ALBERTA INSURANCE COUNCIL
(the "AIC")

In the Matter of the *Insurance Act*, R.S.A. 2000 Chapter I-3
(the "Act")

And

In the Matter of Danielle D Bourne
(the "Agent")

DECISION
OF
The General Insurance Council
(the "Council")

This case involved an allegation pursuant to s. 480(1)(a) of the Act. Specifically, it is alleged that the Agent used credit card numbers of clients without their knowledge or permission and also used her own credit card to purchase insurance coverage for clients that did not request coverage to be put in place. In addition, it is alleged that the Agent recorded receipt of cash payments when none was actually received. In so doing, it is alleged that she is guilty of misrepresentation or dishonesty as contemplated in s. 480(1)(a) of the Act.

Facts and Evidence

This matter proceeded by way of a written Report to Council (the "Report"). The Report was forwarded to the Agent for her review and to allow the Agent to provide the Council with any further evidence or submissions by way of Addendum. The Agent signed the Report on May 30, 2014 and did not adduce any further evidence or submissions.

The Agent is a former holder of a certificate of authority that authorized her to sell general insurance. She first held a certificate of authority on June 19, 1997 and she held a certificate until it was cancelled on June 18, 2000 as she did not advance to the status of a level 2 general insurance agent. The Agent became licensed again on July 30, 2010 and she continuously held a certificate of authority until November 12, 2013.

By letter dated September 13, 2013, counsel acting on behalf of the Agent's employer (the "Complainant") provided the AIC with an internal investigation report that the Complainant completed in relation to the

Agent's conduct (the "Complainant's Report"). Among other things, the Complainant's Report set out the following summary:

1) Between September 2012 and March 2013 there were 32 incidents whereby [the Agent] processed transactions with unauthorized credit card or bank accounts;
2) 32 policies were set up "in error" or without consent of the customer;
3) 17 … policies were set up using [the Agent's] credit card;
4) 25 unidentified cash payments were posted;
5) 8 incidents of withdrawals flowing through [the Agent's] personal bank account occurred; and
6) 3 policies were sent to collections (which have now been recalled).

In addition, the Complainant's Report indicated that the Agent's manager ("PC") met with the Agent on April 1, 2013 to explain to her that her employment was being terminated for cause and the reasons for her termination. According to PC, the Agent did not provide PC with any reasons for her actions. During this meeting, PC delivered a formal letter to the Agent also notifying her that her employment was being terminated for cause.

Also included in the Complainant's Report were the following:

1) Payroll record showing the Agent reviewed and accepted her employer's Code of Ethics and Integrity policies including copies of the policies;
2) Permanent Performance Review, notifying the Agent to undertake corrective action;
3) The Complainant's report on the background of their investigation;
4) Termination letter and Service Canada Record of Employment;
5) Summary of all the credit card numbers used by the Agent;
6) List of the policies that were impacted by the Agent; and
7) Excel spreadsheet which was the "main Policy Tracking" document used by the Complainant's investigators.

On November 4, 2013, the AIC investigator sent a letter to the Agent informing her that she was the subject of a complaint brought by the Complainant. Specifically, the investigator told the Agent that it was alleged that on 14 occasions she processed payments using the credit card numbers of existing clients to purchase insurance for other individuals without their instruction or consent. The investigator also noted that the

complaint alleged that she used her own credit card to pay for insurance premiums and that she registered cash payments on 15 occasions when no cash was actually received.

