CATASTROPHIC ACCIDENT BENEFITS CLAIMS – THE PLAINTIFFS' PERSPECTIVE

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* I wish to gratefully acknowledge the assistance provided to me by Rachel J. Urman, an associate of Bogoroch & Associates, in the preparation of this paper and in particular I acknowledge her significant contribution in the writing of sections II, III and IV.

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With the enactment of the *Automobile Rate Insurance Stability Act*, commonly known as Bill 59, and with the promulgation of O. Reg. 403/96, a two tiered system of benefits was created with profound consequences to injured persons and their families.

This paper will focus on the plaintiff's perspective in handling catastrophic accident benefit claims and will discuss, consider and analyse the tactical considerations to employ when acting for the catastrophically injured.

I. The Statutory Framework

"Catastrophic impairment" is defined in subsection 2(1) of the Statutory Accident Benefits Schedule-Accidents On or After November 1, 1996[1] as follows:

(a) paraplegia or quadriplegia,

(b) amputation or other impairment causing the total and permanent loss of use of both arms,

(c) amputation or other impairment causing the total and permanent loss of both an arm and a leg,

[1] O. Reg. 403/96, as amended by O. Reg. 403/96, 462/96, 505/96 and 551/96; 303/98 made under the *Insurance Act of Ontario* R.S.O. 1990, c.I.8 as amended (hereinafter the "Schedule").

(d) total loss of vision in both eyes,

(e) brain impairment that, in respect of an accident, results in,

(i) a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or

(ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as Published in Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet I:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose

(f) subject to subsections (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person or

(g) subject to subsections (2) and (3), any impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment…results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behaviourial disorder

Subsection 2(3) provides that, for the purposes of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), and impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment[2] shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

The definition of "catastrophic impairment" creates interpretive difficulty because of its utilization of both subjective and objective criteria. Subsections (a) through (d) are objective and there is little interpretive difficulty. The other categories are restrictive and, with respect, unfair. Any amputation of a limb should be considered catastrophic. The loss of a leg or of an arm is catastrophic and represents even with the aid of a prosthetic device, a significant if not a total disruption to an injured person's life. Yet the legislature requires not only that there be an amputation, but it be a double amputation – loss of not only a leg but an arm and a leg.

However, subparagraphs (e) and (f) are recipes for uncertainty, confusion and litigation. Surprisingly, with the exception of *Unifund Assurance company v. Michael Fletcher*[3], which

[2] (4th) American Medical Association (1995).

[3] Decision of Bruce R. Robinson, Arbitrator, rendered January 18, 2000.

was not a court decision, but a decision of the private arbitrator, there have been no cases which have interpreted subsections (e), (f) and (g).

II. The Legislative Purpose of the Regulatory Framework and The Importance of Outcome

The legislative purpose of the Schedule can be best described as the provision of sufficient benefits to enable injured persons to obtain the treatment, rehabilitation and non-medical assistance necessary to carry on a day to day and, insofar as possible, reintegrate them into their families, society and the workforce to try and place them in the same position they were in before the accident. In the case of catastrophically impaired persons, their injuries seriously and continuously impair their functioning and quality of life, such that enhanced benefits are required to enable them to achieve this legislative objective.

III. Subjective Element in the Assessment of Brain Impairment by Use of the Glasgow Coma Scale

As noted above, subparagraph 2(1)(e)(i) provides for a determination of catastrophic impairment, by use of the Glasgow Coma Scale (hereinafter "GCS"). The GCS is a test comprised of objective measures of verbal, oral, visual and muscular responsiveness, used in the diagnosis of brain damage. Although the GCS is compromised of objective measures, the determination of catastrophic impairment through its administration, in subparagraph 2(1)(e)(i) involves at least one subjective component, namely, the

requirement that the GCS be administered "within a reasonable period of time after the accident". The obvious question arising, as in any "reasonableness" standard, is what constitutes a "reasonable" period of time. Neither the Schedule nor the Financial Services Commission of Ontario (hereinafter "FSCO"), which administers the regulatory scheme set out in the schedule, provides any directive in this regard.

The issue of what constitutes a reasonable period of time was considered in *Unifund Assurance Company v. Michael Fletcher*, a decision of a private arbitrator. The case concerned a 14 year old, Michael Fletcher, who was injured in a motor vehicle accident that occurred on September 30, 1997 while riding his bicycle through an intersection. Mr. Fletcher's injuries were such that the ambulance crew responding to the accident took GCS scores at the scene. The initial GCS recording was made at 18:57, 14 minutes after the accident. At that time, Mr. Fletcher's score was 6 out of 15. The second score, recorded at 19:02, was 8 out of 15 and the third recorded at 19:03, at which time the ambulance arrived at the hospital, was 11 out of 15. Sometime thereafter, Mr. Fletcher was transferred to a second hospital. En route, at 21:44, his GCS score was 10 out of 15 and on admission to the second hospital, his GCS score rose to 13 at 23:30 and 14 on 00:30 on October 1, 1997. No further GCS scores were obtained[4].

