Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A12-007465

BETWEEN:

MING RONG LIN

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Arbitrator Alan G. Smith

Heard: In person at ADR Chambers on March 9, 10 and 11, 2015 and by written submissions due April 7, 2015

Appearances: Mr. Adam Ezer participated for Ms. Ming Rong Lin
Ms. Christine Galea participated for State Farm Mutual Automobile Insurance Company

Issues:

The Applicant, Ms. Ming Rong Lin, was injured in a motor vehicle accident on September 10, 2009, and sought accident benefits from State Farm Mutual Automobile Insurance Company ("State Farm"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and Ms. Lin, through her representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

---

[1] *The Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

The issues in this Hearing are:

1. Is Ms. Lin entitled to receive medical benefits for expenses as follows:
   a) $1,295.83 for Assistive Devices supplied by Fairview Assessment Centre;
   b) $972.51 for various Assistive Devices supplied by Pacific Assessment Centre;
   c) $881.71 for a Driving CD ROM supplied by Pacific Assessment Centre?
2. Is Ms. Lin entitled to payments for the Cost of Examinations as follows:
   a) $1,900.00 for a Family and Social Assessment performed by Mr. Avi Davis from Pacific Assessment Centre;
   b) $2,250.00 for a Driving Assessment performed by Dr. Leon Steiner from Pacific Assessment Centre?
3. Is State Farm liable to pay a Special Award because it unreasonably withheld or delayed payments to Ms. Lin?
4. Is State Farm liable to pay Ms. Lin's expenses in respect of the Arbitration?
5. Is Ms. Lin liable to pay State Farm's expenses in respect of the Arbitration?
6. Is Ms. Lin entitled to interest for the overdue payment of benefits?

Result:

1. Ms. Lin is entitled to receive medical benefits for expenses as follows:
   a) $1,295.83 for Assistive Devices supplied by Fairview Assessment Centre;
   b) $972.51 for various Assistive Devices supplied by Pacific Assessment Centre; and
   c) $881.71 for a Driving CD ROM supplied by Pacific Assessment Centre.
2. Ms. Lin is entitled to payments for the Cost of Examinations as follows:
   a) $1,900.00 for a Family and Social Assessment performed by Mr. Avi Davis from Pacific Assessment Centre; and
   b) $2,250.00 for a Driving Assessment performed by Dr. Leon Steiner from Pacific Assessment Centre.
3. State Farm is liable to pay a Special Award in the amount of $17,942.95 because it unreasonably withheld payments to Ms. Lin.

4. State Farm is liable to pay Ms. Lin's expenses in respect of the Arbitration.
5. Ms. Lin is entitled to interest for the overdue payment of benefits at the prescribed rate.

EVIDENCE AND ANALYSIS:

BACKGROUND

The Applicant was involved in a motor vehicle accident on September 10, 2009. She sustained soft-tissue injuries (neck, back and shoulders) as a result of the accident. There is some dispute between the parties as to what treatment the Applicant sought after the accident, but this is not material or relevant to the issues before me.

What is not in dispute is that in 2010, the Applicant did seek treatment from both Pacific Assessment Centre and Fairview Assessment Centre. Together, the two Assessment Centres submitted to State Farm some 123 OCF-21s, 28 OCF-18s, and 23 OCF-22s on behalf of Ms. Lin. The present claim is only with regard to the following OCF-18s, which both parties agree were submitted to State Farm in compliance with applicable *Schedule* provisions and which are in dispute:

a. $1,295.83 for Assistive Devices supplied by Fairview Assessment Centre, submitted February 17, 2010;
b. $972.51 for various Assistive Devices supplied by Pacific Assessment Centre, submitted August 12, 2010;
c. $881.71 for a Driving CD ROM supplied by Pacific Assessment Centre, submitted August 23, 2010;
d. $1,900.00 for a Family and Social Assessment performed by Mr. Avi Davis from Pacific Assessment Centre, submitted May 11, 2010; and
e. $2,250.00 for a Driving Assessment performed by Dr. Leon Steiner from Pacific Assessment Centre, submitted May 27, 2010.

