COURT OF APPEAL FOR ONTARIO

CITATION: Fehr v. Sun Life Assurance Company of Canada, 2018 ONCA 718
DATE: 20180905
DOCKET: C61453, C61497 & C63532

Strathy C.J.O., Hourigan and Miller JJ.A.

BETWEEN

Eldon Fehr, Angela Watters, Gaetan Laurier, Leslie Michael Lucas, James Patrick O'Hara, Rebecca Jean Clark, and Lloyd Shaun Clark

Plaintiffs
(Appellants/Respondents by way of cross-appeal)

and

Sun Life Assurance Company of Canada

Defendant
(Respondent/Appellant by way of cross-appeal)

Won J. Kim, Michael C. Spencer, Megan B. McPhee, and Aris Gyamfi, for the appellants/respondents by way of cross-appeal

F. Paul Morrison, Dana M. Peebles, Glynnis P. Burt, Hovsep Afarian, and Jacqueline L. Cole, for the respondent/appellant by way of cross-appeal

Heard: January 16-18, 2018

On appeal from the order of Justice Paul M. Perell of the Superior Court of Justice, dated November 12, 2015, with reasons reported at 2015 ONSC 6931, 56 C.C.L.I. (5th) 15 and additional reasons reported at 2016 ONSC 455; and from the order dated December 7, 2016, with reasons reported at 2016 ONSC 7659, 62 C.C.L.I. (5th) 96; and from the order dated April 11, 2017, with reasons reported at 2017 ONSC 2218; 66 C.C.L.I. (5th) 201.

Strathy C.J.O.:

A. OVERVIEW

[1] These appeals relate to a proposed $2.5 billion class action concerning more than 230,000 life insurance policies sold by Metropolitan Life Insurance Company ("MetLife") between 1985 and 1998.

[2] In 1998, MetLife sold its Canadian business to Mutual Life, which was renamed Clarica Life Insurance Company ("Clarica"). On December 31, 1992, Clarica amalgamated with Sun Life Assurance Company of Canada, which continued under the name of "Sun Life" and became responsible for administering MetLife's policies.

[3] The plaintiffs[1] commenced the proposed class action in 2010, alleging misrepresentation in the sale of the policies and breach of contractual and other duties relating to premiums and fees charged to policyholders.

[4] When the plaintiffs brought a motion to certify the proceeding as a class action, Sun Life brought a cross-motion for summary judgment, asking that their claims be dismissed as time-barred. The motions were heard together.

---

[1] For ease of reference, as there is both an appeal and a cross-appeal in this matter, I will refer to the appellants Fehr *et al.* as the "plaintiffs" and to the respondent as "Sun Life" or the "defendant".

[5] The certification motion was heard in two phases. At the end of the first phase, the motions judge found that the claims for misrepresentation, deceit, breach of duty of good faith, and rescission failed the common issues requirement. He dismissed the motion for certification of these claims.[2]

[6] The motions judge found that further evidence was required in order to determine whether the claims for breach of contract might be capable of certification. He adjourned the certification motion with respect to those common issues and directed that Sun Life file further evidence.

[7] On Sun Life's motion for summary judgment, the motions judge found that the plaintiffs' misrepresentation claims were barred by the applicable limitation periods and that certain "inchoate" claims were premature. The breach of contract claims were barred for certain time periods, but not for others: 2015 ONSC 6931 ("reasons").

[8] After the release of the motions judge's reasons, Sun Life brought a motion to amend the summary judgment order, to extend the period for which some of the breach of contract claims were found to be time-barred. This motion was dismissed: 2016 ONSC 455.

---

[2] A list of all the proposed common issues is attached as an appendix to these reasons. The proposed common issues are reproduced as they appeared in the motions judge's reasons: 2015 ONSC 6931, at para. 289.

[9] The certification motion was continued, after the submission of further evidence by both sides. The motions judge dismissed the motion for certification of the breach of contract claims, finding there was no "basis in fact" for the plaintiffs' allegations: 2016 ONSC 7659 ("continued reasons").

[10] Finally, the motions judge awarded Sun Life $1 million in costs of the certification and summary judgment motions on a partial indemnity basis: 2017 ONSC 2218.

[11] There are three appeals before this court.

[12] First, the plaintiffs appeal the motions judge's order dismissing their motion for certification. They also seek leave to appeal the costs order.

[13] Second, the plaintiffs appeal the order on summary judgment, insofar as it dismissed their individual claims for negligent misrepresentation and some of the breach of contract claims as time-barred or premature.

[14] Third, Sun Life appeals part of the order on summary judgment and the dismissal of the motion to vary the motions judge's order. It challenges the motions judge's conclusion that there is a "rolling" limitation period for the plaintiffs' breach of contract claims and argues that the limitation period for these claims was not suspended until 2013 when the plaintiffs amended their statement of claim.

[15] For the reasons that follow, I would: (a) dismiss the plaintiffs' appeal as it relates to the refusal to certify the misrepresentation common issues and some

related common issues; (b) allow the appeal as it relates to the refusal to certify the breach of contract common issues; (c) allow the appeal with respect to two other common issues; (d) allow the plaintiffs' appeal from the order granting summary judgment dismissing their individual claims; and (e) dismiss Sun Life's appeal from the order dismissing part of its summary judgment motion and from the order dismissing its motion to vary.

[16] The result is that the class action will be certified with respect to: (a) the breach of contract common issues (common issues 6, 7, and 8); (b) common issue 1, which asks whether Sun Life is liable for the actions of its predecessors; and (c) common issue 10, the fraudulent concealment common issue, as it applies to the limitation period applicable to the breach of contract claims. The representative plaintiffs are entitled to pursue their claims for misrepresentation, either individually or by way of joinder in individual actions, and the defendants will be entitled to raise the limitation period as a defence in that context. The application of limitation periods to the individual plaintiffs' breach of contract claims will be determined, if necessary, after the trial of the common issues.

B. ADDITIONAL FACTS

[17] The following summary draws heavily on the exhaustive reasons of the motions judge. Additional detail will be provided, as necessary, in the Analysis section of these reasons.

[18] To begin, I will explain the nature of the insurance policies at issue.

(1) The insurance policies

[19] This action involves four variations of "universal life" insurance policies sold by MetLife in Canada.[3] The four policies had different features, catering to different consumer preferences.

[20] A traditional "whole life" insurance policy charges fixed premiums to fund a death benefit and an investment account. A universal life policy offers more choice and flexibility to the insured. Like a whole life policy, it has a cash accumulation feature. But it permits the insured to pay premiums in variable amounts on a flexible schedule, to take advantage of different investment options for surplus funds and to vary the death benefit. Premiums paid by the insured are paid into an "accumulation fund". Cash in the accumulation fund is paid out from time to time to cover: the cost of the insurance ("COI"), that is the cost of insuring the death benefit; the costs of administration; and the acquisition of investments. Income on the investments is added to the policyholder's accumulation fund.

[21] Thus, in addition to providing life insurance, the policy serves as an investment vehicle. It has tax advantages, because income in the investment fund accrues on a tax-deferred basis. The policy's cash value may enable the

---

[3] The policies, and the years in which they were sold are: (1) Interest Plus (1985-1998); (2) Universal Plus (1987-1998); (3) Flexiplus (1992-1998); and (4) Optimet (1998).

policyholder to borrow money from the policy. Alternatively, surplus funds can be used to pay future premiums from time to time (a so-called "premium holiday") or for the remaining life of the policy (sometimes referred to as a "vanishing premium").

[22] But universal life insurance is not without risks. Because premiums are not fixed, poor investment returns, due to low interest rates or market declines, can cause premiums to increase and reduce the value of the accumulation fund. If the accumulation fund is depleted, the insured will have to pay increased premiums or see the entire policy lapse.

[23] It is unnecessary to provide a detailed description of the terms of the various policies in order to address most of the issues on this appeal. I will discuss some of the pertinent provisions of the policies when I examine the motions judge's analysis of the common issues.

[24] These policies were fairly complex financial instruments. The manner in which they operated was not obvious from the policy language. It is not surprising, therefore, that MetLife's sales agents frequently used standard sales pitches and illustrations to demonstrate the operation of the policies to their clients.

[25] Many of these policies were sold during times of high interest rates. Most projections given to prospective policyholders were based on those rates continuing. Everything was rosy when interest rates were high. Premiums were

low, accumulation funds grew, and policyholders were happy. But when interest rates began to fall in the mid-1990s and into the 2000s, MetLife's profits also fell. As did the income on policyholders' accumulation funds. Correspondingly, premiums and administration costs charged by MetLife and its successors went up.[4] Some of these increased charges were paid out of policyholders' accumulation funds.

(2) Policyholder complaints, remedial programs, and Indemnity Litigation

[26] As a result of these developments, some policyholders complained to MetLife's successors that MetLife's sales agents had misrepresented the anticipated performance of their policies.

[27] In response to customers' protests, Sun Life established remedial programs to provide relief to some policyholders (the "remedial programs").[5]

[28] Policyholder complaints also inspired Sun Life to take action against MetLife.

---

[4] Sun Life gave notice of an increase of the COI in the Flexiplus policies in 2001, 2006 and 2015. Sun Life increased the COI in the Optimet policy by 10% in 2007 for the balance of the term of the contract.
[5] In 2006, Sun Life implemented an "Under-Funded Life Policies Replacement Program", offering to provide permanent life insurance policies to certain Universal Plus and Interest Plus policyholders whose policies were underfunded and at risk of lapse. In 2008, Sun Life created the "Flexiplus Options Program". To qualify for the program, an applicant was required to supply written evidence of misrepresentation by a MetLife agent at the time of sale. If the application was accepted, the policyholder was required to sign a release, forgoing the option to resolve their claim through litigation. In 2009, Sun Life launched an "Interest Plus Extension of Coverage Offer", which offered to extend coverage from the age of 90 to lifetime coverage for an increased premium or a reduction in face value of the policy.

[29] In the sale of MetLife's book of business in 1998, MetLife had agreed to indemnify the purchaser for "market conduct" claims, including policyholder claims for misrepresentations in the sale of insurance policies. The agreement required that over $1 million in market conduct claims be made or brought before the purchaser would qualify for indemnification.

[30] When MetLife refused to acknowledge that the indemnity had been triggered, Sun Life brought an action in 2006 seeking a declaration that MetLife was required to indemnify it for market conduct claims with respect to three of the four policies at issue in these proceedings (the "Indemnity Litigation").

[31] MetLife brought a summary judgment motion, arguing that the $1 million threshold had not been met. In opposing the motion, Sun Life produced an expert actuarial report calculating the cost Sun Life would incur if all existing policies were administered according to the alleged misrepresentations of the MetLife sales agents, rather than their actual terms. Sun Life argued:

> The evidence establishes that MetLife, through its agents and employees, engaged in and condoned a pattern and repeated practice of misrepresenting and failing to accurately describe to its policyholders the nature, provisions, financial elements and benefits of the Flexiplus, Interest Plus and Universal Plus policies sold by it.

