[TRANSLATION]

Citation: *A. B. v. Canada Employment Insurance Commission*, 2015 SSTGDEI 45

Appeal #: GE-14-3114

BETWEEN:

A. B.

Appellant

and

Canada Employment Insurance Commission

Respondent

SOCIAL SECURITY TRIBUNAL DECISION
General Division – Employment Insurance

SOCIAL SECURITY TRIBUNAL MEMBER:	Normand Morin
HEARING DATE:	January 13, 2015
TYPE OF HEARING:	Teleconference
DECISION:	Appeal dismissed

PERSONS IN ATTENDANCE

[1] The Appellant, A. B., was present during the telephone hearing (teleconference) held on January 13, 2015.

DECISION

[2] The Tribunal finds that the imposition on the Appellant of a disentitlement to special employment insurance benefits (sickness benefits) because he did not prove that he was unable to work is justified under paragraph 18(1)(b) and section 50 of the *Employment Insurance Act* ("the Act") and section 40 of the *Employment Insurance Regulations* ("the Regulations").

[3] The Tribunal also finds that the imposition of a penalty on the Appellant for committing an act or omission by making representations that he knew were false or misleading is justified under section 38 of the Act.

INTRODUCTION

[4] On October 10, 2012, the Appellant made an initial claim for benefits effective October 7, 2012 (Exhibits GD3-2 to GD3-12).

[5] On February 10, 2014, the Respondent, the Canada Employment Insurance Commission ("the Commission"), called the Appellant in for an interview on February 19, 2014 to determine his entitlement to employment insurance benefits (Exhibits GD3-13 and GD3-14).

[6] On March 14, 2014, the Commission informed the Appellant that it had learned that he had claimed special benefits (sickness benefits) for the weeks starting on October 28, November 25 and December 16, 2012 and January 13, February 3 and February 24, 2013 and that he had no doctor's note to confirm that he had been sick. The Commission

concluded that the Appellant had made six (6) false representations, for which a penalty of $1,323.00 was imposed on him (Exhibits GD3-62 and GD3-63).

[7] On April 2, 2014, the Appellant made a Request for Reconsideration of an Employment Insurance (EI) decision (Exhibits GD3-63 to GD3-65).

[8] On July 10, 2014, the Commission informed the Appellant that it was upholding the decision made on March 14, 2014 concerning his claim for employment insurance sickness benefits. The Commission determined that the Appellant was not entitled to sickness benefits for the weeks starting on October 28, November 25 and December 16, 2012 and January 13, February 3 and February 24, 2013, but that those weeks would be converted to regular employment insurance benefits. The Commission also informed the Appellant that the amount of the penalty initially imposed on him, $1,323.00, had been reduced to $637.00. The Commission further informed the Appellant that it had revised its position in his favour by cancelling the notice of violation issued to him (Exhibits GD3-71 and GD3-72).

[9] On August 11, 2014, the Appellant filed a Notice of Appeal with the Employment Insurance Section of the Tribunal's General Division (Exhibits GD2-1 to GD2-8).

[10] On August 13, 2014, the Tribunal informed the Appellant that it had received his Notice of Appeal (Exhibits GD2A-1 and GD2A-2).

FORM OF HEARING

[11] The hearing was held by teleconference for the reasons stated in the notice of hearing dated November 4, 2014. Those reasons are as follows:

(a) The cost-effectiveness and expediency of the hearing choice; and

(b) The appellant was to be the only party attending the hearing (Exhibits GD1-1 to GD1-3).

ISSUES

[12] The Tribunal must determine whether the appeal from the Commission's decision has merit on the following two issues:

(a) the imposition on the Appellant of a disentitlement to special employment insurance benefits (sickness benefits) under paragraph 18(1)(b) and section 50 of the Act and section 40 of the Regulations because he did not prove that he was unable to work;

(b) the imposition of a penalty on the Appellant under section 38 of the Act for committing an act or omission by making representations that he knew were false or misleading.

THE LAW

[13] The provisions on "disentitlement to benefits" are set out in section 18 of the Act.

