Canadian Institute of Actuaries
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# Legal Aspects of Group Insurance in the Province of Quebec

## Complement of information for the CIA Group Benefits track exams

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# Foreword

The Quebec legislation is, on some aspects, significantly different from the legislation in the Common Law provinces. The goal of this study note is to make actuaries aware of some of the important aspects of the Quebec laws, especially those regulating group insurance.

As professionals and as actuaries bound to a code of professional conduct, we must take every possible step to make sure that our work is always done in compliance with all applicable laws and regulations. Oftentimes we are asked to design and/or price insurance products. It is therefore important that we know the laws and regulations applying to those products. While the subject of law and regulation in the Common Law provinces is fairly well covered in various books, the law in Quebec has been evolving so fast that, at this time, there is no comprehensive reference document available. Moreover, group insurance is a quite specialized area of insurance and is generally not the focus of legal publications.

This study note is a work in progress and will be updated periodically.

# The Quebec Civil Code

## General Concepts of the Civil Code Having an Influence on Insurance Contracts

Even though insurance is governed by a specific chapter of the Civil Code (Chapter XV), the Civil Code itself is a whole and some of its other sections do apply to insurance contracts.

### Civil Union

In Canada, marriage and divorce fall mostly under federal jurisdiction. The federal government has the authority over the definition of “marriage” and over legal capacity to marry while the provincial (and territorial) governments can regulate the registration of marriage. The federal government regulates divorce and its consequences through the ***Divorce Act***, but the provinces regulate the division of marital property when a marriage breaks down, under their authority over property and civil rights.

A province has the jurisdiction to create new forms of legal relationships (other than marriage) for the purpose of its own laws and programs.

In 2002, Quebec passed an ***Act instituting civil unions and establishing new rules of filiation***. A civil union is equivalent to marriage and the parties to a civil union are referred to as “spouses” in the Civil Code just as married spouses. The only difference with marriage is that a civil union is a contract that can be dissolved by common agreement, with the assistance of a notary, while a marriage is normally dissolved by a divorce, through a court decree. The notary in Québec must not be confused with the notary public of Common Law jurisdictions whose functions are different. Notaries in Québec belong to a regulated professional corporation and their functions consist in providing legal counsel, negotiating contracts, drafting legal documents, representing clients before courts or governmental administrative agencies in non-contentious matters and, as a public officer, in drafting and receiving authentic acts or deeds.

Civil union was created to accommodate same-sex couples, who were denied the right to marry by the federal government at that time. In order not to discriminate among couples, civil union has been offered from the beginning to opposite-sex couples, in addition to same-sex couples. According to the most recent statistics, civil unions represent approximately 1% of unions with legal status (marriages and civil unions) in Quebec. Among gays & lesbians, civil unions represent approximately 5% of unions with a legal status. More important, unions with a legal status represented only 58% of all unions in Québec, the remainder (42%) being unions without legal status (called “common-law” unions in the Common Law provinces).

For insurance purposes, a civil union spouse has exactly the same rights and obligations as a married spouse.

## Contracts of Adhesion

According to the Civil Code (Section 1378), contracts may be divided into different types:

- contracts of adhesion and contracts by mutual agreement;
- bilateral and unilateral contracts;
- onerous and gratuitous contracts;
- commutative and aleatory contracts; and
- contracts of instantaneous performance or of successive performance.

They may also be consumer contracts.

What matters here is the fact that the insurance contract is a contract of adhesion as defined by the Civil Code. A contract of adhesion is a contract in which the essential stipulations were imposed or drawn up by one of the parties, on his behalf or upon his instructions, and were not negotiable. (Section 1379)

The major consequences for an insurance contract are:

- The insurance contract must be interpreted in favour of the policyholder or the insured. (Section 1432)
- An external clause is null if, at the time of formation of the contract, it was not expressly brought to the attention of the adhering party (policyholder or insured), unless the other party proves that the policyholder or insured otherwise knew of it. (Section 1435)
- A clause that is illegible or incomprehensible to a reasonable person is null if the adhering party suffers injury therefrom, unless the other party proves that an adequate explanation of the nature and scope of the clause was given to the adhering party. (Section 1436)
- A clause that is excessively and unreasonably detrimental to the adhering party and is therefore not in good faith is null, or the obligation arising from it may be reduced. This clause is called an “abusive clause”. (Section 1437).

