In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

MANPREET KAUR BRAR
(the "Licensee")

ORDER

As Council made an intended decision on January 24, 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 February 21, 2023; and

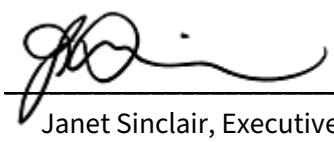
As the Licensee has not requested a hearing of Council's intended decision within the time period provided by the Act;

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

1) The Licensee's life and accident and sickness insurance agent licence is cancelled for a period of two years, with no opportunity to reapply for a licence, commencing on April 3, 2023 and ending at midnight on April 2, 2025.

2) The Licensee is assessed Council's investigation costs of $2,687.50 to be paid by July 4, 2023 and which must be paid prior to the Licensee being licensed in the future.

This order takes effect on the **3rd day of April, 2023**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

Respecting

MANPREET KAUR BRAR
(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 Council Rules 7(8), Code of Conduct section 5 ("Competence"); section 7 ("Usual Practice: Dealing with Clients") and section 8 ("Usual Practice of Dealing with Insurers") of the Code of Conduct for failing to assess the suitability of insurance products for clients and failing to maintain client files and notes.

2. On November 22, 2022, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met 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. The Licensee was given notice of the Review Committee meeting; however, the Licensee did not attend. A discussion of the investigation report took place at the meeting. Having reviewed the investigation materials and discussed the matter, the Committee prepared a report for Council.

3. The Committee's report, along with the aforementioned investigation report, were reviewed by Council at its January 24, 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 became licensed with Council as a life and accident and sickness insurance agent ("Life Agent") on an unaffiliated basis in January 2015.

6. On November 13, 2020, Council received a letter from an insurer with a summary of their investigation of the Licensee's business practices. The insurer terminated its contract with the Licensee on November 4, 2019, on a with-cause basis.

7. At the material time, the Licensee held an advisor agreement with the insurer. This insurer had an arrangement with a second insurance company, whereby financial advisors contracted through their exclusive distribution salesforce could enter into a business agreement with the second insurance company.

8. Through the insurer's arrangement with the second insurer, their financial advisors were permitted to offer the second insurer's disability income products to prospective clients. Following the second insurance company's notification to the insurer with which the Licensee had a contract, it was noted there was a large number of terminated disability income policies sold by the Licensee. Due to the large number of terminated policies, the insurer which the Licensee had a contract with, commenced a review of the business the Licensee had placed with both carriers.

9. During their investigation, the insurer identified 22 insurance applications with the second insurer that they considered to be concerning. In these 22 applications, it was noted that the Licensee was listed as the pre-authorized chequing ("PAC") payor on an unrelated client's application. The Licensee's telephone number was also listed on multiple clients' applications. It was noted that at two specific addresses in Abbotsford, there were more than 20 individuals living in a single-dwelling household. The investigation found that there were significant lapses of policies due to insufficient payments from the bank accounts that were used to pay the premiums for multiple clients. It was determined there were variations in the names and signatures on the applications, and that client notes were photocopied and reused for three additional clients (with the same employer).

10. After identifying these concerns with the Licensee's business, the insurer conducted a review of the insurance business the Licensee had placed with their company, which also "identified similar banking concerns and signature discrepancies." The insurer's review confirmed that the same two bank accounts were paying insurance premiums for multiple clients and the residences listed were the same two previously referenced residences in Abbotsford. It was noted that the premiums for active policies with the insurer that were

being paid from the same bank accounts as the lapsed policies with the second insurer, were also "at high risk for termination."

11. The insurer confirmed the following findings relating to a Canadian bank account:
    - This account was associated with 19 applications for four of the insurer's clients with one PAC payor; eight of the resulting policies had lapsed and the remaining 11 had multiple premiums outstanding, with recent stopped PACs/payments returned non-sufficient funds ("NSF").
    - There were three additional PAC payors associated with this account, paying premiums for 10 disability clients for the second insurer.

12. The insurer confirmed the following findings relating to a credit union bank account:
    - This account was associated with 28 applications for eight of the insurer's clients with seven PAC payors; six of the resulting policies had lapsed and the remaining 22 had multiple premiums outstanding, with recent stopped PACs/payments returned NSF.
    - The review identified two of the PAC payors associated with this account as the Licensee's parents.
    - Two additional PAC payors associated with this account were paying premiums for seven disability clients for the second insurer.