[14] Paragraph 18(1)(b) of the Act states the following about "disentitlement to benefits":

> A claimant is not entitled to be paid benefits for a working day in a benefit period for which the claimant fails to prove that on that day the claimant was . . . (b) unable to work because of a prescribed illness, injury or quarantine, and that the claimant would otherwise be available for work. . . .

[15] Subsection 40(1) of the Regulations states the following about the payment of "sickness" benefits:

> . . . (1) The information and evidence to be provided to the Commission by a claimant in order to prove inability to work because of illness, injury or quarantine under paragraph 18(1)(b) or subsection 152.03(1) of the Act, is a medical certificate completed by a medical doctor or other medical professional attesting to the claimant's inability to work and stating the probable duration of the illness, injury or quarantine.

[16] Subsections 50(1) and (5) of the Act provide as follows with regard to the "claim procedure":

> . . . (1) A claimant who fails to fulfil or comply with a condition or requirement under this section is not entitled to receive benefits for as long as the condition or requirement is not fulfilled or complied with. . . . (5) The Commission may at any time require a claimant to provide additional information about their claim for benefits.

[17] Section 38 of the Act states the following about the imposition of "penalties":

> . . . (1) The Commission may impose on a claimant, or any other person acting for a claimant, a penalty for each of the following acts or omissions if the Commission becomes aware of facts that in its opinion establish that the claimant or other person has (a) in relation to a claim for benefits, made a representation that the claimant or other person knew was false or misleading; (b) being required under this Act or the regulations to provide information, provided information or made a representation that the claimant or other person knew was false or misleading; (c) knowingly failed to declare to the Commission all or some of the claimant's earnings for a period determined under the regulations for which the claimant claimed benefits; (d) made a claim or declaration that the claimant or other person knew was false or misleading because of the non-disclosure of facts; (e) being the payee of a special warrant, knowingly negotiated or attempted to negotiate it for benefits to which the claimant was not entitled; (f) knowingly failed to return a special warrant or the amount of the warrant or any excess amount, as required by section 44; (g) imported or exported a document issued by the Commission, or had it imported or exported, for the purpose of defrauding or deceiving the Commission; or (h) participated in, assented to or acquiesced in an act or omission mentioned in paragraphs (a) to (g). . . . (2) The Commission may set the amount of the penalty for each act or omission at not more than (a) three times the claimant's rate of weekly benefits; (b) if the penalty is imposed under paragraph (1)(c), (i) three times the amount of the deduction from the claimant's benefits under subsection 19(3), and (ii) three times the benefits that would have been paid to the claimant for the period mentioned in that paragraph if the deduction had not been made under subsection 19(3) or the claimant had not been disentitled or disqualified from receiving benefits; or (c) three times the maximum rate of weekly benefits in effect when the act or omission occurred, if no benefit period was established. . . . (3) For greater certainty, weeks of regular benefits that are repaid as a result of an act or omission mentioned in subsection (1) are deemed to be weeks of regular benefits paid for the purposes of the application of subsection 145(2).

EVIDENCE

[18] The evidence in the file is as follows:

(a) On February 10, 2014, the Commission called the Appellant in for an interview on February 19, 2014 to determine his entitlement to employment insurance benefits (Exhibits GD3-13 and GD3-14);

(b) On August 18, 2014, the Commission indicated that, for the period of October 28, 2012 to March 2, 2013, the Appellant's electronic reports and the certification given by an officer of the Commission (copies of the questions and the Appellant's answers were reproduced on August 18, 2014) showed that the Appellant had said he was not ready, willing and capable of working each day, Monday through Friday, during the weeks starting on October 28, November 25 and December 16, 2012 and January 13, February 3 and February 24, 2013 because of illness or injury (Exhibits GD3-17 to GD3-58);

