Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A14-003045

BETWEEN:

BHUPINDER SINGH GREWAL

Applicant

and

AIG INSURANCE COMPANY OF CANADA

Insurer

DECISION ON EXPENSES

Before: Arbitrator Lynda Tanaka

Heard: In person at ADR Chambers on August 24, 2016 and by teleconference on October 17, 2016

Appearances: Mr. Frank Burns for Mr. Bhupinder Singh Grewal
Mr. J. Claude Blouin for AIG Insurance Company of Canada

Issues:

The Applicant, Mr. Bhupinder Singh Grewal, was injured in a motor vehicle accident on January 18, 2009 and sought accident benefits from AIG Insurance Company of Canada ("AIG"), payable under the *SABS*.[1] The parties were unable to resolve their disputes through mediation, and Mr. Grewal, through his representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

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[1] Effective September 1, 2010, the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "new *SABS*") came into force. The transition rules in the new *SABS* provide that, subject to certain exceptions, benefits that would have been available pursuant to the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996* (the "old *SABS*") shall be paid under the new *SABS*, but in amounts determined under the old *SABS*.

I issued my Arbitration Decision and Order on February 16, 2016, ordering that AIG pay benefits and interest to the Applicant, and ordering that if the parties are unable to agree on the entitlement to, or quantum of, the expenses of this matter, the parties could request an appointment with me for determination of same in accordance with Rules 75 to 79 of the *Dispute Resolution Practice Code* ("the *DRPC*"). On August 24, 2016, the parties made oral submissions on the written materials that had been served and filed on the expense claim, and the Applicant raised issues with respect to the provision of interest under my Order. Further, the Applicant has made a request that I make a change in the quantum of one of the medical benefits that had been approved. Counsel for AIG indicated he was taken by surprise by the claim for statutory interest, and further objected on jurisdictional grounds to the Applicant's request for a change in the quantum of the approved medical benefit. To ensure fairness to both parties, I directed a process by which the parties provided written submissions on those two issues, and an additional one-hour teleconference was set for October 17, 2016. This Decision and Order addresses all three issues.

The issues in this Expense Hearing are:

1. Is AIG liable to pay the expenses of the Applicant and, if so, in what quantum?
2. At what rate is the Applicant entitled to interest on overdue benefits, for what period and in what amount?
3. Do I have jurisdiction to change the quantum of the medical benefit approved in the amount of US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), under treatment plan OCF-18, dated January 11, 2015?

Result:

1. AIG is liable to pay the expenses of the Applicant in the amount of $27,910.01, inclusive of HST.
2. The Applicant is entitled to interest on overdue benefits at the rate of 2% compounded per month, calculated for each treatment plan approved in the decision of February 16, 2016, re-listed below, from the date 30 days after receipt by AIG or its adjuster of each treatment plan to date of payment:

a) For services provided by Faith Physiotherapy:

i) $2,144.26 for physiotherapy, treatment plan dated July 23, 2013; and

ii) $1,682.90 for assessment and multiple regions therapy, treatment plan dated March 13, 2014;

b) For services provided by Beverlee C. Melamed & Associates:

i) $4,119.27 for occupational therapy and rehabilitation coaching, treatment plan dated September 9, 2013;

ii) $3,946.01, and not as noted in the Report of Mediator, for occupational therapy and rehabilitation, treatment plan dated February 18, 2014; and

iii) $5,225.97 for a gym membership, cognitive and learning therapy and motor function therapy, treatment plan dated July 24, 2014;

c) $6,915.52 for speech language therapy provided by Michelle Cohen & Associates, treatment plan dated October 4, 2013; and

d) US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), treatment plan dated January 11, 2015.

3. I do not have jurisdiction to change the quantum of the medical benefit approved in the amount of US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), treatment plan dated January 11, 2015.

EVIDENCE AND ANALYSIS:

Issue 1 – Expenses

The Arbitration Hearing was held over two days, December 8 and 9, 2015. The Hearing on December 8 ended at approximately 4:00 p.m. and on December 9 ended at 12:35 p.m. There were only two witnesses who were called by the Applicant — Dr. Stephen Connell, psychiatrist, and Ms. Beverlee C. Melamed, who is the Applicant's Case Manager. AIG declined to call witnesses, but relied on the written record of medical reports and other documents.