The Applicant does not dispute that the following scenario unfolded in 2009 and 2010, as noted in State Farm's written submissions:

> …the respondent was also flooded with Treatment and Assessment Plans by certain clinics, including Fairview and Pacific. These clinics were misusing the system. The Respondent received 3 to 10 times the usual amount of Treatment and Assessment Plans, causing a backlog in the claims process. The Respondent hired over 100 new staff members to address the issue. The "flooding insurers with treatment plans and Section 24 expenses" by Fairview and Pacific was emphasized in the earlier FSCO Decision of *Chor Fong Chung v. Intact Insurance Company*[2] by Arbitrator Wilson.

In essence, State Farm alleges that the two assessment centres perpetrated a scheme to manipulate the provisions of the *Schedule* so as to force State Farm to pay for medical benefits which were not reasonable and necessary, sometimes at prices which were significantly inflated from fair market value.

ANALYSIS

Key Issue of Law – *Section 38 of the Schedule*

To understand the scheme alleged by State Farm to have been perpetrated by Fairview and Pacific Assessment Centres during 2010, a close examination of s. 38 of the applicable *Schedule* is necessary. The relevant portions of that section read as follows:

38. (1) Subject to subsection (2.1), this section applies to,

(a) any claim for medical or rehabilitation benefits…

(2) An application under this section must be signed by the insured person, unless the insurer waives that requirement, and must include…

[2] FSCO A10-002750, July 11, 2012.

(a) a treatment plan…prepared by a member of a health profession or by a social worker; and

(b) a statement by a health practitioner approving the treatment plan referred to in clause (a) and stating that he or she is of the opinion,

(i) that the expenses contemplated by the treatment plan are reasonable and necessary for the insured person's treatment or rehabilitation…

(7) On receiving the application, the insurer shall promptly determine whether the insurer is required to pay for the goods and services contemplated by the treatment plan.

(8) …the insurer shall give the insured person one of the following notices:

1. A notice…

i. that discloses any conflict of interest the insurer has relating to the treatment plan,

ii. that describes the goods and services, if any, contemplated by the treatment plan that the insurer agrees to pay for, and

iii. that advises the insured person, if the insurer has not agreed to pay for all goods and services contemplated by the treatment plan, that the insurer requires the insured person to be examined under section 42 relating to the goods and services the insurer has not agreed to pay for.

(8.1) A notice under subsection (8) must be given,

(a) within 10 business days after the insurer receives the application, in the case of a notice described in paragraph 1 of subsection (8); or

(b) within five business days after the insurer receives the application, in the case of a notice described in paragraph 2 of subsection (8). O. Reg. 281/03, s. 16 (4); O. Reg. 546/05, s. 14 (8).

(8.2) If the insurer fails to give a notice under subsection (8) in accordance with subsection (8.1), the following rules apply:…

2. In the case of a notice under paragraph 1 of subsection (8), *the insurer shall pay for all goods and services provided under the treatment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives the notice described in paragraph 1 of subsection (8).*

> (17.2) An insurer shall pay an expense in respect of medical or rehabilitation benefits that it has agreed to pay or that it is required under this section to pay within 30 days after receiving an invoice for the expense. [Emphasis added]

It is common ground that, with regard to the goods and services which are the subject of the present Arbitration, State Farm failed to meet the deadlines mandated by the *Schedule* s. 38(8.2) and in fact, did not provide OCF-9s[3] rejecting the OCF-18s, pursuant to s. 38(8)(1), until February 2011, many months after their submission. State Farm admits that the rejection of the claims was based entirely on a blanket policy of refusing any claims associated with the Fairview and Pacific clinics. State Farm notes in its written submissions that, "The respondent relied on various Insurance Bureau Alerts and Will Say Statements in its decision to withhold payments to Fairview and Pacific". At the time of denying the claims, State Farm advised Ms. Lin that treatment plans from other service providers would be considered on their merits.