The nullity of an external clause has not been tested yet but one could challenge an individual insurance policy covering dental care if the reimbursement is based on an external reference such as a schedule of fees published by a Dentists’ association, unless it was expressly brought to the attention of the policyholder. The situation in group insurance is even less clear as the policyholder is usually aware of external limitations while the insured may not be. In group insurance, both the insurer and the policyholder must make sure that external clauses, such as which edition (current or anterior) of the dental fee guide, are brought to the attention of the insured.

Illegible clauses are usually not a problem as they are now much less frequent than they once were. However, any insurer selling an insurance product in Quebec must be aware of the fact that “fine print” clauses may not be enforceable. Particular care must also be taken to make sure that insurance contracts are understandable by non-specialists. The greatest challenge in writing an insurance contract is to refrain from writing sentences that are so long that their validity might be challenged as not being understandable by the layman.

A possible example of an illegible clause could be found in old group insurance policies that included pre-written clauses and pre-written intercalary documents modifying these clauses. It once was possible to have a standard waiver of premium clause (saying that the employee was disabled if he/she was unable to perform any occupation for a 9-month period) that was modified by a pre-written document saying that, notwithstanding what was written in the contract, disability had to last only six months to entitle the employee to the waiver of premiums; this modifying document was, in turn, modified by another pre-

written document saying that notwithstanding what was written in the contract, the definition of disability for the waiver clause was the same as for long-term disability (LTD) (own occupation for 2 years).

Abusive clauses are extremely infrequent. However, an AD&D clause that would exclude any injury arising from a road accident would probably be deemed to be abusive as it would exclude a major type of accident.

### The Unwritten Clause

According to Section 1438 of the Civil Code, an unwritten clause is null but does not nullify the contract. It must be noted that such a clause is not necessarily a clause that is not written in the contact. It can be a clause that is considered unwritten by the Civil Code, even though the clause is written and understandable. The best example of an unwritten clause applicable to insurance contracts is given by Section 2402: in non-marine insurance, any general clause whereby the insurer is released from his obligations if the law is violated is deemed not written, unless the violation is a criminal offence. For example, in AD&D insurance or automobile insurance, an insurer cannot turn down a claim because the injured person was driving at an excessive speed as the offence is not criminal per se.

### Nullity

Nullity as a concept is important because the Civil Code specifies situations where an insurance contract or any of its clauses are null. A contract or clause that is null is deemed never to have existed. In such a case, each party is bound to restore to the other the considerations they have received. The nullity of a contract can be either absolute or relative.

Nullity of a contract is absolute when the contract is against the general interest. A contract that is absolutely null cannot be enforced. The absolute nullity of a contract may be invoked by any person having a present and actual interest in doing so. It is automatically invoked at the court.

A contract is relatively null where the condition of formation sanctioned by its nullity is necessary for the protection of an individual interest, such as where the consent of the parties or of one of them is vitiated, or when the Civil Code says that such a contract is null.

The relative nullity of a contract may be invoked only by the person in whose interest it is established or by the other contracting party, if this party is acting in good faith and sustains serious injury therefrom. A contract that is relatively null may be confirmed. In such a case, the confirmation results from the express or tacit will to renounce the invocation of its nullity. It results only if the will to confirm is certain and evident.

The best example of a relatively null insurance contract is funeral insurance. In Quebec, a contract of insurance for funeral expenses is null (Section 2442). This situation is explained in further details later in this study note.

## Specific Provision of the Civil Code regarding Insurance Contracts

As this study note is written for group insurance purposes, this section will focus on the provisions of the Civil Code that are relevant to group insurance.

### Accessory Clauses

According to Section 2394 of the Civil Code, clauses of accident and sickness insurance that are accessory to a contract of life insurance and clauses of life insurance that are accessory to a contract of accident and sickness insurance are governed by the rules governing the principal contract.

The most obvious consequence of this situation is that when there is any doubt as to whether the life insurance rules or the accident insurance rules apply to a contract, the contract must be analyzed to determine what is principal and what is accessory.

## Formation of the Insurance Contract and Effective Date of Insurance

A contract of insurance is formed at the time the insurer accepts the application of the client (Section 2398). As a result, the contract is in force as soon as the insurer (or a person mandated by the insurer) accepts the risk. The policy does not have to be delivered to the plan sponsor in order to take force.

