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• SUPREME COURT OF CANADA DENIES LEAVE TO APPEAL OF ALBERTA RULING ON POST-DEATH LIFE INSURANCE CONVERSION •

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Michelle Chai

Liz Campbell

The Supreme Court of Canada ("SCC") recently denied an insurer's application for leave to appeal the 2023 Alberta Court of Appeal ("ABCA") decision in *Thomson v. Ivari*.[1] In *Thomson*, the ABCA found that the conversion of a life insurance policy to one with a lower death benefit could be cancelled within a 10-day "free look" period, even after the death of the insured, leaving the beneficiary with the higher death benefit.

The decision to deny leave means the SCC won't be addressing this unusual development in the law, creating some uncertainty for lower courts — and for the insurance industry.

Unlike Alberta, the Atlantic provinces do not have legislation in place that provides for a free look period before a consumer decides to purchase an insurance contract. However, free look periods are still a standard practice in the industry. Insurers may need to adjust their approach to this practice to ensure that a policy owner does not have the option to cancel a replacement policy and revive an older policy in the unlikely event of circumstances similar to those in *Thomson*.

Part I sets out some background and the ABCA's decision. Part II discusses how *Thomson* may create a conflict in the law regarding the distinction between an insurance "policy" and an insurance "contract", and provides some additional takeaways for insurers.

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PART I

Background

Janice Thomson owned a life insurance policy with a $1.3 million death benefit, which covered the life of her husband, James Thomson (the "Term Policy"). She opted to convert it to a universal life insurance policy with a lower premium and a reduced death benefit of $400,000 (the "Converted Policy"). The contract for the Converted Policy included a 10-day free look period during which she could cancel it and revert back to the Term Policy.

Mr. Thomson died unexpectedly during the free look period. Ms. Thomson exercised her option to cancel the Converted Policy, and made a claim under the original $1.3 million Term Policy. The insurer, ivari (spelled with a lower-case "i"), denied the claim on the basis that the cancellation period had expired when Mr. Thomson died.

The Alberta Court of Queen's Bench ("ABQB") decided in favour of Ms. Thomson.

ivari unsuccessfully sought to rely on a termination clause in the contract providing that the Converted Policy would terminate when the insured life died. ivari argued that the option to cancel, as part of the policy, was also terminated. The ABQB rejected this argument and held that an insurance "policy" and an insurance "contract" are different, and that the cancellation period was not part of the "policy" but was instead part of the "contract." The contract, along with the option to cancel, continued to exist after the policy was terminated. (see Part II which explores the difference between "contract" and "policy.")

The ABQB further held that cancelling the new policy had the effect of reviving the Term Policy, relying on its decision in *Moss v. Sun Life Assurance Co. of Canada*.[2] In *Moss,* the ABQB found that the cancellation of a converted policy revives the old policy where the conversion constitutes a single transaction. The contracts in *Moss* and *Thomson* provided for both the cancellation of the old policy and the issuance of the converted policy. Thus, the ABQB held revoking the converted policy during the free look period would also reverse the cancellation of the old policy.

The Appeal

The ABCA upheld the trial court's decision. Interestingly, the ABCA also applied section 5 of Alberta's *Fair Practices Regulation*, which had not been raised at trial. Section 5 of the *Fair Practices Regulation* provides:

> *5 (1) A person who buys a contract of life insurance, accident and sickness insurance or, subject to subsection (2)(b), travel insurance underwritten by an insurer may rescind the contract within 10 days after receiving the insurance policy or within any longer period specified in the contract.*
>
> *...*
>
> *(3) A person who rescinds a contract under subsection (1) is entitled to receive from the insurer a refund of the whole premium has been paid.*[3]

The ABCA held that this section applies to replacement life insurance policies. According to the ABCA, the life insurer bears the risk that an insured may die during the 10-day period:

> *The situation is that during the 10-day cancellation period, there is a fortuitous and unpredictable risk about the life of Mr. Thompson. He might survive the 10 days without event, or suffer a life-altering change to his health, or actually die. Which of these fortuitous and unpredictable events actually occurs represents the risk underlying the policy. During the 10-day cancellation period, the insurer is essentially at risk that there might be a material change in the insured's health. The imposition of that risk on the insurer is inherent in the 10-day cancellation right. However, the fact that the insured might die within the 10-day period, as opposed to shortly after its expiry, does not materially alter the nature of the risks being insured against.*

The ABCA relied on the clear wording in the contract that the Converted Policy could be cancelled "at any time" during the free look period, noting that the contract did not state that this option could only be exercised if the insured was still alive.