Counsel for Mr. Fletcher, in an effort to have his client deemed catastrophically impaired, argued that the GCS results of 6 and 8, obtained 14 minutes and 19 minutes after the accident respectively, should apply on the basis that GCS evaluations were conducted within a reasonable period of time following the accident.

Indeed, the report prepared by the catastrophic designation assessment centre (hereinafter "DAC") came to the same conclusion.

The arbitrator, however, adopted the approach of the insurer and its expert, neurologist, Dr. Bruce M. Stewart. Dr. Stewart testified that the standard rule of medical practitioners is that 30 minutes is a reasonable time within which to recover to a normal GCS. He further testified that, while the creator of the GCS, Dr. Jennett, did not comment on timing when developing the scale, a neurologist or neurosurgeon would view a "reasonable time" for assessment of the patient's condition and making a prognosis as six hours at a minimum[5]. Finally, Dr. Steward concluded that, in the Fletcher case, the insured's actual GCS score, which rose from 6 (14 minutes post accident) to 11 (20 minutes after the accident) and at no time after that dropped below 9, is inconsistent with a catastrophic brain injury[6].

It is worth nothing that the arbitrator was critical of the decision of the author of the DAC report to impose his own definition of "a reasonable period of time after the accident" (ignoring the score of 11 at 19:03) rather than accepting the judgment of the clinicians administering the GCS with respect to reasonableness. This, he held, was inconsistent with the erratum issued by the Minister's Committee in June of 1998, which specifies that DAC Committees are not permitted to provide their own definition of what constitutes "a reasonable period of time".

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[4] Ibid at pp.2-3
[5] Ibid., at pp.6-7

[6] Ibid., at p.9.

The Fletcher case, although interesting and informative, does not command the same defence that a court or arbitral decision of the Financial services Commission would. This issue is far from resolved and subsequent decisions will determine whether Mr. Robinson's analysis is correct.

IV. Determination of Catastrophic Impairment – Procedural Requirements

Insurer's Determination of Catastrophic Impairment

Pursuant to subsection 40(1), an insured person may apply to the insurer for a determination of whether the impairment is a catastrophic impairment as defined in the *Schedule*. After receiving the application, the insurer has 30 days to do one of the following:

(a) determine that the impairment is catastrophic and give the insured person notice of the determination;

(b) determine that the impairment is not catastrophic and give the insured person notice of the determination, including the reasons for the determination; or

(c) give the insured person notice that the insurer requires the insured person to be assessed by a designated assessment centre[7].

It is clear from the wording of subsection 40(1) that the onus is on the insured to apply for a determination as to whether the impairment is catastrophic and counsel must so advise. In cases of injuries falling into the categories set out in paragraphs 2(1)(a)-(d), this step will generally be a mere formality. The opposite is true where evaluation of the injuries is more complex and involves a subjective component. For example, injuries falling into the categories set out in the paragraphs 2(1)(e)-(g). In these latter cases, a catastrophic DAC will be conducted, at the request of either the insurer or the injured person[8].

As has been pointed out,[9] in the case of injuries falling within category 2(1)(f), it is essential that the client be fully briefed with respect to the nature of the DAC assessment and the importance of reporting all injuries to the assessor, regardless of their significance to the injured person. If the client fails to do so, he or she may not meet the 55% "whole-body impairment" even though his or her injuries truly justify the finding of such impairment.

In all cases where a catastrophic DAC has been conducted, counsel for the injured person should carefully review the report of the DAC assessor to determine whether anything was overlooked. Further, counsel should obtain an expert addendum to the DAC report, if necessary. The determination of the DAC is not the final answer. Any party may mediate, then arbitrate or litigate this issue.

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[7] The details of the assessment process are set out in s.43 and apply equally to the determination of a non-catastrophic impairment.

[8] See subparagraph 40(2)(c), subsection 40(3) and section 43 of the *Schedule*.

[9] See Howie and Wagman, "How Bill 59 Will Impact Plaintiffs and Their Counsel in the Management of Their Claims" The Canadian Institute Conference re: Bill 59 (March 20 & 21, 1997).

The complexity in determinations of catastrophic impairment under paragraph 2(1)(e), (f) and (g), and the scope for plaintiffs' counsel to argue for or against a given medical assessment, is evident from the Glasgow Outcome Scale's five page article on head injury evaluation and the fact that the AMA Guide attempts to list every possible impairment an injured person may have, with an associated percentage rating of "whole-body impairment".[10] In the later case, each percentage is combined according to a set of tables to determine the percentage of whole-body impairment that the person has sustained. It is important that all counsel dealing with serious injuries understand the list of impairments and calculation tables in the AMA Guide.

Catalogue of Benefits for Catastrophic Impairment – Neutralizing the DAC Assessment.