13. A manager of the insurer attended three residences to attempt to verify the identities of nine clients. The manager was only able to verify the identity of one client. One of the other residences was under renovation, and the individuals living at the remaining residence confirmed that they had moved in earlier that year and did not know the Licensee. The insurer's compliance investigator attempted to call the verified client using four different phone numbers provided on the client's various insurance applications. Three of the four were not assigned, and although the fourth number called was answered, the compliance investigator was told it was not the individual's number.

14. During the ongoing review, a client contacted the insurer after realizing they were paying premiums on two insurance policies that they alleged they had not applied for. The client confirmed that the signatures that appeared on two documents were not theirs. The insurer subsequently sent targeted audit letters to clients to confirm that they had applied for the insurance coverage, that they understood the premium amounts, and that the signatures on the applications were theirs. The insurer did not receive any negative responses to these letters and has not received any related concerns.

15. As a result of the reversal of commissions associated with the terminated Disability Income policies, the Licensee has accumulated more than $146,000 in debt with the second insurer. The Licensee has negotiated a plan for repayment with the second insurer. The Licensee also has a debt of $25,888.51 with the insurer the Licensee held a contract with, which will be offset by the Licensee's future commission earnings.

16. The insurer terminated the Licensee's contract on a with-cause basis effective November 4, 2019. The insurer noted that the Licensee's practices were in violation of their code of professional conduct and advisor agreement, which states "*Advisors **MUST NOT** use their advisor account, personal account or personal PAC agreement to make payment for their clients."* Additionally, the Licensee's practices were not in line with the insurer's sales practices and needs-based selling practices.

17. On July 7, 2021, the Licensee was interviewed by Council's investigator regarding the insurer's allegations. The Licensee maintained that all her sales were legitimate and that she had met with all the clients to complete the disability applications. The Licensee stated that it was very common in some cultures for multiple families to reside in a single-family dwelling. The Licensee received referrals from friends and family and completed all the appropriate applications.

18. With regard to the lapsed policies, the Licensee said that her clients would stop paying premiums when they went abroad to visit family; she stated that DD, her wholesaler with the second insurer, had advised her that she could write policies again for clients who did not want to pay their premiums while they were overseas.

19. The Licensee stated that her bank information was used as PAC payor only for her own policy and the disability policy for her son. When questioned about why the Licensee's bank account appeared on an application with the second insurer for a client, SB, she stated she would have to check, as she only paid for her policy and her son's policy.

20. The Licensee was unsure why some telephone numbers on the application forms came back as not assigned, or why there was no answer to the calls made by the insurer's compliance investigator. The Licensee stated that the two bank accounts used frequently for the PAC belonged to the extended family of the applicants, and the clients had wanted to use one bank account to pay for premiums as it was easier for them to keep track.

21. In terms of notes, the Licensee advised that there would be notes on affordability checks in some client files. The Licensee stated that she believed she had completed needs analyses with these clients previously, as they had completed business with her in the past. The

Licensee said these documents would be in the clients' files, although she could not recall these specific disability applications. When the insurer terminated the Licensee's agreement with the insurer, they retained all the files and copies of documents, so the Licensee had no access to them.

22. Out of the 22 applications noted in the investigation, 13 clients were listed as truck drivers with similar incomes. When asked if she found this suspicious, the Licensee responded, "*there was, yes, kind of suspicion*," but the families "*have their trucking business together*," and she stated she did ask for proof of income.

23. When asked why there was a large number of lapsed client policies that were paid for by the same bank account, the Licensee advised she had "*no idea, I can't answer to that*."

24. The Licensee has offset her debt with the insurer from her commissions and has continued to make monthly payments to the second insurer.

25. On April 6, 2022, DS, director of regulatory reporting for the insurer, emailed Council's investigator to advise that the box of files returned by the Licensee to the insurer did not contain any files concerning the clients related to this matter and investigation. There were no notes or files related to any of the clients that were identified.

26. On April 20, 2022, DD emailed Council's investigator regarding his discussions with the Licensee at the material time and attached a sample Disability Income Protection Contract. DD advised that benefits are not payable for any injuries or illnesses sustained while a client has been travelling outside of Canada for more than 60 days. The clients who purchased these policies from the Licensee often travelled overseas for several months at a time and stopped paying their monthly premiums, which would cause them to lapse. Upon return, they would re-apply for coverage instead of reinstating their previous coverage as the reinstatement process requires a client to complete paperwork as well as catch up on all of the premiums owing from the date the policy lapsed. DD explained to the Licensee that clients needed to reinstate coverage instead of re-applying, and he had never recommended or condoned this practice which may be construed as churning.