The ABCA, citing *Moss*, found that the replacement of the Converted Policy and the cancellation of the Term Policy was a single transaction, which had the effect of reviving the Term Policy once the cancellation right was exercised. The ABCA said that insurers can avoid this result by treating the issuance of a converted policy and the cancellation of an old policy as "two separate transactions".

PART II

It appears the ABCA decision departs from the British Columbia Court of Appeal's ("BCCA") assessment of the distinction between an insurance "contract" and an insurance "policy".

Insurance "Contract" Versus Insurance "Policy"

The ABCA in *Thomson* treated the insurance contract as having an independent existence separate from the policy. This was based on the ABCA's reading of Alberta's *Insurance Act*, which identifies an insurance "policy" as an "instrument evidencing an insurance contract", and potentially draws a distinction between the "policy" and the insurance contract itself. Other provincial and territorial pieces of insurance legislation, including British Columbia, have similar definitions of "policy".

However, in the 2012 decision of *Paul v. CUMIS Life Insurance Co.*,[4] the BCCA treated an insurance "contract" and an insurance "policy" as one and the same. This is consistent with how the terms are defined in the federal *Insurance Companies Act*.

These differences in interpretation have led to very different outcomes on similar facts. In *Moss*, the Alberta Court of Queen's Bench found that the cancellation of a policy by the insured revived an older policy because the insurance contract did not terminate when the policy terminated. This decision was followed in *Thomson*, allowing the policy owner to revert back to the old policy when the new policy was cancelled.

In *Paul*, on the other hand, the BCCA found that a life insurance policy that had been terminated due to non-payment of premiums could not be reinstated after the death of the insured life, because it treated the insurance contract and the insurance policy as one in the same.

In *Paul*, a life insurance policy was terminated due to non-payment of premiums before the insured, Dennis Paul, passed away. The policy provided that it could be reinstated if the premiums were paid in 60 days. The beneficiary of the policy, Susan Paul, contacted the insurer and was erroneously advised that the policy would be reinstated upon payment of the premiums that were owing (the insurer was not advised of Mr. Paul's death). Ms. Paul paid the premiums owed before making a claim for Mr. Paul's death under the policy. The insurer declined to pay the claim, stating that the policy had terminated due to non-payment of the premiums, and that it could not be reinstated after the insured life's death.

On appeal, the BCCA agreed with the trial judge that the policy had terminated before the death of the insured and could not be reinstated as there was no life to insure – and there was no longer an insurance risk. Since the insurance contract did not continue to exist after the policy was terminated, there was no basis for reinstating it – unlike in *Moss* and *Thomson*.

To summarize, the BCCA in *Paul* held that the contract terminated when the policy terminated.

Application to Atlantic Canada

Thomson raises uncertainty for insurers. Insurance legislation applicable to life insurance in Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador defines an insurance "policy" in the same way as the Alberta legislation.

However, unlike British Columbia and Alberta, courts in the Atlantic provinces have yet to consider whether an insurance contract terminates when the policy terminates.

Courts in the Atlantic region appear to largely use the terms insurance "contract" and insurance "policy" interchangeably.[5] The Nova Scotia Court of Appeal in *Linden Estate v. CUMIS Life Insurance Co.* is one instance of a court distinguishing between the policy and the contract, by treating the policy as a component of "the entire insurance contract."[6]

It remains to be seen whether courts in the Atlantic provinces will follow or depart from the ABCA's decision in *Thomson*, if confronted with a similar issue.

Takeaways for Insurers

The ABCA noted that insurers may be able to prevent a policy owner from using the free look period to revive an old policy by treating the replacement of the converted policy and the cancellation of the old policy as two separate transactions. This may be achieved by:

- creating two separate transactions, one for the issuance of the new policy and the other for the cancellation of the old policy (for example, by having the insured complete two different forms and processing them separately);
- requiring proof of insurability at the time the policy is converted; and
- having the policy explicitly state that the option to cancel, convert, etc. may only be exercised when the insured life is still alive – and that the option expires if the insured life dies.

Where the SCC has declined to reconcile the potential differences between an insurance contract and policy in the context of life insurance, insurers may want to include contractual language to the effect that termination of the insurance policy *also* terminates the insurance contract.