However, in the division regarding the insurance of persons, it is specified that life insurance takes effect when the application is accepted by the insurer, provided that it is accepted without modification, that the initial premium has been paid, and that there has been no change in the insurability of the risk since the application was signed (Section 2425). This is different from the Common Law provinces, where life insurance takes effect when the policy is delivered, provided that the premium has been paid and that the applicant's insurability has not changed.

For group life insurance, the difference between Quebec and the other provinces regarding the effective date of coverage is important mostly for new entrants and for additional, facultative amounts. When a new group policy is issued, the policyholder and the insurer normally agree on an effective date, so this difference becomes irrelevant, at least for automatic, mandatory basic life insurance.

On the other hand, there is no significant difference between the Civil Code and the Common Law regarding the effective date of accident and sickness insurance, as the Civil Code states that accident and sickness insurance takes effect upon the delivery of the policy to the client, even if it is delivered by a person other than a representative of the insurer (Section 2426).

In group insurance, the insurer issues the group insurance policy to the client and remits to him the insurance certificates, which he shall distribute to the participants. Participants and beneficiaries may examine and make copies of the policy at the place of business of the client and, in case of discrepancies between the policy and the insurance certificate they may invoke either one according to their interest (Section 2401). Since the insurance contract is a contract of adhesion, it must be interpreted against the insurer. As a result, courts have tended to consider that when there is a conflict between the policy, the certificate and the booklet, the document that is the most favourable to the participant should prevail.

Another consequence of Section 2401 is that the insurer is responsible for the group insurance certificate, since the insurer is considered to be the issuer of the certificate. As a result, when the certificate is issued by the employer or by a third party, the insurer is still responsible to the participant or beneficiary for any errors committed by the third party or the employer. In this type of situation, the insurer should have a clear administration contract with the employer or third party that would set each party's responsibilities.

## Content of the Insurance Contract

The group insurance policy must include the following information (Sections 2399 and 2415):

- Insurer's name;
- Policyholder's (usually the plan sponsor) name;
- A means to identify the insured persons and their beneficiaries;
- The object of the insurance;
- The nature of the risks insured;
- The amount of coverage;
- The time from which the risks are covered;
- The term of the coverage;
- The period during which benefits are payable (if applicable);
- The premium rates;
- The date on which premiums are due;

- The time limit for the payment of premiums;
- The right, if any, of the policyholder to participate in the profits; and
- The right, if any, to convert the insurance.

Even though this requirement is plain common sense, it happens, from time to time, that an actuary comes across a group insurance policy where some of this information is missing. This tends to happen in certain types of association groups, where the rates are sometimes included in the association's internal documents that may not necessarily be referred to in the group insurance policy.

Such a situation is strongly undesirable because it is in conflict with the law (Section 2399) and because the association's documents that are required to apply to the contract are an external clause under Section 1435, that may or may not be enforceable, depending upon the situation. Whenever an actuary comes across this type of situation, he/she should notify the client or the insurer of the potential legal problem.

Where the contract provides coverage against disability, the insurer must set out the terms and conditions of payment of the indemnities and the nature and extent of the disability covered. Failing clear indication as to the nature and extent of the disability covered, the inability to carry on one's usual occupation constitutes the disability (Section 2416).

## Representation of age and risk

In accident and sickness insurance, the insurer may not, except in case of fraud, exclude or reduce the coverage by reason of a medical condition disclosed in the application except under a clause referring by name to the disease or ailment. If the condition is not disclosed in the application, the insurer may not exclude or limit the coverage by reason of such condition after the first two years of coverage except in the case of fraud (Section 2417). In group insurance, the only instance where a medical condition is disclosed to the insurer is when evidence of insurability is required. If the medical condition is properly disclosed, the insurer will presumably limit the insurance amount to the amount offered without evidence of insurability. If the medical condition is not properly disclosed while not being fraudulently hidden (e.g., if the participant was not aware of the condition or of the seriousness of the condition), then the 2-year period referred to in Section 2417 should apply.