[32] MetLife's summary judgment motion was granted on the basis that the $1 million threshold had not been reached. Further, not all policyholders had been misled and the expert evidence did not establish a genuine issue for trial. See *Sun*

Life Assurance Company of Canada v. Metropolitan Life Insurance Company, 2010 ONSC 558, 69 B.L.R. (4th) 32, at paras. 29-30, 32, 34-36.

[33] Sun Life appealed, but later withdrew the appeal, on terms that have not been disclosed.

[34] However, Sun Life's own evidence in the Indemnity Litigation, which echoed the complaints made by the plaintiffs in the proposed class action, was identified as a smoking gun by the plaintiffs on the certification motion. Here was the defendant in this action, Sun Life, complaining in another proceeding that MetLife had engaged in a "pattern and repeated practice" of misrepresentation, including some of the very misrepresentations that these plaintiffs complained about. The plaintiffs relied on the evidence in the Indemnity Litigation, not only to establish "some basis in fact" for their claims and for the common issues, but also to argue that Sun Life had breached its duty of good faith and fair dealing by failing to disclose MetLife's and its own misconduct to policyholders.

(3) The claims

[35] The proposed class action advanced a number of claims, but the following three claims are central in this appeal:

(a) Misrepresentation: The plaintiffs allege that they were misled by MetLife sales agents, to believe that their policies would provide guaranteed interest and would become self-sustaining. Some plaintiffs also claimed that they were told that their COI and premiums would not increase. One plaintiff alleged she was told her policy provided lifetime coverage, as opposed to coverage to age 90.

(b) Breach of contract (COI and Administrative Fee increases): The plaintiffs claim that increases in the COI were in breach of their contracts because the increases were not based on criteria identified in the insurance policies. They also claim that increases in Administrative Fees were not based on increases in administrative costs, but were really additional COI increases in disguise.

(c) Breach of contract (maximum premium): Certain policies made reference to a "minimum premium" and a "maximum premium". There was some evidence that, at some future date, Sun Life would charge a premium higher than the "maximum premium". The plaintiffs admit that no putative class member has yet been charged a premium greater that the maximum premium, but seek a declaration interpreting this provision.

[36] In addition, the plaintiffs relied on the doctrine of fraudulent concealment to answer Sun Life's allegations that their claims were statute-barred.

[37] With this background, I turn to the issues on these appeals.

C. THE ISSUES

[38] In my view, these appeals raise the following issues.

(1) Plaintiffs' appeal of the certification motion

(a) Did the motions judge err in failing to certify the negligent misrepresentation common issues?

(b) Did the motions judge err in failing to certify the breach of contract common issues?

(c) Did the motions judge err in failing to certify any other common issues?

(d) If the answer to any of these questions is "yes", should the proposed class action be certified?

(2) Plaintiffs' appeal and Sun Life's cross-appeal of the summary judgment motion

(a) Did the motions judge err in granting summary judgment with respect to the misrepresentation claims?

(b) Did the motions judge err in granting summary judgment with respect to the claims for breach of contract?

(c) Did the motions judge err in dismissing the maximum premium claim as premature?

(3) Plaintiffs' appeal of the costs award

(a) Did the motions judge err in awarding Sun Life its costs of the motions in the amount of $1 million on a partial indemnity basis?

D. ANALYSIS

(1) Plaintiffs' appeal of the certification decision

(a) The standard of review

[39] I agree with Sun Life that substantial deference is owed to the motions judge's application of the test for certification and his determination of the common issues. See *Pearson v. Inco Ltd.* (2005), 78 O.R. (3d) 641 (C.A.), 261 D.L.R. (4th) 629, at para. 43, leave to appeal refused, [2006] S.C.C.A. No. 1; *Hodge v. Neinstein*, 2017 ONCA 494, 136 O.R. (3d) 81, at para. 115, leave to appeal refused, [2017] S.C.C.A. No. 341. The court's intervention should be restricted to matters of general principle: *Markson v. MBNA Canada Bank*, 2007 ONCA 334, 85 O.R. (3d) 321 (Ont. C.A.), at para. 33.

(b) The relevant criteria for certification

[40] The principles relevant to this appeal are the common issues criterion and the application of the "some basis in fact" test.

[41] At paras. 27 to 55 of his reasons, the motions judge set out the principles and authorities governing the application of the test for certification under s. 5 of the *Class Proceedings Act, 1992*, S.O. 1992, c. 6. He discussed the "some basis in fact" test at paras. 31-37, noting at paras. 35-36 that the test sets a low standard and it is not for the court to resolve conflicting facts or to opine on the strength of the plaintiff's case:

> On a certification motion, evidence directed at the merits may be admissible if it also bears on the requirements for certification, but, in such cases, the issues are not decided on the basis of a balance of probabilities, but rather on that of the much less stringent test of "some-basis-in-fact": *Hollick v. Toronto (City)*, ... [2001 SCC 68], at paras. 16-26; *Cloud v. Canada (Attorney General)* (2004), 73 O.R. (3d) 401 (C.A.) at para. 50, leave to appeal to S.C.C. ref'd, [2005] S.C.C.A. No. 50.
>
> The some-basis-in-fact test sets a low evidentiary standard for plaintiffs, and a court should not resolve conflicting facts and evidence at the certification stage or opine on the strengths of the plaintiff's case; the focus at certification is whether the action can appropriately go forward as a class proceeding: *Pro-Sys Consultants v. Microsoft*, ... [2013 SCC 57]; *McCracken v. CNR Co.*, 2012 ONCA 445.

[42] The motions judge set out the authorities on the common issues criterion at paras. 38-44 of his reasons, stating at para. 38 that "to be a common issue, it must

be a substantial ingredient of each Class Member's claim and its resolution must be necessary to the resolution of each Class Member's claim" and noting, at para. 44, that "[a]n issue can be a common issue, even if it makes up a very limited aspect of the liability question and even though many individual issues remain to be decided after its resolution".

[43] I turn now to the motions judge's application of these principles to the common issues proposed by the plaintiffs. As noted earlier, the proposed common issues are listed in the Appendix to these reasons.

(c) Did the motions judge err in failing to certify the negligent misrepresentation common issues?

[44] The plaintiffs contend that the motions judge erred in refusing to certify the negligent misrepresentation common issues.

[45] While they acknowledge that individual constituent elements of the cause of action, such as reasonable reliance by a plaintiff, will have to be decided after the common issues trial, they argue that determination of the misrepresentation common issues in their favour will establish that MetLife engaged in a pattern of misrepresentation in the sale of the policies. This, they say, would provide context for the proof of class members' individual claims and would help to advance the claim of each class member. They say this satisfies the common issues requirement.

[46] I do not accept this submission.

[47] The key misrepresentation common issue was common issue 4, which asked whether MetLife engaged in a repeated practice of misrepresenting the nature, provisions, financial elements, and benefits of the policies. These misrepresentations included the use of misleading illustrations and marketing materials, and the failure to disclose the effect of lower interest rates and rising costs on class members' premiums and accumulation funds.

[48] The individual proposed representative plaintiffs testified that they had been misled by MetLife's agents about the features and benefits of the policies. However, each plaintiff's claim for misrepresentation is unique.

[49] For the purpose of illustration, I will briefly describe the claims of two would-be representative plaintiffs, Eldon Fehr and Leslie Michael Lucas.

[50] Mr. Fehr claimed that before he purchased his Universal Plus policy (which he later replaced with a Flexiplus policy) in October 1990, he was told by MetLife's agent that the premium "would be guaranteed for life" and that "his payments would not change". He claimed that the agent told him that, based on the premiums he was paying, he would accumulate funds that would continue to grow and would eventually reduce or eliminate his premiums. Alternatively, he would be able to "cash out" the accumulated funds when he retired or when the policy matured.

[51] Mr. Fehr claimed that, contrary to the representations made to him by MetLife's agent, his costs of insurance have increased and his accumulation fund has been depleted.

[52] Mr. Lucas purchased a Flexiplus policy in 1995. He claimed that the agent told him that the COI rates "would never go up", that there would be "considerable growth in the Accumulation Fund" and that the policy "would one day pay for itself." Like Mr. Fehr, he asserted that, contrary to the agent's misrepresentations, his COI had increased and his accumulation fund had been depleted and was insufficient to meaningfully reduce or eliminate his premiums.

[53] The record included affidavits of twelve former MetLife agents who deposed that MetLife's educational courses, manuals, and other sales materials were misleading and caused them to misrepresent the terms of the insurance policies they were selling. On the other hand, seventeen former agents deposed that they had not misrepresented the policies they sold.

[54] The plaintiffs pointed to MetLife's marketing materials, which were used by sales agents to paint an optimistic picture, based on high interest rates, demonstrating a secure future of low premiums and high investment returns. Customers were not given the insurance policy until after they had completed a purchase application. While policyholders were told to read the policy, the plaintiffs argued that a policyholder would not have appreciated, simply from reading the

policy, that declines in interest rates would have serious implications on premiums and on the growth of the accumulation fund.

[55] As they did before the motions judge, the plaintiffs rely on the Indemnity Litigation as a "basis in fact" for the existence of systemic misrepresentations by MetLife's agents. There was considerable debate before the motions judge, and in the parties' written submissions to this court, concerning the admissibility of statements from Sun Life's pleadings and factums in the Indemnity Litigation. The motions judge ruled that these statements were not admissions and could not be used to establish a common issue related to systemic misrepresentation. The motions judge went on to find, at paras. 298-306 of his reasons, that the misrepresentation claims did not satisfy the commonality requirement.

[56] Notwithstanding the plaintiffs' submission that consumer protection and access to justice concerns favour the certification of the misrepresentation common issues, it is my view that the judgment below should be affirmed on this issue, largely for the reasons articulated by the motions judge and by Rosenberg J.A. in *Williams v. Mutual Life Assurance Co. of Canada* (2003), 170 O.A.C. 165 (C.A.), 226 D.L.R. (4th) 112, leave to appeal refused, [2003] S.C.C.A. No. 283. The resolution of the proposed common issues based on "systemic" misrepresentations would not materially advance the claims of the class members. The class action would founder on the host of individual issues raised by the claims of tens of thousands of class members.

[57] The motions judge noted, at para. 292 of his reasons, that, based on the evidence before him, the experiences of the representative plaintiffs were idiosyncratic rather than common. "The alleged misrepresentations were made over the breadth of the class period, 13 years, by thousands of different sales agents who were not uniformly trained about four different policies some of which had revised standard forms over the course of their offering to the public."

[58] I agree with this observation. The evidence of Mr. Fehr and Mr. Lucas, which I briefly summarized above, and the evidence of the other representative plaintiffs, demonstrates that a trial of each individual claim of misrepresentation would be required in order to fairly determine, not just whether the representations were relied upon, but what representations were actually made to each class member and whether those representations were false. This could require the evidence not only of each class member, but of each sales agent involved, as well as an examination of what marketing materials were provided to each class member and what he or she was told about them.

