accommodate the employee, this argument is evidence that the employee was not "totally disabled" as he/she must prove to be in the long-term disability action. Other issues also arise with respect to offsetting settlements and release wording that precludes an action against the long-term disability insurer. Therefore, the member will need to ensure he/she retains counsel to handle all of his/her disability-related claims or that she retains lawyers who are able to coordinate strategies, to maximize his/her entitlements.

b) Motor Vehicle Tort Claims

Often a member becomes disabled as a result of a motor vehicle accident. If another party was at fault for the accident, the member is able to commence an action against the at-fault party (within the 2 year limitation period). Claims against the at-fault party are in addition to Accident Benefits and other benefits, such as long-term disability. The member could be entitled to damages for pain and suffering, loss of income and the inability to earn income, housekeeping and home maintenance, and health care expenses.

With respect to a claim for pain and suffering, the member must suffer a permanent serious impairment of an important and physical, mental or psychological function or permanent serious

disfigurement ("threshold test") and the entitlement is subject to a monetary deductible. In terms of loss of income/inability to earn income, the member is entitled to claim 70% of gross income loss up to trial and future loss claimed based on 100% of gross income. However, he/she must first seek compensation from any disability insurance and accident benefits insurer. Any additional amounts can be claimed from the tort action. To qualify for housekeeping and home maintenance, the member must be unable to maintain his/her home as he/she did before the accident and claim reimbursement for expenses incurred or will incur in the future. However, he/she must first claim this expense from the accident benefits insurer. Lastly, health care expenses may be payable for all past, present, and future healthcare expenses not covered by OHIP, extended health coverage, or Accident Benefits.

c) Accident Benefit Claims

There are two types of possible claims flowing from a motor vehicle accident: No-Fault Accident Benefits (SABS) claims and tort claims (which is a lawsuit against an at-fault party). Accident Benefits claims are made to the member's car insurer, payable regardless of fault and include Medical and Rehabilitation benefits, Attendant Care benefits, Income Replacement benefits, Non-earner benefits, Housekeeping and Home maintenance, and Caregiver benefits. members should be aware that if they were a passenger or a pedestrian, they may be able to apply through a family member's insurance policy if they live at the same address, or through the driver's insurance company.

Medical and rehabilitation benefits are for "reasonable and necessary" medical and rehabilitation expenses not covered by OHIP or an extended health care plan. In addition to various therapies, this benefit can cover medications, assistive devices, transportation to and from treatment, etc. With respect to the attendant care benefit, it is for the reasonable and necessary expenses for a caregiver or attendant for personal care and can be paid up to $65,000 for non-catastrophic injuries and up to $1 million for catastrophic injuries. For minor injuries, the benefit is fixed at $3,500. Income Replacement benefits (IRB) are for people who were employed or self-employed prior to the motor vehicle accident. This benefit is 70% of gross income, minus income from other sources (such as long-term disability). The maximum amount for IRB is $400/week and the definition of disability is similar to that contained in most long-term disability policies. In terms of the non-earner benefit, a member may qualify if he/she is not eligible for IRB or caregiver benefits or if he/she was a full-time student. To be eligible, the member must suffer from a complete inability to carry on their normal activities and if they meet the test, the benefit is $185 per week (in some circumstances $320/week) and payable after 26 weeks. The caregiver benefit for catastrophic injuries is payable if the member is substantially unable to engage in the caregiving activities he/she was previously engaged in. Finally, the housekeeping benefit for catastrophic injuries pays up to $100 per week. members should be advised to keep

good records regarding payment for any expenses related to any of the above claims.

d) Personal Injury Claims

If the member's disability arose from a personal injury (unrelated to a motor vehicle accident or a workplace injury, wherein the employer was WSIB insured), then he/she may commence a lawsuit for damages. For example, if the member was injured as a result of a trip and fall at a coffee shop or a slip and fall at a grocery store or as a result of a dog bite, he or she may commence litigation against the at-fault party. These are generally subrogated actions, in the sense that the insurance company for the store or the homeowner's policy of the dog-owner, will defend the action and pay the settlement up to the policy limits, beyond which the at-fault company/person will be responsible for damages. members should be advised to maintain good records of any expenses incurred as a result of the incident and also any evidence that can be used to prove their claim.

e) Appeal to Social Security Tribunal for CPP Disability Benefits

If the member's CPP Disability Benefit appeal has been denied, he/she may take the matter before the Social Security Tribunal for a final determination. There are strict documentary requirements and time limitations governing Tribunal hearings. While members are often able to complete the initial application and first appeal on their own, it is recommended they seek legal assistance once they are at the Tribunal stage. If they are successful, the Tribunal will award arrears and benefits will be paid to the member, going forward.