[***Michelle Chai*** *provides sound legal solutions and risk management to corporate commercial clients in a variety of industries including banking, energy, telecommunications and construction. She also works with insurers in such areas as disability insurance, personal injury and property insurance. Michelle has represented clients in commercial arbitrations, Nova Scotia Supreme, Small Claims and Federal Court matters, as well as appeals before the Canadian International Trade Tribunal, Federal Court of Appeal, Nova Scotia Court of Appeal and Supreme Court of Canada.*

Liz Campbell *recognizes the importance of hard work and thorough preparation in achieving favourable outcomes for her clients. She takes a practical approach to the litigation process and*

values creative solutions in an ever-changing legal landscape. Some of Liz's recent experience includes assisting with contractual disputes, administrative law matters, and construction litigation.]

1 *Thomson v. Ivari*, [2023] A.J. No. 1341, 2023 ABCA 369 (Alta. C.A.) [hereinafter "*Thomson*"].

2 *Moss v. Sun Life Assurance Co. of Canada*, [2018] A.J. No. 1383, 2018 ABQB 953 (Alta. Q.B.) [hereinafter "*Moss*"].

3 Although other provinces may not have similar provisions in their legislation, most life insurance policies do include some kind of cancellation or "free look" period.

4 *Paul v. CUMIS Life Insurance Co.,* [2012] B.C.J. No. 253, 2012 BCCA 35 (B.C.C.A.) [hereinafter "*Paul*"].

5 See, for example, *Cameron v. Economical Mutual Insurance Co.,* [2016] P.E.I.J. No. 7, 2016 PESC 6, at paras. 7-13 (P.E.I.S.C.); *Elton v. Elton*, [2010] N.J. No. 7, 2010 NLCA 2, at para. 22 (Nfld. C.A.); *Larsen v. Assureway Group*, [2021] N.B.J. No. 241, 2021 NBQB 211 (N.B.Q.B.); *Industrial Alliance Insurance and Financial Services Inc. v. Brine*, [2015] N.S.J. No. 486, 2015 NSCA 104 (N.S.C.A.), leave to appeal refused [2016] S.C.C.A. No. 18 (S.C.C.).

6 *Linden Estate v. CUMIS Life Insurance Co.,* [2015] N.S.J. No. 83, 2015 NSCA 20, at para. 21 (N.S.C.A.).

• H.C. V. SSQ LIFE INSURANCE COMPANY •

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William Harding

Earlier this year, in *H.C. v. SSQ Life Insurance Co.*,[1] the Superior Court of Justice tackled the difficult balance between the principle of disclosure in the context of medical records and the public's interest in protecting those with mental health issues, and the treatment they seek.

The dispute in this case arose out of the denial of Long-Term Disability Payments ("LTD") benefits. The Plaintiff was 55 years old and working in communications, when she applied for LTD benefits after being unable to work due to various impairments, including but not limited to, adjustment disorder and major depressive disorder. Some of her symptoms were attributed to the separation from her husband and the associated family law litigation.

The Plaintiff began a civil suit against her insurer. The Plaintiff had previously disclosed 114 pages of her psychologist's notes and records without redaction. She had further produced 11 pages which were partially or wholly redacted. The Defendant brought a motion for an Order compelling the Plaintiff to produce the redacted and unredacted notes and records of the Plaintiff's psychologist. The Plaintiff also brought a cross-motion seeking to

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anonymize the names of the parties held within the records and sought a sealing order.

The issue before the Superior Court of Justice was whether the Plaintiff was entitled to redact those portions of the psychologist's clinical records and, if so, under what circumstances?

DEFENDANT'S MOTION: PRODUCTION OF UNREDACTED RECORDS

At the hearing, the court was provided with a full copy of the unredacted notes for inspection pursuant to Rule 30.04(6) of the *Rules of Civil Procedure*.[2] The Court reviewed the notes and determined the redactions fell into the following three categories:

- Discussions about the settlement conferences in the family law case, including comments about the judge, the process, and the results;
- Discussions with her family law lawyer about the general status of the family law file and her "bottom line" on the family law file; and
- Discussions with the lawyer on this file regarding this litigation, including preparation for the discoveries and the post-mortem meeting after mediation and the discoveries.

The Defendant argued that Plaintiff had failed to satisfy the *Wigmore* criteria, primarily the 4th criteria which sets out that there is no evidence that her relationship with her psychologist would be destroyed if unredacted information is produced. The Defendant argued that the Plaintiff's thoughts and feelings were relevant as they would reflect her state of mind and have a bearing on the LTD claim. The Plaintiff submitted that the small, redacted sections were not relevant to the action and would serve simply to embarrass and prejudice the Plaintiff.