[59] The observations of Rosenberg J.A. in *Williams v. Mutual Life*, at para. 47, are apt:

> In this case, establishing that Prudential was negligent in any of the ways suggested by the appellant would not represent a substantial ingredient in each of the class members' claims. It would not, to use Campbell J.'s phrase in *Anderson*, "move the litigation forward". As the motions judge pointed out, since Prudential had no direct dealings with any of the class members at the time the

> policies were sold, the class members would still at least have to show that the agents with whom they dealt made representations about premium offset, that those representations constituted negligent misrepresentations about the premium offset feature, and that the prospective policyholder reasonably relied upon the representation. As was stated in *Rumley* at para. 29, "Inevitably such an action would ultimately break down into individual proceedings."

[60] I agree with the motions judge that the misrepresentation claims fail for want of a common issue that would materially advance the case at trial. It is not enough for a common issue to provide "context". The resolution of the common issue must advance the resolution of each class member's claim. The proposed misrepresentation common issues would not do so.

[61] For these reasons, I conclude that the motions judge did not err in dismissing the request for certification of the negligent misrepresentation common issues.

(d) Did the motions judge err in refusing to certify the breach of contract common issues?

[62] The plaintiffs say that the motions judge erred by failing to certify the breach of contract common issues, being issues 6, 7, and 8.

[63] As a preamble to this topic, and because of its impact on the discoverability of the plaintiffs' claims for the purpose of the summary judgment motion, I will make a few additional observations about the insurance policies at issue.

[64] I have noted that the policies are relatively complex financial instruments. They are also relatively complex contracts. The language is technical and legalistic, and important terms are undefined. For example, there is no definition of "minimum premium" or "maximum premium". The actual meaning of those terms is a matter of controversy. According to Sun Life, "minimum premium" does not mean the lowest premium that a policyholder is required to pay in order to keep the policy in good standing. And "maximum premium" does not mean the highest premium that can ever be charged to a policyholder. Some technical terms, such as "non-rated classification", are undefined. Other terms, such as "premium", "monthly cost of insurance" and "monthly insurance charge", are confusing. Key provisions, such as the manner in which Sun Life could adjust the COI from time to time, are opaque.

[65] The motions judge himself required extensive additional evidence, including expert evidence, before he could determine whether Sun Life had breached the policy by adjusting the COI based on factors not enumerated in the policy. He was unable to do so by simply interpreting the policy and comparing it to what Sun Life claimed it was entitled to do. This was a key breach of contract issue, to which I now turn.

Common issue 6: cost of insurance ("COI")

[66] The policies at issue provided that the insurer could adjust the monthly rate for the COI from time to time. Common issue 6 asks whether it was an express or

implied term of the policies that the COI rate could only be adjusted based on specified factors enumerated in the policy, and whether Sun Life breached this term by imposing increases based on other factors.[6] The plaintiffs allege that the COI provision of the Flexiplus policy was breached when Sun Life notified policyholders of premium increases in 2001, 2006, and 2015. A similar allegation was made that the COI provision in the Optimet policy was breached when the COI was increased in 2007, being year nine of the policy.

[67] The motions judge addressed common issue 6 and the other breach of contract common issues in a similar fashion. He stated that answering them would require the court to interpret the express terms of the two standard form insurance policies with respect to the COI and Administration Fees, and to determine whether these terms had been breached. He described this as "standard fare for a common issue in a class action."

[68] In the Optimet policy, the COI was fixed for years one to eight and for year nine and following. That policy was only sold in 1998 and in the ninth year of the policy, Sun Life increased the COI by ten percent for the balance of the policy term. It was argued by the plaintiffs that the ten percent increase was a breach of the policy.

---

[6] "Was it an express or implied term of the policies that the COI rate may be adjusted based on specified factors? If so, did Sun Life breach this term by basing increases, in whole or in part, on other factors?"

[69] The relevant provisions of the Flexiplus policy, with respect to common issue 6, are as follows:

> **Monthly Insurance Charge** – The deduction for any policy month is the sum of the following amounts, determined by us as of the beginning of that policy month:
>
> - The monthly Cost of Insurance
> - The cost for additional benefits and riders
> - An Administrative Fee that will never exceed $12 per month. This monthly fee will never increase by more than $1 in any 12 month period.
>
> **Cost of Insurance** – The Cost of Insurance for any policy month is determined by multiplying the Death Benefit less the value of the Accumulation Fund by the monthly rate. The monthly rate for the Cost of Insurance will be set by us from time to time based on the primary Insured's sex, issue age, underwriting class, policy year and the Specified Face Amount of Insurance. The monthly rate may change, but for non-rated classification it will never exceed the rates shown on the Table of Maximum Monthly Cost of Insurance included with this policy.
>
> In the 8th year there will be no monthly Cost of Insurance. [Emphasis added.]

[70] The underlined words were relied on by the plaintiffs in support of their submission that any adjustment to the COI had to be "based on the primary Insured's sex, issue age, underwriting class, policy year and the Specified Face Amount of Insurance" and on no other factors.

[71] The motions judge described the manner in which the COI was set in the Flexiplus policy in his continued reasons, at para. 17:

> In the Flexiplus policy, the insurer set the COI from time to time within a maximum limit for years one to seven and within a maximum limit for year nine and the following years. There was no COI in year eight. Thus, there was a two-step structure for the COI in the Flexiplus policy and the COI could increase at any time other than year eight within the maximum rates set out in the table in the policy. In the Flexiplus policy, the maximum rate the insurer could charge the policyholder for the COI in each period was stated in a table, categorized by age, sex, and smoking status, entitled: "Table of Maximum Monthly Cost of Insurance Per Thousand of Insurance."

[72] The plaintiffs argue that the increases implemented under the Flexiplus policy were not based on the specified factors (age, sex, etc.) and were therefore in breach of the contract.

[73] In asserting "some basis in fact" for the common issue, the plaintiffs relied on correspondence from Clarica, Sun Life's predecessor, to Flexiplus policyholders in 2001-2002 and communications from Sun Life in 2006, announcing an increase in the COI. In a letter from Clarica to one of the representative plaintiffs, Mr. Lucas, in October 2000, it was stated:

> The monthly insurance charge is the sum of three different charges; two of them will be changing in March, 2001. I am writing now to give you ample time to review the changes with your agent. The monthly insurance charge, described on page 7 of your contract, includes:
>
> * a monthly administration fee -- This fee will increase by $1.00 from $5.50 to $6.50 a month, effective March 2001;
>
> * the charges for any additional benefits or riders ...

> * Your monthly costs of insurance -- This is the amount we charge to provide your life insurance protection. The costs of insurance (the rate charged per $1,000 of life insurance benefit) is increasing due to interest rates that have declined steadily since the Universal Flexiplus product was first introduced. Your policy states: "the monthly rate for the Cost of Insurance will be set by us from time to time." It is now necessary to increase the costs of insurance to better reflect current interest rates.
>
> We guarantee your new monthly cost of insurance rate does not exceed the maximums shown in the Table of Maximum Monthly Cost of Insurance in your contract. ...
>
> Your agent ... can provide you with your new monthly insurance charge and illustrate how these changes will impact the future value of your policy's accumulation fund. [Emphasis added.]

[74] The underlined words were relied upon by the plaintiffs to assert a basis in fact for the existence of a common issue – namely, that Sun Life increased the monthly COI "to better reflect current interest rates", a factor that was not mentioned in the COI provision of the policy, quoted above.

[75] In addition, the plaintiffs referred to the evidence of Sun Life's witness, Ms. Sauvé, who testified about the manner in which COI rates were periodically adjusted. The motions judge referred to her evidence in his continued reasons, at para. 24, as follows:

> In her testimony for Sun Life, Ms. Sauvé, the Director of Customer Relations for the Individual Business Unit, said that the factors listed in the letter explaining the increase

> in the COI were consistent with the policy terms. In her affidavit, she explained that COI rates were affected by: (a) current mortality experience relative to what was assumed when the rates were initially set; (b) incurred expenses relative to what was assumed when the rates were initially set; (c) actual investment earnings compared to the interest rates assumed when the rates were initially set; and (d) policy lapse rates compared to the lapse rate assumed when the rates were set. She deposed that a periodic assessment is done of the actual experience using the risk factors in the policy, such as sex, issue age, underwriting class, *etc.*, compared to the assumed experience that formed the foundation for the pricing when the policy was issued. She said that when there is a significant deviation from the actual experience as compared to the assumed experience, a price increase or decrease is made.

[76] To summarize, the letter from Sun Life to Mr. Lucas indicated that the COI had been adjusted (i.e., increased) to "better reflect current interest rates". Ms. Sauvé's evidence was that the COI had been adjusted to reflect changes in assumptions made by Sun Life, when the COI was originally determined, concerning such matters as Sun Life's actual expenses and actual investment earnings.

[77] In my view, the evidence of Ms. Sauvé and the letter from Sun Life provided "some basis in fact" for common issue 6. There was some basis in fact that the COI adjustment had been calculated on a common basis for all class members

who owned Flexiplus policies.[7] And there was some basis in fact to establish that the adjustment was calculated, for all policyholders, in a manner that was inconsistent with the express terms of the policy. To use the motions judge's language, there was some basis in fact to establish a common issue that would have been "standard fare" for a breach of contract common issue: the interpretation of a provision of a standard form contract that was common to all class members and the determination of whether the adjustment of the COI, on a basis common to all class members, was in breach of the contract. The determination of whether a breach of contract had actually occurred was not an issue for the certification judge.

[78] However, instead of certifying the proposed common issue, the motions judge concluded that he could not determine how the increase in the COI had been calculated. He said there was no evidence before him to enable him to determine whether there was a "basis in fact" for the allegation that Sun Life had breached the contracts. He stated, at para. 106 of his reasons, "[i]t may or may not be the case that the increase of the COI because of declining interest rates was based

---

[7] As the motions judge observed in his continued reasons, 2016 ONSC 7659, at paras. 33 and 40, not all policyholders received COI adjustments. Moreover, depending on the cohort, some received increases in the COI and others received decreases. Nevertheless, the method of calculation was common across the class.

on the primary insured's sex, issue age, underwriting class, policy year, and the specified face amount of insurance."

[79] He adjourned the certification motion with respect to these common issues and ordered Sun Life to deliver affidavit evidence explaining how the COI and Administrative Fees were calculated. The plaintiffs were entitled to file responding evidence. He ordered that, after any necessary cross-examinations, the matter could be brought before him for continuation of the certification motion.

[80] This duly occurred. Sun Life served two affidavits from one of its Vice Presidents, who was responsible for pricing and re-pricing individual life insurance products. The plaintiffs filed two affidavits from an expert consulting actuary. Both affiants were cross-examined. The certification hearing resumed, more than a year later.

