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 Sean Ronson Nethercott
(the "Agent")

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

This case involves allegations pursuant to s. 480(1)(a) of the Act or, alternatively, s. 509(1) of the Act. It is specifically alleged that the Agent misrepresented premium amounts to his clients, used his client's financial information to process unauthorized payments, concealed information, altered policy documentation, and placed insurance policies without the consent and knowledge of his clients. In so doing, it is alleged that the Agent made misrepresentations or acted in a dishonest, deceitful, fraudulent or untrustworthy manner as contemplated by s.480(1)(a) of the Act. In the alternative, it is alleged that the Agent made false or misleading statements as contemplated by s. 509(1)(a) of the Act, and subsequently violated s. 480(1)(b) of the Act.

Additionally, it is alleged that the Agent contravened s.452(2)(a) of the Act by acting in the capacity of an insurance agent without valid certificate of authority to do so, in violation of s.452(2)(a) of the Act and subsequently s.480(1)(b) of the Act.

Finally, it is alleged that the Agent contravened s.467(1)(c) of the Act by misrepresenting information on his application for the reinstatement of his certificates of authority. In doing so, it is alleged that the Agent violated s. 467(1)(c) of the Act by failing to provide the information requested by the Minister, and subsequently violated s.480(1)(b) of the Act.

Facts and Evidence

This matter proceeded by way of a written Report to the Council dated March 5, 2019 (the "Report"). The Report was forwarded to the Agent for review and to allow the Agent to provide the Council with any further evidence or submissions by way of Addendum. The Agent submitted substantial materials for the Council's consideration. In

arriving at their conclusion, the Council carefully weighed all of the evidence presented. Given the breadth of the material provided, the Council did not outline each item of evidence submitted in its' reasons for Decision.

The Agent holds certificates of authority authorizing him to act in the capacity of a life insurance and accident and sickness ("A&S") insurance agent. The Agent held both certificates of authority during the year of 2007 and again intermittently between the period of 2015 to present.

The Alberta Insurance Council ("AIC") commenced an investigation in response correspondence received from the Agent's employer, [redacted] (hereinafter referred to as "the Insurer"). The Insurer, at that time, advised the AIC of the Agent's termination which included alleged activities in relation to premium payment discrepancies, misrepresentation of premium amounts, insurance policies issued without the consent and/or knowledge of clients, amendments made to insurance policies without authorization, and unlicensed activity.

In a letter dated October 12, 2018, the Insurer's Senior Compensation and Compliance Manager advised the AIC that:

> […] The purpose of this letter is to bring to your attention the activities of Sean Nethercott which may be of concern. […] It has come to our attention that Mr. Nethercott **submitted forged insurance applications on at least two occasions** ([redacted][Client 3] and [redacted][Client 4]) **intentionally misrepresented premium requirements to clients on at least two life insurance policies** ([redacted][Client 1] and [redacted][Client 3]) and other items. Nethercott was terminated on July 19, 2018. The matter was investigated by our internal Sr. Fraud Examiner (SFE) [..]
> [Emphasis added]

On October 15, 2018, the AIC received a detailed internal investigation report, dated October 10, 2018, from the Insurer's Senior Compensation and Compliance Manager (hereinafter referred to as the "Investigation Report"), which reported the Agent for "non-compliance". The investigation report reads:

> […] Mr. Sean Nethercott was employed by [the Insurer] during the period from February 1, 2016 to July 19, 2018. During that period, he received all required training on products sold by [the Insurer].
>
> On July 19, 2018, Mr. Nethercott ([redacted]) was terminated from [the Insurer] […] His Property and Casualty license sponsorship was terminated with the Alberta Insurance Council as of that date and his life, accident and sickness and property/casualty, was eliminated.
> Subsequent to his termination, the following concerns were identified:
> - Premium payment discrepancies, whereby client credit cards were charged for premiums on polices owned by other individuals
> - Client contact whether Mr. Nethercott was holding out as continuing to represent [the Insurer];
> - Misrepresentation of life and property and casualty products issued whilst Mr. Nethercott was employed with [the Insurer], and;
> - Potential fraudulent policy documents and/or forged signatures and altered policy document relating to life products.
>
> Audit Services was required to review these allegations and perform an investigation. […]
>
> **Payment Discrepancies**
>
> <u>Payment Discrepancies-Policy [Client 1]</u>

Life policy ********* [redacted] was issued on the life of [Client 1] on October 26, 2017. Premiums for this policy were determined to be $377.55. The policy issued was based upon an application taken by Mr. Nethercott on August 10, 2017 and placed on monthly pre-authorized Debit payment.