The original claim under the Applicant's Bill of Costs was for $45,770.88, as follows:

Total Legal Fees	$13,140.20 (plus HST of $1,708.23)
Medical Reports and witness attendance	$30,410.00 (inclusive of HST)
Disbursements	$512.45 (inclusive of HST)

AIG resisted payment of some of the invoices for the medical reports of Dr. Connell and Ms. Melamed, and also of a Dr. Young (whose report was included in the Exhibits but who did not testify), on the basis that the reports had been obtained for the earlier Arbitration before Arbitrator Feldman. Arbitrator Feldman had ordered costs payable to AIG, not to the Applicant. Counsel also took the position that AIG had not seen the reports for which fees were charged.

A Revised Bill of Costs was submitted, reducing the claim for fees to $13,140.20, plus HST of $1,708.23, reducing the claim for experts' reports and attendance to $12,679.08, inclusive of HST, and reducing the disbursements claim to $382.50. Specifically, the Applicant is no longer seeking reimbursement of the balance of the cost of Dr. Young's report.

All the reports included in the claim here were part of Exhibit 1 filed in these proceedings, and all of them informed me in relation to my decision-making. In the case of Dr. Connell and Ms. Melamed, the reports were part of the witnesses' evidence in this matter. Therefore, the submission that AIG had not seen the reports cannot be sustained. The fact that some of the reports were filed with Arbitrator Feldman earlier does not take away from their importance in my decision-making. Therefore, the Applicant is entitled to be reimbursed for the Connell and Melamed reports and the cost of the witness attendances.

Rule 75.2 of Schedule F of the *DRPC* outlines the appropriate criteria to be considered on an application for expenses. I have considered the various relevant criteria from that Rule.

Criteria 1: Each party's degree of success in the outcome of the proceeding

The Applicant was successful in this proceeding.

Criteria 2: Any written offers to settle that were made in accordance with the rules of practice and procedure applicable to the proceeding after the conclusion of Mediation and before the conclusion of the Arbitration

The Applicant advises that no offers were made by AIG.

Criteria 3: Whether any novel issues are raised in the proceeding

There was only one precedent for an Order that an Applicant attend an out-of-country provider for a medical benefit payed for by an Insurer. Further, there had been a previous Arbitration Hearing on the issue of an OCF-18 similar to the one before me.

Criteria 4: The conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including the failure to comply with undertakings and orders

No conduct to prolong, obstruct or hinder the proceedings through failure to comply with undertakings or orders or to hinder the proceedings was alleged. What is clear on the record, however, is that AIG has insisted on strict compliance with procedural requirements and has resisted providing the medical benefits that this Applicant is entitled to have. AIG has not assiduously followed up on his need for support. For instance, while AIG's medical assessors stated that the medical treatment he needed was available in Ontario, there was no follow-up by AIG to give any real substance to that position, even though AIG was regularly updated on the difficulties that the Applicant was having in finding such treatment.

I agree with the counsel for the Applicant that AIG has played hardball. The dockets submitted by the Applicant's counsel show that AIG was asked to agree to a failed mediation report and refused to do so, despite the fact that both parties are represented by experienced counsel who understand the advantages of early resolution. This procedural disagreement is instructive of the process that AIG insisted the Applicant follow.

Counsel for the Applicant points out that AIG had in its possession, prior to the Hearing before Arbitrator Feldman in 2013, the report of Dr. Young, who obtained valid neuropsychological test results confirming that the Applicant had sustained a brain injury with severe cognitive impairments. Dr. Young's opinion was confirmed in March 2015 by the assessors for AIG, who concluded that the Applicant suffers from a Major Neurocognitive Disorder. But AIG objected to that report being placed before Arbitrator Feldman, and the Hearing proceeded based on a record of medical reports that did not include Dr. Young's opinion. When the Applicant appealed Arbitrator Feldman's decision, AIG continued to take an adversarial position.

