**In the Matter of the**

***FINANCIAL INSTITUTIONS ACT,* RSBC 1996, c.141**
(the "Act")

**and the**

**INSURANCE COUNCIL OF BRITISH COLUMBIA**
("Council")

**and**

**PARAMJEET KAUR JOHAL**
(the "Licensee")

# ORDER

As Council made an intended decision on April 26, 2022, pursuant to sections 231, 236, and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Licensee with written reasons and notice of the intended decision dated May 13, 2022; and

As the Licensee has not requested a hearing of Council's intended decision within the time period provided by the Act;

Under authority of sections 231, 236, and 241.1 of the Act, Council orders that:

1. The Licensee is fined $5,000, to be paid by August 30, 2022;

2. The Licensee's life and accident and sickness insurance agent ("Life Agent") licence is suspended for one year, commencing on June 1, 2022 and ending at midnight on June 1, 2023;

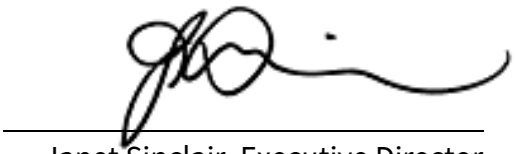
3. The Licensee is assessed investigation costs in the amount of $1,812.50, to be paid by August 30, 2022;

4. The Licensee is required to complete the Council Rules Course for life and/or accident and sickness insurance by August 30, 2022;

5. A condition is imposed on the Licensee's Life Agent licence that the Licensee must complete the Council Rules Course for life and/or accident & sickness insurance and pay the fine and the investigation costs by August 30, 2022 and the Licensee will not be permitted to complete any annual licence renewal while the Licensee's licence is under suspension and has not complied with the conditions listed herein; and

6. A condition is imposed on the Licensee's Life Agent licence that requires the Licensee to be supervised for a period of two years by a supervisor, as approved by Council, commencing from when the Licensee has completed the above conditions and the suspension is lifted.

This order takes effect on the **1st day of June, 2022**.



Janet Sinclair, Executive Director
Insurance Council of British Columbia

**INTENDED DECISION**

**of the**

**INSURANCE COUNCIL OF BRITISH COLUMBIA**
("Council")

Respecting

**PARAMJEET KAUR JOHAL**
(the "Licensee")

1. Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether the Licensee acted in compliance with the requirements of the Act, Council Rules, and Code of Conduct, and in particular to determine whether the Licensee breached section 3 ("Trustworthiness"); section 4 ("Good Faith"); section 5 ("Competence"); and section 8 ("Usual Practice of Dealing with Insurers") of the Code of Conduct by filing fraudulent insurance claims for total disability and making a false misrepresentation or false information on an insurance application form.

2. On March 29, 2022, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met with the Licensee's legal counsel and the Licensee's former team lead via video conference to discuss the investigation. An investigation report prepared by Council staff was distributed to the Committee, the Licensee and Licensee's legal counsel prior to the meeting. A discussion of the investigation report took place at the meeting and the Licensee's legal counsel was given an opportunity to make submissions and provide further information. Having reviewed the investigation materials and discussed the matter with the Licensee's legal counsel, the Committee prepared a report for Council.

3. The Committee's report, along with the aforementioned investigation report, were reviewed by Council at its April 26, 2022, meeting, where it was determined the matter should be disposed of in the manner set out below.

**PROCESS**

4. Pursuant to section 237 of the Act, Council must provide written notice to the Licensee of the action it intends to take under sections 231, 236 and 241.1 of the Act before taking any such action. The Licensee may then accept Council's decision or request a formal hearing. This intended decision operates as written notice of the action Council intends to take against the Licensee.

**FACTS**

5. The Licensee became licensed with Council as an accident and sickness insurance agent ("A&S agent") in April 2014 and a life insurance agent in May 2020. The Licensee held a contract with an insurer to sell Accident and Sickness insurance from March 31, 2014, to September 27, 2019, when the contract was terminated.

6. On October 3, 2019, Council received an email from the insurer regarding the termination of the contract between the insurer and the Licensee. The insurer alleged that the Licensee made material misrepresentations when she submitted an application for insurance for herself and made two fraudulent insurance disability claims on her own policies.