Under a group insurance plan, misrepresentation or concealment by a participant as to age or risk affects only the insurance of the persons who are the subject of the misrepresentation or concealment. Hence, if a participant gives an incorrect age to the insurer:

- The life insurance benefit may be adjusted to reflect the difference in premiums corresponding to the difference between the actual age of the participant and the incorrect age.
- In accident and sickness insurance, however, the insurer may elect to adjust the premium to make it correspond to the premium applicable to the true age of the insured; in such a situation, the insurer would presumably simply correct the situation going forward as any recalculation of past premiums would be unduly cumbersome.
- If the actual age of the participant is such that he/she would no longer qualify for insurance, then the insurance coverage may be declared void; however, if the error is discovered after the death of the participant, the insurer may not be able to deny life insurance coverage.
- In the absence of fraud, misrepresentation or concealment as to risk does not justify the annulment or reduction of insurance once it has been in force for two years. This rule does not apply in the case of disability insurance if the disability begins during the first two years of insurance.

## Premiums

In life insurance, the policyholder is entitled to thirty days for the payment of each premium, except the initial premium (Section 2427). This period may not be reduced and the insurance remains in force during

the thirty days. Accident & sickness insurance cannot be cancelled for non-payment of the premium unless fifteen day's prior notice in writing is given to the policyholder (Section 2430). In group insurance, the insurer can charge interest on the premium during the "grace" period allowed for payment (Section 2429).

The insurer may require the payment of overdue premiums when settling a claim under a group life insurance contract or an accident and sickness insurance contract (Section 2433).

## Claims

The insurer must give at least 30 days to the participant or beneficiary for giving notice of an accident & sickness claim and at least 90 days to submit all the information required to settle the claim. When it is impossible for the participant or beneficiary to act within these delays, the insurer is still under the obligation to pay the claim if it receives a notice within one year of the loss (Section 2435).

Insurers are usually less stringent than the Civil Code and allow participants to submit a claim (other than for disability) within 365 days of the occurrence. For disability benefits, insurers tend to require the participant to submit a claim as soon as possible (without being more stringent than the Civil Code) in order to be able to manage the situation efficiently.

The insurer must pay a death benefit within 30 days after receiving the required proof of loss. For accident & sickness insurance, the insurer has 60 days to pay benefits after receiving the proof of loss, except for disability benefits. In this case, the first payment is due no later than 30 days after the end of the elimination period and subsequent payments must be made at intervals of 30 days or less, provided that a proof of the continuation of disability is furnished to the insurer on request (Sections 2436 and 2437).

## Suicide

The insurer may not refuse payment of the sums insured by reason of the suicide of the insured unless it stipulated an express exclusion of coverage in such a case and, even then, the stipulation is without effect if the suicide occurs after two years of uninterrupted insurance (Section 2441).

## Funeral Insurance

A contract of insurance for funeral expenses whereby a person undertakes, for a premium paid in a single payment or by instalments, to provide services or goods upon the death of another person, to pay funeral expenses or to set aside a sum of money for that purpose is null. Only the person who paid the premium or instalments or the Autorité des marchés financiers acting on his behalf may bring an action for the annulment of the contract or recovery of the premium (Section 2442).

The situation of funeral insurance is interesting as the nullity is relative, not absolute. Since the insurer cannot nullify the contract, there is a huge risk of anti-selection. If the insured person dies in the early years of the contract, the insurer has to pay the death benefit. If the insured survives to a point where the accumulated premiums exceed the death benefit, the insured may nullify the contract and get the premiums back.

## Beneficiary

The subject of beneficiaries under the Civil Code is important, yet complex.

The designation in a written document other than a will, by the policyholder or participant, of his or her married or civil union spouse as beneficiary is irrevocable unless otherwise stipulated. The designation of any other person as beneficiary is revocable unless otherwise stipulated in the policy or in a separate writing other than a will. Where revocation is permitted, it may only result from a writing but it need not be express (Section 2449).

Regardless of the terms used, every designation of beneficiaries remains revocable until received by the insurer (Section 2451). Designations and revocations may be set up against the insurer only from the day it receives them; where several irrevocable designations of beneficiaries are made separately and at different times, they are given priority according to their dates of receipt by the insurer. The insurer is discharged by payment in good faith in accordance with these rules to the last known person entitled to it (Section 2452).

Where the designated beneficiary of the insurance is the married or civil union spouse, descendant or ascendant of the policyholder or of the participant, the rights under the contract are exempt from seizure until the beneficiary receives the sum insured (Section 2457).