Binding Precedent: *Perth Insurance Company and Channoch Shmuel*[4]

In my view, Director's Delegate Evans' decision in *Shmuel* is determinative of the present case. In the decision, Delegate Evans explains the operation of the applicable portion of the *Schedule* as follows:

> Subsection 38(8.2) does not deem the treatment plan approved, does not require the insurer to pay the entirety of the treatment plan, and does not speak of a treatment plan being "incurred." Rather, *the insurer must only pay for those goods and services provided under the treatment plan* that relate to the period starting on the 11th business day after the day the insurer received the application. [Emphasis added]

As State Farm points out quite correctly in its written submissions with regard to the *Shmuel* decision: "Director's Delegate Evans found that s. 38(8.2) could not apply because it was impossible to determine what goods and services were provided to the Applicant or when. The

[3] Exhibits No. 9 and No. 10.
[4] FSCO 4235, Appeal P13-00026, July 22, 2014, cited at paragraph 27 of State Farm's written submissions.

expenses were not payable in that case". Therefore, in my view, the key question in the present case is: can it be determined whether the goods and services, which are the subject of Ms. Lin's application, were actually provided to her during the period described in s. 38(8.2)(2) of the *Schedule*? If they were provided during this period, then State Farm must pay the amounts claimed.

THE RESPONDENT'S ARGUMENTS

Abuse of Process

State Farm argues that the flooding of documentation on it by the Fairview and Pacific clinics was an abuse of process. The Respondent cites Rule 65.7 of the Financial Services Commission of Ontario *Dispute Resolution Practice Code*,[5] which permits an arbitrator to prevent an abuse of process in the hearing of a matter. In its written submissions State Farm explains its argument as follows:

> The Respondent submits that where there is an abuse of process, an Arbitrator is not precluded from considering the claim on the merits simply because of a procedural issue. As discussed above, the Respondent was flooded with treatment plans and assessments by Fairview and Pacific and could not respond to these claims on a timely basis. This was a strategy used by Fairview and Pacific to rely upon the deemed approval provisions. It would be unfair to the Respondent to be subject to the deemed approval provisions in this Arbitration when the evidence demonstrates that the claims submitted on behalf of the Applicant were excessive, unreasonable and inappropriate....
>
> It would be perverse for this Arbitrator to indirectly compensate the very same clinics when FSCO has ordered penalties against the clinics.

[5] 4th Edition, November 2013.

I appreciate the Respondent's position i.e., that subjecting State Farm to the strict provisions of the *Schedule* s. 38(8.2) to the ultimate benefit of the impugned clinics might seem "unfair" or "perverse". However, in my view, I have no choice but to apply the mandatory directives of the *Schedule*. In that regard, I agree with the written submissions of the Applicant:

> The Insurer submits that Rule 65.7 of the *Dispute Resolution Practice Code* somehow permits an Arbitrator to override the deemed approval laws in the *SABS*. This rule permits the Arbitrator to prevent an abuse of process in the hearing of the matter. It clearly does not permit an Arbitrator to override mandatory provisions under the *SABS* or the *Act*.
>
> The Supreme Court of Canada has interpreted the verb "shall" in legislation to be mandatory, allowing for no discretion to relieve against the statutory provision. Please see *C.B. v. The Queen*, [1981] 2 SCR 480, 1981 CanLII 213 (SCC).
>
> The Insurer's own adjuster testified that he understood that State Farm had either three or ten days to deny a request, and if they wanted to dispute it, they would send it for evaluation through section 44 of the *SABS*.
>
> The Ontario Court of Appeal confirmed that mandatory means mandatory with respect to the word "shall" in interpreting the *SABS*; our Province's highest Court issued an order preventing an insured from trying to ignore the mandatory statutory language. Please see *Daly v. ING Halifax Insurance Co.*, 85 O.R. (3d) 70.

Contrary to what the Respondent appears to argue, it is clear to me that my jurisdiction as an Arbitrator in this matter flows exclusively from Part VI of the Ontario *Insurance Act*,[6] the *Statutory Powers and Procedure Act*[7] and the *Schedule* itself. I am not vested with any inherent or implied powers to correct perceived unfairness or perversity. I am bound by the mandatory provisions of the *Schedule*.

---

[6] R.S.O. 1990, c.I.8.
[7] R.S.O. 1990, c.S.22.

Power to Review Whether Claim was Reasonable and Necessary

For essentially the same reasons I provide above with regard to the Respondent's abuse of process argument, I cannot accept State Farm's submission that I have some sort of residual ability to review the reasonableness and necessity of a claim once the mandatory provisions of the *Schedule* s. 38(8.2) are engaged.

