In the Matter of

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

and

The INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

PETER CALVIN DE JONG
(the "Licensee")

ORDER

As Council made an intended decision on February 15, 2011, 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 March 4, 2011; 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:

1. the suspension of the Licensee's life and accident and sickness insurance agent's licence for a period of one month, commencing on **April 8, 2011**;

2. a condition imposed on the Licensee's life and accident and sickness insurance agent's licence that the Licensee successfully complete an errors and omissions course as approved by Council no later than **September 30, 2011**. If the Licensee does not successfully complete the errors and omissions course by this date, the Licensee's life and accident and sickness insurance agent's licence is suspended as of **October 1, 2011**, without further action from Council and the Licensee will not be permitted to complete any annual filing until such time as the ordered course is successfully completed;

3. the Licensee is fined $2,000.00;

4. the Licensee is assessed Council's investigative costs of $1,300.00; and

.../2

5. a condition imposed on the Licensee's life and accident and sickness insurance agent's licence that the Licensee pay the above mentioned fine and investigative costs no later than **June 30, 2011**. If the Licensee does not pay the ordered fine and investigative costs in full by this date, the Licensee's life and accident and sickness insurance agent's licence is suspended as of **July 1, 2011**, without further action from Council and the Licensee will not be permitted to complete any annual filing until such time as the ordered fine and investigative costs are paid in full.

This Order takes effect on the **30th day of March, 2011.**

Barbara MacKinnon, CAIB
Chairperson, Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

PETER CALVIN DE JONG
(the "Licensee")

INTRODUCTION

Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether there was compliance by the Licensee with the requirements of the Act.

As part of Council's investigation, on December 16, 2010, an Investigative Review Committee (the "Committee") met with the Licensee to discuss an allegation that the Licensee withheld health information about a client from an insurer during the process of procuring a life insurance policy for the client.

The Committee was comprised of one voting and two non-voting members of Council, all of whom have significant experience in the insurance business. Prior to the Committee's meeting with the Licensee, an investigation report was distributed to the Committee and the Licensee for review. A discussion of this report took place at the meeting and the Licensee was provided an opportunity to clarify the information contained therein and make further submissions. Having reviewed the investigation materials and after discussing this matter with the Licensee, the Committee made a recommendation to Council as to the manner in which this matter should be disposed.

A report setting out the Committee's findings and recommended disposition, along with the aforementioned investigation report, was presented to Council at its February 15, 2011 meeting. At the conclusion of its meeting, Council accepted the Committee's recommended disposition and determined that the matter should be disposed of in the manner set out below.

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INTENDED DECISION PROCESS

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/or 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

Based on the information contained in the investigation report, Council made the following findings of fact:

Licensing and Employment Information:

1. the Licensee was first licensed with Council as a life and accident and sickness insurance agent on May 10, 1982;

2. the Licensee is currently licensed as a life and accident and sickness insurance agent nominee for Peter C. de Jong Insurance Agency Inc.;

3. the Licensee's agent contract with Manulife Financial ("Manulife") was terminated effective July 9, 2009;

4. the Licensee has not been subject to discipline by Council in the past;

Life Insurance Application for Clients A and B (collectively referred to as the "Clients"):

5. on February 29, 2008, the Licensee met with Clients A and B, a husband and wife respectively;

6. at the time, Clients A and B had five term 10 joint life insurance policies of varying amounts, covering mortgages on warehouse properties they owned;

7. Clients A and B had just purchased another warehouse and wanted to insure the mortgage relating to the newly acquired property;

8. the Licensee suggested to Clients A and B that they apply for five term 20 joint life insurance policies to replace the existing term 10 policies, which were then in the eighth or ninth year;

9. during the same meeting, Client A applied for an additional million dollar Manulife policy on his life only; and Clients A and B applied for a $350,000.00 joint term 20 Manulife policy ("Policy X");

10. Manulife permitted the Licensee to use a single application for all seven policy applications. The single application was signed on February 29, 2008;

11. the Licensee did not collect any money for the policies that were replacing the five existing policies, however, he collected premiums on the additional million dollar policy pertaining to Client A and Policy X;

12. the Licensee also issued a temporary insurance agreement ("TIA") for Policy X;

13. the standard form for Manulife's TIA provides, in part, as follows:

> *The temporary life insurance outlined in this agreement will end the earliest of:*
>
> - *the date we deliver a life insurance policy as a result of this application*
> - *the date we mail you a notice that we have declined your application for life insurance*
> - *the date we mail you a notice that the insurance under this agreement has been cancelled*
> - *90 days from the date this application was signed*
>
> *This agreement terminates on the date specified above regardless of whether we have refunded the premium that you paid with this application.*
>
> *If we issue a life insurance policy to you based on the terms of the application, we will apply your first premiums due under the policy. If we decline your application, or if we offer you a policy based on terms other than those outlined in your application and you do not accept the policy, we will refund your first premium payment.*

14. Manulife required full medical evaluations for the new policies. The Licensee submitted that he ordered medical evaluations on March 3, 2008. On April 9, 2008, he noticed the medical evaluations had yet to be completed and reordered them;

15. the Licensee cited discrepancies with the medical service provider as a major concern throughout this case. According to the Licensee, the service provider's internal client site indicated medicals had been completed when in fact, they had not. Further, when they were finally completed, the date the paramedical was witnessed was incorrect on Client B's file. The nurse had recorded the date as Wednesday, May 29, 2008, but according to the Licensee and Client B, the nurse met with Client B to complete the paramedical on May 25, 2008;

16. on July 11, 2008, Manulife issued the policies, including Policy X. The policies were sent to the Licensee for him to deliver to the Clients. Included with Policy X was a policy delivery receipt which expressly required the Clients to confirm the following:

    - *I received the policy described above on (____/_____/___).*
      day/month/year

    - *I received and reviewed a copy of the application and agree that the information in it is accurate.*

    - *If I am an insured person, I affirm that since the application date there has been neither a detrimental change to my health nor change to my occupation or lifestyle that could increase the risk to my health or life.*

    - *I understand that the insurance coverage provided by the policy will not take effect until the later of*

        - *the policy date shown on the policy summary or policy specifications pages of the policy, or*

        - *the date the first payment is made.*

    - *I understand that the policy will not be in effect if, since the application date,*

        - *there has been a detrimental change to the health of any of the insured people, or*

        - *any of the insured people have made a change to their occupation or healthstyle that could increase the risk to their life or health.*

17. in late July 2008, the Licensee contacted the Clients to arrange for delivery of the policies. It was at this time the Licensee first learned Client B had been diagnosed with breast cancer and was scheduled to undergo a mastectomy. In particular, Client B advised the Licensee that during a scheduled annual check-up on Monday, May 26, 2008, her breast cancer was first detected;

18. the Licensee decided to contact his managing general agency ("MGA") to explain the circumstances before he delivered the policies to the Clients. The principal of the MGA confirmed that the Licensee contacted him on July 25, 2008, and he submitted that he asked the Licensee to read the policy receipt aloud. It was clear to him that confirmation of health was required as part of the delivery requirement. The principal of the MGA further submitted he advised the Licensee to notify Manulife's underwriter since he viewed that as the Licensee's responsibility as a "field underwriter". Accordingly, he provided the Licensee with the contact information for Manulife's VP of Underwriting;

19. the Licensee took the position that he was not permitted to communicate with Manulife directly and submitted that he believed he must deal directly with the MGA;

20. the Licensee's understanding of the advice he received from the MGA's principal was that Policy X could be deemed void if Manulife determined that the Licensee had knowledge of Client B's change in health and failed to disclose it to Manulife;

21. the Licensee was "unsettled" as to the right course of action to take. The circumstances reminded him of a case he dealt with as an agent in 1985. According to the Licensee, he delivered a policy to the spouse of an applicant who had been hospitalized for liver cancer. When he reported it to the particular insurer on risk, he was advised he should not have delivered the policy as the insurer would have to wait for a claim in order to initiate investigation of insurability;

22. the Licensee contacted a lawyer at the head office of his errors and omissions insurance carrier to get a third party opinion on his professional liability in the current matter involving Client B's breast cancer. According to the Licensee, the lawyer advised him he should look after the Clients' best interests and, under contract law, there was a valid contract. The Licensee accepted the lawyer's opinion as correct;

23. the Licensee's belief that the TIA on Policy X constituted a valid contract was also based in part on the fact that "money was on the contract because his clients had not been refunded, nor were they advised in writing that the TIA was cancelled";

24. on or around August 12, 2008, the Licensee was advised by the MGA not to deliver Policy X to the Clients. The Licensee disputes he ever received such instructions;