[81] The motions judge accepted the evidence of Sun Life's witness concerning the way in which the company adjusted the COI. It was based on two types of factors: (a) "policy factors", such as the insured's sex, age, underwriting class, policy year, and face amount of insurance – in other words, the factors listed in the COI provision of the policy; and (b) "experience variables", such as anticipated future mortality rates, anticipated policy lapse rates, expenses, and investment earnings. These experience variables were not set out in the COI provision of the policy. The policy factors were used to divide insured individuals into "cohorts" against which the experience variables were applied for the purpose of adjusting

the COI applicable to each cohort. The plaintiffs' expert generally agreed that this methodology was applied in practice. He was not satisfied, however, that the Flexiplus policy language was adequate to allow for such adjustments, although he acknowledged that this was a legal issue.

[82] To put it simply, the evidence disclosed that Sun Life adjusted the COI from time to time based, among other things, on its actual experience in comparison to the assumptions it had made when the rates were set. This would ensure that, no matter what happened to investment returns, Sun Life could meet its obligations to its policyholders while sustaining the level of earnings it anticipated when it launched the product. The plaintiffs' proposed common issue asked whether Sun Life was entitled to adjust the COI in this way.

[83] After reviewing the evidence, the motions judge concluded, at para. 52 of the continued reasons, that there was "no evidence – no basis in fact – proving the alleged breach of contract" (emphasis added). He stated, at para. 49, that the re-pricing of the insurance was done "in accord with insurance industry actuarial practice."

[84] He concluded, at para 55:

> In the case at bar, the truth of the matter is that the Plaintiffs plead what the contract means; i.e., they plead what promises were made by Sun Life, and they allege how those promises were breached; visualize, they plead in paragraph 60 of the Statement of Claim that Sun Life "used factors different from the permissible factors in

> calculating and imposing cost of insurance rate increases on the Policies, which was a breach of contract." As it turns out (much like what happened with the Plaintiffs' maximum premiums breach of contract), there is no basis in fact for this allegation. The evidence is that in both setting and re-setting the COI, Sun Life set the price based on the primary insured's sex, issue age, underwriting class, policy year and the specified face amount of insurance, and it did so in the way that was in accord with insurance industry practice. There is no basis in fact for the breach of contract as pleaded by the Plaintiffs.

[85] The question for the motions judge was whether there was some basis in fact for the existence of common issues of fact and law concerning the interpretation of the policy and the manner in which Sun Life adjusted the COI for all affected policyholders.

[86] In my view, it is entirely reasonable for a certification motion judge to expect the parties to produce evidence relevant to whether there is some basis in fact that the issue is common across the class. However, by requiring the parties to file additional evidence and analyzing that evidence to assess whether or not Sun Life had actually breached the contract, the motions judge went beyond determining whether there was "some basis in fact" for the common issue. Rather, he decided the proposed common issue by interpreting the contract and making a finding that there was no breach. This, respectfully, was an error in principle. This determination was a task for the judge at the common issues trial, not the judge dealing with certification.

[87] As McLachlin C.J. observed in *Hollick v. Metropolitan Toronto (Municipality)*, 2001 SCC 68, [2001] 3 S.C.R. 158, at para. 16, "[t]he question at the certification stage is not whether the claim is likely to succeed, but whether the suit is appropriately prosecuted as a class action." This point was re-iterated by Rothstein J. in *Pro-Sys Consultants Ltd. v. Microsoft Corp.*, 2013 SCC 57, [2013] 3 S.C.R. 477, at para. 99. He noted, at para. 100, that *Hollick* requires that the court ask, not whether there is a basis in fact for the claim itself, but whether there is some basis in fact which establishes each of the certification requirements.

[88] Moreover, it is not clear that the motions judge was entitled as a matter of law to rely on "industry practice" to support Sun Life's position on the adjustment of the COI, when that practice was not specifically identified in the contract. While industry practice or "custom" may be impliedly incorporated into a contract between two parties who operate in the same industry – for example, a contract between two insurance companies – it is not at all clear that, as between an insurer and policyholder, the policyholder can be said to contract with reference to a custom of an industry in which he or she is simply a consumer.

[89] This point was made by the Alberta Court of Appeal in *885704 Alberta Ltd. v. Oxford Properties Group Inc.*, 2005 ABCA 274, 371 A.R. 178, at para. 43:

> An interpretation of a contract is a search for intent of the parties to that particular contract. While standard terms of a trade may be found to have the intended meaning of the parties to the contract, that can only be true where both parties are members of the same trade. Industry

> practice that might identify one party's intention is not sufficient. It must be of such a nature that a trial judge can comfortably conclude that both parties would have known of that practice and therefore have intended that meaning. Here, we are concerned that the trial judge relied too heavily on expert opinions and standards of an industry without determining whether Met Centre was part of the industry and could be said to have known those industry terms.

[90] In my view, it was for the common issues trial judge, and not the certification judge, to determine whether the insurance contract, properly interpreted, permitted Sun Life to adjust the COI based on "experience variables", such as changed interest rates and investment returns. And it will ultimately be for the common issues trial judge to ascertain the role, if any, of industry practice in the determination of that question.

[91] For these reasons, it is my view that the motions judge erred in failing to certify common issue 6.

Common issue 7: Administrative Fees

[92] Common issue 7 asked a question similar to common issue 6: whether Sun Life breached the contract by adjusting Administrative Fees based on factors

unrelated to the costs of administering the policies.[8] The motions judge also considered this common issue to be "standard fare" for a class action.

[93] In the second phase of the certification motion, the motions judge declined to certify common issue 7. He found that, while the insurance contracts demonstrated a "lack of transparency", the Administrative Fee, like the COI, was "set in accordance with industry practices and no unfairness was perpetrated on the policyholders": continued reasons, at para. 59.

[94] In my view, as with common issue 6, the motions judge went too far. There was an appropriate common issue of contractual interpretation concerning the meaning of "Administrative Fee" (a term that was not defined in the policies) and the basis on which the insurer was entitled to adjust that fee. The Administrative Fee was adjusted in a manner that was common to all class members who owned the Flexiplus policy. There was some evidence that Sun Life had used adjustments in the Administrative Fee to avoid making additional increases to the COI. This was sufficient to satisfy the "some basis in fact" test for common issue 7.

---

[8] "Was it an express or implied term of the policies that Administrative Fees may be adjusted based on factors related to the cost of administering the policies? If so, did Sun Life breach this term by basing increases, in whole or in part, on other factors?"

[95] For the reasons I have stated in relation to the COI issue, it will be for the common issues trial judge to determine what role, if any, industry practice will play in determining this common issue.

[96] Common issue 7 ought to have been certified by the motions judge.

Common issue 8: maximum premium

[97] Common issue 8 asked whether it was an express or implied term of the Universal Plus, Flexiplus, and Optimet policies that the "maximum premium" identified in the policies was the highest premium the policyholder would be required to pay in a policy year and, if so, whether Sun Life breached this term by charging a class member a premium in excess of the amount of the maximum premium.[9]

[98] Each of these policies had a Policy Specifications page attached, with a chart showing a "projected premium" and a "maximum premium". As I have noted, the term "maximum premium" was not defined.

[99] It was acknowledged by the representative plaintiffs that neither they, nor any other class member that they were aware of, had been charged more than the maximum premium at the time of the motions for certification and summary

---

[9] "Was it an express or implied term of Universal Plus, Flexiplus and Optimet policies that the 'Maximum Premium' set out in the policies was the highest amount of premium that the policyholder would ever be required to pay for the policy in any year, in order to prevent lapse of the policy? If so, did Sun Life breach this term by charging any Class Members in excess of the Maximum Premium?"

judgment. But they argued that they were entitled to a declaration interpreting the maximum premium provision of the policies, in spite of the fact that there was no evidence of a breach to date.

[100] As with common issues 6 and 7, the motions judge concluded that common issue 8 was capable of being a suitable common issue, provided the plaintiffs met the "some basis in fact" threshold. He noted that at an earlier stage of this proceeding, in *Kang v. Sun Life Assurance Co. of Canada*, 2013 ONCA 118, 303 O.A.C. 64, this court had observed that the term "maximum premium" was ambiguous and that the pleading should not have been struck. Laskin J.A. stated, at para. 42:

> I do not think that the express terms of the Universal Plus policy are as clear as the motion judge considered them to be. The term "Maximum Premium" is not defined anywhere in the policy. The words "Maximum Premium" appear at the top of a chart on pages 3 and 3T of the policy, with corresponding rates for various forms of coverage. There is no express provision that Sun Life can charge a policyholder more than the "Maximum Premium". One available and reasonable inference is that the very term "Maximum Premium" means that the corresponding rates are the most a policyholder will have to pay. At the very least, the meaning of the term is ambiguous. Thus, in my view, the claim ought to stand.

[101] However, the motions judge concluded that there was no basis in fact for the existence of a breach of contract and no basis in fact for proposed common issue 8, because there was no evidence that any of the representative plaintiffs,

or any class member for that matter, had been charged a premium greater than the stated "maximum premium". He concluded, at para. 319 of his reasons:

> Thus, there is no basis-in-fact for questions based on an alleged breach of the Maximum Premium provisions of the insurance policies. This some-basis-in-fact deficiency cannot be cured by adjourning the certification motion for further evidence. Put simply, the proposed common issues based on an alleged breach of the Maximum Premium provisions of the insurance contracts are not certifiable.

[102] The motions judge also dismissed the maximum premium claims of the representative plaintiffs on summary judgment, not because they were time-barred, but because the claims, which he described as "inchoate", were premature.

[103] In support of the existence of some basis in fact for the proposed common issue, the plaintiffs had pointed to evidence that some class members would eventually be charged more than the stated "maximum premium". Kevin Morrissey, a Vice President of Sun Life, had deposed in the course of the Indemnity Litigation that "the year 2030 is the median point at which Universal Plus policyholders are likely be required to pay an amount in excess of the 'Maximum Premium' set out in their policy specifications pages."

[104] In my view, there is some basis in fact for the existence of a common issue concerning the meaning of the term "maximum premium" in the three contracts. There is an existing dispute about the meaning of an arguably ambiguous term. Although Sun Life's interpretation of "maximum premium" is not entirely clear, it

appears that it was the highest premium that a policyholder would be able to pay in order to be eligible for tax-exempt treatment in the accumulation fund. On the plaintiffs' interpretation, "maximum premium" means the highest premium that they will ever have to pay. As this court noted in *Kang*, that is one available and reasonable interpretation. Moreover, Sun Life has not disavowed the assertion that, at some time, some policyholders will be charged a premium that is greater than the stated maximum premium.

[105] This is the type of case in which a declaration would be appropriate, to define the rights of the contracting parties so they can govern themselves accordingly and avoid future disputes. In *LeBar v. Canada*, [1989] 1 F.C. 603, 90 N.R. 5, the Federal Court of Appeal described the nature of declaratory relief, at p. 610:

> A declaration differs from other judicial orders in that it declares what the law is without pronouncing any sanction against the defendant, but the issue which is determined by a declaration clearly becomes *res judicata* between the parties and the judgment a binding precedent.