As previously mentioned the determination of the DAC as to whether an injury or impairment is catastrophic or is non-catastrophic is not final. Each insured person has the right to arbitrate or litigate his dispute with the insurer. Counsel must retain a suitably qualified expert to review, consider and analyze the report of the Designated Assessment Centre and to provide a critique and criticism of the methodology employed and the findings reached. The issue in Fletcher as to what constitutes "a reasonable period of time" is as much more a legal issue rather than a medical issue. The neurologists, neurosurgeons and other experts may disagree, but it will be up to a judge or an arbitrator to determine what is reasonable. One can anticipate that there will be divergence of opinions between judges and arbitrators and ultimately it may be for the Court of Appeal to resolve this controversy.

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[10] *Supra* note 2.

Realistically, whether there is $100,000.0 or $1,000,000.00 of medical/rehabilitation funding available may not be always of practical significance. If the injured person does not have ongoing medical and rehabilitation needs beyond the $100,000.00 limit whether the claim is or is not catastrophic may not change anything. However, if the injured person suffers form chronic pain, fibromyalgia, or from mild or moderate brain injury, one could anticipate the need for ongoing medical and rehabilitation care needs which normally would exceed the $100,000.00 limit.

Consider the example. Smith, is injured in a car accident in which his car was broad sided by a tractor trailer. Smith was not wearing a seatbelt and he struck his head on the windshield. Smith suffered a loss of consciousness and his Glasgow Coma Scale score was 7 out of 15. One hour later at the hospital it was 15 out of 15. Is this claim catastrophic? As a result of the accident, Smith is no longer able to work. He suffers from memory loss, depression, personality change, irritability, anxiety, poor concentration, nightmares and has developed a phobic reaction such that he cannot be with people or in cars. One can easily anticipate that he would require in excess of $100,000.00 in medical/rehabilitation services. He will require the services of a psychologist, social worker vocational counselor, job coach, occupational therapist, chiropractor, message therapist, acupuncturist and physiotherapist.

Assume that the $100,000.00 limit will be exhausted in less than 3 years. Are Mr. Smith's impairments considered catastrophic? Much depends on what the term "reasonable means". Cases like this will have to be litigated and guidelines set by the courts to fill in the gaps created by the regulations in order to help resolve these

interpretational difficulties. Smiths impairments could be considered catastrophic either because his GCS was below 9 within a "reasonable period of time" or because his impairments constitute a 55% impairment of the whole person within the meaning of Section 2(1)(f) of the Schedule.

These cases will be expensive to litigate, but it is absolutely critical that counsel for the injured victim must be able to marshal on his or her client's behalf, pertinent, credible and compelling expert evidence.

V. The "Catch All" 55% Impairment of the Whole-Person

The American Medical Association's Guide to Permanent Impairment adumbrates a difficult test for permanent impairment. Few people understand what is required. Indeed the guide to Permanent Impairment is not a guide, but a lengthy book in which every human activity is weighed, analyzed and considered. Every activity is carved up into discrete percentages.

For example, is a person suffering from a mild brain injury, chronic pain, fibromyalgia, or post-traumatic stress disorder a catastrophic case? Much depends on whether the person is capable of carrying on a normal life. It will be extremely difficult to persuade any trier of fact that a person suffering from impairments common to chronic pain or fibromyalgia meets the rigorous and restrictive test found in the American Medical Association's Guides to the Evaluation of Permanent Impairment. However, there will be cases where the extent of the depression, post-traumatic stress, or pain is so disabling and debilitating as to constitute a total disruption of the person's life, that he or she may qualify under this heading. The effect

on the activities of daily living, self care, personal hygiene, communication, travel, sexual function, sleep and social recreational activities are so profound and limiting that the impairments could very well constitute a 55% impairment of the whole person[11]. There will be few cases that meet this requirement.

VI. Cashing-Out Catastrophic Claims

In previous articles[12], I have written about some of the considerations involved in negotiating "cash-outs" of statutory accident benefit claims. Catastrophic claims present a host of difficulties. While the claims are substantial, different considerations apply. Timing and the discount rate to employ are among the most important factors to consider. Counsel would be doing his or her client a disservice if the claim is cashed-out too soon after the initial injury, or if too great a discount to present value is accorded to the insurer.

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[11] Chapter 14: "Mental and Behavioral Disorder" to the American Medical Association's Guides to the Evaluation of Permanent Impairment, supra note 2.

[12] R. M. Bogoroch, "Cashing Out Accident Benefits Claims Under the Statutory Accident Benefits Schedule" The Law Society of Upper Canada Conference on Personal Injury Litigation (June 11, 1997); and

R. M. Bogoroch, "Cashing Out Accident Benefits: Planning the Approach, Executing the Plan". The Advocates' Society conference: Practical Strategies for Advocates VII (January 23-24, 1998).

Timing

In the early stages of catastrophic injury the insurer generally devotes a great deal of time, resources and energy to properly adjust this claim[13]. Adjusting techniques mean not only reviewing the claim and arranging for medical assessments, but ensuring that capable, experienced claims personnel are placed on the file[14]. A Case Manager is retained and coordination of medical and rehabilitation treatment is planned, organized and implemented. The insured person, in the early stages, is provided with a panoply of services generally from highly qualified service providers. It is a mistake obviously, at this stage to even contemplate a "cash-out". As your client's condition stabilizes, or if it is determined that no further improvement is contemplated, it is reasonable to start considering a "cash-out" of benefits.