(c) In a document dated August 18, 2014, the Commission stated that the Appellant had received 17 weeks of regular benefits and six weeks of sickness benefits. The Commission explained that, as requested by the Appellant, the weeks of sickness benefits he had received had been converted to regular benefits. The Commission stated that, in establishing his claim for benefits, the Appellant was entitled to a maximum of 17 weeks of regular benefits and that the six weeks of sick leave could not be converted to weeks of regular benefits because he had received the maximum regular benefits. The Commission explained that this situation had created an overpayment of $2,646.00. It explained that it had then set the amount of the penalty imposed on the Appellant at $637.00 after reviewing his file. The Commission concluded that the Appellant had made six false representations in order to receive additional benefits. The Commission maintained that the Appellant had known he would be entitled to weeks of sickness benefits after receiving his 17 weeks of

regular benefits and had not thought the Commission would require a medical certificate for each of the weeks in question (Exhibit GD3-59);

(d) In two documents dated March 22, 2014 providing details on the notice of debt (DH009), which were reproduced on August 18, 2014, the total amount of the Appellant's debt was established as $10,231.00 (Exhibits GD3-60 and GD3-61);

(e) On June 26, 2014, the Appellant requested that the weeks claimed as sickness benefits be converted to regular benefits (Exhibits GD3-68 to GD3-70);

(f) To his Notice of Appeal filed on August 11, 2014, the Appellant attached a copy of the Commission's letter (reconsideration decision) dated July 10, 2014 (Exhibits GD2-7 and GD2-8).

[19] The evidence presented at the hearing is as follows:

(a) The Appellant went over the main elements of the case;

(b) He stated that he had not obtained a medical certificate from a medical professional attesting to his inability to work and stating the probable duration of the illness, injury or quarantine. He noted that it was difficult to obtain a medical certificate for a short-term absence or inability to work.

PARTIES' ARGUMENTS

[20] The Appellant made the following submissions and arguments:

(a) He explained that it was difficult or complicated to obtain a medical certificate from a medical professional for a short-term absence or inability to work, since he did not always see a doctor or, when he did, he did not ask for a certificate because he did not know that he had to do so (Exhibits GD3-66, GD3-67, GD3-69 and GD3-70). He

also stated that he could not provide a doctor's note for the periods since December 12, 2010 when he received special benefits (sickness benefits), since he never saw a doctor and did not think he had to provide a doctor's note for "separate" weeks or for each sick week claimed (Exhibits GD3-15 and GD3-16). He argued that, in this sense, the Commission did not favour short-term illness.

(b) He submitted that the decision concerning him was unjustified. He argued that he had been convinced, in good faith, that a doctor's note was not necessary for an illness or injury that might make him unable to work for a week or less. He stated that, when he had back pain last fall, he went to see a therapist for relief during the most difficult periods rather than hanging around clinic waiting rooms. He explained that he had therefore answered "no" to the question asking him whether he was ready, willing and capable of working at all times and that that answer was justified by a temporary inability to work (Exhibit GD3-65);

(c) He stated that he disagreed with the assertion that he had reported [translation] "being unable to work for full weeks even though this was not the case", as stated in the Commission's reconsideration decision dated July 10, 2014 (Exhibit GD2-71);

(d) He stated that he had reported being unable to work for full weeks, Monday through Friday, when in some cases he had been sick from Saturday to Wednesday, for example, or in some combination other than Monday to Friday. He submitted that he did not see the difference, since he was sick for the equivalent of a week anyway (Exhibits GD2-4 and GD2-5);

(e) He argued that it was unfair that he had to report his inability to work (sick days) on a daily basis, as requested by the Commission, while the Commission counted or dealt with those days (days of inability to work) by making a weekly assessment when it came time to penalize to establish the right to benefits. He wondered: [translation] "If it's being counted by the week, why ask by the day?". He stated that this approach made him lose regular weeks of benefits if he was not claiming the full week as a sick week. He submitted that he was therefore penalized in relation to his

bank of weeks of sickness benefits and the number of weeks of regular benefits. He stated that, when he reported a sick day during a week, employment insurance cut a full week from his bank of 15 weeks of benefits and that the same thing happened with his bank of 14 weeks [17 weeks] of regular benefits if he reported being available for one day during the week. He said that he found this disparity unfair and questionable. He stated that, by reporting that he was unable to work for full weeks, he was therefore [translation] "rationalizing" things to make them "fair" (Exhibits GD2-4, GD2-5, GD3-69 and GD3-70). He explained that he had therefore shifted days when he was unable to work within the same reporting week, even if those days did not correspond to the actual periods when he was unable to work. He stated that he had thereby [translation] "rationalized the week";