Arbitrator Feldman made a finding that the invalid test results obtained by AIG's assessors, and the inconsistent reporting by the Applicant to various assessors, could reflect a deliberate attempt by the Applicant to manipulate the assessors.[2] Arbitrator Feldman specifically found that the test results and inconsistent reporting could also be "a symptom of the Applicant's cognitive and psychological impairments."[3] It appears to me that AIG does not accept its own assessors' 2015 opinions that the Applicant is genuinely as impaired as the medical experts now agree he is. There were opportunities for AIG to adjust this file so as to resolve this Arbitration proceeding; instead, it insisted on an adversarial approach to this case.[4] Therefore, the Applicant's counsel and his medical advisors and Ms. Melamed have spent more time than would have been necessary if AIG had not pursued an adversarial strategy, and the whole process has been longer and more costly than it should have been. I see no basis for denying any part of the Applicant's expenses.

Criteria 5: Whether any aspect of the proceeding was improper, vexatious or unnecessary

AIG's adversarial approach has been unnecessary in light of its own assessors' opinions.

AIG submits that the preparation time for the Applicant's counsel should be limited to two hours of preparation for each hour of Hearing time. I decline to place that limit in this case because of

[2] *Grewal and AIG Commercial Insurance Company of Canada*, FSCO A09-002980, August 7, 2014, at p. 29

[3] *Ibid.*, p. 29.

[4] I note that I included in my decision specific reference to Ms. Melamed providing reports to the adjuster, some of them included in Exhibit 1, Tab 10. Specifically, she provided a report in each of July and September 2013, March 2014 and October 27, 2015. These reports set out the status of the Applicant's progress and treatment and her recommendations.

AIG's adversarial approach to this matter, outlined above. Counsel for the Applicant has necessarily had to spend more time than otherwise. For example, while counsel for AIG insisted on dockets being produced, no argument was made that any of the time spent was unnecessary or spent on matters not properly included in this application for expenses. Rather, AIG argued for a standard ratio of preparation time to Hearing time. That argument could have been made without putting the Applicant to producing the detailed dockets. The context of the history of this case makes what might otherwise be an appropriate step seem directed to forcing the Applicant to incur further expense, simply for the sake of having him incur more expense.

Mr. Burns requests in the claim for expenses an hourly rate as a senior counsel at $150.00 per hour, and in my view this is the appropriate rate. The remaining time is also claimed at appropriate rates, and I order that the legal fees, including HST, be paid in full in the amount of $14,848.43.

With respect to the disbursements of $382.50, they consist of the filing fee and photocopying, and therefore are proper charges. They are also approved.

The remaining expenses are the invoices of Dr. Connell and Ms. Melamed.

AIG submits that Dr. Connell's invoice should be reduced to reflect the rates that can be awarded under the Schedule to the *Expense Regulation* forming part of Ont. Reg. 664, as amended at section 5(3). AIG also agrees to pay $1,500.00 for each of three invoices (August 14, 2012, August 25, 2013 and April 7, 2015) for a total of $4,500.00. Additional fees are requested by the Applicant for reports, dated July 6, 2012, September 13, 2013, January 7, 2015 and April 7, 2015, totalling $3,195.00. I have reviewed Exhibit 1 in which Tab 7 (specifically the sub-tabs A to H inclusive) contains those reports. The fees charged for the reports reflect the difference in the reports, some of which would have required extensive file review to prepare, and others less so. As noted above, all these reports formed part of the evidence on which my decision was based, and therefore since all the fees are at or less than $1,500.00, the fees should be paid in full. The Revised Bill of Costs submitted by the Applicant reflects AIG's position that the maximum that can be awarded for Dr. Connell under the heading of expenses for the Hearing is based on the

$500.00 for preparation time for the Hearing and $200.00 per hour for his attendance (4.5 hours) as a witness, and totals $1,400.00.

With respect to Ms. Melamed's invoices shown on the Bill of Costs, AIG objected to paying:

a) an invoice for a Cost of Future Care Report because it is not payable under Section 25(5)(b) of *SABS*,

b) an invoice for accompanying the Applicant to an Insurer Examination,

c) an invoice for occupational therapy services provided by Ms. Melamed, and

d) an invoice for services after the Hearing under an invoice, dated March 14, 2016.