The *Superintendent's Guidelines* (*"Guidelines"*)

State Farm argues that some of the ancillary charges claimed with respect to the assistive devices and driving CDs are not payable because they exceed maximum amounts specified in the *Guidelines*.[8] The applicable section of the *Guidelines* states:

> Administration Fees
>
> "Expenses related to professional services" as referred to in the SABS and the Professional Services Guideline include all administration costs, overhead, and related fees. Insurers are not liable for any administration or any other charges or surcharges that have the result of increasing the *effective hourly rate beyond what is permitted under the Professional Services Guideline.* [emphasis added].

However, I agree with the Applicant as she notes in her submissions:

> The Insurer has not alleged that any effective hourly rate charged is beyond any prescribed rate in the Professional Services Guideline…the goods charged for did not include any charges for the services of professionals as listed at the Appendix to the Guideline, and the Insurer's submission that this rule applies to the provision of goods is clearly wrong on its face. The rule quoted above does not stand for the proposition that no administrative fees can be charged under the *SABS* or the *Guidelines*.

[8] No. 03/12 (Professional Services Guideline), July 2012.

Claims are being made for the benefit of the Assessment Centres, not the Applicant

The Respondent submits that, "All of the claims being advanced in this Arbitration are for payments to Fairview and Pacific and/or its treatment providers rather than the Applicant herself. The Applicant is personally detached from the claims being advanced". Noting that FSCO levied an administrative penalty on the two assessment centres in question in 2014, State Farm argues that it would be perverse for me to compensate Fairview and Pacific and/or its treatment providers when FSCO has disciplined the same clinics for engaging in unfair or deceptive acts or practices. The argument seems to be that if any administrative penalty is assessed under part XVIII.I of the *Insurance Act*,[9] an insurer is retroactively relieved from liability to pay for an insured's claims.

Again, I find this submission must fail. I agree with the Applicant that the argument flies in the face of the entire mandatory insurance coverage regime established under the *Insurance Act*[10] and the *Schedule*. I reiterate that my jurisdiction is restricted solely to that prescribed by legislation. I am bound by the mandatory provisions of the *Insurance Act* and the *Schedule*, neither of which provide me with the ability to relieve an insurer of liability because an Applicant is somehow "detached from the claims being advanced" or because a service provider has been administratively sanctioned.

Were the Goods and Services *Provided* to the Applicant?

The Assistive Devices supplied by Fairview Assessment Centre, claim submitted February 17, 2010; and The Assistive Devices supplied by Pacific Assessment Centre, claim submitted August 12, 2010

According to the OCF-18 application and OCF-21 invoice, the goods supplied to Ms. Lin by Fairview Assessment Centre were an ergonomic exercise mat, a hand therapy ball, an eight pound

[9] *Supra*, footnote 5.
[10] *Ibid.*

medicine ball, a therapy ball, and an exercise flex bar. The "Assistive Devices Delivery Confirmation" document proffered at the Hearing noting the above goods is dated March 10, 2010.

According to the OCF-18 application and OCF-21 invoice, the goods supplied to Ms. Lin by Pacific Assessment Centre were an ergonomic side to side seating pillow, an easy reach automotive seat belt, two blind spot automotive mirrors, a clip-on wide angle panoramic automotive mirror, a custom backrest, and an easy grip steering wheel cover. The delivery document proffered at the Hearing noting the above goods is dated November 11, 2010.

Ms. Lin confirmed, in cross examination, that she received supplies to use for exercise and to stretch her muscles. She confirmed that she received a string to exercise, a large ball, a smaller ball, a long mat or mattress, and a pillow. Ms. Lin also confirmed, in cross examination, that she received a recommended seatbelt, a device to tie around the headrest, a wheel grip, and side and front mirrors for her vehicle.

State Farm urges me to find that the Applicant's testimony, "is not credible or, at the very least, not reliable". However, I find that Ms. Lin gave credible and forthright testimony. Particularly given the fact that five years have elapsed since when the deliveries are said to have taken place and that the Applicant cannot be expected to have perfect recollection of all items, given her complaint of memory loss resulting from the accident. I also note that she was not impeached or contradicted by any other evidence.

I accept that both the exercise equipment and driving assistive devices were delivered to Ms. Lin well after the eleven day deadline provided for in s. 38(8.2) of the *Schedule* and before receipt of State Farm's Form 9 denial. Therefore, both assessments were "provided" pursuant to the *Schedule* s. 38(8.2) and are payable. Since no evidence was presented to the contrary, I have no choice but to accept the dollar amount charged for the equipment and devices as detailed in the respective OCF-21s as that payable by the Insurer.