(f) He explained that he reported full sick weeks so he could have extra weeks in his claim for benefits, even though he was not unable to work for the entire week. He stated that he made such reports so he could receive a week of sickness benefits without reducing his bank of regular benefits. He said that he did not want [translation] "to dip into the regular bank" when he had sick days (less than five days) and that otherwise his bank of regular benefits decreased even though he did not want to start using it. He said that he had no choice but to take this approach given his situation as a seasonal worker entitled to fewer weeks of regular benefits. He explained that it was ill-conceived, since he had a bank of regular benefits and, if he was sick for less than five days, regular benefits were paid for the week, so he lost the week in his bank of weeks of regular benefits (Exhibits GD3-69 and GD3-70);

(g) He said that he knew he was granted more weeks of benefits and that this suited him (Exhibits GD3-15 and GD3-16). He submitted that his method of reporting the days he was unable to work did not detract from the fact that he was unable to work. He stated that, each time he reported being sick in his four claims for benefits, it was because he was unable to work for the entire period in question. He stated that, when he spoke to an investigator, he told her that he could not deny the fact that he got more weeks of benefits by claiming sickness benefits. He submitted that he had not

claimed sickness benefits to get more benefits but that the situation resulted from his periods of inability to work (Exhibits GD3-66 and GD3-67);

(h) He submitted that he had been told at a meeting (employment insurance) not to report less than five sick days, since otherwise he would lose a week of benefits and it did not count anyway. He stated that, if he had known that short sick weeks were recognized, he would not have reported being unable to work for full weeks. He said that he had been unaware that a week of regular benefits might be payable if there were less than five sick days that week. He stated that he had not been informed in advance and that he could not be doubly penalized. He submitted that, at an employment insurance information session in November 2013, he had learned that he could waive any day of benefits he saw fit so he would not lose a full week in his stock of sickness benefits or his regular benefits. He submitted that this information was not written anywhere and that it would have given him better guidance in reporting his sickness and would probably have prevented the dispute over his previous reports (Exhibits GD2-4, GD2-5, GD3-66 and GD3-67);

(i) He said that he would like the standards broadened. He said that he finds things absurd. He said that he has made contributions his entire life and that he should be entitled to receive benefits (Exhibits GD3-15 and GD3-16);

(j) He requested the cancellation of all the penalties imposed on him, the withdrawal of the retroactive charges in his file and reimbursement of the amounts paid in advance when the case was under review (Exhibits GD2-4 and GD2-5).

[21] The Commission made the following submissions and arguments:

(a) It stated that the Appellant's appeal to the Tribunal concerns the claim for benefits starting on October 7, 2012 (Exhibit GD4-1);

(b) It explained that the information and evidence to be provided to the Commission by a claimant in order to prove inability to work because of illness, injury or quarantine under paragraph 18(1)(b) or subsection 152.03(1) of the Act, is a medical certificate completed by a medical doctor or other medical professional attesting to the claimant's inability to work and stating the probable duration of the illness, injury or quarantine (Exhibit GD4-5);

(c) It noted that, in this case, the Appellant claimed and was paid sickness benefits but that it reserved the right, at any time, to require a medical certificate justifying the periods of illness, which the Appellant was unable to demonstrate. It explained that the Appellant had wanted to convert his special benefits (sickness benefit) to regular benefits, for a total of 23 weeks, but that he had received the maximum regular benefits payable in his situation, 17 weeks, so there was an overpayment of $2,646.00 (Exhibit GD4-5);

(d) It explained that, in some situations, it may pay special (sickness) benefits without requiring evidence of an inability to work for periods of four weeks or less, but it noted that it may, at any time, require evidence of such inability to work (Exhibit GD4-5);