Separation from bed and board does not affect the rights of the spouse, whether a beneficiary or a subrogated policyholder, but the court may declare them revocable or lapsed when granting a separation. Divorce or nullity of marriage or the dissolution or nullity of a civil union causes any designation of the spouse as beneficiary or subrogated policyholder to lapse (Section 2459).

The subject of beneficiaries has been the object of much discussion in Quebec over the last 30 years. The most important issues for an insurer or administrator of a group insurance plan are the following:

- When the beneficiary is the spouse (married or in a civil union but not in a “common law” union), the designation is irrevocable unless the participant has expressed, in writing, his/her intention that the beneficiary be revocable. By the way, here we have a situation where a same-sex spouse in a civil union has more rights than an opposite sex spouse in a “common law” union. (Actually, the same-sex or opposite sex spouse in a civil union has the same rights as a married spouse.)
- A designation of beneficiary becomes irrevocable only when received by the insurer.

The management of beneficiaries is a major problem for insurers. In particular, a change of insurers may not be considered as the beginning of a new group insurance plan, especially if the plan does not really change. In this situation, even though the new insurer normally asks all participants to designate their beneficiaries, a designation of beneficiary under the new contract may not be valid if it would result in replacing a beneficiary who was irrevocable in the previous plan.

In Lalonde *c*. Sun Life du Canada, Cie d’assurance vie, [1992] 3 R.C.S. 261, the Supreme Court of Canada ruled that the replacement of a group insurance policy by another insurance policy with different terms and conditions does not extinguish the original policy, the new policy being simply the continuation of the old policy, unless there is an intention to make a change and there is actually a change in the object or in the cause of the insurance contract.

There is almost no way for the insurer to be sure that a designation of a beneficiary is valid. The problem is compounded further by the fact that the consent of the irrevocable beneficiary may not have been asked before designating a different beneficiary. The best advice for a new insurer is probably to ask a complete list of beneficiaries from the former insurer (including information as to whether the beneficiary was a married spouse, a spouse under a civil union or any other type of irrevocable beneficiary).

Some have considered avoiding the problem of the management of beneficiaries by keeping the written designation of beneficiary at the employer’s, so that no designation would ever be irrevocable since none would ever have been received by the insurer. This is not a solution since it would presumably deceive the law. Moreover, it would expose the employer to lawsuits from former beneficiaries.

## Regulation under the Act respecting insurance

The Regulation under the Act respecting insurance now refers to the new Insurers Act that has replaced the Act respecting insurance in 2018. This regulation includes a specific chapter (Chapter XI) devoted to group insurance. This chapter deals mainly with the formation of the group, compensation to the policyholder, the conversion right, changes of insurer and creditors’ insurance.

## Legitimate Groups

A group life insurance contract or a group sickness or accident insurance contract must be issued only to cover a specified group of persons and, in some cases, their families or dependents. A specified group of persons is a group whose members share common activities or interests before a group insurance plan is offered to them, including socio-economic or cultural interests and may be composed of a group of employees (or retirees) of one or several employers, a group of persons of the same profession or usual occupation, members of a financial service cooperative, members of a mutual insurance association or members of a voluntary retirement savings plan registered in accordance with the Voluntary Retirement Savings Plan Act (Sections 60 and 60.1).

Obviously, a group may not be constituted for the sole purpose of entering into a group insurance contract.

This definition of "legitimate group" is different from the definition under the Quebec Prescription Drug Insurance Act and is less stringent. As a result, a group maybe recognized as legitimate under this regulation, yet not be allowed to offer prescription drug coverage.

## Conversion Right (Applicable to Life Insurance Only)

Every group life insurance contract must give to the participant who ceases to belong to the group before age 65 the right to convert all or part of his/her life insurance, with the exception of sickness or accident coverage incidental to the life insurance coverage, into individual life insurance within the 31 days after leaving the group, without having to provide evidence of insurability. This participant can also convert the life insurance coverage of his/her dependents into individual policies, at the same conditions. The group insurance coverage remains in force during that 31-day period or until converted into individual insurance (Sections 62-63).

The amount of insurance on the participant's life that may be converted must be at least $10,000 and may not exceed the lesser of the amount of all the life insurance protections that the participant held under the contract on the conversion date and $400,000. In addition, the amount of life insurance that may be converted must be at least $5,000 for each family member and each dependant, without exceeding the amount of insurance on the life of those persons on the conversion date (Section 62).