[106] Similarly, in *Harrison v. Antonopoulos* (2002), 62 O.R. (3d) 463, 46 C.C.L.I. (3d) 89 (S.C.), Lang J. (as she then was) described the purpose of declaratory relief in commercial matters, at para. 27:

> Declaratory relief, being only a declaration of parties' rights, is mainly sought in commercial matters to help parties define their rights, and as a means to settle matters amicably where reasonable people would otherwise disagree on their mutual obligations and wish to resolve the matter in order to avoid future disputes. In

> other words, a cause of action need not be extant at the time a party requests declaratory relief. Because declaratory relief is in essence a request for an advance ruling, courts have discretion to refuse such relief. This is the type of relief contemplated by s. 108(2) of the *CJA* - a declaration of parties' rights with no coercive effect or remedial entitlement.

[107] The declaration sought here is consistent with that contemplated in *Harrison*. Declaratory relief should be available to the class. It is in the interests of both Sun Life and its affected policyholders to know whether the stated maximum premium can be exceeded.

[108] In summary, I conclude that the motions judge erred in failing to certify common issue 8.

[109] For the foregoing reasons, I would allow the appeal from the certification decision with respect to the breach of contract common issues 6, 7, and 8.

(e) Did the motions judge err in refusing to certify any of the other common issues?

[110] Having concluded that the class proceeding should have been certified with respect to the breach of contract common issues, it is my view that several additional common issues should have been certified.

[111] I will review all the proposed common issues in order.

[112] Common issue 1, which asks whether Sun Life is liable for the actions of its predecessors, should be certified. The motions judge did not consider it necessary

to address this issue because he did not certify either the misrepresentation or the breach of contract common issues. As I would certify the latter, common issue 1 becomes relevant. The first two COI increases occurred while the policies were being administered by Clarica. The resolution of common issue 1 would determine whether Sun Life is liable in the event that those COI increases were in breach of contract. It would also determine whether the plaintiffs are entitled to rely on the actions of MetLife and Clarica in response to Sun Life's limitations defences, discussed below.

[113] Common issue 2 asks whether Sun Life is estopped by positions it took in the Indemnity Litigation. As this issue relates primarily to the proposed misrepresentation common issues, the motions judge properly declined to certify it.

[114] Common issues 3, 4, and 5 are the misrepresentation common issues. I would dismiss the appeal in respect of those issues for the reasons set out above.

[115] Common issues 6, 7, and 8 are the breach of contract common issues. For the reasons above, I would allow the appeal with respect to these issues, which, in my view, should have been certified.

[116] Common issues 9 and 10 relate to claims that Sun Life owed policyholders a duty of good faith and that the policies were administered in a deceitful and fraudulent manner. As set out in the plaintiffs' factum, both issues "contend that

Sun Life was required to tell its policyholders about the pattern and repeated practice of sales misrepresentations".

[117] Specifically, common issue 9 asks whether Sun Life owed class members a duty of good faith and fair dealing, and whether such a duty was breached. As with the misrepresentation claims and as found by the motions judge, this turns on individual issues and is not suitable for certification.

[118] Common issue 10 asked:

> Did Sun Life administer the policies in a deceitful and fraudulent manner, including by engaging in fraudulent concealment, or in a manner that violated section 439 of the *Insurance Act* ... (prohibiting unfair and deceptive practices)?

[119] To the extent that this issue relates to a claim for damages, as with the claims for misrepresentation and breach of duty of good faith described above, and as found by the motions judge, it breaks down into individual issues and is not suitable for certification.

[120] However, as the motions judge noted in his reasons, at paras. 493-494, the allegations of breach of the duty of good faith, deceit, and fraud were asserted in two ways: as causes of action against Sun Life and as a bar to Sun Life's limitation period defences, based on the doctrine of fraudulent concealment.

[121] As I will explain shortly, it is my view that the trial judge erred in granting Sun Life's motion for summary judgment on the limitations issues. Having concluded

that the action should be certified with respect to the breach of contract common issues, it is my view that the fraudulent concealment aspect of common issue 10 is pertinent to Sun Life's limitation period defences, which may be raised as individual issues after a common issues trial. While the motions judge accepted that the parties were in a relationship of "utmost good faith", he found that there was nothing in Sun Life's administration of the policies that concealed the plaintiffs' causes of action such that the doctrine of unconscionability or fraudulent concealment was engaged. He focused on whether Sun Life's failure to inform the plaintiffs of a potential claim, specifically of the information disclosed in the Indemnity Litigation, could constitute concealment, finding, at para. 415 of his reasons, that "Sun Life made no statement to mislead the Plaintiffs".

[122] However, the motions judge failed to consider whether other communications by Sun Life to the plaintiffs might have had the effect of concealing their claims. This is particularly relevant to the claims that I would certify, namely those based on the increases in COI rates and Administrative Fees. While the motions judge determined there was no breach of contract, he did not consider whether Sun Life's communications to the plaintiffs representing that it had an entitlement to make these adjustments had potentially delayed their discovery of a breach of contract claim, if one did exist.

[123] In its Fresh as Amended Statement of Defence, Sun Life pleaded that as a result of letters and statements delivered to the plaintiffs, they knew or ought to have known of the facts that gave rise to the claims.

[124] In response to this pleading, the plaintiffs pleaded in their Reply to the Fresh as Amended Statement of Defence that:

> ... the insurer's letters and statements misrepresented and fraudulently concealed the policy terms concerning adjustments in cost of insurance rates and administrative fees, which also constituted fraud and deceit and breach of the duties of good faith and fair dealing by Sun Life in administering the policies.

[125] The letters and statements referred to in this paragraph included letters from Clarica and Sun Life to policyholders in 2000 and 2006 advising them of increases in their COI rates, and annual policyholder statements and other standard form documents sent to the proposed representative plaintiffs. Some of these notices included language to the effect that the plaintiffs' policies allowed the insurer to adjust the COI "from time to time", without including the remainder of the wording of the policies, which the plaintiffs argue qualified that statement.

[126] In my view, there is some basis in fact for the assertion that Sun Life concealed or misrepresented to affected policyholders the manner in which the COI was adjusted and misrepresented its entitlement to do so. This would be a relevant determination to a limitation period defence and could be substantially or partially resolved within the common issues trial.

[127] The proposed common issue 10 would thus apply, not as a stand-alone cause of action, but only as it relates to the limitation period defence, and would focus entirely on the communications and conduct of Sun Life and its predecessors on a policy-wide or cohort-wide basis, as opposed to the conduct of Sun Life or its agents in relation to individual class members.

[128] Resolution of this issue could impact on whether, and to what extent, Sun Life is entitled to raise any limitation period defences to these breach of contract claims. For example, in *Halloran v. Sargeant* (2002), 217 D.L.R. (4th) 327, 163 O.A.C. 138 (C.A.), this court upheld a finding by the majority of the Divisional Court that the doctrine of fraudulent concealment applied to negate a limitations defence where an employer had misrepresented an employee's legislative entitlements upon his dismissal. Given the special relationship between the parties, and that the employer was in a position to ascertain the state of the law and to provide accurate information to the employee, this court found it "unconscionable for the company to invoke the limitation period ... when it was responsible for ... [the plaintiff's] delay in filing the claim": at para. 33.

[129] Resolution of this issue, following the other breach of contract common issues, would also result in findings of fact and law that could have a bearing upon and could be applied commonly to all class members affected by the COI increases. The fact that individual issues may still remain is not a bar to certification.

[130] Common issue 11 asks whether the releases signed by some class members are subject to rescission. I agree with the motions judge that this turns on individual issues and is not suitable for certification.

[131] Common issues 12, 13, 14, and 15 deal with damages. I see no point in addressing these issues at this time. If the plaintiffs are unsuccessful on the breach of contract common issues, the damages issues will be irrelevant. If the plaintiffs succeed on the breach of contract issues, the common issues trial judge or the case management judge may give further directions on the determination of both individual and common issues with respect to damages.

(f) Should the proposed class action be certified?

[132] I conclude that the class action should be certified with respect to common issues 1, 6, 7, 8, and 10. It is accepted that the policyholders affected by those common issues have a cause of action in breach of contract. A suitable class can be defined, with sub-classes, if necessary, grouped by policy and time period. The resulting proceeding will meet the preferable procedure criterion. Representative plaintiffs who do not share these common issues can be removed from the class proceeding.

[133] I note in this regard that at para. 340 of his reasons on certification, the motions judge observed that "a representative plaintiff must have a viable claim in

order to represent the class" and that "if the proposed representative plaintiff's claims are statute-barred, then he or she cannot be a representative plaintiff".

[134] In *Stone v. Wellington County Board of Education* (1999), 120 O.A.C. 296, 29 C.P.C. (4th) 320 (C.A.), leave to appeal refused, [1999] S.C.C.A. No. 336, this court observed, at para. 10, that "[w]here a representative plaintiff, for reasons personal to that plaintiff, is definitively shown as having no claim because of the expiry of a limitation period, he or she cannot be said to be a member of the proposed class" (emphasis added).

[135] Here, the motions judge found that some of the representative plaintiffs' breach of contract claims were not time-barred, a finding that the respondents dispute. The fact that some claims may potentially be time-barred does not prevent the plaintiffs from representing the class. In *Amyotrophic Lateral Sclerosis Society of Essex County v. Windsor (City)*, 2015 ONCA 572, 387 D.L.R. (4th) 603, this court approved representative plaintiffs who had some claims that were timely and some that were presumptively time-barred.

[136] As I explain below, the limitations issue should not have been resolved on summary judgment. In the particular circumstances of this case, the fact that some of the breach of contract claims of some of the representative plaintiffs may be wholly or partially time-barred, should not preclude them from representing the class. It has not been definitely shown that all the breach of contract claims of

every representative plaintiff are time-barred. There is a reasonable likelihood they are not.

[137] I would direct that the proceeding be remitted to the Superior Court of Justice for certification in accordance with these reasons and for such further directions as may be necessary.

[138] I turn to the appeal and cross-appeal of the order on summary judgment.

(2) Plaintiffs' appeal of summary judgment

(a) Overview

[139] The proposed representative plaintiffs appeal the summary judgment order dismissing their misrepresentation claims and some of their breach of contract claims as time-barred.

[140] The context is important. Although the motions judge dismissed the certification motion, the seven putative representative plaintiffs were entitled to pursue their individual causes of action for misrepresentation, unless they were time-barred, as he found they were. They were also entitled to pursue their individual causes of action for breach of contract, which he found were only partially time-barred. Finally, they were entitled to pursue individual claims for deceit and breach of duty of good faith, which the motions judge found were not time-barred.

[141] As I would affirm the motions judge's decision not to certify the misrepresentation claims, the issue remains whether those individual claims should have been dismissed as time-barred on summary judgment. And, as I would allow the appeal in relation to some of the breach of contract common issues, the issue also remains whether the individual plaintiffs' claims for breach of contract are wholly or partially outside the limitation period.

[142] For the reasons that follow, I conclude that the motions judge erred in principle in granting summary judgment with respect to both the misrepresentation and breach of contract claims, as he failed to give consideration to important individual and contextual factors in his analysis of the limitation period issue.

