In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

ALINE MARIE JACOB
(the "Licensee")

ORDER

As Council made an intended decision on April 25, 2023, 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 June 8, 2023; 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 January 2, 2024;

2) The Licensee's life and accident and sickness insurance agent licence is suspended for a period of one year, commencing on June 29, 2023, and ending at midnight on June 28, 2024;

3) The Licensee is assessed Council's investigation costs of $1,062.50, to be paid by January 2, 2024;

4) The Licensee is required to complete the following courses, or equivalent courses, as acceptable to Council, prior to the licence suspension being lifted:

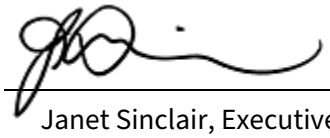
    a) Council Rules Course for life and/or accident and sickness insurance; and

b) Making Choices I: Ethics and Professional Responsibility in Practice, currently available through Advocis;

Collectively, the "Courses".

5) A condition is imposed on the Licensee's life and accident and sickness insurance agent license that requires the Licensee to pay the above-ordered fine and investigations costs in full and complete the Courses prior to the Licensee's suspension being lifted.

This order takes effect on the **29th day of June, 2023**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

Respecting

ALINE MARIE JACOB
(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") and section 4 ("Good Faith") of the Code of Conduct by filing fraudulent insurance claims for accident benefit claims.

2. On February 22, 2023, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met with the Licensee via video conference to discuss the investigation. An investigation report prepared by Council staff was distributed to the Committee and the Licensee prior to the meeting. A discussion of the investigation report took place at the meeting and the Licensee was given an opportunity to make submissions and provide further information. Having reviewed the investigation materials and discussed the matter with the Licensee, 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 25, 2023, 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 first became licensed with Council as a life and accident and sickness insurance agent ("Life Agent") in January 2017.

6. On January 26, 2022, Council received a letter from KK (the "Complainant") notifying Council of the insurer's termination of the Licensee. The Complainant reported that the Licensee had been terminated following an investigation in which she admitted to falsifying medical treatment records and submitting fraudulent claims to the insurer between November 2020 and June 2021. The Licensee received a total of $1,500 as a result of the fraudulent claims made with the insurer.

7. On March 11, 2022, the Complainant provided copies of the fraudulent claim forms along with the falsified medical documents. From the documentation, it was noted that the Licensee submitted five fraudulent emergency accident benefit claims between November 2020 and June 2021. The insurer's investigation revealed that the Licensee did not receive medical care from the clinic noted in the medical documentation attached to the emergency benefit claim forms. The insurer's investigation further determined that the name of the treating doctor in one of the claims was fictitious. When the insurer questioned the Licensee about the authenticity of the claims, she admitted to falsifying medical treatment records and submitting fraudulent claims to the insurer. As a result, the Licensee's agent contract with the insurer was terminated.

8. The Licensee was forthright and honest throughout the insurer's and Council's investigation. The Licensee acknowledged that her conduct was wrong and took full accountability for her actions. As a result of this incident, the Licensee felt embarrassed, especially when her manager at the insurer advised all the agents at the office as to why the Licensee was being terminated. Further, the Licensee stated that she has lost approximately $30,000 in backend and renewal commissions due to her termination.

9. The Licensee explained that as a result of COVID, she was experiencing difficulty seeing a doctor and that she was not in a good frame of mind when this conduct took place. The Licensee explained how the work environment at the insurer's organization, and particularly her location and management, impacted her outlook of the organization. The Licensee recalled instances when she was troubled by particular sales tactics or techniques and addressed these issues with her manager only to be dismissed.

ANALYSIS

10. Council has concluded that the Licensee failed to engage in the usual practice of the business of insurance by submitting fraudulent insurance claims. The Licensee has acknowledged that this behaviour was inappropriate, however, Council notes the serious nature of the Licensee's conduct. The Licensee altered and falsified medical records to support her fraudulent claims on five separate occasions. As there were multiple claims over a period of time, it demonstrates a deliberate nature in committing this offence.

11. The Licensee's actions brought into question her 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.

12. 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") and section 4 ("Good Faith"). The Committee concluded that the Licensee's conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

13. Prior to making its recommendation in this matter, Council took into consideration the following precedent cases related to fraudulent insurance claims. While Council recognizes that it 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.

14. *Harpal Kaur Sandhu* (August 2022): The licensee submitted three different total disability claims with an insurer but continued to work during the total disability periods. Council concluded that the licensee made fraudulent insurance claims for total disability by claiming for periods of total disability and continuing to complete work duties and submit insurance applications in the relevant time frame. Whether intentional or not, the licensee should have known that by providing information stating that she was unable to perform all the duties related to her occupation, she should not have continued working during that relevant time. Council ordered that the licensee be fined $7,500, that the licensee's life and accident and sickness insurance agent licence be suspended for one year, that the licensee be required to take courses, assessed investigation costs, and be supervised for a period of two years when the licensee's suspension is lifted.

