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 Christy Price
(the "Agent")

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

This case involved allegations pursuant to s. 480(1)(a) of the Act. Specifically, it was alleged that the Agent acted in an untrustworthy or dishonest manner, whereby the Agent sold insurance policies that surpassed her clients' needs, the insurance products did not align with the clients' financial ability to pay, or premiums payments were in excess of what was discussed with the clients. It was also alleged that the Agent acted in an untrustworthy or dishonest manner by making representations that she would supplement, pay a portion of, or make free a portion of the clients' insurance premiums for a period of time, in order to induce them to purchase insurance. In the alternative, it was alleged that the Agent's actions constituted false or misleading statements as contemplated by s. 509(1)(a) of the Act.

Facts and Evidence

This matter proceeded by way of a written Report to Council dated June 29, 2018 (the "Report"). The Report was forwarded to the Agent for review and to allow her to provide the Council with any further evidence or submissions by way of Addendum. The Agent signed the Report and submitted Addendum materials for consideration on July 6, 2018.

The Agent is the former holder of life and accident & sickness ("A&S") certificates of authority, and had held these licenses from October 3, 2016 to June 23, 2017. The Agent's certificates of authority were suspended on June 23, 2017 as a result of the termination of her employment. By "Notice of Termination of Sponsorship" dated June 23, 2017, Combined Insurance advised the AIC that:

> […] For sales involving a number of customers, among other things, the sales representative did premium rebating, failed to provide full, complete and accurate information to the insurer, failed to provide full and accurate disclosure to the customers, and failed to comply with the insurer's underwriting rules. Because the sales representatives [sic] indulged in these unacceptable sales practices, she was deemed to not be suitable.

In response to the Notice of Termination, the AIC emailed the writer at Combined Insurance and requested further information surrounding the Agent's dismissal. Correspondence received from Combined Insurance on October 24, 2017 provided a chronology of events, copies of client complaints, the Investigation Report conducted internally, and warning letters issued to the Agent for the past year.

In a written complaint forwarded by Combined Insurance to the AIC, a client recalled the following events:

> I was referred to her by a long time acquaintance of mine. By the way there is an issue with the life insurance as well! I am speaking with that company as well! Foresters Canada protection plan.. Christy Price clearly sold me 10 policies???? She told me your company needed numerous copies of the policy, I did ask why I was signing so much. Why would anyone need so many policies? When an insurance agent comes to your home you trust them. I told her I was interested in an accident policy after she mentioned it on the phone before she came to my house with all the paperwork prepared at a cost of 48.00/month which was FREE for 6 months. You can imagine my shock when my bank account was debited $579.00 yesterday, May 30, 2017. […] I do not want or need this insurance. It was supposed to be a promotion for 6 months FREE to me. By the way your agent mentioned this was the second payment… obviously yesterday was the first time it came out of my account! I have never had a payment before from combined insurance. If someone paid last month it did not come from me! […] Fyi. I pulled out the paperwork and noticed the pre authorized form is blank!

The AIC contacted clients of the Agent who had raised complaints to Combined Insurance. Wholly, their claims aligned with the client's complaint, above, or set out a similar series of events, whereby the premiums payable on the insurance policies were in excess of what was agreed to.

The Investigation Report of Combined Insurance (the "Investigation Report")(undated) purported the following (names redacted for privacy):

> **<u>Ms. [ML] ID# [redacted]:</u>**
> Ms. [ML] called the Company on May 18, 2017 to state that she had discussed with the agent Christy Price that the total amount of $140.00/month will be coming from her bank account for her policies and her children but in fact, $792.50/month was taken from her bank account. Ms. [ML] cancelled all her policies because she can't afford them. She said the agent was Christy Price.
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> **Interview with Agent Christy Price:**
> […] She stated that Ms. [ML] was aware that she had purchased four accident policies and two sickness policies from her on March 13, 2017 and twenty-four policies for her four children. She did explain to her that the $140.00 payment was for each child and maybe Ms. [ML] did not understand it that way. Ms. [ML] is also paying for her boyfriend [DK]. Ms. [ML] paid the initial premium from the referral fees which agent had given to her.
> Agent stated that Ms. [ML] did not contact her on May 18, 2017 because of the $792.50 which was taken from her bank account but wanted to know about the claim which she had put through. She was not aware that Ms. [ML] had called to cancel her policies because she (Ms. Price) was in the hospital and she did not advise her to reinstate her own policies for the time being and will be sending her the money that was taken from her bank account afterwards.
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> **<u>Mr. [TW] – ID # [redacted]</u>**
> Mr. [TW] called the Company on May 29, 2017 when he found out that $320.50 had been taken from his bank account for Combined Insurance policies. When he signed the pre-authorized debit agreement the

agent had written $48.00 and not $320.50. After calling the Company, Mr. [TW] decided to keep three accident policies for $48.00 and has cancelled the other three policies (2 sickness & 1 accident policies) and asked for refund of $272.50 from inception date of April 12, 2017.