Prior to negotiating a "cash-out" you should do the following:

1. Obtain copies of the complete file to ensure that your brief is similar to the insurer's;

2. Retain a highly qualified occupational therapist or other experienced experts to prepare a future care cost report outlining the goods and services that your client will require. See Appendix "A" for a sample report;

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[13] See also in this regard, Joseph J. Sullivan's comments in his paper, "The Defence Perspective."

[14] See Sulivan, *supra*.

3. Obtain a list from the insurer of all the benefits paid to date to know how much of the policy limit remains;

4. Retain an actuary or chartered accountant and calculate the present value of the future care costs as well as the income replacement benefits to which your clinet is entitled; and

5. Ensure that you are in receipt of a report regarding your client's life expectancy.

Persons with catastrophic impairments, not always, but frequently, have reduced life expectancies. It is essential if you are going to negotiate settlement of your client's claim that you know what his or her life expectancy is. Invariably, the insurer will have a report with the most pessimistic view o fyour client's life expectancy. That report must be reviewed, analyzed and critiqued by an expert of your choosing. You should never accept the insurer's opinion of life expectancy without having that opinion vetted by your own expert.

How Much Discount is Appropriate in a Catastrophic Case?

The insurer is not required to "cash-out" benefits. They are required to adjust the case and to pay benefits to its insured in accordance with the *Schedule* and the arbitral and court decisions which have interpreted the *Schedule*. A "cash-out" or "lump-out" is a monetization of its contractual obligations under the Schedule and is of tremendous benefit to the injured person. The insurer, therefore, quite properly seeks a discount from

the net present value of the injured person's entitlement. The discounts should not be significant. The injured person requires the money for life. The injured person will require continuous and regular medial and rehabilitation and attendant care. A 25% discount is more than reasonable. A discount of more than 25% under the circumstances, may not be in the best interest of the injured person. The "cash-out", therefore, may not be in your client's best interest. If the discount sought is too significant do not "cash-out".

The Advantages to Cashing Out

Most clients whish to be free of the overarching supervision and direction of the insurer. They want the insurer out of their lives. They want to be free to control their medical treatment and rehabilitation without having to seek permission for the funding approval from the insurer and without having to constantly seek reimbursement for any and all expenses. There are psychological and very real advantages to terminating the relationship between the insured and the insurer. As indicated above, if the price is too high it is not worth it. Nonetheless if clients wish to embark on "cash-outs" after making fully informed decisions and considering carefully the advantages and disadvantages of "cashing-out", counsel must abide by his or her client's instructions. I have attached a sample form, as Appendix "B", which I trust will provide counsel with assistance.

VII. Representing the Mentally Incapable Client

Practicing law in the millennium is difficult, often times complex and always challenging. Representing persons under disability creates a host of difficulties for even the most

experienced counsel. Mentally incapable clients must have a guardian appointed pursuant to the *Substitute Decisions Act*[15]. Even if no such guardian is appointed, any settlement must be court approved pursuant to Section 7 of the *Rules of Civil Procedure*. Court approval documentation should be explicit, detailed and should also contain a clear description of the fees proposed to be charged as the court must approve the client's account. This protection is not just for the benefit of the client, but for the benefit of the insurer as well. Any settlement not so approved is open to be attacked and set aside if it is determined that the insured person lacked capacity to instruct counsel.

VIII. Reversionary Interests

One of the interesting features of "cashing- out" benefits is the use of reversions in structured settlements. The reversion simply provides that, if the insured person does not live beyond a certain period of time, the structure reverts to the insurer.

For the longest time I have had an aversion to reversions. I simply would not settle a case if the insurers sought a reversionary interest. Because we have utilized "cash-outs" as a way to monetize settlements and to provide for the injured person's family in the event of his or her demise, there is something jarring about giving that money back to the insurer in the event of death. In theory, however, there should be no such theoretical obstacle. If the purpose of the "cash-out" is to provide for the future care, future medical and future income needs and if

[15] S.O. 1992, c.30, as amended.

those requirements need not be funded because of the death of the insured, there is nothing wrong in principle with the funds reverting back to the insurer.

However, everything is a question of negotiation. Much depends on the "cards" you have drawn, the nature of the case, the facts underlying the case and the way the insurer has behaved from the inception of the file. All of these are the levers to be utilized in the negotiation with the insurer.

There are numerous combinations and permutations to employ. Reversions can be granted for only a portion of the principal amount of the settlement, or you can share in the reversion with the insurer. If the insured dies within the guaranteed period, half of the money or a quarter of the money, or whatever percentage you arrive at would then revert back to the insurer. As I said earlier, much depends on negotiation.