(e) It explained that it may impose a penalty under section 38 of the Act for any false representation made knowingly by the Appellant. It specified that "knowingly" means that it can reasonably conclude that the Appellant knew the information he was providing was wrong when he provided it or that he failed to report certain information. It submitted that there is no element of intent in this consideration (Exhibit GD4-6);

(f) It explained that it first bears the onus of proving that there was a false representation. It specified that, once it can reasonably conclude that benefits were paid as a result of an act or omission, the onus shifts to the claimant (the Appellant) or the employer to prove that events can be interpreted as having occurred unintentionally. It noted that the act or omission must be proved on the balance of

probabilities standard. It submitted that it is not enough simply to disbelieve a claimant who claims to be innocent. It explained that, for it to conclude that a false representation was made knowingly, the evidence must show: (1) that an act or omission objectively occurred; (2) that the representation misled the Commission; (3) that it resulted in the payment of actual or potential benefits to which the claimant was not entitled; and (4) that at the time of making the representation, the claimant knew that he or she was not reporting the facts properly (Exhibit GD4-6);

(g) It noted that, on February 21, 2014, the Appellant stated that he had claimed special (sickness) benefits a few times but had never seen a doctor because he thought he did not have to submit a medical certificate to the Commission for separate sick weeks, that is, one week out of two, since the electronic reports were completed every two weeks. It noted that the Appellant stated that claiming sickness benefits gave him more weeks of benefits; he was entitled to 17 weeks of regular benefits plus a possible maximum of 15 weeks of special (sickness) benefits (Exhibits GD3-15 and GD3-16). The Commission argued that it had shown that the Appellant made false representations so he could collect regular benefits and special benefits. It explained that the Appellant had received his 17 weeks of regular benefits and also six (6) weeks of sickness benefits, which he had asked to convert to regular benefits. It stated that it could not convert the six (6) weeks of sickness benefits to regular benefits because the Appellant had already received the maximum regular benefits, namely 17 weeks (Exhibits GD4-6 to GD4-8);

(h) It submitted that it had exercised its discretion judicially by considering all the relevant circumstances of the case at the time it determined the amount of the penalty. It explained that that amount had been established as follows: the penalty was initially imposed on the total overpayment for the entire period of unreported or partially reported earnings, resulting in a penalty of $1,323.00, but following the administrative review, the penalty was reduced by 25% to a total of $637.00 (Exhibits GD4-7 and GD4-8);

(i) It explained that it had imposed a monetary penalty on the Appellant for the false representations he had made during the period of October 28, 2012 to March 2, 2013 (six weeks), after it received evidence from which it could reasonably conclude that the Appellant knew that, by claiming special benefits (sickness benefits), he was increasing the total number of weeks paid, since the number of special weeks claimed did not affect the number of regular weeks payable (Exhibit GD4-8);

(j) It argued that the sanctions provided for in the Act must be viewed not as punishment but as **a necessary deterrent** to protect the entire scheme, the proper application of which rests on the truthfulness of the representations made by recipients (Exhibit GD4-8).

ANALYSIS

Disentitlement to special benefits (sickness benefits)

[22] To assess the issue of disentitlement to special employment insurance benefits (sickness benefits), the Tribunal must consider sections 18 and 50 of the Act and section 40 of the Regulations. Section 18 of the Act requires proof of entitlement. Section 40 of the Regulations specifies the nature of the evidence required for this purpose. Section 50 of the Act deals with the "claim procedure".

[23] In ***Muir*** **(A-284-94 – CUB 24383)**, the Federal Court of Appeal ("the Court") affirmed the principle that the onus is on claimants to prove their inability to work. The judge upheld the umpire's decision in that case because the medical evidence on file did not prove that the claimant was incapable of work. The board of referees had found that, while the claimant's activities might be somehow limited, he had not shown that he was incapable of carrying out work, and it had dismissed the appeal.