(b) The standard of review

[143] Absent a palpable and overriding error in his assessment of the evidence, or an error of law, the exercise of the motions judge's powers to grant summary judgment is entitled to deference. The palpable and overriding error standard typically applies to the question of whether a limitation period has expired. See: *Crombie Property Holdings Limited v. McColl-Frontenac Inc.*, 2017 ONCA 16, 406 D.L.R. (4th) 252, at para. 31, leave to appeal refused, [2017] S.C.C.A. No. 85.

(c) The *Limitations Act, 2002*

[144] Section 4 of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sch. B. states that, unless the Act otherwise provides, there is a two-year limitation period commencing from the day on which the claim was "discovered".

[145] Section 5 of the Act provides that:

> (1) A claim is discovered on the earlier of,
>
> (a) the day on which the person with the claim first knew,
>
> (i) that the injury, loss or damage had occurred,
>
> (ii) that the injury, loss or damage was caused by or contributed to by an act or omission,
>
> (iii) that the act or omission was that of the person against whom the claim is made, and
>
> (iv) that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it; and
>
> (b) the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a).

(d) The motions judge's reasons

[146] The motions judge set out the relevant law at paras. 383-390 of his reasons, which I condense, drawing liberally from his language and without reference to the authorities, as follows:

> (a) There is a statutory presumption, in s. 5(2) of the *Limitations Act, 2002*, that unless the contrary is proven a claimant is presumed to

have known the elements of his or her claim on the day the events of the claim occurred.

(b) The plaintiff may attempt to rebut that presumption by tendering evidence that he or she both subjectively and objectively did not discover the claim until some later date.

(c) Section 5(1) of the Act defines discovery in relation to "the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a)." The matters referred to in clause (a) include (i) the identity of the wrongdoer, (ii) his or her wrongdoing, and (iii) knowledge that litigation would be an appropriate means to seek a remedy for the wrongdoing.

(d) The limitation period runs from when the prospective plaintiff has, or ought to have, knowledge of a potential claim and the question is whether the prospective plaintiff knows enough facts to base a cause of action against the defendant. If so, then the claim has been discovered, and the limitation period begins to run.

(e) Thus, when a limitation period defence is raised, the onus is on the plaintiff to show that their claim is not statute-barred and that he or she behaved as a reasonable person would have in the same or similar circumstances using reasonable diligence in discovering the material facts.

(f) The circumstance that a potential claimant may not appreciate the legal significance of the facts does not postpone the commencement of the limitation period if he or she knows or ought to know the existence of the material facts, which is to say the constituent elements of his or her cause of action. Error or ignorance of the law or legal consequences of the facts does not postpone the running of the limitation period.

[147] It has not been suggested that the motions judge erred in his statement of these principles.

[148] As the motions judge noted, the misrepresentations alleged by the plaintiffs varied, but they were made by MetLife sales agents around the time the policies

were sold. All the plaintiffs subsequently received a copy of the policy. The policies contained standard exculpatory language about the limited authority of the sales agents. From time to time the plaintiffs also received notices to pay increased premiums and other information about the status of their insurance.

[149] The motions judge stated, at para. 391 of his reasons, that the issue to be determined on summary judgment of the misrepresentation claims was when each of the plaintiffs discovered, or ought to have discovered, that what they had been told by a MetLife sales agent was untrue. He noted, at para. 386, that discovery is a fact-based analysis that depends on the particular cause of action and the subjective or objective knowledge of the material facts of the cause of action: referring to this court's decision in *Lawless v. Anderson*, 2011 ONCA 102, 276 O.A.C. 75, at paras. 22-23.

[150] In view of what the motions judge described as an ample evidentiary record, he ignored the presumption in s. 5(2) of the *Limitations Act, 2002* that the day on which a reasonable person ought first to have known of his or her claim is the day the act or omission occurred – that is, the day on which the representation was made. On the facts of this case, when the representations were made before class members even received their policies, it could not possibly be said that the presumption applied.

[151] In determining when each plaintiff knew or ought to have known that a misrepresentation had been made, the motions judge applied what he described

as "venerable law", that "once an insurance policy is delivered to an insured, he or she is taken to have read the policy and accepted its terms". He referred in particular to *The Provident Savings Life Assurance Society of New York v. Mowat* (1902), 32 S.C.R. 147.

[152] He qualified this principle by stating, at para. 398 of his reasons, that delivery of the policy would not start the running of the limitation period "unless a reading of the policy or some other record or information disclosed to the insured would have disclosed a contradiction between the representation and the policy terms". He said that in this case a reading of the policies would have disclosed some or all of the plaintiffs' misrepresentation claims, but not the breach of contract claims.

[153] Applying these principles, the motions judge found that each individual plaintiff's claim for misrepresentation was time-barred. Each knew or ought to have known either that the terms of the policy were inconsistent with what was allegedly represented upon receiving their policy, or that the policy was not performing in the manner allegedly represented upon receiving further policy illustrations or other communications from the insurer over the following years.

[154] To illustrate the motions judge's reasoning, I will use two examples, quoting from his reasons.

[155] First, in the case of the representative plaintiff Ms. Clark, the motions judge found, at paras. 438-442 of his reasons:

> Ms. Clark received her Interest Plus policy in 1988. Had she read the policy, she would have appreciated that its terms were inconsistent with what had been represented to her. Nova Scotia's six-year limitation period began to run and it expired in October 1994.
>
> In the alternative, Ms. Clark actually knew by 1999 that her Interest Plus policy was not performing in the manner represented to her. Under this alternative, the limitation period would have expired in 2005 long before she was added as a Plaintiff in 2013.
>
> Ms. Clark received her Flexiplus policy in October 1994. Had she read the policy, she would have appreciated that its terms were inconsistent with what had been represented to her. British Columbia's two-year limitation period began to run and it expired in October 1996.
>
> In the alternative, Ms. Clark knew or ought to have known that her Flexiplus policy was not performing in the manner represented to her when in December 2000 and again in September 2006, she received a letter explaining the terms of the Flexiplus policy and advising that her monthly insurance charge was increasing. Under this alternative, her misrepresentation claims with respect to the Flexiplus policy became statute-barred in 2002 or 2008 before she was added as a Plaintiff in 2013.
>
> In the further alternative, Ms. Clark's Annual Policyholder Statements in October 2007 revealed that the Flexiplus policy was not performing as represented. A limitation period would begin to run to expire in October 2009 well before Ms. Clark was added as a Plaintiff in 2013.

[156] In the case of Mr. Fehr, he found at paras. 450-453:

> Mr. Fehr received his Universal Plus in November 1990 and his Flexiplus policy in March 1995. Upon the receipt of the policies, he could or should have known that their terms were inconsistent with what had been represented to him. Saskatchewan's six-year limitation period began to run, and it expired in November 1996 for the Universal Plus policy and March 2001 for the Flexiplus policy.

> In the alternative, Mr. Fehr was advised in December 2000 and in October 2006 that his COI was increasing. When he paid a premium higher than his initial premium, he knew or ought to have known that his policy was not performing as represented to him. The then-applicable six-year limitation period in Saskatchewan would begin to run and expire in December 2006.
>
> In the further alternative, Mr. Fehr made amendments to his policy in March 1996 and again in March 2003. Each policy amendment was a fresh occasion for Mr. Fehr to review his policy. Mr. Fehr knew or ought to have known that the policy was not as represented to him. The then-applicable six-year limitation period would begin to run and expire at the latest in March 2009.
>
> In my opinion, a trial is not necessary to determine that Mr. Fehr's misrepresentation claims are statute-barred.

[157] To summarize, the motions judge found that the misrepresentation claims of all representative plaintiffs were time-barred because: (a) by virtue of *Provident Savings*, he or she was taken to have read the policy and accepted its terms; (b) on reading the policy, he or she would have appreciated that the terms were inconsistent with the alleged misrepresentations; and (c) further or in the alternative, as a result of subsequent events and communications from Sun Life, he or she would have realized that the policy was not performing as represented.

[158] The motions judge did not enter into an analysis of the specific representations, communications, and context related to each of the plaintiffs' claims in determining whether their individual claims were time-barred.

[159] The motions judge rejected the submission that the doctrine of unconscionability or fraudulent concealment prevented Sun Life from relying on

the limitation period defence. He also rejected the argument, based on *407 ETR Concession Co. v. Day*, 2016 ONCA 709, 133 O.R. (3d) 762, leave to appeal refused, [2016] S.C.C.A. No. 509, that the limitation period was postponed until such time as the plaintiffs were able to prosecute their claims on a class action basis.

[160] As regards the plaintiffs' claims for breach of contract, the motions judge found that the proper law governing the contracts was Ontario law and therefore the *Limitations Act, 2002* applied. He found the plaintiffs with Flexiplus policies knew or ought to have known that they had a claim for breach of contract against Sun Life in 2001, when Sun Life implemented an increase in the COI, and again in 2006, when a second increase was implemented. Mr. O'Hara, the plaintiff with an Optimet policy, knew or ought to have known that he had a breach of contract claim in 2007 (the ninth year of the policy) when Sun Life increased his COI by ten percent.

[161] With respect to the Flexiplus policy, he found that any breach of contract claims were statute-barred for the years 2001-2008, but not for the subsequent years. With respect to the Optimet policy, he found that any breach of contract claims were statute-barred for 2007 and 2008, but not for the subsequent years.

[162] He found, at para. 479 of his reasons, that each monthly charge of an unlawful COI rate would constitute a discrete breach of an ongoing contract, with each repetition of the overcharge triggering the running of the limitation period. In

other words, he found that a "rolling" limitation period applied to the breach of contract claims, such that breaches alleged within two years prior to the commencement of the action would not be statute-barred.

[163] Finally, he found that the plaintiffs' claims for good faith and rescission were not statute-barred and the maximum premium breach of contract claims were not statute-barred but were "premature".

(e) The parties' submissions

[164] The plaintiffs contend that the motions judge erred in relying on *Provident Savings*. This reliance led him to apply a presumption about discoverability, when he instead should have determined when the plaintiffs had actual knowledge of their claims and when a person with the abilities and in the circumstances of the plaintiffs first ought to have known of the claims.

[165] The plaintiffs also assert, with respect to the breach of contract claims, that the notices sent to the policyholders were not sufficient to enable them to discover a breach of contract. A reasonable person in the plaintiffs' position, reading the notices, would have believed the insurer was entitled to make adjustments to the COI.

[166] Sun Life, for its part, says that *Provident Savings* is good law and that, in any event, the plaintiffs received information during the life of their policies that contradicted the misrepresentations they now rely upon. Communications to

policyholders clearly stated that the COI was being adjusted based on factors that the plaintiffs could have seen, by reading their policies, were not among the factors identified in the policies.

[167] I turn first to summary judgment on the misrepresentation claims.

(f) Did the motions judge err in granting summary judgment with respect to the misrepresentation claims?

[168] While the motions judge identified alternative grounds on which to dismiss the plaintiffs' misrepresentation claims as time-barred, he made errors in principle that, in my view, vitiate his decision. As a result, summary judgment should be set aside and the individual plaintiffs should be free to pursue their misrepresentation claims, if they choose. Sun Life will be entitled to raise limitation period defences applicable to each plaintiff in the course of that litigation.