27. The Licensee does not have any record of disciplinary action with Council.

ANALYSIS

28. Council has concluded that the Licensee failed to engage in the usual practice of the business of insurance by selling insurance products to clients that were not appropriate or suitable to the clients' needs. Given the very significant reversal of commissions by the insurers, it is evident that a substantial amount of insurance products sold by the Licensee resulted in the termination of the disability income policies. Additionally, Council determined that the insurance products did not align with the client's financial circumstances, given the high number of policies that were lapsed due to non-payment.

29. Council noted that, even if it were to accept the Licensee's submissions that all products that were sold were suitable and legitimate, it is the Licensee's responsibility to ensure that each client understood that the products were suitable. It is also the Licensee's responsibility to ensure that she kept records to demonstrate that the products were suitable to the clients and that the clients understood the products being sold to them. The Licensee did not have any records and the insurer confirmed that the client files returned did not have any client files or notes for the policies in question. The Licensee has been unable to produce any records that would support her recommendations for the products sold regarding the applications that were subject to this investigation.

30. Council concluded that the Licensee's practice of writing new policies for clients who did not want to pay premiums while they were overseas and had their policies lapse was not in line with the usual practice of the business of insurance. Council noted that the Licensee should have advised the clients of their ability to reinstate their policies instead of writing new policies for clients who did not pay premiums and had their policies lapse. Council determined that in doing so, the Licensee failed to provide the clients with full information about their policies. Council has concluded that the Licensee demonstrated poor judgement in this regard and was not acting in the clients' or insurer's best interests. Council has concluded that the Licensee's conduct has brought into question the Licensee's ability to act in a competent manner.

31. Council concluded, based on the seriousness of the Licensee's misconduct, that the Licensee should not hold a licence. Council considers the competency breaches to be significant, due to the large number of policies that were reversed, indicating that numerous clients were sold products that were not suitable. Council has concluded that given the high number of clients affected by the Licensee's lack of competency, the Licensee would pose a threat to the public if allowed to continue holding an insurance licence.

32. Council considered the impact of Council Rule 7(8) and Council's Code of Conduct guidelines on the Licensee's conduct, including section 5 ("Competence"), section 7 ("Usual Practice Dealing with Clients") and section 8 ("Usual Practice of Dealing with Insurers"). Council concluded that the Licensee's conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

33. Prior to making its recommendation in this matter, Council took into consideration the following precedent cases. While Council recognized 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.

34. *Edraline Buentipo Borgonia* (June 7, 2016), a Life Agent, was alleged to have sold life insurance policies to a client to replace existing policies, contrary to the client's best interests. Council found no evidence to suggest that the new policies were inferior to the existing ones. However, it did find that the process by which the licensee implemented the new policies was less than satisfactory in that the policy comparison provided by the licensee was based on incomplete information. Council found that by providing comparisons without full information, the licensee failed to act in accordance with the usual practice of the business of insurance. Council also found it was inappropriate for the licensee to have had the client sign post-dated policy cancellation letters. While accepting that the licensee was attempting to act in the client's best interests, Council found that the licensee failed to demonstrate good judgment in dealing with the client, which brought into question her ability to act in a competent manner, and in accordance with the usual practice of the business of insurance. As a result, Council imposed conditions on the licensee's licence requiring her to be supervised for a period of 24 months, complete the Advocis Getting Established course, and pay Council's investigation costs of $1,112.50.

35. *Pamela Peen Hong Yee* (June 2019) concerned a former Life Agent licensee alleged to have submitted a life insurance application for a policy on a client's behalf without their knowledge or consent. Additional allegations included that the former licensee misrepresented the client's financial and medical circumstances in the life insurance application, improperly attempted to influence the client to keep the policy after the client declined to proceed with the insurance and failed to maintain adequate records. Council concluded that the former licensee's misconduct required a period of licence cancellation as well as a fine, and that a longer period of cancellation was warranted given the former licensee's prior history of misconduct. As such, Council cancelled the former licensee's licence with no opportunity for relicensing for a two-year period, fined her $5,000, and assessed her investigative and hearing costs of $1,862.50 and $20,209.10, respectively.