Conclusion

Representing disabled members, while challenging, is extremely rewarding. By providing information, guidance, and encouragement, union representatives are able to make immediate and long-lasting differences in the lives of these members.

Members who feel supported and confident in the information they receive from their union representatives are more likely to feel empowered and motivated to pursue the benefits to which they are entitled. With proper representation, these members are able to focus on improving their health, while their counsel fight to obtain benefits and other compensation to which they are entitled. As a result, not only do the members' financial circumstances improve but so too does their stress; allowing them to move on with their lives and focus on their health and returning to work, one day.

Glossary

Aggravated Damages - damages resulting from emotional and financial distress caused by how the insurance company assessed the claim and by the denial/termination of the claim; includes a deterioration or aggravation of medical condition due insurer's conduct.

Any Occupation - definition of disability usually after 24 months; a person must show they are not medically able to do any type of work that they are qualified to do, earning a commensurate income (which is about what their disability benefit amount would be).

Appeal - offered by the insurer when the claim is denied or terminated; ask for a list of new information to support the claim; often appeal is reviewed by the same case manager who made initial decision and difficult to overturn decision on appeal; appeals do not necessarily extend the limitation period for commencing an action.

Appropriate Treatment - whatever the insurance company deems appropriate; sometimes require that the member have treatment from a medical doctor; internal medical consultants may find that treatment is not appropriate (i.e. not proper medication or dosage or physiotherapy would help); may deny claim on this basis.

APS (Attending Physician's Statement) - one of three forms used by the insurer in the initial assessment of a disability claim; members can get this form from employer or online or insurer and should have a doctor who has most information about disabling conditions to complete it.

ASO (Administrative Services Only) - when an insurance company is contracted by the employer to assess claims; the insurer does not pay the benefits; the employer collects premiums and pays benefits based on the insurer's opinion on disability; in these cases the insurer is sued for negligent adjudication and the employer is sued for payment of benefits.

Booklet - not the actual contract/policy; usually prepared by the employer based on a summary or interpretation of the policy; member's will usually have a copy of this; wording may differ between booklet and policy and policy is the governing document and must be used in litigation.

CPP-D (Canada Pension Plan Disability) - federally sponsored plan for eligible employees who have a severe and prolonged disability; paid on a monthly basis, going back 12 months from initial application; increases on an annual basis; may be offset from LTD benefits.

Claimant's Statement - one of three forms used by the insurer in the initial assessment of a disability claim; members can obtain this form from the employer or the insurer or online; the member should include as much detail as possible about all disabling conditions.

COLA (Cost of Living Adjustment) - some disability policies have this provision that serves to increase the benefit on an annual basis; increase is usually tied to the consumer price index; with individual disability policies, this provision may be purchased for additional premiums.

Creditor LTD - benefits that are tied to lines of credit, credit cards and mortgages; if a member qualifies, the insurer will pay off the balance or make monthly payments or make interest payments, depending on the policy.

Denial - when the insurance company will not pay benefits for some specified reason; should be done in writing; the date of denial is important to calculating the limitation period for commencing an action; denials can be appealed.

Employer's Statement - one of three forms used by the insurer in the initial assessment of a disability claim; member can obtain this form from the employer or the insurer or online; the member might not see this form completed, as the employer will send it directly to insure; details job description and benefit amount and any workplace issues and work history.

Employee's Statement - same as Claimant's Statement; one of three forms used by the insurer in the initial assessment of a disability claim; member can obtain this form from the employer or the insurer or online; the member should include as much detail as possible about all disabling conditions.

EI (Employment Insurance) Sickness - 15 weeks of disability benefits; can apply for this when a member is not receiving disability benefits; will need to be paid back if disability benefits are later approved.

Gainful Employment - work that allows a member to earn enough money to meet basic living expenses; calculation of gainful income is usually around 60% to 70% of the person's pre-disability gross earnings; if person is medically able to work at any job earning this amount, then not disabled.

Group LTD Benefits - benefits provided by an employer or organization; usually insured by an insurance company or paid by an employer; premiums may be paid by employee or employer or combination; policy usually pays about 66.6% of gross pre-disability earnings, if member is disabled

Individual LTD Benefits - member purchases his/her own insurance policy and pays the premiums; usually the benefit is a higher amount and may take the person's business income into account; often these policies will provide for residual and partial disability coverage in addition to total disability.