IX. Conclusion

In the years to come, case law and arbitral decisions will, I expect, resolve some of the interpretive difficulties arising from the definition of a catastrophic impairment. Few cases will present much difficulty. For those that do, it is hoped that this paper will shed some light on a difficult and complex task, will enable counsel who represent the catastrophically injured to have a better understanding of the issues involved in catastrophic impairments, and to illuminate some of the tactics and considerations involved in negotiating "cash-outs".

APPENDIX "A" -

Sample Future Care Cost Report

Draft
For Discussion
Purposes Only

April 30, 1998

Re: Your Client
Automobile Accident
Your File No.

INTRODUCTION

You have requested our assistance on behalf of your client, , ("the Plaintiff"). Specifically, you asked us to quantify the present value of his future costs of care, attributable to an automobile accident (the "Accident") on (the "Accident Date"), as detailed in:

i the December 17, 1998 report of the Canadian Paraplegic Association ("CPA"), and
ii the February 16, 1998 report of Rehabilitation Management Inc. ("RMI").

We understand the purpose of this report will be to assist you in litigating or settling a claim on behalf of the Plaintiff, and we further understand that this report may ultimately be used in arbitration proceedings or a court of law should the matter proceed to arbitration or trail.

Conclusion

Subject to the restrictions, definitions and assumptions noted herein, and as detailed on Schedules 1 and 2 hereto, we estimate the present value of medical, rehabilitation and attendant care benefits at March 31, 1998 to be as follows:

	PER CPA	**PER RMI**
Medical and Rehabilitation Costs (statutory maximum)	$1,025,046	$1,025,046
Attendant Care Costs	$200,067	$735,753
Home Maintenance Costs	$nil	$129,068
Present Value of Costs of Care, at February 28, 1998	**$1,225,113**	**$1,889,867**

Draft
For Discussion
Purposes Only

SCOPE OF OUR REVIEW

During the course of our work, we relied upon inter alia:

- "Long Term Functional Needs and Costs Analysis" prepared by RMI, dated February 16, 1998
- "Future Cost of Disability Report" prepared by CPA, dated December 17, 1997.
- Relevant economic and statistical publications, including the Life Tables, Canada and Provinces 1990 – 1992 published by Statistics Canada.
- Insurance Act, R.S.O. 1990, as amended and Statutory Accident Benefits Schedule – Accidents On or After January 1, 1994 ("SABS"), O. Reg. 776/93.

BACKGROUND

We understand the relevant facts and circumstances to be as follows:

- The Plaintiff, was injured in an automobile accident on
- Born on , at the time of the Accident he was approximately years of age.
- Pursuant to subsections 45(1) and 80(1) of the SABS, medical and rehabilitation expenses are in this case limited in quantum to $1,025,046.
- Pursuant to subsections 47(4) and 80(1) of the SABS, attendant care expenses are in this case limited to $3,075 per month.
- Pursuant to subsection 55 of the SABS, the Plaintiff is entitled to reasonable housekeeping and home maintenance expenses.

ASSUMPTIONS

For purposes of this report, we have assumed the following:

- life expectancy remains equal to that of the general male population in Canada
- Any medical and rehabilitation costs paid by the no fault insurer remain to be deducted from the statutory maximum detailed above.
- Future costs of care will increase in line with inflation. Thus, in accordance with subclause 53.09(1) of the Ontario Rules of Civil Procedure, a discount rate of 2.5% per annum is applicable.
- A gross up for income taxes of $33.3% of ongoing costs of care, which rate is assumed to approximate the formula detailed in subclause 53.02(2) of the Ontario Rules of Civil Procedure.

Draft
For Discussion
Purposes Only

- There are no significant factors that bear on our estimate future cost of care calculations that we have not considered in reaching our conclusions as noted herein.

CONTINGENCIES

Except for mortality, this report does not reflect the impact of contingencies, either positive or negative, unless specifically addressed herein.

SCHEDULES

The following Schedules and the Notes thereto, form an integral part of this report:

Schedule 1	Summary of Future Costs of Care per RMI, at March 31, 1998
Schedule 2	Present Value of Future Costs of Care per RMI, at March 31, 1998
Schedule 3	Summary of Future Costs of Care per CPA, at March 31, 1998
Schedule 4	Present Value of Future Costs of Care per CPA, at March 31, 1998

RESTRICTIONS

This report is not intended for general circulation or publication, nor is to be reproduced, referred to or used for any other purpose other than to assist in establishing the present value of future costs of care.

We reserve the right, but will be under no obligation, to review all calculations included or referred to in this report and, if we consider it necessary, to revise our opinion in the light of any information existing at or prior to the date of this report, which becomes known to us subsequent to the date thereof.