36. *Paul Brian Bradbeer (December 2018):* an insurer's investigation concluded that the former licensee had submitted over 100 fictitious applications for life insurance certificates, accepted commissions for each of these fictitious applications, and then used part of the commissions he received to pay the monthly premiums. Approximately $650,000 in commissions was paid to the former licensee as a result of this fraud. Council ordered that the former licensee was unsuitable to hold an insurance licence; he was fined $10,000; and he was assessed investigation costs of $1,000.

37. *Virlie Aimendral Canlas (November 2020)*: in 2017, in response to financial problems, the former licensee began a scheme of convincing clients to obtain life insurance, even if they did not require coverage, with the agreement that he would pay their first-year premiums in full. He had also been conducting unlicensed securities activities with funds received from clients. 79 of the former licensee's clients terminated or lapsed their insurance policies between February 2017 and January 2019, which led to $258,940.93 in chargebacks. Council ordered that no insurance applications from the former licensee would be considered for five years; he was also assessed investigation costs of $1,500. Council considered fining the former licensee as well, as is usually done when a licensee perpetrates financially self-serving misconduct to the detriment of others. However, since the former licensee stated that he was currently attempting to re-pay clients who were financially harmed by his conduct, Council decided to not fine, on the basis that such a fine might harm or delay the former licensee's attempts to repay his clients.

38. *Yazdi & Associates Financial Services Inc. and Arvin Nazerzadeh-Yazdi (May 2017):* the former licensee established a group health plan for his agency. His agency had only six employees, but the plan had 25 members, most of whom were the former licensee's family members. The former licensee submitted a number of health claims on his own behalf through the plan, most of which were not valid; he also assisted others, including family members, to submit claims that were found to be false. Council ordered that the former licensee be prohibited from holding an insurance licence for a minimum period of five years; it ordered that he be prohibited from being an officer or director of an insurance agency for a minimum period of five years; he was fined $10,000; and he was assessed investigation costs of $812.50.

39. Council considered relevant mitigating and aggravating factors in this matter. Council considered that the Licensee had no previous disciplinary history, that she cooperated throughout the investigation, and that she was planning to repay the insurers as mitigating factors. Council noted that the Licensee's lack of competence demonstrated a risk of harm to the public and considered this as an aggravating factor.

40. Council is of the opinion that it is in the public's interest that the Licensee's Life Agent licence be cancelled and that the Licensee not be permitted to apply for an insurance licence for a period of two years. Council has determined that it is important if the Licensee is to re-enter the industry, that the Licensee requalify as the competency issues identified suggest that remedial courses would not properly address or rectify the lack of competency demonstrated.

41. Council noted that the circumstances of this case tended to be on the higher end of the precedents, and that the number of clients affected by the unsuitable products sold resulted in very substantial harm. The number of policies that would have had to lapse resulting in a reversal of commissions in the amount of $146,000 with the second insurer and $25,888.51 with the first insurer, would be very significant. Additionally, at least 22 policies were noted in this investigation as problematic and demonstrate that at least 22 clients were affected by the Licensee's conduct, which is more significant than the number of individuals who were harmed in the precedents. Given this, Council concluded that it is necessary for the Licensee to be removed from the industry and have to requalify before re-entering the industry. The requalification would ensure the Licensee is familiar with the obligations, requirements, and standards of the usual practice of the insurance industry.

CONCLUSIONS

42. 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's Life Agent licence to be cancelled with no opportunity to reapply for an insurance licence for a period of two years. Council concludes that it is appropriate for the Licensee to be assessed the investigation costs of $2,687.50.

43. 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 a reason to not apply this principle in the circumstances.

INTENDED DECISION

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

a) Cancel the Licensee's life and accident and sickness insurance agent with no opportunity to reapply for an insurance licence for a period of two years, commencing on the date of Council's order; and

b) Assess Council's investigation costs against the Licensee in the amount of $2,687.50 to be paid within 90 days of the date of Council's order and which must be paid prior to the Licensee being licensed in the future.

45. 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.

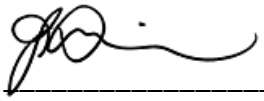
RIGHT TO A HEARING

46. 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.

47. 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 **21st day of February, 2023**.

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director