15. *Paramjeet Kaur Johal* (June 2022): The licensee submitted two total disability claims with an insurer but continued to work during the total disability periods. The licensee completed the appropriate total disability claim forms and claimed that she was unable to do all the duties pertaining to her usual occupation, but internal reports from the insurer demonstrated that the licensee continued to work and submit policy applications during the relevant time frames. Council determined that the licensee knew or ought to have known that her conduct resulted in fraudulent total disability claims and that the licensee has a duty to disclose any information fully and accurately to an insurer. Council determined that the misconduct brought into question the licensee's trustworthiness and ability to act in good faith. Council ordered that the licensee be fined $5,000, that the licensee's life and accident and sickness insurance agent licence be suspended for one year, that the licensee be required to take courses, assessed investigation costs, and be supervised for a period of two years when the licensee's suspension is lifted.

16. *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 $2,570. 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, for 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.

17. *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 masseuse 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, and required her to pay investigation costs of $2,025 and hearing costs of $2,500.46.

18. Council considered relevant mitigating and aggravating factors in this matter. Council concluded that as a less experienced Life Agent, and with the Licensee's account of having little to no support from management, there was a potential for the Licensee to be more susceptible to laxer compliance and processes due to the Licensee's description of the culture cultivated within the organization. Council believes it is important to recognize the environment the Licensee said she

experienced to understand her mindset at the time of the misconduct and concluded this was a mitigating factor in the circumstances. Additionally, the Licensee suffered from her termination with the insurer, including a loss of commissions. Council noted that the Licensee was remorseful and has taken the appropriate steps to repay the insurer the money that was received from the emergency accident benefit claims. After the Review Committee meeting, the Licensee provided proof that the cheque she had sent to the insurer for repayment had been cashed. As for aggravating factors, Council noted that this was not an isolated incident and that the Licensee made five fraudulent claims. Additionally, Council noted that fraudulent claims indirectly impact the public in that insurers may become increasingly reluctant to offer disability products or offer them at a higher premium.

19. Council felt sympathetic to the Licensee, particularly as the Licensee has admitted and recognized her wrongdoing, the Licensee's actions in creating falsified documents and fraudulent claims are directly relevant to the Licensee's trustworthiness. Trustworthiness is a fundamental element in holding an insurance licence and is essential to public confidence in the industry. An appropriate penalty is not only relevant to the punishment of the offender, but to the need to promote specific and general deterrence thereby protecting the public. With these principles in mind, Council determined a licence suspension is warranted in the circumstances. Council noted that given the mitigating factors, the suspension period should be on the lower end of the precedents and determined that a one-year suspension is appropriate.

20. Council concluded 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 ethically. Council notes that as of 2020, the Act provides that the maximum fine that Council can order against an individual is $25,000. It is noted that the misconduct in the precedents held a maximum fine of $10,000 as allowed by the Act at that time. In weighing an appropriate fine amount, Council considered that the amounts of the fines in the precedents were under the previous maximum and tried to reconcile what would be a proportional and appropriate fine amount that would be in line with the current maximum fine increase. Council concluded that the mitigating factors, especially the Licensee's circumstances at the time, exceeded the mitigating factors identified in the precedents, such that a lower fine is supported. Council therefore concluded a fine of $5,000 was appropriate in this case.

21. Council further concluded that the Licensee be required to complete the Council Rules Course, to review her obligations as a licensee. Furthermore, Council requires the Licensee to complete the "Making Choices I: Ethics and Professional Responsibility in Practice" course currently available from Advocis.

22. 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. The Committee has not identified any reason for not applying this principle in the circumstances. Council concludes that it is appropriate for the Licensee to be assessed the investigation costs of $1,062.50.

23. Council further determined that given the circumstances of this case, the Licensee should be given additional time to pay and is given a period of 180-days to pay the fine and investigation costs, opposed to the usual 90-day timeframe.

INTENDED DECISION

24. 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 180 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 the Licensee Council's investigation costs in the amount of $1,062.50, to be paid within 180 days of Council's order;

    d. Require the Licensee to complete the following courses, or equivalent courses as acceptable to Council, the Council Rules Course for Life and/or accident & sickness insurance, and Making Choices I: Ethics and Professional Responsibility in Practice, currently available through Advocis (collectively the "Courses") prior to the licence suspension being lifted; and

    e. Impose a condition on the Licensee's life and accident and sickness insurance agent licence that requires the Licensee to pay the fine and the investigation costs in full prior to the licence suspension being lifted.

25. 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.

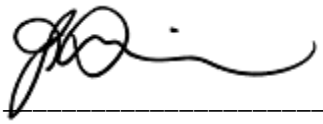
RIGHT TO A HEARING

26. 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.

27. 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 https://www.bcfst.ca/app/uploads/sites/832/2021/06/guidelines.pdf.

Dated in Vancouver, British Columbia, on the **8th day of June, 2023**.

For the Insurance Council of British Columbia



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Janet Sinclair
Executive Director