The Driving CD ROMs supplied by Pacific Assessment Centre, claim submitted August 23,

2010

The delivery document proffered at the Hearing noting the CDs is dated November 26, 2010. Ms. Lin confirmed, in cross examination, that she received four driving CDs in one or two cases. Some of the CDs had sounds of water, birds chirping, and just sounds. Other CDs had English words that she found appealing.

For the same reasons provided above, I accept Ms. Lin's testimony that the CDs were indeed delivered to her. I also accept that the delivery date was well after the eleven day deadline provided for in s. 38(8.2) of the *Schedule* and before receipt of State Farm's Form 9 denial. Therefore, the CDs were "provided" pursuant to the *Schedule* s. 38(8.2) and are payable. Again, since no evidence was presented to the contrary, I have no choice but to accept the dollar amount charged for the CDs as detailed in the OCF-21 as that payable by the Insurer.

The Family and Social Assessment performed by Mr. Avi Davis from Pacific Assessment Centre, claim submitted May 11, 2010; and The Driving Assessment performed by Dr. Leon Steiner from Pacific Assessment Centre, claim submitted May 27, 2010

The Respondent submits only that the Reports of Avi Davis and Leon Steiner are not payable because they were not reasonable or necessary. I therefore accept as undisputed the *viva voce* testimony of the two assessors that they did in fact assess the Applicant and prepare and finalize their respective reports. Both assessments were conducted in July 2010, i.e., after the eleven day deadline provided for in s. 38(8.2) of the *Schedule* and before receipt of State Farm's Form 9 denial. Therefore, both assessments were "provided" pursuant to s. 38(8.2) and are payable.

CONCLUSION

Pursuant to s. 38 of the *Schedule,* as interpreted in the *Shmuel*[11] decision, I find that all the goods and services which were the subject of the Hearing were "provided" under the respective treatment plans. I further find that goods and services were provided during the period starting on or after the 11th business day after the day that State Farm received the OCF-18s and before the OCF-9s denying the claims were sent to Ms. Lin. I also accept that, with no contrary evidence having been proffered, that the OCF-21s filed with the Respondent accurately reflect the cost of each good or service. In the result, State Farm is liable for the cost of the goods and services claimed by Ms. Lin in this proceeding.

Special Award

Section 282(10) of the Ontario *Insurance Act*[12] provides the statutory basis for me to make a Special Award:

> If the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, shall award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the Schedule.

Entitlement to a Special Award is therefore contingent on the Insurer's behaviour having been "unreasonable". In *Erickson and The Guarantee*,[13] the Oxford English Dictionary definition of "unreasonable" was relied on. The Arbitrator found that "unreasonable" required: "1. Going beyond the limits of what is reasonable or equitable; 2. Not guided by or listening to reason".[14] FSCO jurisprudence also establishes that an insurer's actions could be determined to have been

---

[11] *Supra*, footnote 4.
[12] *Supra*, footnote 6.
[13] FSCO Decision on Special Award, A-000560, July 16, 1992, at p. 7.
[14] *Ibid.* at p. 8.

unreasonable without having been egregious or performed in bad faith.[15] In *Plowright and Wellington,* Arbitrator Palmer described unreasonable behaviour in the withholding of payments as, "behaviour which was excessive, imprudent, stubborn, inflexible, unyielding or immoderate".[16]

An insurer's behaviour, aimed at mitigating unreasonableness, can also be taken into consideration in ordering a Special Award. Conceding of benefits payable after the Applicant's evidence was heard during the Hearing shortens the proceedings, spares having a decision being written on the merits, and hence can be seen as mitigating the original unreasonableness.[17]

In the concluding paragraph of her submission, the Applicant opines:

> The Insurer's conduct towards Ms. Lin was contrary to the purpose of the *SABS*, which are, "designed to ensure the timely submission and resolution of accident benefits". (Please see *Sagan v. Dominion of Canada General Insurance Company*, 2014 ONCA 720…). They have continued to deny Ms. Lin's claims now that the Arbitration is over, having refused her mandatory treatment and assistive devices for almost five years.