Mr. [TW] contacted on May 30, 2017. He stated that he is receiving pension from the Government because he is handicapped (had been involved in a car accident) a few years ago. [sic] He said the agent mentioned on application that he works for Government of Alberta as Assistant and has a monthly income of $2,000.00, when he confirmed he is receiving $800.00 pension from the Government. Agent told him to purchase three accident policies for $48.00 and after 15 years he will be getting a return of premium. So, he signed for three accident policies and gave the agent his banking information but did not pay for the initial premium.

Interview with Christy Price:
Agent stated that Mr. [TW] was a referral from client [MM]. She stated that Mr. [TW] was fully aware that he was purchasing four accident policies and two sickness policies; most of the talking and explanation was done over the phone; she does not know the exact premium but it was [MM] who paid for his initial premium of $320.50 because the sale was done at her place and she paid for it out of the referral money she had received from Agent who had made an e-transfer to [MM] for $250.00. She is not sure how the initial premium was paid, if it was by cash or cheque.

Agent explained that Mr. [TW] wanted the ROP policies over the phone but they were not offered to him afterwards. She mentioned that all the documents were already pre-filled before she met with Mr. [TW] at [MM's] place.

Agent stated that she did not know that [TW] was on disability and is receiving pension from Government of Alberta but had told her that he has been an assistant for years with Government of Alberta.

Ms. [GNS], ID # [redacted]
Mrs [GNS][sic] sent an e-mail via Contract Customer Service to the Company on June 1, 2017 stating that she signed ten (10) policies for $48.00/month and the agent told her it was free for six (6) months. She was surprised when her bank account was debited $579.00. She said the agent was Christy Price.

Interview with Agent Christy Price:
Agent stated that Ms. [GNS] was a referral from client [MM]. She knows Ms. [GNS] had cancelled all her policies because she had called her two days after the sale to let her know that she does not have a job. Agent mentioned that Ms. [GNS] might not have paid the initial premium because she had given her three referral names and the premium was paid from the referral fee.

When agent was asked if she had left Ms. [GNS] Pre-Authorized Debit Agreement (PAD) with no fixed monthly premium amount on it, she said she did not know what she had left her but had dropped her form afterwards. She stated that she forgot to rip off the client copy but remembered having given it to her three days after the sale.

Agent mentioned that before getting to the client's house, she always pre-filled the sales documents. She knew what policy they were getting because she does the sale first on the phone and then meets them in order to sign the documents.

Agent was asked if there were other clients whose Pre-Authorized Debit agreements were not fully completed, she stated that maybe there was one. She was not aware what she was doing was wrong. In the case of Ms. [GNS] she did not find anything wrong because she was going to cancel her policies anyway.
Agent stated that the more referrals the clients send her, the more referral fees they were getting. She does not remember the referral names Ms. [GNS] had given to her.

Agent was asked if she had sold Edge Benefits products to Ms. [GNS] and she stated that she had given Ms. [GNS] the login for the Edge Benefits which she can do it herself. When agent refers a client to Edge Benefits, she gets $10.00 referral fee. Agent has a friend with Foresters and when she referred clients to him for Health & Dental, she gets referral fees.

Mr. [M] [Interviewer] brought to the attention of the agent that at the beginning of the interview she had mentioned that all her documents were completed but now ware are finding out a couple of cases where the documents were not completed. She said she thought she did.

Ms. [VP] ID # [redacted]
Ms. [VP] sent an e-mail via Contact Customer Service to the Company on June 1, 2017 stating that she signed four (4) policies for $169.30/month. She could not understand why the premium was now $500.00.