25. in any event, the Licensee met with the Clients on August 15, 2008, and stated he never gave them Policy X. Rather, during this meeting, the Licensee had them sign a policy delivery receipt which did not include any of the health related questions that usually form part of the standard delivery receipts required by Manulife; the Licensee advised that his assistant created the policy delivery receipt upon his instruction;

26. the policy delivery receipt signed by the Clients was identical to Manulife's short form delivery receipt with the exception of questions relating to the health of Client B;

27. the Licensee sent the policy delivery receipt that was signed by the Clients to Manulife, along with a cover letter that read as follows:

> *We are sending you the difference of premium of $9.66 required from the cheque originally submitted for $154.60 (copy enclosed) for the above numbered policy as there was no refund of premium given by Manulife.*
>
> *There was also no notification that the temporary insurance agreement was no longer in force as the client did not receive a letter cancelling the temporary insurance agreement and I also did not receive a copy of the letter.*
>
> *The policy receipt has been amended to reflect the above.*
>
> *Thank you.*

28. the Licensee submitted the intent of his letter to Manulife was to prompt Manulife to refund the money submitted on Policy X by the Clients;

29. in explaining why he used his own version of a policy delivery receipt for Policy X, the Licensee indicated that Manulife's delivery receipt was too extensive and there had been other occasions in the past when Manulife did not require this type of receipt to be signed by a client. He also referred to an email from Manulife's Head of Underwriting and Compliance to the MGA as evidence that his delivery receipt was acceptable to Manulife. In particular, the email reads as follows:

> *I spoke with our compliance area and our Underwriting Director on these cases and after lengthy reviews I have finally received the go ahead to proceed as an exception. See comments below received from compliance:*
>
> *"I would like it made clear to both the advisor and the MGA that we are doing this on an exception basis and that we expect to be contacted if there are questions/concerns with the delivery receipt that has been included with the contract. I can understand why it was done, however he should have come back to Manulife to ask why we sent the delivery receipt out that we did. At that time, we could have agreed to produce the short delivery receipt and send it out. We could also have pointed out that we waived the 69G requirement and therefore, the longer delivery receipt was more appropriate."*
>
> *Policies...8195763, 8195754, 8378126, 8278281, 8229493 and 8677683 have all been sent to the reissue area to be reissued with the female client removed and 8195761 I have processed the delivery requirements received.*

30. the Licensee submitted that because Manulife had not returned the monies paid on Policy X within 90 days of the date of the application, he believed there was a valid insurance contract;

31. the Licensee advised the Clients he would maintain possession of the contract for Policy X until the issue was resolved with Manulife. In his view, which he conveyed to the Clients, either Manulife would approve Policy X or not; in the latter case, it was a contractual issue between them and Manulife;

32. the Licensee also advised the Clients that they would not be covered on the other policies that were submitted without premium payments and, therefore, those policies would need to be returned to Manulife and reissued without Client B as a life insured;

33. the Licensee returned all of the policies without premium payments to Manulife and requested that they be issued without Client B as a life insured; however, he did not advise Manulife of Client B's breast cancer at that time;

34. on or around September 25, 2008, Manulife reissued all of the joint policies without Client B, including Policy X. Manulife sent a declaration as part of a new policy delivery receipt indicating that Client A had issued a request to remove Client B from the policies, which included Policy X;

35. the Licensee returned Policy X to Manulife asking for an explanation as to why the policy was "changed" and requesting it be reissued with Client B;

36. Client A refused to sign the declaration to remove Client B from Policy X;

37. on January 9, 2009, the MGA advised the Licensee that he needed to return Policy X and have it reissued without Client B included. The Licensee advised the MGA that Client A had refused to sign the declaration to remove Client B and it was a "contractual issue" between Manulife and the Clients. In his view, he could not get involved with a contractual issue between Manulife and the Clients;

38. in or around February 2009, the Licensee submitted he was called by the Head of Underwriting at Manulife and asked if there were any concerns with Client B's health. At that time, the Licensee advised Manulife's Head of Underwriting that Client B had been diagnosed with breast cancer after the medical evidence had been collected by the paramedical company;

39. Manulife's Head of Underwriting asked the Licensee to return Policy X;

40. the Licensee advised Manulife that he was an "intermediary" and not the "issuer" of the policy and, therefore, if Manulife wanted to retract the contract, it would have to be rescinded by Manulife;