It was established in *McGee v. London Life Insurance Co.,*[3] that generally relevant documents must be produced in their entirety and a party may not redact portions on the basis that the portions are not relevant. However, if the document is not relevant and the production would cause significant harm to the producing party or infringe public interests then the litigant may be excused from having to make that disclosure. The party resisting disclosure has the onus to show that the redacted portion is irrelevant, and the redaction is necessary.

If the portions are relevant and there is no good reason why they should not be produced, the portions may still be redacted if they are protected by privilege. This solicitor/client privilege or a common law privilege which is governed by the Wigmore criteria.

The Wigmore test as to whether a communication will qualify as privileged requires that:

1. the communications must originate in a confidence that they will not be disclosed;
2. this element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties;
3. the relation must be one which in the opinion of the community ought to be sedulously fostered;
4. the injury that would enure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

Upon reviewing the redacted portions of the notes and records, the Court determined that they were irrelevant and that there was no good reason for the Plaintiff to have to produce them as they did not help to resolve the issues in the litigation and could potentially embarrass and prejudice the Plaintiff. The Court found that most of the redactions involved discussions about the Plaintiff's current lawsuit and her family law file, in addition to her thoughts on the court process and her lawyers. The Court held that disclosure of her litigation strategy and sentiments expressed to her counsel could only prejudice the Plaintiff in her family law case and in this matter and dismissed the Defendant's motion.

PLAINTIFF'S MOTION: ANONYMIZATION OF THE PARTIES & SEALING ORDER

Regarding the Plaintiff's motion for an Order anonymizing the parties' names and a sealing order with respect to her psychologist's redacted and unredacted notes, the Plaintiff submitted that the

entries went to her "biographical core" and as such should be anonymized and sealed. The Plaintiff referenced the highly personal and detailed nature of her psychologists notes and how they included comments on her childhood, her parents, and general details on her emotional and psychological well-being.

The Defendant and media took no position on this motion.

The Court considered the test set out by the Supreme Court of Canada in *Sherman Estate v. Donovan,*[4] which outlines that a party seeking a sealing order or publication ban must establish that:

- Court openness poses a serious risk to an important public interest;
- The order sought is necessary to prevent this serious risk to the identified interest because reasonably alternative measures will not prevent this risk; and,
- As a matter of proportionality, the benefits of the order outweighs its negative effects. The first prong of this test requires an applicant to show that the open court principle poses a serious risk to an important public interest in the context of the case.

Considering the principles set out in *Sherman* and considering the nature of the Plaintiff's discussions with her psychologist, the Court ordered the anonymization of the names in addition to a sealing order. The Court reasoned that the records revealed intimate details of Plaintiff's life going to her biographical core, including childhood issues, feelings of self, and perception of her relationships with close family members and friends. As the Defendants did not oppose the motion, nor did the media, the Court held that ordering the anonymization of names was the least disruptive to the open court principle.

The Court commented on the balance between the open court principle and the public's interest in protecting those with mental health issues. The Court reasoned that:

> There exists a strong public interest that individuals with mental health issues who are involved in litigation have remedies to ensure that their private lives that have been opened up for the purposes of litigation are not available to the general public who should have no interest or need to view these personal and private discussions.
>
> The core public interest is the public's need to ensure the non-publication of private and confidential information dealing with one's self-worth and innermost feelings which could jeopardize their healing and therapy.[5]

Ultimately, the Court held that the Plaintiff should not be forced to make available to the general public confidential discussions she has had with her psychologist whom she has seen for over 15 years.

While the values of freedom of expression reign strong, the Court reasoned that in this case, the benefits of ensuring that the public interest of protecting therapist/patient relationships which assist individuals with mental health issues outweighed any negative effects. This decision marks an important step in safeguarding medical records that deal with such an intimate and sensitive nature, especially in the context of mental health, from unnecessary publication, disclosure, and production.

[***William Harding*** *has appeared at the License Appeal Tribunal, the Ontario Superior Court of Justice and the Ontario Court of Appeal. Acting as counsel, William successfully obtained a Superior Court judgment of over $12,100,000 in a case involving a woman who had suffered a severe spinal cord injury. William is a member of the Ontario Trial Lawyers' Association, the Ontario Bar Association, The American Association for Justice, The Advocates' Society, Canadian Bar Association and the Law Society of Ontario. William was included in The Best Lawyers: Ones to Watch in Canada™ 2023 for his expertise in Personal Injury Litigation.*]

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1 *H.C. v. SSQ Life Insurance Co.*, 2024 ONSC 53, 170 O.R. (3d) 518 (Ont. S.C.J.).