By letter dated November 15, 2013 the Agent responded. Among other things, she wrote:

> Without knowing the exact cases and dates of the alleged cases, I will to the best of my knowledge respond on a generalized manner accordingly.
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> Within the computer system that we worked on, I believe it was a [sic] older system. We had the ability to put a policy that was effective up to 60 days in advance in the system, as a post dated cheque or on Monthly payment plan. Our Manager supported this and also had used this himself and was the person who advised me that was possible. The Manager advised that if we were confident with verbal confirmation from the customer to proceed, that this was a good process to get the policy on the books. The issue with this was that you could have the customer change their mind due to pricing, or we were dealing with the wife, the husband would not wish to proceed. We would get off risk. Also after the fact advise we had a wrong effective date and need to reissue. Our Manager had advised to use our own banking or credit card information if it was not provided 60 days in advance as it would ensure we would remember to go back into the policy and add the customers once the customer provided. The issue with this was with the high volume of sales in a busy month, it was very possible to miss getting this changed prior to the effective date, resulting in this being charged against our information. It also was possible that someone would advise they would be in to make payment and not get into the office when they stated and Agents would make the payment and be reimbursed when the customer came in.
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> It was very possible during busy times and the amount of paper that you could have on your desk to mistakenly put a wrong credit card on the wrong policy in error as you may have written down on wrong piece of paper. The system had no way of showing that this was in error. You could be in one file and have a call come in which resulting [sic] in opening a second screen and an agent could accidently change banking or credit card information on a wrong file if you were rushing as the system had no way of matching the information to file you were applying the payment on. This mistake had happened with other agents in the office as well making this error, on new business and existing clients [sic] policies. When brought to our manager's attention we would have accounting reverse and credit the transaction accordingly. Unfortunately the only way we usually became aware was when the customer called in.
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> We were to use our own funds to fix misquotes and other errors under the direction of our Manager, as he stated that it was at our error and we needed to resolve the issue. Therefore there could have been policies where cash was applied by the Agents. He did advise the best way was to use cash, but to handle accordingly.
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> All our policies were to be reviewed by the Manager and errors should have been brought forward [sic], so we could contact the customer and correct any errors. Our policies were

also reviewed by Underwriting prior to being released and policy was sent out to the customer.

The start of 2013 we implemented a welcome call which would have a service representative make contact and review all of the details to ensure we had better accuracy. As we had Agents producing high sales volumes and mistakes were being made by multiple Agents. This was a great process as would help with any errors or corrections that needed to be made.

Our production had a direct impact on the Manager's bonus. There were other agents who had followed these practices to push out business as well making the same errors. We were pushed and expected to work long hours to get sales numbers, without support on the actual paperwork or any follow up on our files, until the Welcome call was introduced.

A large portion of my sales were on a referral basis, from centers of influences 1 had made many direct and indirect personal referrals, I enjoy being involved in a community where I worked and lived. I enjoy volunteering within the community…

…

…My Manager was not willing to allow me to slow down with my new business production and would put pressure on me regarding same. As I was one of his top producing sales Agents, he benefitted from my production with large bonus's [sic] and a trip which he earned as a direct result of my production. I did not receive full bonus the first two quarters due to performance which I had discussed with my Manager in February.

I had believed that I gave my manager my resignation on April 1/2013 after a brief dialogue in the morning regarding my performance and I could not continue under those working conditions, it was a very difficult decision and emotional … I knew that I needed to slow down and find a position that would not have the same expectations or require the long hours. I left immediately. It was after the fact that I was made aware that the Company had let me go with cause. I feel now that my Manager was aware that this was to happen however, accepted my resignation. I was confused as I had received no documentation from the Company regarding same other than a copy of the Non Compete Clause as well as the contact information regarding my benefits through Sun Life was mailed to me. I believe that Allstate would have 2 managers present when letting someone go with cause. This is not what had happened and as it was only the Manager involved in our discussion.[1]

[1] References in this letter to personal matters causing the Agent great stress have been deleted so as to protect the privacy of third parties. However, we have taken the entirety of her submissions into account in arriving at our decision.

Given the statements the Agent made regarding her manager's conduct, the investigator wrote to the manager on January 15, 2014. In this letter, the investigator outlined the Agent's allegations and requested that he provide a response.