[169] The motions judge correctly observed that discoverability is a fact-based inquiry. It takes into account what a reasonable person with the abilities and in the circumstances of the person with the claim ought to have known about the matters described in s. 5(1)(a) of the *Limitations Act, 2002*. He cited this court's decision in *Lawless v. Anderson*, above, at paras. 22-23, which states:

> The principle of discoverability provides that "a cause of action arises for the purposes of a limitation period when the material facts on which it is based have been discovered, or ought to have been discovered, by the plaintiff by the exercise of reasonable diligence. This principle conforms with the generally accepted definition

> of the term 'cause of action' - the fact or facts which give a person a right to judicial redress or relief against another": *Aguonie v. Galion Solid Waste Material Inc.* (1998), 38 O.R. (3d) 161 (C.A.), at p. 170.
>
> Determining whether a person has discovered a claim is a fact-based analysis. The question to be posed is whether the prospective plaintiff knows enough facts on which to base an allegation of negligence against the defendant. If the plaintiff does, then the claim has been "discovered", and the limitation begins to run: see *Soper v. Southcott* (1998), 39 O.R. (3d) 737 (C.A.) and *McSween v. Louis* (2000), 132 O.A.C. 304 (C.A.).

[170] In dismissing the motion for certification of the misrepresentation claim, the motions judge pointed to the "idiosyncratic" nature of the plaintiffs' claims, which made them unsuitable for resolution as common issues. He stated, at para. 292 of his reasons, that the pre-contractual dealings between the plaintiffs and MetLife's agents were not uniform:

> As demonstrated by the stories of each of the proposed Representative Plaintiffs, their experiences in purchasing insurance policies were not common or uniform experiences. All the stories of the sales of the insurance policies are idiosyncratic both from the perspective of the putative Representative Plaintiffs and from the perspective of the MetLife sales agents who sold the insurance policies. And some proposed Representative Plaintiffs dealt with more than one idiosyncratic sales agent who made different alleged misrepresentations. There are six alleged misrepresentations and how these misrepresentations were actually expressed and heard by the policyholders is multifarious. The alleged misrepresentations were made over the breadth of the class period, 13 years, by thousands of different sales agents who were not uniformly trained about four different policies some of which had revised standard

> forms over the course of their offering to the public. [Emphasis added.]

[171] The motions judge found that the post-contractual dealings between the plaintiffs and Sun Life were also idiosyncratic, at para. 293:

> Further, the proposed Representative Plaintiffs' subsequent dealings with Sun Life, from which dealings the deceit (fraudulent misrepresentation), breach of duty of good faith, and rescission claims are derived, are idiosyncratic, and these causes of action do not show commonality.

[172] Finally, he noted in the same paragraph that the facts pertaining to Sun Life's limitation period defences were not common but rather "emerge from the personal histories of each Plaintiff and each putative Class Member".

[173] However, when it came to assessing the limitation period defences applicable to the individual plaintiffs, the motions judge did not engage in a detailed examination of these idiosyncrasies. In particular, he did not consider the impact of each plaintiff's circumstances and experiences on the critical issue of when each plaintiff discovered his or her claim or knew or ought to have known of the requisite facts grounding their claim. He failed to engage in an individualized and contextual analysis, and, instead, applied a broad presumption as to when they ought to have known of certain alleged misrepresentations.

[174] An individualized and contextual analysis was necessary in this case for the very reason that misrepresentation claims are not generally amenable to class actions: people receive, process, and act upon written and verbal statements in

different ways. Their behaviour varies depending upon a variety of factors, including their own particular circumstances, what specific representations and information they received and from whom, how they understood or processed those representations and information, the extent to which they relied upon them, and their own wishes and intentions.

[175] An individualized and contextual analysis was particularly important in this case because, among other things: (a) there is a relationship of vulnerability between insurer and insured; (b) many of the plaintiffs are unsophisticated with respect to the insurance industry; (c) the insurance policies are complicated and not easily understood; (d) misrepresentations were made to some consumers and not others; (e) some or all of these misrepresentations were made by individuals on whom the plaintiffs might reasonably rely; (f) there is no evidence that the insurer expressly corrected the misrepresentations; and (g) the insurer may have reinforced or made further misrepresentations, to some or all of the plaintiffs, during the life of the policies.

[176] While the motions judge was prepared to take the plaintiffs' claims at face value, he did not conduct the kind of granular analysis that was required in order to support his conclusion that they could each have discovered their claims by reading their policy or as a result of subsequent communications made to them by Sun Life or its predecessors.

[177] In dismissing both the misrepresentation claims and portions of the breach of contract claims, the motions judge applied a presumption, based on *Provident Savings*, that once an insurance policy is delivered to an insured, the insured is taken to have read the policy and accepted its terms. He therefore concluded that the plaintiffs ought to have discovered the insurer's misrepresentations when they received their insurance policies. This resulted in an analysis that was divorced from the plaintiffs' individual circumstances and knowledge, which forms the heart of the discoverability analysis.

[178] The factual and legal landscape of *Provident Savings*, a 1902 decision of the Supreme Court of Canada, is far removed from this case. The jurisprudence in relation to the duties of insurers and their agents has evolved. Case law, such as the decision of this court in *Fine's Flowers Ltd. et al. v. General Accident Assurance Co. of Canada* (1977), 17 O.R. (2d) 529, 81 D.L.R. (3d) 139, and the decision of the Supreme Court of Canada in *Fletcher v. Manitoba Public Insurance Co.*, [1990] 3 S.C.R. 191, 74 D.L.R. (4th) 636, has confirmed an obligation on sellers of insurance to provide accurate advice and information to their customers.

[179] Further, Mr. Mowat, in *Provident Savings*, was quite unlike the plaintiffs in this case. He dealt directly with the insurer's agent and the insurer's general manager in negotiating the terms of his policy. He submitted an application for insurance and attached a "slip" or memorandum allegedly containing certain terms he wished to have included in the policy. One of these terms, he said, was that the

premium was to be fixed for the life of the policy. When he received the policy, which included his application but not the memorandum or its terms, he pronounced himself satisfied and paid the premiums for seven years before raising any issue. In fact, the policy he received stated that the premium could be increased. When the company claimed the right to do so, Mr. Mowat objected. The Supreme Court held that he was bound by the terms of the policy.

[180] Mr. Mowat was clearly a sophisticated insured. He insisted on terms he wanted included in the policy and when he received the policy he could have determined, had he read it, that those terms were not included. It was reasonable in the circumstances to hold him bound by the language of the policy.

[181] It is in my view unrealistic to apply *Provident Savings* to a case in which the policy language was complicated, the plaintiffs were not sophisticated purchasers, and the insurer had made representations about what the policy language meant.

[182] In addition to relying on a presumption based on *Provident Savings*, the motions judge relied on subsequent communications from the insurer to the plaintiffs, advising of increases in the COI. He found that the communications about the COI increases should have revealed to the plaintiffs the alleged misrepresentations with respect to those rates. In some of those communications, however, Sun Life represented that it had a right to make COI adjustments, a matter that is very much in issue in this proceeding.

[183] The motions judge further relied on the actual or projected performance of the plaintiffs' policies, at various times, to find that the plaintiffs discovered or ought to have discovered the misrepresentations claimed.

[184] In my view, while these were relevant general considerations, the motions judge erred by failing to further consider the specific circumstances of each plaintiff and his or her dealings with the insurer or its agents. His analysis should have included consideration of, among other things:

- the individual plaintiff's experience and sophistication in relation to insurance and financial matters;
- the relationship between the plaintiff and MetLife's agent and the extent to which the plaintiff relied on the agent for advice before the policy was issued and during the life of the policy;
- the representations made by MetLife's agent when the policy was sold and whether those representations were false;
- whether the language of the policy, read through the lens of the plaintiff's circumstances and the representations made by the agent, was sufficient to disclose "the truth" to the plaintiff;
- communications made by the insurer or the agent to the plaintiff after the policy was issued and whether those communications disclosed to the plaintiff the falsehood of the representations, reinforced them, or contained fresh misrepresentations; and

- whether the representations made at the time the policy was sold affected or could have affected the plaintiff's understanding of subsequent communications from MetLife and Sun Life.

[185] The analysis would also take into consideration the special relationship between the parties, which the motions judge himself acknowledged contained a duty of utmost good faith.

[186] This relationship of particular vulnerability and corresponding duty of utmost good faith are contextual factors which should have been taken into consideration in the motions judge's analysis of when, with reasonable diligence, the plaintiffs ought to have discovered the alleged misrepresentations, and the reasonableness of any reliance they placed on the initial or subsequent representations made by the insurer and its agents.

[187] There was much to consider in this regard. As I have said, the policy language was impenetrable and confusing. It is not at all clear that the policy language plainly contradicted some of the representations allegedly made. There was evidence in the Indemnity Litigation that Sun Life knew or ought to have known that there had been misrepresentations in the sale of the policies, and that those misrepresentations were not corrected.

[188] I agree with the plaintiffs that the motions judge failed to consider the objective aspect of the discoverability test in s. 5(1)(b) of the *Limitations Act, 2002* which asks what a "reasonable person with the abilities and in the circumstances

of the person with the claim" ought to have known. In making his determination on the limitations issue, he failed to give due consideration to each plaintiff's abilities and circumstances.

[189] For these reasons, it is my view that the motions judge erred in principle in granting summary judgment with respect to the misrepresentation claims. As such, I would allow the plaintiffs' appeal with respect to these claims. The plaintiffs should be allowed to proceed with these claims in the course of individual litigation, without prejudice to Sun Life's ability to raise any applicable limitation period defences in that context.

[190] I turn to summary judgment in relation to the breach of contract claims.

(g) Did the motions judge err in granting summary judgment with respect to the claims for breach of contract?

[191] As noted in the discussion of the certification appeal, the representative plaintiffs who held Flexiplus and Optimet policies asserted that Sun Life, and its predecessor Clarica, breached the contracts by raising the COI on the basis of factors other than those set out in the policies. They made similar arguments with respect to the Administrative Fee – namely, that the fee was increased for reasons unrelated to the cost of administration of the policies.

[192] Although the motions judge had not yet decided whether there was a basis in fact for the allegation of breach of contract – that issue having been deferred for

the submission of further evidence and later disposed of in his continued reasons – he proceeded with summary judgment on the assumption that the increases made by Sun Life were in breach of contract.

[193] He found that neither the delivery of the policies to the plaintiffs, nor of any earlier documentation before the notices of the COI increases, provided the plaintiffs with the necessary knowledge to trigger the running of the limitation periods. He held, however, as argued by Sun Life, that the plaintiffs with Flexiplus policies knew or ought to have known that they had claims for breach of contract in relation to both the COI and the Administrative Fee in 2001 when Sun Life announced and implemented an increase in the COI, and when this occurred again in 2006. He held that Mr. O'Hara, who had an Optimet policy, knew or ought to have known that he had a breach of contract claim in 2007, when his COI was increased by ten percent.