41. Manulife reviewed the medical evidence and, ultimately, rescinded Policy X for misrepresentation;

42. on June 23, 2009, the MGA's principal advised the Licensee that his producer contract with Manulife was being terminated because Manulife believed he had material knowledge respecting Client B's insurability since February 29, 2008, and because of the concerns surrounding his use of his own policy delivery receipt;

43. the Licensee disagreed with Manulife's position and reiterated that Client B's change in health was only diagnosed on May 26, 2008, three months after the date of the application for Policy X;

44. the Licensee further disputed Manulife's position with respect to the policy delivery receipt. He maintained that he had "received an exception not to include the F69G as it was not required", referring to the longer form of Manulife's policy delivery receipt; and

45. the policy delivery receipt presented to the Clients for Policy X was neither the longer form of Manulife's policy delivery receipt nor the shorter form. Further, both of the standard Manulife policy delivery receipts include health related questions, whereas the one the Licensee had signed by the Clients and returned to Manulife did not.

LEGISLATION

Rule 7(8) of the Council Rules

(8) A licensee must comply with Council's Code of Conduct, as amended from time to time.

Section 231 of the Act
Part 7 – Administration of the Regulation of Financial Institutions
Division 2 – Insurance Council of British Columbia

Council may suspend, cancel or restrict licences and impose fines

(1) If, after due investigation, the council determines that the licensee or former licensee or any officer, director, employee, controlling shareholder, partner or nominee of the licensee or former licensee
- (a) no longer meets a licensing requirement established by a rule made by the council or did not meet that requirement at the time the licence was issued, or at a later time,
- (b) has breached or is in breach of a term, condition or restriction of the licence of the licensee,
- (c) has made a material misstatement in the application for the licence of the licensee or in reply to an inquiry addressed under this Act to the licensee,
- (d) has refused or neglected to make a prompt reply to an inquiry addressed to the licensee under this Act,
- (e) has contravened section 79, 94 or 177, or
- (e.1) has contravened a prescribed provision of the regulations,

then the council by order may do one or more of the following:
- (f) reprimand the licensee or former licensee;
- (g) suspend or cancel the licence of the licensee;
- (h) attach conditions to the licence of the licensee or amend any conditions attached to the licence;
- (i) in appropriate circumstances, amend the licence of the licensee by deleting the name of a nominee;
- (j) require the licensee or former licensee to cease any specified activity related to the conduct of insurance business or to carry out any specified activity related to the conduct of insurance business;
- (k) in respect of conduct described in paragraph (a), (b), (c), (d), (e), or (e.1), fine the licensee or former licensee an amount
  - (i) not more than $20 000 in the case of a corporation, or
  - (ii) not more than $10 000 in the case of an individual.

(2) A person whose licence is suspended or cancelled under this section must surrender the licence to the council immediately.

(3) If the council makes an order under subsection (1)(g) to suspend or cancel the licence of an insurance agent, or insurance adjuster, then the licences of any insurance salesperson employed by the insurance agent, and of any employees of the insurance adjuster are suspended without the necessity of the council taking any action.

(3.1) On application of the person whose licence is suspended under subsection (1)(g), the council may reinstate the licence if the deficiency that resulted in the suspension is remedied.

(4) If an insurance agent's licence or an insurance adjuster's licence is reinstated, the licences of any insurance salespersons or employees of the insurance adjuster who
- (a) were employed by that agent or adjuster at the time of the suspension, and
- (b) remain employees of that agent or adjuster at the time of reinstatement,

are also reinstated without the necessity of the council taking any action.

Section 236 of the Act
Part 7 – Administration of the Regulation of Financial Institutions
Division 2 – Insurance Council of British Columbia

Power to impose conditions

(1) The commission, superintendent or council, depending on which of them has the power to make the order, give the consent or issue the business authorization permit or licence may
- (a) impose conditions that the person considers necessary or desirable in respect of
  - (i) an order referred to in section 235(1),
  - (ii) a consent referred to in section 235(2),
  - (iii) a business authorization,
  - (iv) a permit issued under section 187(1), or
  - (v) a licence issued under Division 2 of Part 6, and
- (b) remove or vary the conditions by own motion or on the application of a person affected by the order or consent, or of the holder of the business authorization, permit or licence.

(2) A condition imposed under subsection (1) is conclusively deemed to be part of the order, consent, business authorization, permit or licence in respect of which it is imposed, whether contained in or attached to it or contained in a separate document.