Counsel for the Applicant revised the Bill of Costs to delete those services, but he retained a claim for reports, dated July 2, 2013, March 5, 2014, and October 27, 2015. Ms. Melamed is approved as the Case Manager, and I have reviewed the four reports contained in Tab 10 of Exhibit 1. Ms. Melamed testified at the Hearing, and her reports are referenced in my decision. Her invoices for those reports are therefore approved in the amount of $2,284.08.

In addition, Ms. Melamed's fees for the Hearing are approved at $1,085.00, reflecting a total of 8 hours at the hourly rate that she charged of $130.00 (rather than the maximum expert witness attendance rate of $200.00) and the $500.00 preparation fee. To award the $200.00 per hour rate rather than the rate actually charged is contrary to the legislative provisions, which provide for the expenses claimed to reflect those incurred.

Therefore, the amount recoverable as disbursements for the experts in this Arbitration is $12,679.08.

I therefore find that AIG is liable to pay the expenses of the Applicant in the amount of $27,910.01, inclusive of HST.

Issue 2 – Interest

Section 46 provides for the payment of interest as follows:

> (1) An amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part.
> (2) If payment of a benefit under this Regulation is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly.[5]

AIG resists paying interest on the benefits under the treatment plans approved in my decision of February 16, 2016 on the basis that because no invoice was ever submitted under the treatment plans, there was nothing overdue. Since the accident, the system of payment now includes the HCAI system whereby service providers submit their invoices for payment under approved treatment plans. If a treatment plan is not approved, the provider cannot submit an invoice under the system.

In this case, after my decision was issued, AIG's adjuster required the service providers to issue new treatment plans to reflect the treatment plans approved in my decision through HCAI, and she approved those treatment plans. Therefore, the benefits approved to be provided under the treatment plans that were the subject of my decision have never in fact been paid. New treatment plans have been submitted seeking benefits of the same nature as was included in the approved treatment plans.

Counsel for AIG acknowledged in argument that the sole purpose of this requirement by the adjuster that new treatment plans be submitted was to defeat the Applicant's claim for interest. The Applicant's counsel provided extensive case law to support the proposition that interest runs on benefits from the date of the receipt of the treatment plan, not from the date of a positive adjudicative outcome. The Applicant does not forfeit his claim of interest because an Insurer has received an independent assessment report that says the services are not reasonable and necessary.[6]

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[5] O. Reg. 403/96 as amended ("old *SABS*").
[6] *Allstate Insurance Company of Canada and Boyer*, FSCO P09-00022, May 5, 2010, at p. 13.

The old *SABS* does not speak to overdue invoices but rather to benefits being overdue. The case law cited by the Applicant is clear that benefits run from the point of receipt of the treatment plan. The denial of the treatment plan delays the payment of interest, but does not stop it running. The Insurer enjoys the use of the money that properly should be spent on the Applicant's medical care. Interest is compensatory, not punitive.[7]

I reject AIG's position that it has defeated the Applicant's claim for interest through this ruse. This is yet another example of AIG acting in an adversarial manner, rather than as a partner in care. AIG cannot accomplish indirectly what it could not do directly. AIG provided no case law to support its position that interest runs from the invoice date and not from the benefit claim, nor that by submitting new treatment plans, the payment of interest is somehow waived.

The treatment plans approved under my decision were the following:

a) For services provided by Faith Physiotherapy:

i) $2,144.26 for physiotherapy, treatment plan dated July 23, 2013;

ii) $1,682.90 for assessment and multiple regions therapy, treatment plan dated March 13, 2014;

b) For services provided by Beverlee C. Melamed & Associates:

i) $4,119.27 for occupational therapy and rehabilitation coaching, treatment plan dated September 9, 2013;

ii) $3,946.01, and not as noted in the Report of Mediator for occupational therapy and rehabilitation, treatment plan dated February 18, 2014; and

iii) $5,225.97 for a gym membership, cognitive and learning therapy and motor function therapy, treatment plan dated July 24, 2014;

c) $6,915.52 for speech language therapy provided by Michelle Cohen & Associates, treatment plan dated October 4, 2013.