Trusting that our comments and calculations are of assistance to yourself and your client. Please do not hesitate to contact the undersigned at your convenience should you require any additional information or explanation

Yours very truly,
RICH ROTSTEIN LIMITED

Ian Wollach, CA, MBA, CFE
IW/dt

Automobile Accident SCHEDULE 1

Summary of Future Costs of Care at March 31, 1998 PER RMI

	Actual Costs (note1)	Statutory Maximum (note 2)	Total Costs of Care
Medical & Rehabilitation Costs	$1,116,132	$1,025,046	$1,025,046
Home Maintenance Costs (note 3)	$129,100	- n/a	$129,100
Attendant Care Costs (note 4)	$735,937	- n/a	$735,937
Aggregate Present Value of Future Care Costs at March 31, 1998	**$1,981,170**		**$1,890,084**

NOTES:

(1) Amounts per Schedule 2.
(2) Pursuant to subsections 46(1) & 80(2) of the SABS, aggregate medical and rehabilitation expenses are limited in quantum to $1,025,046.
(3) Section 55 of SABS has not aggregate limits.
(4) Per subsections 47(4) and 80(1) of SABS limited to $3,075 per month, which limit has not been exceeded.

Based on February 16, 1998 report of Rehabilitation Managemetn inc.

Automobile Accident SCHEDULE 2

Present value of Furture Costs of Care at March 31, 1998 PER RMI Page 1 of 3

ITEM/SERVICE	SABS Ref.	INITIAL OUTLAY	ANNUAL OUTLAY	P.V. OF LIFETIME COSTS
MEDICAL				
Oxybutynin Chloride	36(1)(c)		$763	$19,656
Lorazepan	36(1)(c)		$160	$4,128
Apobisacodyl	36(1)(c)		$139	$3571
Amitriptyline	36(1)(c)		$91	$2,352
Cascara & Magnesia	36(1)(c)		$66	$1,700
Cranex Capsules	36(1)(c)		$300	$7,726
Duoderm Cream	36(1)(c)		$45	$1,163
Duoderm Patch	36(1)(c)		$161	$4,136
Antibiotics	36(1)(c)		$313	$8,056
Papavrine	36(1)(c)		$64	$1,640
Syringes	36(1)(f)		$28	$714
Mentor Coude – Tipped Catheter	36(1)(f)		$5,932	$152,767
Golden Drain External C	36(1)(f)		$1,825	$46,998
Hollister Urinary Leg Bag	36(1)(f)		$2,537	$65,327
Med-RX Tubing	36(1)(f)		$584	$15,039
Hollister Leg Bag Straps	36(1)(f)		$101	$2,596
Disposable Underpads	36(1)(h)		$355	$9,149
Alpine Fresh Appliance Cleaner	36(1)(h)		$793	$20,422
HealthCare Lubricant	36(1)(h)		$116	$3,000
Glove Seal Latex Exam Gloves	36(1)(h)		$486	$12,525
Plastic Urinal Blue	36(1)(h)		$219	$5,649
Peace of Mind Cleaner	36(1)(h)		$551	$14,178
Vitamin B	36(1)(h)		$105	$2,715
Vitamin C	36(1)(h)		$81	$2,089
Vitamin E	36(1)(h)		$66	$1,692
Remind Nu-Source	36(1)(h)		$265	$6,827
St. John's Wort	36(1)(h)		$154	$3,976
Ginseng	36(1)(h)		$221	$5,699
Echinacea & Goldenseal	36(1)(h)		$343	$8,833
Saw Palmetto	36(1)(h)		$390	$10,037
NON-MEDICAL				
Hand-Held Shower Head and Hose	36(1)(h)		$7	$181
Bath Gelmat	36(1)(h)		$45	$1,160

Based on February 16, 1998 report of Rehabilitation Management Inc.

Automobile Accident SCHEDULE 2

Present value of Furture Costs of Care at March 31, 1998 PER RMI Page 2 of 3

ITEM/SERVICE	SABS Ref.	INITIAL OUTLAY	ANNUAL OUTLAY	P.V. OF LIFETIME COSTS
Commode	36(1)(h)		$89	$2,290
Wheeled Commode-Maintenance	36(1)(h)	$55	$14	$389
Toilet Seat	36(1)(h)	$135	$22	$662
Mirror-Overhead of Stove	40(5)(e)	$51	$10	$293
TENS Unit	36(1)(f)	$541	$108	$3,125
TENS Rechargeable Batteries	36(1)(f)	$17	$12	$307
TENS Lead Wires	36(1)(f)		$39	$1,000
TENS Electrodes	36(1)(f)		$46	$1,185
Wheelchair Accessible Home Gym Unit	36(1)(h)	$7,000		$7,000
MOBILITY				
Overhead Trapeze Bar	36(1)(h)	$372	$21	$755
Wheelchair Quickie GPV	36(1)(f)		$1,090	$28,066
Wheelchair Maintenance	36(1)(f)		$145	$3,734
Standing Wheelchair-Levo Chair	36(1)(f)	$10,110		$10,110
Leg Braces	36(1)(f)		$1,470	$37,856
Roho Enhancer Cushion	36(1)(f)	$632	$506	$13,425
Vehicle Modifications	40(5)(e)	$29,259	$,852	$169,000
Cellular Telephone	40(5)(e)		$70	$1,807
Cellular Telephone Service	40(5)(e)		$55	$1,422
CAA Enrolment Fee	40(5)(e)	$15		$15
CAA Plus Membership	40(5)(e)		$85	$2,199
PROFESSIONAL SERVICES				
Rehabilitation Case Co-ordination	40(5)(c)	$9,581		$9,581
Rehabilitation Case Co-ordination - Ongoing	40(5)(c)		$1,597	$41,120
Durham Sports Medicine and Rehabilitation	36(1)(h)	$7,100		$7,100
Psychological Counseling	36(1)(b)	$18,288		$18,288
Physiotherapy Treatment	36(1)(b)		$172	$4,429
Occupational Therapy	36(1)(b)	$2,525		$2,525
Psychovocational Counseling	40(5)(b)	$2,363		$2,363
Daytimer	40(5)(e)		$21	$542