[24] In the instant case, the Tribunal is of the view that the Appellant cannot be entitled to special employment insurance benefits (sickness benefits) for the six weeks in question,

namely the weeks starting on October 28, November 25 and December 16, 2012 and January 13, February 3 and February 24, 2013.

[25] While the Appellant stated that he was not ready, willing and capable of working each day, Monday through Friday, during the weeks in question, he did not show that he was "unable to work because of a prescribed illness, injury or quarantine, and that the claimant would otherwise be available for work", as specified in paragraph 18(1)(b) of the Act.

[26] The Appellant argued that he was unable to provide a medical certificate for the weeks in question because it was difficult or complicated to obtain such a document for a short-term absence or inability to work, since he did not always see a doctor or, when he did, he did not ask for a certificate. On this point, the Tribunal also considers the Appellant's assertion contradictory, since, in a previous statement, he claimed that he had never seen a doctor during his employment insurance benefit periods since 2010 because he did not think he would be required to provide a doctor's note for "separate" sick weeks or for each sick week claimed (Exhibit GD3-16).

[27] In its arguments, the Commission explained that the Appellant claimed and was paid special benefits (sickness benefits) but that it reserved the right to require, at any time, a medical certificate attesting to his inability to work and justifying the payment of sickness benefits.

[28] The Appellant did not provide the evidence or information required for that purpose, namely "a medical certificate completed by a medical doctor or other medical professional attesting to the claimant's inability to work and stating the probable duration of the illness, injury or quarantine", in accordance with section 40 of the Regulations.

[29] Subsection 40(1) of the Regulations clearly specifies that:

> . . . (1) The information and evidence to be provided to the Commission by a claimant in order to prove inability to work because of illness,

> injury or quarantine under paragraph 18(1)(b) or subsection 152.03(1) of the Act, is a medical certificate completed by a medical doctor or other medical professional attesting to the claimant's inability to work and stating the probable duration of the illness, injury or quarantine.

[30] In this context, the Tribunal finds that the Appellant does not comply with the requirements set out in the Act for being entitled to receive such benefits for the weeks in question.

[31] Subsections 50(1) and (5) of the Act clearly specify that:

> . . . (1) A claimant who fails to fulfil or comply with a condition or requirement under this section is not entitled to receive benefits for as long as the condition or requirement is not fulfilled or complied with. . . . (5) The Commission may at any time require a claimant to provide additional information about their claim for benefits.

[32] In its arguments, the Commission also explained that the amount of the overpayment remained $2,646.00, which represented six weeks of special benefits (sickness benefits) received by the Appellant, since he had already received regular benefits for the maximum number of weeks to which he was entitled, namely 17 weeks.

[33] In short, the Appellant was not able to provide the medical evidence required by the Commission to show that he was entitled to receive sickness benefits, and the reasons he gave could not exclude the Act's requirements in this regard.

[34] The Tribunal finds that the Appellant was not entitled to special employment insurance benefits (sickness benefits) under paragraph 18(1)(b) and section 50 of the Act and section 40 of the Regulations.

[35] The appeal is without merit on this issue.

Penalty

[36] The Court has affirmed the principle that a false or misleading representation is made only where claimants have subjective knowledge of the falsity of the information given or representations made by or about them (***Mootoo*, 2003 FCA 206, *Gates*, A-600-94**).

[37] In ***Ftergiotis* (2007 FCA 55)**, the Court affirmed that the claimant was liable to a penalty under section 38 of the Act because there was ample evidence to support the Commission's opinion that the claimant knew he had earnings during the weeks he was receiving benefits.

[38] In ***Gagnon* (A-52-04)**, the Court specified how the Commission may be justified in adopting its own guidelines on the imposition of penalties in order to guarantee some consistency nationally and avoid arbitrariness in such matters.

[39] The Court also confirmed the principle that the Commission has the discretion to impose a penalty under subsection 38(1) of the Act. Further, the Court stated that no court, umpire or tribunal is authorized to interfere with a penalty decision by the Commission as long as the Commission can prove that it exercised its discretion "judicially". In other words, the Commission must show that it acted in good faith, considered all the relevant factors and disregarded irrelevant factors (***Uppal*, 2008 FCA 388, *Tong*, 2003 FCA 281**).