I agree. I reject State Farm's submission that it:

> …did not act unreasonably given the demonstrated conduct of Fairview and Pacific. The Respondent relied on the *SABS* and *PSG* in its decision making process…
>
> The Respondent relied on various Insurance Bureau Alerts and Will Say Statements in its decision to withhold payments to Fairview and Pacific…

On the contrary, I entirely agree with Ms. Lin's argument that:

---

[15] *Ibid.* at p.6.
[16] FSCO A-003985, October 29, 1993, at p. 17.
[17] *Erickson and the Guarantee*, *supra*, footnote 13.

> The Insurer admits at paragraph 36 of its Submissions that the Applicant, Ms. Lin, did not commit wilful misrepresentation or fraud. The dispute that State Farm has had all along is with select medical clinics, due to its suspicions and charges laid several years later resulting in administrative fines unrelated to this case. In furthering this dispute, the Insurer turned its back on its insured who by all accounts was injured in an automobile accident. It ignored the law, and several years later commenced an all-out attack on the Applicant, using illogical hindsight, and without any relevant evidence or authority at law.

I also find no mitigating factors in the manner in which State Farm litigated this matter. I cannot agree that there was a "novel legal issue" to be decided. In my view, as explained earlier in this decision, the reasons in *Shmuel*[18] are dispositive of the applicable law in the current matter. State Farm was fully aware of the *Shmuel* decision since it was cited in their written submissions. I also note that *Shmuel* was decided in July 2014, some eight months before the current Arbitration Hearing. After opening statements were provided by counsel in the Arbitration, I requested to be supplied with jurisprudence from Respondent counsel substantiating State Farm's position that I had the jurisdiction to override the strict provisions of s. 38(8.2) of the *Schedule*. I repeated this request several more times during the Hearing, but was never provided with any relevant case law. Nonetheless, the Respondent did not concede that any benefits were payable even after the uncontested testimony of Mr. Davis and Dr. Steiner that their respective assessments had indeed been conducted (and hence their services "provided" pursuant to the *Schedule* s. 38(8.2)). Again I agree with the Applicant's argument that, "The Insurer should not receive any benefit or credit for making legal arguments that have no basis in law…This should be discouraged and certainly not encouraged or rewarded."

Finally, I reject the suggestion that the fact that Ms. Lin choose not to seek treatment from service providers other than the Pacific and Fairview clinics should be considered in deciding the question of a Special Award. In my view, State Farm acted in a high-handed manner in denying payment for goods and services supplied by Ms. Lin's chosen providers once OCF-18s were submitted and

---

[18] *Supra*, footnote 4.

the provisions of the *Schedule* s. 38(8.2) became operative. As the Applicant correctly states, "State Farm could not force Ms. Lin to start anew at a new clinic due to its fight with her health care providers. Such conduct is improper and made Ms. Lin a pawn in a dispute not of her making."

In the result, I believe the maximum quantum of Special Award is appropriate in the present case. Therefore, State Farm is ordered to pay Ms. Lin $17,942.95 as a Special Award because it unreasonably withheld payments to her. That amount represents the maximum allowable pursuant to s. 282(10) of the Ontario *Insurance Act*.[19]

EXPENSES:

The Applicant was successful in the Application; therefore, costs shall follow the event and the Applicant shall have her costs of the Arbitration.

Alan G. Smith
Arbitrator

JUNE 23, 2015
Date

[19] *Ibid.*

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A12-007465

BETWEEN:

MING RONG LIN

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Ms. Lin is entitled to receive medical benefits for expenses as follows:
   a) $1,295.83 for Assistive Devices supplied by Fairview Assessment Centre;
   b) $972.51 for various Assistive Devices supplied by Pacific Assessment Centre; and
   c) $881.71 for a Driving CD ROM supplied by Pacific Assessment Centre.
2. Ms. Lin is entitled to payments for the Cost of Examinations as follows:
   a) $1,900.00 for a Family and Social Assessment performed by Mr. Avi Davis from Pacific Assessment Centre; and
   b) $2,250.00 for a Driving Assessment performed by Dr. Leon Steiner from Pacific Assessment Centre.
3. State Farm is liable to pay a Special Award in the amount of $17,942.95 because it unreasonably withheld payments to Ms. Lin.
4. State Farm is liable to pay Ms. Lin's expenses in respect of the Arbitration.
5. Ms. Lin is entitled to interest for the overdue payment of benefits at the prescribed rate.

Alan G. Smith
Arbitrator

JUNE 23, 2015
Date