Interest on the treatment plans should run at 2% per month compounded commencing 30 days after receipt of each treatment plan by AIG (or its adjuster) to date of payment. I note that while AIG at one point disputed the 2% interest rate, counsel did not pursue that point.

[7] *Sorokin v. Wawanesa Mutual Insurance Company*, (2008) 92 O.R. (3rd) 314.

With respect to item d), the January 11, 2015 treatment plan for US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), the Applicant has submitted extensive argument that, on the unique circumstances of this case, interest should run from the date of the original treatment plan which was dated September 24, 2012. This treatment plan was the subject of the decision of Arbitrator Feldman, who rejected the claim but held that once reliable results from valid neuropsychological tests for the Applicant were obtained, "the Applicant was free to submit a new treatment plan to the insurer for whatever treatment his experts deem to be reasonable and necessary".[8] In 2014, the Applicant commenced the Application for Mediation and for Arbitration in this file. In a January 6, 2015 ruling, Arbitrator Drory, as Pre-Hearing Arbitrator, informed the Applicant that because of the two-year limitation on proceedings for the 2012 treatment plan, the Applicant should submit another treatment plan substantively similar to the disputed treatment plan if he still wished to pursue it. This process was consistent with the holding by Arbitrator Feldman that the Applicant was "free to submit a new treatment plan".

Therefore, interest should run from 30 days after the date of receipt by AIG or its adjuster of the January 11, 2015 OCF-18, submitted by Dr. Connell. This date is consistent with my ruling on interest for the balance of the medical treatment plans, in that there is an Arbitrator's ruling and Appeal disposing of the claim under the 2012 treatment plan. There is no such ruling with respect to the other medical treatment plans that were dealt with in my decision.

Issue 3 – Do I have jurisdiction to change the quantum of the medical benefit approved in the amount of US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), treatment plan OCF-18 dated January 11, 2015?

In my Order, I found that the treatment plan, dated January 11, 2015, prepared by Dr. Connell was reasonable and necessary. After my Order was issued, the Applicant made inquiries and discovered that the cost of treatment was no longer the amount identified in the treatment plan,

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[8] *Grewal and AIG Commercial Insurance Company of Canada*, FSCO A09-002980, August 7, 2014, at p. 29.

and he asked that the amount approved be increased to reflect the 2016 cost. AIG refuses to allow the increase in its obligations under the treatment plan, and objects to any change in my Order on the basis that I have no jurisdiction to make the change. AIG says I am *functus* with respect to the approval of this treatment plan.

The Applicant says that I can change the cost of the treatment plan because:

a) I have a power under the *DRPC* to make corrections etc. of my decisions and this falls within that Rule;

b) The quantum included in the claim reflected the treatment which had been requested in a treatment plan submitted in 2012, and therefore it conformed to Arbitrator Drory's position that the new treatment plan could be brought forward "substantially the same" as the 2012 treatment plan;

c) The *SABS* is consumer protection legislation, and to permit the amendment is consistent with that legislative intent;

d) To find in favour of AIG is to reward it inappropriately for delaying the approval of the treatment plan which should have been approved once AIG received its own assessors' reports in March 2015.

The Applicant also submits that AIG has been further delaying his ability to undertake the treatment, following my decision to approve the treatment. The out-of-country facility required payment in advance – something which is not usually done under the accident benefits system in Ontario. AIG refused to either pay the money to the Applicant or to pay the treatment facility. It is not clear whether this refusal was simply another example of its adversarial insistence on strict adherence to procedural requirements, or out of a concern that the facility would not conduct itself in a business-like way and refund monies not used for treatment, or out of a concern that the Applicant would simply take the money and forgo treatment. Given the Applicant's lack of funds, AIG's position in essence defeats the Applicant's entitlement and ability to take the treatment. A compromise has been worked out so that AIG has guaranteed the payment in the approved amount if the treatment is undertaken, and I was advised that the Applicant is to attend the treatment in November 2016. I have also been advised that the Applicant intends to request approval for additional treatment.