[194] The motions judge therefore held that the breach of contract claims were statute-barred up to 2008, but not subsequent years thereafter.

[195] The plaintiffs submit that they could not have known that they had a claim for breach of contract based on the letters they received announcing the increases in their COI rates and Administrative Fees. Sun Life argues, and the motions judge found, that the plaintiffs knew or ought to have known from these notices that they had a claim for breach of contract. In support of this assertion, Sun Life points out that the notices advised that the monthly insurance rates could increase or

decrease based on a number of factors, including the number of claims received, policy year, interest earnings, taxes, and other expenses. These factors, however, were not among those listed in the policies.

[196] In considering this issue, it is instructive to re-visit the evidence, set out above, concerning the relevant terms of the Flexiplus policy and the letter sent to the representative plaintiff Mr. Lucas, announcing the increase in the COI and explaining the reasons. That letter did not quote the full language of the policy. It simply said "[y]our policy states: 'the monthly rate for the Cost of Insurance will be set by us from time to time.' It is necessary to increase the costs of insurance to better reflect current interest rates." It omitted the wording in the policy itself which stated that the COI would be set from time to time, "based on the primary Insured's sex, issue age, underwriting class, policy year and the Specified Face Amount of Insurance", an omission which the plaintiffs argue was misleading.

[197] In my view, as with the misrepresentation claims, the issue of whether the individual plaintiffs knew or ought to have known the matters set out in s. 5(1)(a) of the *Limitations Act, 2002* with respect to the breach of contract claims required a much more individualized and contextual analysis. That analysis would have considered many of the matters I have referred to at para. 184, above. It would consider whether the individual plaintiff, or a reasonable person with his or her abilities and in his or her circumstances, would have understood, from reading the policy, how the COI would be adjusted and whether that was different from what

was represented by the insurer. It would also consider whether any subsequent communications sent to the plaintiff by the insurer accurately described the basis of the adjustment and the insurer's contractual entitlement to adjust the COI on that basis.

[198] For example, as noted above with respect to the certification of common issue 10, a finding that Sun Life misrepresented how the policy operated or misrepresented its right to adjust the COI could well have influenced the motions judge's assessment of when the breach of contract claim was discovered.

[199] It also seems to me that an individual and contextual analysis of what each plaintiff knew or ought to have known would consider the content of the insurer's communications in relation to the plaintiffs' abilities and circumstances. An important consideration would be whether a reasonable person in the plaintiffs' situation would have accepted Sun Life's explanation of the increase (e.g. to reflect current interest rates) and relied upon Sun Life's statement that it was entitled to make the adjustment, or if they would have examined their policy to determine whether Sun Life's explanation was accurate and whether the increase was permitted. It was an error in principle for the motions judge not to consider these relevant contextual factors in his assessment of discoverability.

[200] For these reasons, it is my view that the motions judge erred in granting summary judgment with respect to the breach of contract common issues. As with the individual claims for misrepresentation, a more thorough and contextual

analysis was required to determine to what extent, if any, the individual plaintiffs' claims for breach of contract were statute-barred.

[201] I would allow the plaintiffs' appeal with respect to summary judgment of the breach of contract claims. As I have found that these claims are suitable for certification, and that certain factual determinations on the common issues trial may impact the issue of discoverability in this case, it is appropriate that any limitations analysis with respect to the individual plaintiffs take place following completion of the common issues trial, should the plaintiffs succeed on the breach of contract common issues. Sun Life will be entitled to raise any applicable limitation period defences at that time.

(h) Did the motions judge err in dismissing the maximum premium claim as premature?

[202] As discussed above, in relation to the certification appeal, the owners of the Universal Plus, Flexiplus, and Optimet policies alleged that it would be a breach of contract for Sun Life to charge a premium in excess of the "maximum premium" and sought a declaration that the policy would be breached in that eventuality. There was significant overlap in the parties' submissions on this issue across the two appeals.

[203] With respect to the motion for summary judgment, relying on s. 16(1)(a) of the *Limitations Act, 2002*, the plaintiffs asserted that their claim for a declaration

would not be subject to a limitation period. Section 16(1)(a) provides that there is no limitation period in respect of "a proceeding for a declaration if no consequential relief is sought".

[204] The motions judge observed that s. 16(1)(a) applies only where there is no claim for "consequential relief" in addition to the declaration. Since the plaintiffs sought damages for breach of the policies, he found there would be a limitation period applicable to the claim: see *Alberta Municipal Retired Police Officers' Mutual Benefit Society v. Alberta*, 2010 ABQB 458, 504 A.R. 41, at paras. 100-103.

[205] However, he went on to find that the maximum premium breach of contract claim was not statute-barred, because the plaintiffs acknowledged that no one had ever been charged a premium in excess of the maximum. Rather, he said, the claim was "premature". He therefore dismissed this claim because there was no evidence that this term of the contract had been breached.

[206] Although the statement of claim sought damages for the alleged breach, in addition to a declaration, the plaintiffs acknowledged that no damages had yet been sustained and they were seeking prospective relief. It is inaccurate, therefore, to call the claim for declaratory relief "premature". While no breach of contract had occurred, the plaintiffs reasonably apprehended that at some future date the contract would be breached when some policyholders were charged more than the "maximum premium" stated in their policies. That apprehension is based on Sun

Life's interpretation of the term "maximum premium" and the projections of when premiums would exceed that amount.

[207] As stated in my reasons on the certification issue, this is a case in which declaratory relief would be appropriate. It fits within the scope of s. 16(1)(a) of the *Limitations Act, 2002*. Here, the claim for a declaration is not ancillary to a claim for damages that are barred by a limitation period. Rather, the claim requests a pronouncement on the legal rights of the parties, without any order for enforcement or execution. I rely on my analysis and the authorities cited above, in the certification reasons, in making this determination.

[208] What the plaintiffs seek in this case is simply a determination of their rights, so that both parties can understand their positions and govern themselves accordingly. The claim for a declaration is not time-barred. Nor is it premature. I would therefore allow the plaintiffs' appeal as it relates to the dismissal of this claim for declaratory relief.

(i) The doctrine of unconscionability and *407 ETR v. Day*

[209] As I have granted the plaintiffs' appeal with respect to summary judgment on both the misrepresentation and breach of contract claims, without prejudice to Sun Life raising limitation period defences in the future, it is unnecessary to make a determination at this time with respect to the plaintiffs' arguments on the doctrine of unconscionability or the application of *407 ETR v. Day*.

(j) Sun Life's appeal of summary judgment

[210] As Sun Life is free to raise a limitations defence to both the misrepresentation and breach of contract claims in the future, I do not find it necessary to consider Sun Life's appeal, with respect to the issues of when the breach of contract claims were first properly pleaded or the applicability of a rolling limitation period to such claims.

(k) Limitation period common issues

[211] I would add that, in my view and subject to the discretion of the common issues judge, the individual limitations issues pertaining to the breach of contract claims should be deferred until after the common issues trial. If the plaintiffs are unsuccessful on the breach of contract common issues, the operation of the limitation period becomes academic. If the plaintiffs succeed on the breach of contract common issues, individual trials may be necessary on limitations issues. There may, however, be some common issues of fact and law pertaining to the limitations issues that could be addressed as part of the common issues trial.

(3) Costs

[212] In the result of this appeal, success has been divided and it would not be appropriate to address the costs without further submissions. The parties shall be entitled to make submissions as to the costs arising from the proceedings below, and in this court. Those submissions shall be limited to 10 pages in length,

excluding the costs outlines. The plaintiffs shall deliver their submissions within 15 days of the release of these reasons and the defendant shall then have 15 days within which to respond. There shall be no reply submissions.

E. ORDER

[213] For these reasons, I would dismiss the plaintiffs' appeal from the order dismissing their motion for certification with respect to the misrepresentation common issues (common issues 3, 4, and 5) and allow the appeal with respect to the breach of contract common issues (common issues 6, 7, and 8), as well as common issue 1 and common issue 10 as it relates to the applicability of the doctrine of fraudulent concealment to counter Sun Life's limitation period defenses. I would certify the class action with respect to those common issues. I would allow the plaintiffs' appeal from summary judgment. I would direct that, if necessary, the issues relating to the applicable limitation periods for the breach of contract claims be tried after the common issues trial.

Released: SEP 0 5 2018

George R. Strathy C.J.O.

I agree.

I agree J.A.

Appendix

Common Issues

1. Is Sun Life liable for any wrongful conduct of MetLife, Mutual, and Clarica?

2. Is Sun Life estopped or precluded from denying the assertions it made and the positions it took in the indemnification litigation against MetLife?

3. Did MetLife owe Class Members a duty of care when selling the policies?

4. Did MetLife, through its agents and employees, engage in and condone a pattern and repeated practice of misrepresenting and failing to accurately describe to its policyholders the nature, provisions, financial elements and benefits of the relevant policies sold by it?

    (a) Interest Plus lifetime-coverage misrepresentation

    (b) Universal Plus, Flexiplus, and Optimet "Maximum Premium" misrepresentation

    (c) Flexiplus level Cost of Insurance misrepresentation

    (d) Optimet Cost of Insurance and Administrative Fees not disclosed for year nine and onward

    (e) Misleading illustrations and vanishing premiums

5. Were the misrepresentations made negligently?

6. Was it an express or implied term of the policies that the COI rate may be adjusted based on specified factors? If so, did Sun Life breach this term by basing increases, in whole or in part, on other factors?

7. Was it an express or implied term of the policies that Administrative Fees may be adjusted based on factors related to the cost of administering the policies? If so, did Sun Life breach this term by basing increases, in whole or in part, on other factors?

8. Was it an express or implied term of Universal Plus, Flexiplus and Optimet policies that the "Maximum Premium" set out in the policies was the highest amount of premium that the policyholder would ever be required to pay for the

policy in any year, in order to prevent lapse of the policy? If so, did Sun Life breach this term by charging any Class Members in excess of the Maximum Premium?

9. Did Sun Life owe the Class Members a duty of good faith and fair dealing in administering the Policies? If so, did the Defendant breach that duty and in what way?

10. Did Sun Life administer the policies in a deceitful and fraudulent manner, including by engaging in fraudulent concealment, or in a manner that violated section 439 of the *Insurance Act*, S.O. 1990, c. I.8 (prohibiting unfair and deceptive practices)?

11. Are releases obtained by the Defendant from Class Members subject to rescission?

12. If the Defendant is found liable on any claims asserted by Class Members, what types of damages and/or equitable remedies are the Class Members entitled to receive: (a) compensatory, reliance, or expectation damages; (b) rectification (provide policy benefits as represented to Class Members); (c) restitution (return amounts improperly charged to Class Members); (d) disgorgement (allocate profits related to the misconduct to Class Members)?

13. How should recoveries under each type of remedy be measured?

14. If the measure of any type of remedy is aggregate, what is the aggregate amount and how should it be applied to the Class Members?

15. Should the Defendant be required to pay punitive or exemplary damages?