Based on February 16, 1998 report of Rehabilitation Management Inc.

Automobile Accident SCHEDULE 2

Present value of Furture Costs of Care at March 31, 1998 PER RMI Page 3 of 3

ITEM/SERVICE	SABS Ref.	INITIAL OUTLAY	ANNUAL OUTLAY	P.V. OF LIFETIME COSTS
RESIDENTIAL				
Home Accessibility Report	40(5)(e)	$2,750		$2,750
RECREATION				
Side Car for Motorcycle	40(5)(e)	$26,751		$26,751
Side Car/Hand Control Maintenance	40(5)(e)		$150	$3,863
VOCATION				
College-Part Time Courses	40(5)(b)	$1,478		$1,478
Computer with CD ROM and Printer	40(5)(b)	$2,589	$518	$14,956
PERSONAL SUPPORT SERVICES				
Brain Injury Ass. Of Toronto Membership	40(5)(e)		$30	$773
Canadian Paraplegic Ass. Membership	40(5)(e)		$25	$644
MEDICAL & REHABILITATION COST				867,501
HOME MAINTENANCE				
Handyman Services	55		$2,527	$65,064
Snow Removal	55		$485	$12,486
Lawn and Garden Care	55		$748	$19,275
HOME MAINTENANCE COSTS				$551,953
ATTENDANT CARE COSTS	47(1)(a)		$21,433	$551,953
Aggregate Present Value of Future Care Costs, at March 31, 1998 before tax gross up				$1,516,280
Gross Up for Taxation				$464,890
Aggregate Present Value of Future Care Costs, at March 31, 1998				$1,981,170

NOTES

(1) Schedule based on February 16, 1998 report prepared by Rehabilitation Management Inc.

(2) Ongoing expenses have been grossed up for income tax @ 33%.

Based on February 16, 1998 report of Rehabilitation Management Inc.

AUTOMOBILE ACCIDENT - SCHEDULE 3
SUMMARY OF FUTURE COSTS OF CARE AT MARCH 31, 1998 PER CANADIAN PARAPLEGIC ASSOCIATION

	Actual Costs (note1)	Statutory Maximum (note 2)	Total Costs of Care
Medical & Rehabilitation Costs	$1,356,525	$1,025,046	$1,025,046
Home Maintenance Costs (note 3)	$200,067	- n/a	$200,067
Aggregate Present Value of Future Care Costs at March 31, 1998 (note 4)	**$1,556,691**		**$1,225,113**

NOTES:

(1) Amounts per Schedule 2.
(2) Pursuant to subsections 46(1) & 80(2) of the SABS, aggregate medical and rehabilitation expenses are limited in quantum to $1,025,046.
(3) Section 55 of SABS has not aggregate limits.
(4) Schedule based on December 17, 1997 report prepared by Canadian Paraplegic Association.

Based on December 17, 1997 report prepared by Canadian Paraplegic Association.