7. The wording of the definition of the insurer's total disability policy at the material time the disability claims in question were made was: "*Totally disabled or total disability means the inability to perform each of the substantial and material duties of your business or occupation (usual activities if not employed). If you are able to perform any of the substantial and material duties of your business or occupation (usual activities if not employed), you are not Totally Disabled. You must be under the care of a Physician.*"

8. The insurer provided Council staff with a form dated April 3, 2019, signed, and completed by the Licensee. Legal counsel for the Licensee confirmed that the form was in the Licensee's handwriting and that the signature was the Licensee's. The form has a section titled "complete for accident or sickness," and in this section there is a part for "dates during which you were unable to do all the duties pertaining to your usual occupation or perform your usual daily activities," as well as a part for "dates which you were able to perform part of the duties pertaining to your usual occupation or perform part of your usual daily activities." The Licensee claimed that during the period of March 13, 2018, to May 21, 2018, she was unable to do all the duties pertaining to her usual occupation or perform her usual daily activities. The insurer paid a total of $4,360 for this claim.

9. The insurer provided internal reports that list policy applications submitted by the Licensee to the insurer. These reports showed a list of numerous policy applications submitted by the Licensee to the insurer from March 26, 2018, to May 14, 2018. This demonstrates that the Licensee continued to work during her total disability period.

10. The insurer provided a form dated May 28, 2019, signed and completed by the Licensee. Legal counsel for the Licensee confirmed that the form was in the Licensee's handwriting and that the signature was the Licensee's. The form had the same section titled "complete for accident or sickness" as the April 3, 2019, form. The Licensee claimed that during the

period of February 21, 2019, to April 29, 2019, she was unable to do all the duties pertaining to her usual occupation or perform her usual daily activities. The insurer paid a total of $8,562.50 for this claim.

11. The insurer provided internal reports listing policy applications submitted by the Licensee to the insurer, which showed a list of numerous policy applications submitted by the Licensee to the insurer from February 21, 2019, to April 30, 2019. This demonstrates that the Licensee continued to work during her total disability period.

12. The Licensee submitted a policy application for herself to the insurer dated October 28, 2018. On page 2 of the application, the Licensee answered "No" to the question on Disability Benefits "within the past 12 months, have you applied for or received Disability Benefits (including Workers Compensation or Social Security)." However, the Licensee had made an application to another insurer, evidenced by a form titled "initial attending physician's statement – short term disability benefits" in which the Licensee completed the section "part one" of the application on March 23, 2018. Therefore, the answer "No" on the October 28, 2018 form was false, as the Licensee had made an application for disability benefits on March 23, 2018.

13. The Licensee's counsel advised that the application to the insurer dated October 28, 2018, was not, in fact, a new application, but a replacement of the Licensee's previous policy with the insurer. The submission by the Licensee's counsel was that this form went towards replacing the Licensee's previous policy and was not for the issuance of a new policy, therefore the Licensee did not intentionally answer incorrectly the question regarding applying for or receiving previous disability benefits.

14. The Licensee was interviewed by the insurer on August 28, 2019. The insurer provided Council staff with the audio recording and a summary of this interview. The Licensee advised the insurer's representatives in the interview that she had made a mistake when she checked "No" to the question of whether in the past 12 months she had applied for or received disability benefits. The Licensee advised during the interview that she had sent an email regarding an offer to repay money received from her total disability claims.

15. At the Committee, the Licensee's counsel confirmed that the Licensee has not reimbursed the insurer for the amount received for total disability claim. The Licensee's counsel advised that there has been no request made by the insurer for the money from the disability claims to be paid back. The Committee was advised that the Licensee did not pay the insurer the money because although she offered to pay back the money initially, the

insurer subsequently terminated the Licensee's contract therefore she decided not to return the money collected on the disability claims.

16. The Licensee provided a written response to inquiries from Council staff on April 11, 2021, wherein she stated that in relation to the disability claims for 2018 and 2019, both claims had been approved, with physician reports to substantiate the claims. The Licensee provided medical documentation supporting a knee injury in 2018 and a shoulder injury in 2019.

17. In a letter dated December 3, 2021, the Licensee provided further details in response to additional inquiries from Council staff. The Licensee stated that in relation to the knee injury from March 2018, she had submitted physiotherapy receipts for reimbursement. The Licensee further stated that when payment for the physiotherapy was not received, she made inquiries with the insurer and was advised the insurer did not have a claim form. The Licensee had her physician fill out the appropriate form for the claim and stated she received "disability payment for the time loss for the months that [she] was off work." The Licensee did not provide information relating to the forms dated April 3, 2019, and May 28, 2019, which were completed by the Licensee.

18. The Licensee's counsel confirmed that the payments the Licensee received from the insurer for both insurance disability claims detailed which portions of moneys paid was for reimbursement of physiotherapy and for loss of income. Therefore, it would be apparent to the recipient what money was allotted for treatment and loss of income.