[40] The Tribunal is of the view that the Appellant knowingly made false representations concerning his inability to work for the weeks starting on October 28, November 25 and December 16, 2012 and January 13, February 3 and February 24, 2013 so he would be entitled to more weeks of benefits.

[41] The evidence in the file clearly shows that, for each of those weeks, the Appellant answered "no" to a question that was unambiguous (script no. 1170), namely: "Were you

ready, willing, and capable of working each day, Monday through Friday, during this period?".

[42] However, the representations he made to that effect did not reflect reality in terms of his inability to work. The Appellant stated that the periods he reported being unable to work could correspond to different days than Monday through Friday. He also explained that, by shifting days when he was unable to work within the same reporting week, even if those days did not correspond to the actual periods when he was unable to work, he could obtain more weeks of employment insurance benefits by adding weeks of special benefits (sickness benefits) (Exhibits GD2-4 and GD2-5).

[43] The Appellant explained that, through the scheme he used, namely reporting that he was unable to work for full weeks (Monday through Friday) even though he was not unable to work on all the days concerned, he made the situation fairer, since he could avoid being penalized in the payment of his regular employment insurance benefits and also obtain special benefits (sickness benefits). He knew that, in addition to being entitled to 17 weeks of regular benefits, it was possible for him to be entitled to special benefits (sickness benefits) on certain conditions. The evidence shows that he used those conditions to his advantage.

[44] Although he argued at the hearing that he disagreed with the Commission's assertion that he had reported being unable to work for full weeks even though this was not the case, he clearly explained how he could receive special benefits (sickness benefits) without his number of weeks of regular benefits being affected by the periods he reported being unable to work. He explained that he found the situation unfair otherwise.

[45] The Tribunal is of the opinion that the Appellant knowingly made false representations. In the Tribunal's view, the Appellant had to complete his reports properly. It was not up to him to determine how to report the days he was unable to work to derive the maximum personal benefit or to make the situation fairer based on his own analysis. If he

was unable to work, he had to be able to indicate correctly and honestly the exact days on which that inability had to apply.

[46] In the Tribunal's opinion, the Appellant was well aware that he had to complete his reports accordingly, and it finds that he cannot avoid responsibility for the actions alleged against him. The Tribunal finds that the Appellant had the required knowledge of the fact that he was responsible for properly reporting that he was unable to work, if that was the case.

[47] Because of all the very clear messages he received at the time he completed his reports, the Appellant could not ignore the fact that he was making false representations so he would be entitled to more weeks of benefits.

[48] The Commission made the following point: [translation] "However, it is not because he [the Appellant] did not provide a medical certificate, but rather because he was not unable to work as he reported" (Exhibit GD3-69).

[49] In its arguments, the Commission provided the following explanation:

> [Translation]
>
> The Commission imposed a monetary penalty for these false representations during the period of October 18, 2012 to March 2, 2013 (six weeks) after it received evidence from which it could reasonably conclude that the claimant knew that, by claiming special (sickness) benefits, he was increasing the total number of weeks paid, since the number of special weeks claimed does not affect the number of regular weeks payable. . . (Exhibit GD4-8)

[50] The Commission also provided the following explanation to justify reducing the penalty imposed on the Appellant to $637.00:

> [Translation]
>
> The Commission reduced the penalty because of the claimant's situation, namely seasonal employment, and the small number of weeks

> of entitlement. The penalty is 25% of the net overpayment, or $637. (Exhibit GD4-4)

[51] The Tribunal is of the opinion that, by reducing the amount of the Appellant's penalty to $637.00, the Commission exercised its discretion judicially. The Commission considered all the relevant facts of the case, including the Appellant's seasonal employment and his small number of weeks of entitlement.

[52] The appeal is without merit on this issue.

CONCLUSION

[53] The appeal is dismissed on both issues.

Normand Morin
Member, General Division

DATE OF REASONS: March 12, 2015