2 *Rules Civil Procedure,* R.R.O. 1990, Reg. 194.

3 *McGee v. London Life Insurance Co.,* [2010] O.J. No. 898, 2010 ONSC 1408 (Ont. S.C.J.).

4 *Sherman Estate v. Donovan,* [2021] S.C.J. No. 25, 2021 SCC 25 (S.C.C.).

5 *H.C. v. SSQ Life Insurance Co.,* 2024 ONSC 53, 170 O.R. (3d) 518, at paras. 53-54 (Ont. S.C.J.).

• ONCA DENIES RELIEF FROM FORFEITURE FOR NON-COMPLIANCE WITH NOTICE CONDITION IN A CLAIMS-MADE POLICY •

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Michael Dunk

In a recent Ontario Court of Appeal decision, *Furtado v. Lloyd's Underwriters*,[1] the court upheld the lower court's ruling and denied the appellant's request for relief from forfeiture due to non-compliance with the notice requirement in a claims-made policy.

BACKGROUND

The Appellant, Oscar Furtado, was the directing mind of Go-To Developments Holdings Inc. ("Go-To"). Mr. Furtado was covered under a Directors and Officers Insurance Policy ("the Policy") issued by the Respondent insurer, Lloyd's Underwriters ("Lloyd's"). The Policy was a claims-made policy. The policy required that claims be both made and reported to the insurer by the insured during the policy period, a common requirement in this type of policy.

In March 2019, the Ontario Securities Commission ("OSC") began an inquiry into Go-To's business activities. In May 2019, Mr. Furtado was summoned to an examination by the OSC. At this time, section 16(1) of the *Securities Act* prevented Mr. Furtado from disclosing the nature or the content of the investigation to anyone except his counsel. The Policy also specified that Mr. Furtado was not required to report an investigation to Lloyd's while he was legally barred from doing so ("the Suspension Clause"). Consequently, Mr. Furtado did not inform the Insurer about the investigation.

In December 2019, a new section 16(1.1) of the *Securities Act* was enacted, permitting the disclosure of the investigation to the Insurer. Mr. Furtado was made aware of the legislative change in February 2021, but did not report the investigation to the Insurer. In December 2021, the OSC commenced an application against Mr. Furtado, Go-To, and its affiliated entities alleging breaches of the *Securities Act* and sought the appointment of a receiver. In March 2022, the OSC commenced a receivership application and an enforcement proceeding against Mr. Furtado and the Go-To entities.

Mr. Furtado first reported the claims to the Insurer in February and March 2022. Lloyd's subsequently denied coverage in September 2022.

THE APPLICATION DECISION

The application judge held that Mr. Furtado breached the notice provisions of the Policy and that the equitable doctrine of relief from forfeiture was not applicable in the circumstances. The application judge held that pursuant to the Policy's "suspension clause" he was not required to notify Lloyd's of an investigation while he was prevented from doing so by law. However, Mr. Furtado was informed that he could notify Lloyd's of the OSC investigation in February 2021, but he did not act with reasonable promptness and did not report to Lloyd's until one year later.

The application judge held that this was a breach of the notice provisions of the claims-made policy which constituted non-compliance with a condition precedent to coverage rather than imperfect compliance with a policy term. As such, Mr. Furtado was not entitled to relief from forfeiture.

THE COURT OF APPEAL DECISION

The Court of Appeal upheld the lower court's decision that the failure to report the claims constituted non-compliance with the Policy and Mr. Furtado was not entitled to coverage or relief from forfeiture.

The court first highlighted the differences between occurrence and claims-made policies. Occurrence based policies cover incidents that take place within the policy period, and are not dependent on notice of the claim being made during the policy period. In contrast, claims-made policies provide coverage based on the condition that claims are both made against the insured and reported to the insurer during the policy period.

Courts have discretion to grant relief from forfeiture under either section 129 of the *Insurance Act* or section 98 of the *Courts of Justice Act*. The court clarified the differences between the two provisions. Section 129 of the *Insurance Act* applies only to policy conditions related to proof of loss, while section 98 of the *Courts of Justice Act* confers a general and broad power to grant relief against forfeiture. Both provisions apply only when the breach constitutes imperfect compliance, rather than non-compliance with a policy term.