The insurer must allow the participant to select either:

- an individual life insurance contract, temporary or permanent, at the participant's option, with coverage comparable to that provided under the group insurance contract both as to amount and term, except that the premium for the first year of insurance may not exceed the premium for a 1-year term insurance; or
- an individual life insurance contract for one year, providing protection comparable to that provided under the group insurance contract, but convertible at the end of the year, at the participant's option, into insurance described in subparagraph a).

The premium rates must be those applicable to standard risks (Section 64) and the insurer must allow the participant to pay the 1st-year premium on a quarterly basis (Section 65). However, the insurer may, in respect of a participant subject to an extra premium before the conversion of the group insurance, apply a comparable increase at the time the premium for the individual insurance is established (Section 64).

A group life insurance contract must give a participant who has been insured for at least five years the option to convert all or part of the life insurance protection into individual life insurance within 31 days after the expiry of the master policy, without evidence of insurability, if the master policy is not replaced or the replacement contract provides for a lesser amount of insurance. The amount of insurance that may be converted must be at least $10,000 or 25% of the amount of the participant's life insurance on the expiry of the master policy, whichever amount is greater. The conversion option does not apply to sickness or accident insurance incidental to the group life insurance contract.

## Continuation of Coverage

### Responsibility of the Former Insurer

Section 68 of the new Regulation applies to life insurance coverage and reads as follows: “Every group life insurance contract must stipulate that its expiry or the cancellation of any contract protection may not be set up against a claim based on an event that occurred while the contract was in force or on a death resulting from a disability that arose while the contract was in force”. The former version of the Regulation referred to a “disability provided for in a provision for waiver of premiums” (Section 269 of the old regulation). This qualification has not been carried over to the current Regulation.

Section 69 applies to accident and sickness coverage and stipulates that the expiry or the cancellation of the contract may not be set up against a claim based on death or mutilation resulting from an accident that occurred while the contract was in force; or a disability that arose or a sickness contracted while the contract was in force. It also stipulates the obligation, for the insurer, to continue disability payments after the expiration of the contract.

The requirements of Sections 68 and 69 must be put in writing in any group insurance contract. It must be noted that these sections apply to all situations where a group insurance contract is terminated, including situations (such as the employer going bankrupt, for example) where the group contract is not replaced with another group insurance contract.

However, the impact of Sections 68 and 69 is mitigated by the fact that when there is a change of contract, the former contract ceases to apply as soon as the insured has accumulated 30 days of full-time work after the expiry of the former contract, in a class covered by the new contract (section 74).

Also, under Sections 70 and 72, the former insurer is not liable for the recurrence of the disabling affliction following the expiry of the contract once the participant has been free of disability for more than 180 days (90 days in the previous Regulation) **or** once the participant has accumulated 30 days of full-time work while covered by a new group contract.

As there is no requirement that Sections 68 and 69 apply only to contracts that include a waiver of premiums benefit, the Regulation might be interpreted as mandating extended coverage for disabled employees when there is no replacing insurer, whether the terminated insurance contract had a waiver of premiums benefit or not. This is rather unexpected and will eventually be tested in court.

### Responsibility of the New Insurer

According to Section 71, if a group life insurance contract or a group sickness or accident insurance contract is terminated and replaced within 31 days by a contract providing comparable coverage for all or part of the same group, the new group insurance contract must stipulate that:

- a person insured under the former contract may not be excluded from the new contract or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former contract, or because the person is not at work on the date of coming into force of the new contract; and
- every person insured under the former contract is covered *pleno jure* by the new contract on the termination of the former contract if the cessation of insurance is exclusively attributable to the termination and the person belongs to a class of participant covered by the new contract.

The new insurer must also cover an insured who suffers from a disabling affliction that arose under the former contract but was declared to the previous insurer more than 180 days after it arose, during the new contract (Section 72).

Since, under Section 72, the former insurer is not liable for the recurrence of the disabling affliction following the expiry of the contract once the participant has accumulated 30 days of full-time work while covered by a new group contract, the new insurer cannot, for a recurring disability, apply a waiting period

if the new disability period is attributable to the same or related causes **and** a period of less than 180 days has elapsed since the last premium was waived or the last periodic benefit was paid (Section 73).