Interview with Agent Christy Price
Agent said that Ms. [MM] (payor) was well aware of the eleven policies sold to her sister, Ms. [VP]. When asked why Ms. [MM] did not have to pay for the initial premium, agent stated that she had used the referral fee to pay for the initial premium because she kept sending people to her. Agent gave her cash and sent her $250.00 (e-transfer) for each referral.

At the beginning of the interview, we asked agent if she completed all documents before they were handed over to the clients and she replied "Yes, all documents are completed with the policy numbers". We showed her the PAD Form which did not have an amount or policy number written on it; she said it was her mistake, she missed that one but afterwards had written the policy number on it and given it to the clients. We told her that she cannot add a policy number on a document after leaving the customer's home; otherwise how would the customer know how much he will be paying? She said it's her mistake and she takes full responsibility for it. […]

On November 9, 2017 the AIC emailed the Agent and requested that she provide an explanation surrounding the alleged activity. The Agent responded on November 9, 2017, via email, and stated:

[…] 1) […] b. At that time they [Combined Insurance] advised me that one of my clients "[MM]" and a couple of the people she referred to me had complained premiums weren't what they thought they would be but in my opinion this couldn't have been correct as they had already paid them for a couple of months […]
c.[…] [District Leader] was provided all the correspondence between the complainant and myself and felt I didn't do anything wrong other than a client had a misunderstanding which could have easily been corrected if I was given the opportunity to speak with my clients but I was told not to reach out to anyone after that so I did not.
[…] 5. I did not hold myself out as a Combined Insurance agent after termination. I assisted a trainee that I referred to Combined as an agent, [CA], as per [District Leader]'s approval, but this was during my suspension, not after termination letter was received. I also provided referrals to combined agents after I was terminated.

The AIC posed new questions to the Agent on January 24, 2018, by way of email, which consisted of the following:

[…] Further to your response below, please advise:

1. Why did you advise [ML] she was going to pay $140 per month but her premiums ended up being $792.50 per month?
2. Why did you advise [TW] he was going to pay $48 per month while his premium turned out to be $320/month?
3. Why did you advise [GNS] her premiums were $48/month while her premiums were $830.86/month?
4. Why did you advise Ms. [VP] her premiums were $169.30/month while her premiums ended up as $500/month?
5. Did you pay initial premiums for these other any other clients? [sic]

6. Did you insure these or any other clients without their consent?

to which the Agent responded:

1) [ML] was never informed her payments were $140. She has 4 children and her common-law that were being withdrawn from her account. A misunderstanding if anything.
2) [TW] originally only wanted HERO coverage which is the accident coverage and then decided he wanted sickness as well. Premiums were discussed with him.
3) [GNS] had received multiple quotes from multiple insurance companies and when we originally spoke just discussed accident coverage not sickness. When we met she advised she wanted both.
4) [VP] is a combined agent as well and knew the coverage. She was just starting out and everything was being withdrawn from her sisters [sic] account. All premiums were discussed and trained to her prior to signing
5) No payments were made on clients behalf no [sic]. Only referral payments which were sent via etsf [electronic funds transfer] or provided in form of gift certificate. Which is my regular practice as I receive referrals on daily basis.
6) every policy was done with consent in front of the client. Absolutely not was anyone insured without consent

As previously mentioned, the Agent was provided an opportunity to produce additional materials for consideration by way of Addendum. The Agent did provide an Addendum in two parts: “1) Text messages from District Leader and 2) Letters from my clients (copies)”. Item 2 provided 10 letters of reference, received from the Agent’s clients.

The Text Messages provided spanned over a number of days prior to and following the Agent’s suspension, and termination. Excerpts included:

> **[District Leader]** They [the compliance department of Combined Insurance] are doing their job which is to protect the company, can’t fault them for that, we just need to fall on the good side of this
> **[Agent]** Yes but they [sic] calling all my clients making them very upset so that’s combined fault. I’m doing everything they said
> **[District Leader]** Yes u are! The problem is their is a stack of policies and procedures that have been broken, normally u would just get fired so have to be thankful we are still in it
> **[Agent]** Fired for what? A mistake on paperwork. That’s not a good reason since I was told by [C] I could do that and did the whole time except for [MM][…]
> **[District Leader]** The biggest issue was the client complaining the premium was way more then what they agreed to And because the needs & pad [ipad data entry] didn’t match their copies which were blank it raises major issues
> **[Agent]** They never complained at all until [MM] started. Yes I know and that’s my fault filling out after but wasn’t meant for issue I was just rushed.
> **[District Leader]** I know but then they said they agreed to $48 one client and they got charged $400 […] I understand why it happened it was their [sic] was no proof to show what u had agreed to purchase w them […]
> **[Agent]** I know but it was never my intention
> **[District Leader]** Imagine from the company perspective, they have a client saying they wanted $X premium and they have no document showing that on their person as it’s blank And u submitted a document showing $Y premium
> **[Agent]** I understand completely. I’m just saying That wasn’t my intention at all.