On February 3, 2014, the AIC received a fax from a human resource official with the Complainant that responded on behalf of the Complainant and the Agent's manager. In response to the Agent's allegation that the manager instructed the Agent to use her own banking information for policies put in place 60 days in advance of their effective date, the letter explained that this practice was contrary to the Complainant's privacy policy. The letter included copies of certain sections of the Complainant's privacy policy. One of these required employees "to not conduct business unethically by falsifying documents such as but not limited to applications, misclassifying and misrating [sic], and forging signatures…"

In response to the Agent's statement regarding "mistakenly put a wrong credit card on the wrong policy", the Complainant had completed an investigation into the Agent's misconduct, which investigation determined that there was a "pattern of deliberate misuse of client information."

In response to the Agent's allegation that her manager directed the agents to use their own personal funds to fix any misquotes, the Complainant stated that the manager did not instruct the Agent to use her "own funds to fix misquotes" as this was prohibited under the Complainant's privacy policy that state, in part, that "[y]ou must not use your own personal funds, i.e. cash or credit card, to pay insurance premiums on behalf of [the Complainant's] customers."

Discussion

As a preliminary matter, we note that pursuant to s. 480 of the Act, we have jurisdiction to adjudicate allegations against holders and former holders of insurance agent certificates of authority. Therefore, we have jurisdiction over this matter notwithstanding the fact that the Agent no longer holds a certificate of authority.

In order to conclude that the Agent has committed an offence pursuant to s. 480(1)(a) of the Act, the Report must prove, on the basis of clear and cogent evidence, that it is more likely than not that the Agent committed the impugned acts as alleged. While the normal civil burden of proof applies, the necessity of clear and cogent evidence recognizes that our decisions impact an agent's professional

standing.

Misconduct offences found in s. 480(1)(a) were discussed by the Alberta Court of Queen's Bench in *Roy* v. *Alberta (Insurance Councils Appeal Board)*, 2008 ABQB 572 (hereinafter "*Roy*"). In *Roy*, the Council found that an Agent committed an offence pursuant to s. 480(1)(a) of the Act when he attested to completing his required continuing education when he did not, in fact, do so. The Insurance Councils Appeal Board also found the Agent guilty of an offence and the Agent appealed to the Court of Queen's Bench. In his reasons for judgment, Mr. Justice Marceau reviewed the requisite test to find that an offence pursuant to s. 480(1)(a) of the Act has been made out and expressed it as follows at paragraphs 24 to 26:

> [24] The Long case, albeit a charge under the Criminal Code of Canada where the onus of proof is beyond a reasonable doubt (not on a preponderance of evidence as in this case), correctly sets out the two step approach, namely the court or tribunal must first decide whether objectively one or more of the disjunctive elements have been proven. If so, the tribunal should then consider whether the mental element required has been proved. While the Appeal Board said it was applying the Long decision, it did not make a finding as to whether step 1 had been proved with respect to each of the disjunctive elements. Rather it immediately went into a step 2 analysis and found that the mental element required for untrustworthiness might be less than the mental element required for fraud (as a given example).
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> [25] I am of the view that statement was in error if it was made to convey a sliding scale of mens rea or intent depending on which of the constituent elements was being considered. In my view, the difference between the disjunctive elements may be found in an objective analysis of the definition of each and certainly, as demonstrated by the Long case, what constitutes fraud objectively may be somewhat different from untrustworthiness. However once the objective test has been met, one must turn to the mental element. Here to decide the mental element the Appeal Board was entitled, as it did, to find the mental element was satisfied by the recklessness of the Applicant.
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> [26] While the language used by the Appeal Board may be characterized as unfortunate, on this review on the motion of the Applicant I need not decide whether the Appeal Board reasonably could acquit the Applicant on four of the disjunctive elements. Rather, the only matter I must decide is whether the Appeal Board acting reasonably could conclude, as they did, that the Applicant's false answer together with his recklessness justified a finding of "untrustworthiness". (emphasis added)

In applying this test to the facts as set out in the Report, we are of the view that the Agent repeatedly used the credit cards of existing clients to pay for insurance for individuals that did not request insurance and without their knowledge. The business records provided by the Complainant leave us with little doubt that

this was the case. In case after case, the cards were used to process down payments only to then be subsequently cancelled. In addition, in many cases the down payment with the wrong client's card was then followed by the Agent entering "dummy" banking information to set up alleged monthly premium withdrawals. This was also done in situations when the Agent initially used her own credit card.