Mitigation - member's efforts to improve his/her medical condition and financial condition; such as seeking and participating in all appropriate treatment and applying for all possible sources of income.

Offset - a benefit or income from some other source that reduces the LTD benefit; sometimes insurers will deem offsets, meaning that they will reduce the benefit even if the member has not been approved for or received the other income source.

ODSP (Ontario Disability Support Plan) - offers financial assistance to help members and their families with essential living expenses; benefits, for the member and his/her family, including prescription drugs and vision care; and help finding and keeping a job, and advancing his/her career.

OW (Ontario Works) - income support to help with the costs of basic needs, like food, clothing and shelter and health benefits for members and their families; also available to people who are in a crisis or an emergency situation.

Own Occupation - definition of disability for the first 24 months of disability; member must not be able to do the material/essential duties of his or her own occupation; different from "own job" in that person might be able to do his own occupation for a different employer or do own occupation with lesser job duties.

Plan Sponsor Statement - same as employer's statement; one of three forms used by the insurer in the initial assessment of a disability claim; member can obtain this form from the employer or the insurer or online; the member might not see this form completed, as the employer will send it directly to insure; details job description and benefit amount and any workplace issues and work history.

Policy - the governing document or contract; in group policies, the employer and insurer are the parties to the contract and not the member; the policy wording is what the insurer should be using to assess claims and may differ from what the wording is in the Booklet.

Pre-Existing Medical Condition - term in policy if member becomes disabled within 12 months of being insured, disability can not be related to any condition the person had/investigated for in the three or more months before coverage took effect; wording may differ between policies and careful reading necessary.

Punitive Damages - awarded to the plaintiff in order to punish the insurer for bad faith conduct.

Termination - denial of benefits after they have been paid for a period of time.

Waiver of Premium - if approved for LTD, premiums for life insurance are waived.

WSIB (Workplace Safety and Insurance Board) - financial assistance if the member is injured or became ill because of his/her job. WSIB provides income replacement benefits, as well as other support, such as return to work assistance.

Resources

MK Disability Lawyers
Law firm specializing in Long-Term Disability Litigation and authors of this Guide.
Website: www.mkdisabilitylawyers.com
Email: info@mkdisabilitylawyers.com

CPP Disability
Federally funded disability benefit for eligible workers with severe and prolonged disability.
Website: https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit.html
Phone: 1-800-277-9914

Service Canada - Application for CPPD Benefits
Federal service provider for applications for social assistance and disability benefits.
Website: http://www.servicecanada.gc.ca/fi-if/index.jsp?app=prfl&frm=isp1151

Service Canada - Find a Service Canada Office
Federal service provider for applications for social assistance and disability benefits.
Website: http://www.servicecanada.gc.ca/tbsc-fsco/sc-hme.jsp?lang=eng

Canada Benefits - Benefits Finder - to obtain a customized list of federal and provincial benefits for which you may be eligible
Resource for determining which benefits to apply for based on potential eligibility.
Website: http://www.canadabenefits.gc.ca/f.1.2c.6.3z.1rdq.5.2st.3.4ns@.jsp?lang=en

Canada Revenue Agency (Tax Credits and Deductions for Persons with Disabilities)
Information on tax deductions and savings plans for people not working due to disability.
Website: http://www.cra-arc.gc.ca/tx/ndvdls/sgmnts/dsblts/menu-eng.html

Legal Aid
List of neighbourhood legal aid clinics and specialty clinics providing legal support.
Website: http://www.justice.gc.ca/eng/fund-fina/gov-gouv/aid-aide.html

Contact Us

MK Disability Lawyers is a boutique and experienced disability insurance law firm, specializing in long-term disability insurance litigation. Between the three partners, we have over 50 years experience litigating disability insurance claims. We also have extensive experience litigating individual LTD, life insurance and critical illness claims and we have represented our disabled members at CPP Disability Tribunal hearings and in actions against their employers and in their motor vehicle and personal injury cases. We appreciate that your members have serious physical and cognitive limitations and restrictions and strive to accommodate them throughout the litigation and in the service we provide.

As part of our commitment to assisting and empowering disabled individuals, we offer a **free, confidential consultation** by telephone, in-person or by video conferencing. Although our practice is located in the **Toronto and Markham areas, we represent members throughout the province**. Please feel free to pass on our contact information to your member or to contact us directly by email or telephone if you have a member that requires our assistance or if you have any questions about this area of law. We also appreciate that some members may be anxious to call a lawyer, and as such, we are happy to reach out to initiate contact, if requested by you or your member. We are here to help.

Please see our website for more information: www.mkdisabilitylawyers.com.