When a policy clearly stipulates that a claim must be made and reported to the insurer to trigger coverage, failure to comply with the obligation constitutes non-compliance with an essential condition. In this case, the Policy explicitly required giving written notice as a condition precedent to the coverage. Mr. Furtado did not report the claim to Lloyd's until February 2022, nearly three years after the OSC began its investigations, over two years after the law changed permitting him to advise his insurer of the investigation in December 2019, and one year after he became aware that he was permitted by law to report the investigation to Lloyd's. The obligation to report was clearly breached, and therefore, relief from forfeiture was not available to Mr. Furtado.

The timing of the insured's obligation to report claims remains an issue, particularly when they are initially prohibited by law but later allowed to disclose information due to legislative changes. In this case, the *Securities Act* was amended in December 2019 to allow such disclosure to the insurer, and Mr. Furtado was advised of the change in February 2021. Despite this, Mr. Furtado did not report the claim to the Insurer until February 2022. The court found that Mr. Furtado's continued failure to report the claim after learning of the legislative change constituted clear non-compliance with the reporting requirement.

However, the court did not resolve whether the reporting obligation arose when the legislation was amended in December 2019 or when Mr. Furtado became aware of the change in February 2021. On the facts of the case it was not necessary for this to be addressed. The court simply stated that:

> In my view, once the law changed to permit Mr. Furtado to inform the Insurer (and thereby trigger coverage for a claim), and certainly after he was specifically advised of this fact in February 2021, notice of the circumstance had to be given in order to trigger coverage for any Claims arising therefrom.
>
> Mr. Furtado's failure to report the circumstance to the Insurer when the law permitted him to do so, and at the very least when he was informed of his ability to do so in February 2021, meant that any claim arising from the circumstance could not be treated as reported within the Policy period.[2]

TAKEAWAYS

The *Furtado* decision helpfully summarizes the relevant legal principles relating to claims made versus occurrence policies and relief from forfeiture. The Court of Appeal reinforced the importance of adhering to the reporting requirement under claims-made policies.

However, if a policy does not explicitly make it clear that making and reporting claims is a condition precedent to coverage, relief against forfeiture may be available to the insured. For insurance companies, it is crucial to clearly define all conditions precedent in policies in order to rely on them, as the insurer was

able to do in this case. For policyholders, those with claims-made policies should ensure that claims are reported promptly to their insurer.

[***Michael Dunk*** *has over 3 years of civil and insurance litigation experience in a wide range of areas, including representation in class action and appeal proceedings. Michael has experience in the areas of municipal liability and public entity defence, as well as professional negligence for police officers, lawyers, and real estate appraisers. He also has expertise in the areas of property damage, motor vehicle accidents, commercial and general liability, roads liability, transit liability, cyber insurance, and insurance coverage issues.*]

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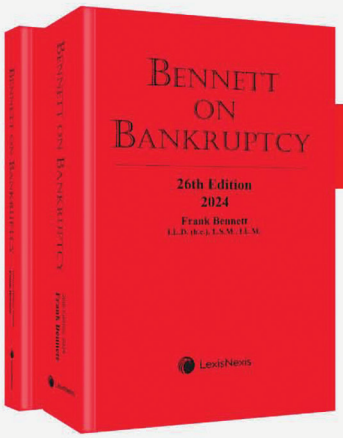
1 *Furtado v. Lloyd's Underwriters,* [2024] O.J. No. 3312, 2024 ONCA 579 (Ont. C.A.) [hereinafter "*Furtado*"].

2 *Furtado*, at paras. 96-97 (Ont. C.A.)



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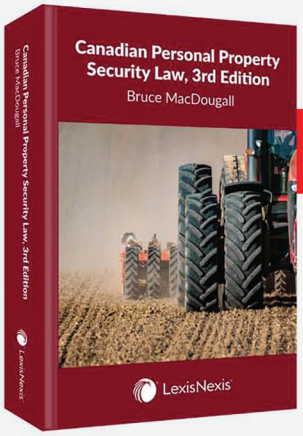

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  - *Guraya v. Kaila*
  - *Factors Western Inc. v. DCR Inc.*
  - *Atlantic Lottery Corp. Inc. v. Babstock*
  - *900351 Ontario Inc. v. Martian Properties Inc.*
- New legislation in Ontario, P.E.I. and Saskatchewan
- Amendments to the *Uniform Commercial Code*

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