We likewise cannot accept that this was done as a result of carelessness or accident. The particular patterns and regularity of the transactions and the numerous steps that would have to be completed in regard to each demonstrate that the Agent was not simply making an occasional entry error on the Complainant's computer system.

The Agent's statement does little to refute these conclusions. She wrote that the use of her own credit card arose where misquotes occurred or to facilitate renewal prior to the policy expiring where she did not have up to date credit card information for the client. One of the difficulties with this is that payments were repeatedly being applied to individuals that did not request the policies. The other is that there is no indication that she ever approached these alleged clients to get up to date payment information. Given the fact that she was paying for the policies, one would have expected this. It is also strange that she did not seek or receive reimbursement from her employer after processing a payment of this type. In point of fact, it was the Complainant's investigation that led to the Complainant issuing refunds to the Agent. Given the totality of the evidence, we are of the view that the Report contains sufficient clear and cogent evidence to prove that she made misrepresentations or acted in a dishonest manner as alleged.

As to the appropriate sanction for this conduct, we typically have the ability to levy civil penalties in an amount up to $5,000.00 for offences pursuant to s. 480(1)(a) and 13(1)(a) of the *Certificate Expiry, Penalties and Fees Regulation,* A.R. 125/2001. We also have the ability to order that certificates of authority be revoked for one year or suspended for a period of time. While the Agent has no disciplinary history with the AIC and she states that she was under a great deal of stress during the period of time in which she committed these acts, we believe that a significant civil penalty is warranted. The Agent's actions were deliberately conducted and extended over a period of time. They likewise appear to be planned so as to attempt to conceal her actions from her employer and the clients involved. As such, we levy a civil penalty of $5,000.00. As she no longer holds a certificate of authority, we have no ability to order a suspension or revocation. The civil penalty must be paid within thirty (30) days of receiving this notice. In the event that the civil penalty is not paid within thirty (30) days, interest will

begin to accrue. Pursuant to s. 482 of the Act (copy enclosed), the Agent has thirty (30) days in which to appeal this decision by filing a notice of appeal with the Office of the Superintendent of Insurance.

This Decision was made by way of a motion made and carried at a properly conducted meeting of the General Insurance Council. The motion was duly recorded in the minutes of that meeting.

Date: August 13, 2014

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Lloyd Hickman, Vice-Chair
General Insurance Council

Extract from the *Insurance Act*, Chapter I-3

Appeal

482 A decision of the Minister under this Part to refuse to issue, renew or reinstate a certificate of authority, to impose terms and conditions on a certificate of authority, to revoke or suspend a certificate of authority or to impose a penalty on the holder or former holder of a certificate of authority may be appealed in accordance with the regulations.

Extract from the *Insurance Councils Regulation*, Alberta Regulation 126/2001

Notice of appeal

16(1) A person who is adversely affected by a decision of a council may appeal the decision by submitting a notice of appeal to the Superintendent within 30 days after the council has mailed the written notice of the decision to the person.

(2) The notice of appeal must contain the following:

a) a copy of the written notice of the decision being appealed;

b) a description of the relief requested by the appellant;

c) the signature of the appellant or the appellant's lawyer;

d) an address for service in Alberta for the appellant;

e) an appeal fee of $200 payable to the Provincial Treasurer.

(3) The Superintendent must notify the Minister and provide a copy of the notice of appeal to the council whose decision is being appealed when a notice of appeal has been submitted.

(4) If the appeal involves a suspension or revocation of a certificate of authority or a levy of a penalty, the council's decision is suspended until after the disposition of the appeal by a panel of the Appeal Board.

Address for Superintendent of Insurance:

Superintendent of Insurance
Alberta Finance
402 Terrace Building
9515-107 Street
Edmonton, Alberta T5K 2C3