All these provisions may look confusing, so here are the most important issues:

- When a contract terminates without being replaced with a new contract, the former insurer may be held responsible for a death resulting from a disability that arose when the contract was in force, whether there was a waiver of premiums benefit of not. The former insurer's responsibility terminates 180 days after the termination of disability. The application of this requirement to contracts without waiver of premiums will eventually have to be tested in court.
- When a group plan includes critical illness coverage and there is a change of insurer, Section 71 may preclude the new insurer from applying an exclusion for pre-existing conditions even to conditions that were not covered under the former contract, if such conditions are covered under the new contract. This type of situation may end up in court.
- For two successive periods of disability to be considered as distinct episodes of disability, these periods must now be separated by at least 180 days if the group insurance contract terminates.
- When a change of insurer happens while an employee is disabled and still within the elimination period for the waiver of premiums under the life insurance coverage, the employee has to be covered by the new insurer, even though he/she is obviously not actively at work.
- At the end of the elimination period, the employee returns to the former insurer, by virtue of the waiver of premiums provision. If the employee dies after the change of insurer but before the end of the elimination period, two possibilities arise: the former insurer is responsible for the death benefit if the death results from the same cause as the disability, and the new insurer is responsible for the death benefit if death results from an independent cause.
- When there is a change of insurer, the general principle applicable to recurring disabilities is somewhat modified:
    - a person who was formerly disabled and who becomes disabled again within 180 days of the end of his/her previous disability benefits does not have to go through a new elimination period if the new disability is related to the former one;
    - a person, who was formerly disabled and who becomes disabled again after having worked 30 days full-time while covered by the new insurer, seems now to be under the responsibility of the new insurer for life and AD&D coverage, even when the former period of disability ended less than 180 days before the beginning of the new period of disability; in this last situation (less than 180 days), the new insurer would not be allowed to apply the elimination period.

Some of these issues are not 100% clear and may be subject to conflicting interpretations. Actuaries working in the valuation of liabilities should be familiar with their company's policy and interpretations regarding these issues as they can have an impact on the valuation of actuarial liabilities. When accepting a group that was insured with another insurer, the new insurer needs to pay particular attention to disabled employees, especially those who are not already benefiting from the waiver of premiums or long term disability benefits.

## Group Creditor Insurance

A group health insurance contract on debtors may provide coverage up to the amount loaned (Section 76) while the amount payable under a group life contract of debtors is limited to the net debt at the time of death of the debtor (Section 78). However, the contract may, at the debtors' option, provide for an amount payable that is equal to the amount of their loan or, in the case of a contract extending variable credit, equal to the amount of the variable credit authorized by the creditor. In this situation, the maximum amount payable to the creditor is limited to the net debt of the debtor, the balance being paid to the designated beneficiary or, if applicable, to that person's succession (Section 79).

If the debtors are responsible for payment in full of the insurance premiums, the master policy must state the amount of the premiums; the amount may not be greater than the amount remitted by the policyholder to the insurer (Section 82).

### Experience-Rating Refunds

No dividend or experience refund may be directly or indirectly paid to the policyholder of a group insurance contract on the life or health of debtors, either during the contract or after its expiry, unless the premiums are paid in full by the policyholder. The master policy may, however, stipulate that experience rebates and dividends are payable retroactively to the participants, that they may be applied to reduce premiums or that they are deposited with the insurer for the purpose of reducing future premiums (Section 84). Particular attention must be paid to this provision because experience-rating refunds are sometimes seen as an interesting source of profit for creditors. In Quebec, such refunds are illegal. Traditionally, to go around this provision, certain creditors used to set up captive reinsurers and used direct insurers as a flow-through. This is done by requiring the insurer to cede 100% of the risk to the captive reinsurer. In this situation, there is no need for an experience refund as all the profits go back to the creditor through the captive reinsurer. Now, as most important creditors own insurance companies, they just need to have the insurance provided on a non-participating basis, by their own insurer.

### Compensation to Policyholder

In group insurance on the life or health of debtors, the master policy may not provide for policyholder remuneration other than reimbursement for expenses actually incurred by the policyholder to administer the contract. Those expenses may not be calculated as a percentage of the premiums or be otherwise associated with the premiums, except in the case of expenses incurred for the collection of the premiums (Section 85). The former Regulation allowed the policyholder a maximum of 5% of premiums for the collection. As this maximum is no longer specified, any policyholder wishing to charge a percentage of premiums as a collection fee must be able to demonstrate that such percentage produces an amount that corresponds to the actual expenses incurred to collect premiums.