No request was made in the course of the Hearing to amend the Arbitration claim to revise the cost of the treatment plan upwards.

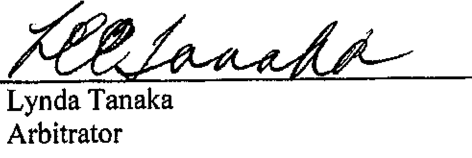
I find that I do not have jurisdiction to change the quantum for the treatment plan. There is substance to the Applicant's strenuous argument that the cost of treatment would not have increased so much if AIG had not so unreasonably resisted the claim for so long; but the request for an increased quantum is too late in this particular process. However much sense it might make to shorten the extraordinarily drawn-out process of obtaining treatment for the Applicant, there is a principle of finality in the Arbitration process which must be respected. The rule that permits changes to decisions after they are issued was not intended to accommodate substantive changes but rather typographical errors or slips. For example, under that rule, I had jurisdiction to change the original decision I issued, which did not reflect the US dollars. I find the change in the cost of treatment of the magnitude sought here is a substantive change, and not a typographical or inadvertent slip. Procedural fairness requires that AIG know the case it has to meet, i.e. the services to be provided and the quantum that is being claimed against it.

If the funds approved under the treatment plan are insufficient to provide the treatment that the Applicant needs, then approval of a further treatment plan can be requested as reasonable and necessary treatment. If AIG is true to its obligations to adjust the file in good faith and be a partner to this Applicant in his treatment and recovery, then the filing of a further treatment plan might not be the subject of the same resistance that AIG has put up with respect to this treatment plan. If, however, AIG does not change its approach, then the Applicant and his counsel have their remedies, which will no doubt be considered in the context of the history of the adjustment of this Applicant's accident benefits claims.

EXPENSES:

AIG is liable to pay the expenses of the Applicant in the amount of $27,910.01, inclusive of HST. The Applicant is entitled to interest on overdue benefits at the rate of 2% compounded per month, calculated for each treatment plan approved in the decision of February 16, 2016, listed in the

Result section and following Order, from the date 30 days after receipt by AIG or its adjuster of such treatment plan to date of payment:



Lynda Tanaka
Arbitrator

January 3, 2017
Date

Financial Services
Commission
of Ontario

Commission des
services financiers
de l'Ontario

FSCO A14-003045

BETWEEN:

BHUPINDER SINGH GREWAL

Applicant

and

AIG INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1. AIG is liable to pay the expenses of the Applicant in the amount of $27,910.01, inclusive of HST.
2. The Applicant is entitled to interest on overdue benefits at the rate of 2% compounded per month, calculated for each treatment plan approved in the decision of February 16, 2016, listed below, from the date 30 days after receipt by AIG or its adjuster of such treatment plan to date of payment:

    a) For services provided by Faith Physiotherapy:

        i) $2,144.26 for physiotherapy, treatment plan dated July 23, 2013;

        ii) $1,682.90 for assessment and multiple regions therapy, treatment plan dated March 13, 2014;

    b) For services provided by Beverlee C. Melamed & Associates:

        i) $4,119.27 for occupational therapy and rehabilitation coaching, treatment plan dated September 9, 2013;

ii) $3,946.01, and not as noted in the Report of Mediator for occupational therapy and rehabilitation, treatment plan dated February 18, 2014; and

iii) $5,225.97 for a gym membership, cognitive and learning therapy and motor function therapy, treatment plan dated July 24, 2014;

c) $6,915.52 for speech language therapy provided by Michelle Cohen & Associates, treatment plan dated October 4, 2013; and

d) US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), treatment plan dated January 11, 2015.

3. I do not have jurisdiction to change the quantum of the medical benefit approved in the amount of US$56,600.00 for multi-disciplinary rehabilitation treatment provided by Sierra Tucson (Arizona), treatment plan dated January 11, 2015.

Lynda Tanaka
Arbitrator

January 3, 2017
Date