AUTOMOBILE ACCIDENT - SCHEDULE 4
SUMMARY OF FUTURE COSTS OF CARE AT MARCH 31, 1998 PER CANADIAN PARAPLEGIC ASSOCIATION

ITEM/SERVICE	SABS Ref.	INITIAL OUTLAY	ANNUAL OUTLAY	P.V. OF LIFETIME COSTS
Bladder Program	36(1)(f) &(h)		$14,073	$362,411
Bowel Program	36(1)(f) &(h)		$827	$21,304
Bowel Equipment	36(1)(f) &(h)	$25	$321	$7,688
Mobility Equipment	36(1)(f) &(h)		$1,230	$31,684
Skin Management				
Roho enhancer	36(1)(h)	$553	$116	$3,316
Foam base for Roho enhancer	36(1)(h)	$20	$4	$116
Backup low profile Roho	36(1)(h)	$415	$88	$2,516
2 cushion covers for Roho enhancer	36(1)(h)	$117	$39	$1,080
2 cushion covers for Roho	36(1)(h)	$86	$29	$793
Gel pad for tub	36(1)(h)	$45	$9	$260
Mattress and box spring	36(1)(h)	$919	$92	$2,919
Bed frame	36(1)(h)	$35	$3	$110
Environmental Controls				
Cell Phone	40(5)(e)	$114	$96	$2,211
TV Remote	40(5)(e)	$34	$7	$199
Transport				
Driving Assessment	40(5)(e)	$575	$115	$3,321
GMC Safari Van	40(5)(a)	$33,255	$6,651	$192,081
Modifications	40(5)(a)	$36,397	$7,679	$219,781
ADL Equipment				
Microwave over	40(5)(a)	$450	$75	$2,211
Stove top mirror	40(5)(a)	$53	$5	$168
Hand held shower	40(5)(e)	$53	$11	$305
Mirror to check skin	40(5)(e)	$15	$3	$87
Long handled reacher	40(5)(e)	$14	$5	$131
Therapies & Exercise				
Fitness membership	36(1)(h)		$150	$3,863
Levo Chair	36(1)(f)	$9,896	$1,065	$33,064
Medications	36(1)(c)		$5,691	$146,544
Medical and Rehabilitation Costs		$83,071	$38,384	$1,038,161
Attendant Care Services	47(1)(a)		$5,827	$150,050
		$83,071	$44,210	
Aggregate Present Value of Future Care Costs, at Feb. 28 1998				$1,188,211
Gross Up for Income Taxes @ 33.3%				$368,380
				$1556,591

Based on December 17, 1997 report prepared by Canadian Paraplegic Association.

APPENDIX "B" -

INSTRUCTIONS
Re: SETTLEMENT OF STATUTORY ACCIDENT BENEFITS – WHERE THERE IS NO IMPACT ON THE TORT CLAIM

TO: LAW FIRM

RE:

1. I instruct you to accept the offer of settlement of $, made by the Insurance company at the mediation on , for a Full and Final Release of all Statutory Accident Benefits.

2. I understand that by accepting this offer, I will no longer be able to claim for weekly income benefits, medical and rehabilitation benefits, attendant care or other expenses as against insurance company as a result of my accident on .

3. I acknowledge that by settling for the lump sum, I have compromised my claim for statutory accident benefits and I will never be able to claim again for medical, rehabilitation, attendant care and weekly indemnity payments that would be available to me.

4. I acknowledge as well, that the present value of the benefits due to me may be much more than $.

5. I agree to settle at this time in order to obtain a lump sum payment in order that I need not become compelled to attend on assessments, medical appointments, and participate in rehabilitation programs mandated by the accident benefit insurer and to avoid the risks of proceeding to arbitration.

DATED at Toronto, the day of , 2000.

CLIENT NAME

APPENDIX "C"

COMPARISON OF BENEFITS UNDER THREE ACCIDENT SCHEMES

		BILL 59 (ACCIDENTS FROM NOV. 1/96)	BILL 164 (JAN. 1/94 TO OCT. 31/96)	O.M.P.P. (JUNE 22/90 TO DEC. 31/93)
1	Weekly indemnity or income replacement benefits	80% of net income up to $400 per week. May be increased if optional coverage purchased.	90% of net income up to $1,000.00 per week.	80 % of gross income up to $600.00 per week
2	Time frame for Short-Term Income Replacement Benefits	Payable for 104 weeks after the accident if the insured person suffers a substantial inability to perform the essential tasks of his/her employment.	Payable for up to 2 years from the date of the accident if the insured person suffers a substantial inability to perform the essential tasks of his/her employment.	Payable for 156 weeks while insured person suffers a substantial inability to perform the essential tasks of his/her occupation or employment.
3	Long-Term Income Replacement Benefits	After 104 weeks, weekly benefits is payable if injury prevents insured from *"engaging in any occupation or employment for which he or she is reasonably suited by education, training or experience."* Benefits payable to age 65, The benefits reduced according to a formula.	After two years, loss of earning capacity benefit is payable if there is a total or partial restriction on earning capacity. Payable to age 65. At age 65, benefits are generally reduced.	After 156 weeks (3 years), if the insured person is continuously prevented from engaging in any occupation or employment for which he or she is reasonably suited by education, training or experience, he/she is entitled to receive Statutory Accident Benefits for the duration of the disability, i.e. for life.
4	Medical and Rehab Benefits	$100,000 basic limit. 10-year limit for adults, or 25 years, minus the age of the child, whichever is greater. $1 milliion cap for catastrophic impairments.	$1 million cap – no time limit.	$500,000.00. 10 years for adults. For children 20 years less the age of the child at the time of the accident.
5	Attendant Care	$3,000.00 per month limit for 2 yeas for non-catastrophic impairments up to $72,000.00. $6,000 monthly limit for catastrophic impairments with overall limit of $1 million. Optional coverage may be purchased.	$3,000.00 per month or $6,000.00 per month or $10,000.00 per month depending on extent of injury. No time limit. Indext to inflation.	$500,000.00. No time limit but payable $3,000.00 per month.
6	Benefits if no income	$185.00 per week. 6-month waiting period.	$185.00 per week.	$185.00 per week.