**ANALYSIS**

19. Council has concluded that the Licensee failed to engage in the usual practice of the business of insurance by submitting fraudulent total disability claims, which she knew, or ought to have known was fraudulent. The two claim forms submitted by the Licensee to the insurer requested information regarding the period in which the Licensee was either unable to do *all* the duties pertaining to their usual occupation or the period in which the Licensee was unable to perform *part* of their usual occupation. The Licensee should have a level of competency to complete an insurance claim form accurately. Whether intentional or not, the Licensee should have known that by providing information stating that she was unable to perform all her duties related to her occupation, she should not have continued working during that relevant time. The evidence provided by the insurer to Council demonstrates that during the periods in which the Licensee claimed for total disability in 2018 and 2019, she continued to work by submitting numerous insurance applications for clients. While Council believes there was legitimacy and medical documentation supporting a disability

claim, the Licensee did not make the appropriate disability claim. The Licensee claimed for total disability in 2018 and 2019, as opposed to partial disability. Had the Licensee claimed partial disability she could have continued to complete part of her usual occupation duties and received partial disability payments from the insurer. However, the Licensee in these two instances made two claims for total disability, yet she had continued to work during the disability period.

20. Council has concluded the Licensee made fraudulent insurance claims by claiming for periods of total disability in 2018 and 2019 and continuing to work in the relevant time frame.

21. Council has concluded that the Licensee made a false declaration to the insurer when she answered “no” to the question regarding any previous applications or claims for disability within the last twelve months. Regardless of whether the application was for a replacement policy or the issuance of a new policy, the Licensee must answer each question of the insurance form truthfully at the time the document is being completed. The Licensee should have known or ought to have known that she has a duty to disclose any information fully and accurately to the insurer. Completing basic insurance forms are fundamental tasks to the usual practice of insurance business and should be completed competently and accurately.

22. Council has concluded that based on the seriousness of the Licensee’s misconduct, it has brought into question the Licensee’s trustworthiness, ability to act in good faith and in accordance with the usual practice of the business of insurance, as set out in sections 3 and 4 of the Code of Conduct.

23. Council considered the impact of Council Rule 7(8) and Council’s Code of Conduct guidelines on the Licensee’s conduct, including section 3 (“Trustworthiness”), section 4 (“Good Faith”) section 5 (“Competence”) and section 8 (“Usual Practice of Dealing with Insurers"). Council has concluded that the Licensee’s conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

24. Prior to making its recommendation in this matter, Council took into consideration the following precedent cases. While it is recognized that Council is not bound by precedent and that each matter is decided on its own facts and merits, Council found that these decisions were instructive in terms of providing a range of sanctions for similar types of misconduct.

25. *Martin Hroch* (February 2020) The former licensee submitted 74 false insurance claims for physiotherapy services through the employee health and wellness program during the period of May 2017 to June 2018. This resulted in a payment to the former licensee of $2570. The physiotherapy clinic and former licensee admitted the physiotherapy sessions did not take place. Additionally, the former licensee admitted to making two false vision claims in June 2018, which he received $475. The former licensee agreed to repay the insurer for the fraudulent claims but only ended up paying $425. Given the misconduct, Council determined that the former licensee did not meet the standards of trustworthiness and good faith. Council ordered that the licensee not be eligible to reapply for a licence for five years, fined $5,000 and assessed investigation costs. Council further ordered that until the insurer is paid back for the fraudulent claims, Council will not consider any applications from the former licensee.

26. *Mahin Heidari* (June 2015) concerned a licensee who submitted at least 35 false personal health insurance claims through her group benefits insurance provider, including 18 claims for chiropractic services, 13 claims for massage therapy services, and four claims for visits to a psychologist. The licensee received a total of $2,269 for these false claims. Despite all the evidence against the legitimacy of her claims, the licensee continued to justify her actions and displayed dishonest behavior throughout the disciplinary process. Council prohibited the licensee from holding an insurance licence for three years, fined her $10,000 (which could be reduced to $5,000 if the licensee reimbursed the insurance company for the full amount she received for her illegitimate claims), and required her to pay investigation costs of $2,025 and hearing costs of $2,500.46.

27. *Yazdi & Associates Financial Services Inc. and Arvin Nazerzadeh-Yazdi* (May 2017) concerned a former licensee who established a group health plan for a company for which he was director. The company had only six employees, yet 25 individuals were registered in the group health plan. During the time that the health plan was in effect, the former licensee submitted several invalid health claims on his own behalf, and also assisted others, including family members, with making false claims. The former licensee admitted to his misconduct when it was discovered and cooperated with the insurance company's investigation. Council prohibited the former licensee from holding an insurance licence for five years and prohibited him from serving as an officer or director of an insurance agency for five years. Additionally, the former licensee was fined $10,000 and assessed investigation costs of $812.50.