The Agent sought approval from her District Leader to continue training opportunities for new hires under the Agent’s management:

> **[Agent]** Hey. My hires can still go on the zoom tonight right? I have 2 wanting to join
> [**District Leader]** Ya

And with respect to amounts promised to clients as referral fees, the text messages stated:

> **[District Leader]** FYI clients are saying u r promising them money […]
> **[Agent]** Only referrals that they already got. Nothing else since I was let go.

Discussion

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 offence, as alleged. The requirement of clear and cogent evidence reflects the fact that the findings of the Council can dramatically impact an insurance agent's ability to remain in the industry.

The elements of s. 480(1)(a) offences have been 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 applicable continuing education ("CE") when he did not, in fact, do so. The agent also held a securities license and stated that he believed that the CE required to maintain his securities license was applicable to his insurance agent requirements. The Insurance Councils Appeal Board upheld the Decision of the Council and found the agent guilty of the offence. The agent appealed the decision of the Insurance Councils Appeal Board 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, expressed 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 case before us it is clear from the Investigation Report, and by the Agent's own admission, that on multiple occasions, the Agent failed to complete insurance applications in the presence of the client and improperly completed forms after the fact, based on her own recollection of the clients' requests. This extended to backfilling pre-authorized debit forms where amounts were not approved by the client, and was substantiated by comparing client records to applications submitted by the Agent to Combined Insurance. In that, it is clear that the Agent made representations to Combined Insurance and clients that certain policy terms and payments had been agreed to when, in fact, they had not.

Turning to the Agent's intent, on grounds that a form of reimbursement would be applied by way of referral fee, a promotional rate would be applied to reduce the premium cost, or, more disturbingly, the total value of the premium(s) were never disclosed to the clients, the Agent induced her clients to purchase insurance. In many cases, the policies sold to the clients far exceeded their insurance needs or financial ability to pay. Insurance consumers rely on insurance agents to make appropriate recommendations and, where there is an abuse of this process, financial hardship can be inflicted on the client. It is difficult for the Council to determine why the Agent would make such recommendations, if not to generate commissions in the short-term. As a result of the Investigation Report, almost all of the policies outlined were cancelled or did not proceed to issuance despite the commission payments to the Agent. Based on the evidence presented, the Council is satisfied that the Agent committed an offence pursuant to s. 480(1)(a) of the Act.

As to the appropriate sanction for this conduct, the Council has the ability to levy civil penalties in an amount up to $5,000.00 for each offence pursuant to s. 480(1)(a) and 13(1)(a) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. As the Agent no longer holds a certificate of authority, the jurisdiction to suspend or revoke certificates of authority is not applicable in the circumstances.

This is the Agent's first disciplinary offence, and the Agent was licensed for under one year. As noted above, the Agent has readily admitted that she had backfilled insurance applications after the fact, that were not completed in the presence of the client. While the Agent demonstrates a degree of contrition in her responses to the District Leader, in many respects she casts herself as the victim in this matter. In an email sent to the AIC the Agent indicates that her clients voluntarily applied for policies and paid the premiums "for a couple of months" however, she does not seem to recognize that clients could not either afford to pay, had no need for the extent of the insurance applied for, or had no willingness to enter into or knowledge of the insurance policies they had entered into.

In light of all of the circumstances, the Council orders that a civil penalty in the amount of $5,000.00 be levied against the Agent. The civil penalty must be paid within thirty (30) days of receiving this notice. In the event that the penalty is not paid within thirty (30) days, interest will begin to accrue at the prescribed rate under s. 13(2) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. Pursuant to s. 482 of the Act (excerpt 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 Life Insurance Council. The motion was duly recorded in the minutes of that meeting.

Date: September 18, 2018

[Original signed by]

Kenneth Doll, Chair
Life 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
Email: tbf.insurance@gov.ab.ca