(3) Except
- (a) on the written application or with the written permission of the holder, or
- (b) in the circumstances described in section 164, 231 or 249(1),

a power of the commission, superintendent or council under this Act to impose or vary conditions in respect of
- (c) a business authorization is exercisable only on or before its issue date, or
- (d) a permit under section 187(1) or a licence under Division 2 of Part 6 is exercisable only on or before its issue date

with effect on and after that date.

Section 241.1 of the Act
Part 7 – Administration of the Regulation of Financial Institutions
Division 2 – Insurance Council of British Columbia

Assessment of Costs

(1) If an order results from an investigation or hearing, the commission, the superintendent or the council may by order require the financial institution, licensee, former licensee or other person subject to the order to pay the costs, or part of the costs, or either or both of the following in accordance with the regulations:
  (a) an investigation;
  (b) a hearing.

(2) Costs assessed under subsection (1)
  (a) must no exceed the actual costs incurred by the commission, superintendent or council for the investigation and hearing, and
  (b) may include the costs of remuneration for employees, officers or agents of the commission, superintendent or council who are engaged in the investigation or hearing.

(3) If a person fails to pay costs as ordered by the date specified in the order or by the date specified in the order made on appeal, if any, whichever is later, the commission, superintendent or council, as the case may be, may file with the court a certified copy of the order assessing the costs and, on being filed, the order has the same force and effect and all proceedings may be taken on the order as if it were a judgment of the court.

ANALYSIS

Council found these facts constituted a breach of section 231(1)(b) of the Act in that the Licensee failed to act in good faith and in accordance with the usual practice of the business of insurance. In particular, he failed to disclose material information about a client's health to an insurer during the procurement of a life insurance policy for the client.

Licensees have a duty to insurers on whose behalf they transact insurance business. The duty includes an obligation to make reasonable inquiries into the risk and provide full and accurate information. Council found the Licensee did not fulfill this duty. Rather, he acted in a manner that was directly in conflict with this.

Council recognized that the Licensee was not motivated by any personal or financial benefit; appeared concerned about his own legal liability; and, found himself in an emotionally charged situation. However, the preparation of a policy delivery receipt that omitted relevant health questions and the lack of forthrightness with the insurer about the client's breast cancer could have resulted in the insurer being on risk for a life it would not otherwise have insured and the client paying for a false sense of security since it is unlikely that the policy would have ever been paid out upon her death.

There were ample opportunities for the Licensee to be forthright with the insurer and he had an obligation to disclose the breast cancer to the insurer. This duty persists throughout the whole underwriting process, not just at the time of application, and this is a fundamental responsibility which the Licensee failed to meet. Council also noted that it is not a licensee's responsibility to determine whether a contract of insurance is valid, something the Licensee appeared to be doing in this matter.

Council acknowledged the Licensee had notified the MGA about the client's breast cancer, however, it also found that the Licensee was told not to deliver Policy X by the MGA. In the end, by acting contrary to the MGA's instruction in delivering the policy and taking certain steps to withhold the client's health issue from the insurer, the Licensee did not act in good faith.

Council was concerned that someone with the Licensee's experience would fail to meet such a fundamental requirement. Council found this occurred because the Licensee let his duty to the client supersede his responsibility to the insurer and caused him to make very poor decisions along the way.

In determining the appropriate parameters for discipline, Council reviewed similar cases in which licensees were found to have not acted in good faith and outside of the usual practice of the business of insurance.

In the decision regarding *S. Matthews ("Matthews")*, Council determined the former licensee failed to act in the best interests of her clients and made unsuitable recommendations to invest in similar universal life insurance policies, regardless of their individual needs and financial circumstances. Council also determined the former licensee failed to keep adequate documentation and notes on client files. Council found that the former licensee was unsuitable to hold an insurance licence for a minimum period of three years. She was ordered to successfully complete courses towards a CFP designation and an ethics and practice course as a requirement of any future application for an insurance agent's licence. She was also fined $10,000.00 and assessed the costs of Council's investigation.

In the decision regarding *I. Khabra ("Khabra")*, the former licensee accepted funds from a client for the purposes of an investment, misled the client about the nature of the investment and failed to substantiate the existence of the investment at any time throughout the investigation. The former licensee admitted to mishandling the transaction, but was not completely forthcoming and submitted inconsistent explanations for his actions. The former licensee was also evasive in dealing with client requests for information. Council determined that the former licensee had failed to act in a trustworthy manner and in good faith. As a result, his life and accident and sickness insurance agent's licence was cancelled for a minimum period of two years, he was fined $10,000.00 and he was assessed the costs of Council's investigation.