28. Council considered relevant mitigating and aggravating factors in this matter. The Licensee's failure to reimburse the insurer any of the money received by the fraudulent claims was considered by Council to be an aggravating factor that further called the

Licensee's trustworthiness and good faith into question. Council considered that the Licensee had no previous disciplinary history and her cooperation throughout the investigation as mitigating factors.

29. Council determined that a fine of $5,000 was appropriate in the present case, given that the Licensee's misconduct was somewhat less egregious than what had occurred in the precedents, as the Licensee did not conduct the same number of false claims as in the precedents. However, Council is of the opinion that it is in the public's interest for the Licensee to be prohibited from holding a licence for one year, and to require mandatory supervision for two years, by a supervisor approved by Council, following the suspension.

30. Council notes the circumstances of the precedents resulted in lengthy suspensions, which would require the licensees to re-apply to become licensed. In those circumstances, the mandatory supervision period would automatically be applied to new life agents or accident and sickness agents. Council has concluded that if the Licensee enters the industry again, it would be appropriate for the Licensee to be supervised by an approved supervisor for two years.

31. Council has concluded that the Licensee must complete the Council Rules Course to appraise herself with the relevant duties and requirements of the usual practice of the insurance industry.

32. After weighing all of the relevant considerations, Council views the Licensee to be in breach of Council's Rules and the Code of Conduct and concludes that it is appropriate for the Licensee to be fined $5000, suspended for one year, and impose a condition on the Licensee's life and accident sickness agent licence that requires the Licensee to be supervised for a period of two years by a supervisor, as approved by Council, and be required to complete the Council Rules Course. Council concludes that a fine is appropriate in the circumstances to communicate to the Licensee, the insurance industry, and the public, that insurance agents are expected by Council to perform their roles and conduct insurance business competently and ethically.

33. With respect to investigation costs, Council believes that these costs should be assessed against the Licensee. As a self-funded regulatory body, Council looks to licensees who have engaged in misconduct to bear the costs of their discipline proceedings, so that those costs are not otherwise borne by British Columbia's licensees in general. Council has not identified any reason for not applying this principle in the circumstances.

**INTENDED DECISION**

34. Pursuant to sections 231, 236 and 241.1 of the Act, Council made an intended decision to:

    a. Fine the Licensee $5,000, to be paid within 90 days of Council's order;

    b. Suspend the Licensee's life and accident and sickness insurance agent licence for one year, commencing on the date of Council's order;

    c. Assess Council's investigation costs in the amount of $1,812.50, against the Licensee, to be paid within 90 days of Council's order;

    d. Require the Licensee to complete the Council Rules Course for life and/or accident and sickness insurance within 90 days of Council's order;

    e. Impose a condition on the Licensee's life and accident and sickness insurance agent licence that the Licensee must complete the Council Rules Course for life and/or accident & sickness insurance and pay the fine and the investigation costs within 90 days of Council's order and the Licensee will not be permitted to complete any annual licence renewal while the Licensee's licence is under suspension and has not complied with the conditions listed herein; and

    f. Impose a condition on the Licensee's life and accident sickness insurance agent licence that requires the Licensee to be supervised for a period of two years by a supervisor, as approved by Council, commencing from when the Licensee has completed the above conditions and the suspension is lifted.

35. Subject to the Licensee's right to request a hearing before Council pursuant to section 237 of the Act, the intended decision will take effect after the expiry of the hearing period.

**RIGHT TO A HEARING**

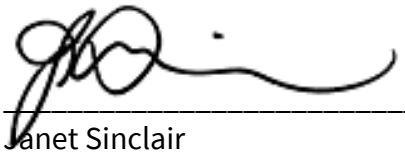
36. If the Licensee wishes to dispute Council's findings or its intended decision, the Licensee may have legal representation and present a case in a hearing before Council. Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Licensee must give notice to Council by delivering to its office written notice of this intention within fourteen (14) days of receiving this intended decision. A hearing will then be scheduled for a date within a reasonable period of time from receipt of the notice. Please direct written notice to the

attention of the Executive Director. If the Licensee does not request a hearing within 14 days of receiving this intended decision, the intended decision of Council will take effect.

37. Even if this decision is accepted by the Licensee, pursuant to section 242(3) of the Act, the British Columbia Financial Services Authority ("BCFSA") still has a right of appeal to the Financial Services Tribunal ("FST"). The BCFSA has thirty (30) days to file a Notice of Appeal once Council's decision takes effect. For more information respecting appeals to the FST, please visit their website at www.fst.gov.bc.ca or visit the guide to appeals published on their website at www.fst.gov.bc.ca/pdf/guides/ICGuide.pdf.

Dated in Vancouver, British Columbia, on the **13th day of May, 2022**.

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director