Even though large financial institutions tend to act in strict conformity with the law, particular attention must be paid to this provision because smaller entities (such as car dealers, for example) have, in the past, asked insurers to design creditor insurance products for which they would have been the policyholders, and yet be compensated above what is allowed by the Regulation. As actuaries are sometimes involved in the design and pricing of creditors insurance products, there is a professional risk here.

## Act Respecting the Distribution of Financial Products and Services

Over the years, insurers, associations, creditors and brokers have set up insurance products that were more or less contravening with the old Regulation under the Quebec Insurance Act. In order to allow reasonable mass marketing of creditor and association products and be able to manage these products within a legal framework, Quebec passed the Act Respecting the Distribution of Financial Products and Services in 1998.

A whole part of this Act deals with the distribution of insurance other than through an insurance agent or broker. The law creates a new type of insurance seller, called a “distributor”.

A distributor is a person who, in pursuing activities in a field other than insurance, offers, as an accessory, for an insurer, an insurance product that relates solely to goods sold by the person or secures a client’s adhesion in respect of such an insurance product (Section 408). Travel insurance, credit card and debit card insurance, funeral insurance, car rental insurance and replacement insurance are deemed to be products that relate solely to goods (Section 424). (Replacement insurance is property insurance that guarantees the replacement of an insured vehicle).

There seems to be an inconsistency between the Civil Code (Section 2442) and Section 424 (4) of the *Act Respecting the Distribution of Financial Products and Services*. According to the Civil Code, a contract of insurance for funeral expenses is null while funeral insurance is defined as a product deemed to relate solely to goods. This situation dates back to 2018, when Section 2441.1 of the Civil Code that allowed one single company to sell funeral insurance was intended to allow all companies to sell funeral insurance. In response to the lobby by certain organizations, Section 2441.1 was repealed instead of being broadened. At the same time, funeral insurance was included in Section 424 (4) probably to make it consistent with the initial intent of broadening 2441.1 in the Civil Code. The safest approach to funeral insurance in Quebec is to consult both a specialized lawyer and the Autorité des marchés financiers.

Debtor life, health and employment insurance and investor life, health and employment insurance are deemed to be insurance products that relate solely to goods and to which clients adhere (Section 426). It has been ruled that these products can be sold by a distributor only on a group basis.

A person who distributes an insurance product, whether the person is a distributor or a natural person assigned that task by the distributor, must describe the product to the client and explain the nature of the guarantee. The person distributing the product must clearly explain the exclusions under the guarantee to enable the client to decide whether the situation applying in the client's case constitutes an exclusion under the guarantee. The person distributing the product must also, if the remuneration received by the distributor for the sale of the product exceeds 30% of its sale price, disclose that remuneration to the client (Section 431).

The provision regarding the disclosure of the remuneration received by the distributor implicitly recognizes the fact that a distributor may receive a compensation that can reach or exceed 30% of the premium. This provision may be wrongly interpreted as meaning that the policyholder can receive such compensation, which would be against the Regulation under the *Quebec Insurers Act*.

An insurer must, at the request of the Autorité, disclose the remuneration it grants to distributors for the sale of a product. A distributor offering more than one insurance product for the same goods must disclose to the client the remuneration paid by the insurer for the sale of each insurance product (Sections 432-433).

The person distributing a product must inform the client of the procedure and time limits for making a claim. Where a client of a distributor has not received the information regarding the exclusions, the distributor is liable for any resulting injury to the client (Sections 434-436).

A distributor may not subordinate the making of a contract to the making of an insurance contract with the insurer specified by the distributor (Section 439). For example, a lender can require that the borrower be insured against death or disability, but the lender cannot force the borrower to buy the required insurance from him. The borrower may buy insurance anywhere on the market.

A distributor that, at the time a contract is made, causes the client to make an insurance contract must give the client a notice, drafted in the manner prescribed by regulation of the Autorité des marchés financiers, stating that the client may cancel the insurance contract within 10 days of signing it. A client may cancel an insurance contract made at the same time as another contract, within 10 days of signing it, by sending notice by registered or certified mail (Sections 440 and 441).

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