Council also noted the decision relating to *C. Leung ("Leung")*, in which Council found that the licensee had altered and modified numerous insurance application signature pages. Council found the licensee's actions were done out of convenience for both the clients and himself, and the clients had not been misled or harmed. Council noted that the licensee had subsequently taken a number of steps to address the administrative challenges that resulted in his actions and he accepted full responsibility for his conduct. Council concluded that the licensee did not pose a risk to the public; however, found the licensee's actions in manipulating insurance documents had been intentional and repeated and that such conduct was not acceptable. Council imposed a $5,000.00 fine, required the licensee to complete an errors and omissions course, and required the licensee to pay the costs of Council's investigation.

In both *Matthews* and *Khabra*, the licensees intentionally carried out improper transactions to obtain a personal financial benefit and acted against their clients' best interests. Further, the misconduct was extensive and ongoing over a period of time. Serious questions as to the licensees' trustworthiness, particularly in relation to handling financial transactions, and their ability to carry on the business of insurance in good faith, rendered both licensees unsuitable to hold an insurance licence.

In the present case, the Licensee mishandled the transaction, but he did not set out to deceive anyone for his own benefit. His actions were misguided, but Council did not view them as completely analogous to the *Matthews* and *Khabra* decisions. Council considered the *Leung* decision to be informative in that it related to improper practice, but did not involve clear malicious intent. Although the Licensee's misconduct was deemed to be more egregious; this was somewhat offset by the Licensee's otherwise clean record and the isolated nature of the misconduct, as compared to the repeated transgressions in the *Leung* decision. Council also noted that the *Leung* decision reflected that he was a captive agent and that his insurance market had imposed greater oversight of his conduct as a result of the transgressions. On balance, Council found the decision helpful in establishing a range of disciplinary measures for conduct that is not indicative of untrustworthiness.

Based on Council's findings of fact and the decisions cited above, Council decided that the disposition in this case ought to assist the Licensee, through education, to better understand the significance of his misguided actions. In addition, because the Licensee did not act in good faith and fundamentally breached his obligation to the insurer, Council found that the disposition must also be punitive in nature, and consideration be given to both specific and general deterrence. Council acknowledged that the Licensee had a significant number of years in the industry without any disciplinary history. In the circumstances, Council concluded that a fine and a one month suspension would serve as a deterrent to the Licensee and to other licensees respecting this type of misconduct. In combination with the Licensee completing an errors and omissions course, Council concluded that such measures would achieve the paramount goal of protecting the public and maintaining public confidence in the integrity of the industry.

INTENDED DECISION

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

1. suspend the Licensee's life and accident and sickness insurance agent's licence for a period of one month;

2. impose a condition on the Licensee's life and accident and sickness insurance agent's licence that the Licensee successfully complete an errors and omissions course as approved by Council, within six months from the date of the Order;

3. fine the Licensee $2,000.00; and

4. assess the Licensee Council's investigation costs of $1,300.00.

The Licensee is advised that should the intended decision become final, the suspension will commence 10 days from the date of the Order and the costs and fine which form part of the Order, will be due and payable within 90 days of the date of the Order.

The intended decision will take effect on **March 30, 2011**, subject to the Licensee's right to request a hearing before Council pursuant to section 237 of the Act.

RIGHT TO A HEARING

If the Licensee wishes to dispute Council's findings or its intended decision, the Licensee may have legal representation and present a case at 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 by **March 29, 2011**. 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 by **March 29, 2011**, the intended decision of Council will take effect.

Even if this decision is accepted by the Licensee, pursuant to section 242(3) of the Act, the Financial Institutions Commission still has a right to appeal this decision of Council to the Financial Services Tribunal ("FST"). The Financial Institutions Commission has 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 contact them directly at:

Financial Services Tribunal
PO Box 9425 Stn Prov Govt
Victoria, British Columbia
V8W 9V1

Reception: 250-387-3464
Fax: 250-356-9923
Email: FinancialServicesTribunal@gov.bc.ca

Dated in Vancouver, British Columbia, on the **4th day of March, 2011.**

For the Insurance Council of British Columbia

Gerald D. Matier
Executive Director

GM/ig