Subsequent to issue, the following attempts were made to collect three months' worth of back premium owing in the amount of $1,132.00:

- *April 17, 2018 Visa payment:*
  This amount was receipted to the client as $1,132.00; however, a processing error resulted in $11.32 being entered into the payment terminal. This error was corrected and reversed with the full amount still owing by the client. It should be noted that the credit card used to make this payment was also used to pay Mr. Nethercott's personal policy on April 10, 2017 and therefore this was likely his card used for the April 2018 payment.
- *May 14, 2018 cheque payment:*
  This cheque was returned by the bank as dishonored on May 15, 2018. Upon examination, this returned cheque appeared to be drawn on a Royal Bank Visa credit card.
- *May 31, 2018 cheque payment:*
  This cheque was returned to the bank as dishonored on June 8, 2018. This cheque also appeared to be drawn on a Royal Bank Visa credit card.
- *June 27, 2018 Visa payment:*
  This payment was applied to the policy but was subsequently identified as being taken from a credit card belonging to a different client. This payment was refunded to the credit card owner by [the Insurer] with the premium owing by [Client 1] still outstanding.

During a phone conversation with [Client 1] on or about July 24, 2018, [Client 1] claimed that she did not have any Visa credit cards and only had Mastercard credit cards.

It should also be noted that the signatures on the cheques, particularly on the check returned on May 15, 2018 are not likely that of [Client 1]. […]

[Client 2]
Payment Discrepancies […]
During a review of Mr. Nethercott's email account while at [Insurer], it was identified that a client, [Client 2], had complained to Mr. Nethercott of unauthorized charges on his credit card on July 11, 2018. The following dates and amounts were noted:

- *June 13, 2018, $91.00* - This payment was applied to life policy 001322902 owned by [redacted, an unrelated client of the Insurer]
- *June 29, 2018, $216.00*- This payment was applied to life policy [redacted, a secondary unrelated client]. In the same payment batch, an additional $86.76 payment was made by Mastercard to policy [redacted; secondary unrelated party]. Both of these payments appear to be in response to an email sent by [the Insurer] regarding premiums in arrears collection […] The second payment of $86.76 appears to be made **on the same credit card used to pay premium on life policy 001316381 owned by Sean Nethercott.** This is the same credit card used to pay an $11.31 premium for [Client 1].[…]
  [Emphasis added]

Both payments were made by different staff members at the agency. *[Emphasis added by the Insurer]*

This issue was not identified prior to this review and was confirmed with [Client 2] who responded via email that the matter had been resolved by Mr. Nethercott to his satisfaction via a reimbursement payment made towards his home policy. This reimbursement payment was made on July 12, 2018. While the payment was made by a Visa credit card, the investigation was unable to confirm the identity of the cardholder. […]

Misrepresentation of Life/Property and Casualty Insurance Policies
Two clients were specifically reviewed with respect to misrepresentation, [Client 1] and [Client 3][…]

<u>[Client 1]- Life Policy *********</u>

[Client 1] was interviewed by the SFE on September 11, 2018. […]

An application taken for life insurance was taken by Mr. Nethercott from [Client 1] on August 10, 2017[…] An illustration of this policy, […] was located in the policy file. The illustration shows a premium amount of $242.19 […]

An $800,000 Mortgage Guard term policy was issued on the life of [Client 1] effective October 26, 2017. Due to underwriting reasons, the premium on the policy was increased to $377.55. […] This amendment was required to be signed by the client in order to place the policy in-force[…]

In her statement […] [Client 1] claims that a premium range of between $160 and $170 was quoted to her. […] [Client 1] provided […] a copy of cheque […] dated August 11, 2017, in the amount of $163.00 that she provided to Sean Nethercott as the TIA premium for the policy.

In her statement, [Client 1] claims that she was unaware that the premium on policy ********* had changed to $377.55. […] In her statement, [Client 1] denies providing a signature on this amendment. […] Mr. Nethercott was fully aware of the premium requirements of the policy and was clearly avoiding explaining to [Client 1] the change in premium from what was originally applied for vs. what was actually issued and in force.

It should be noted that, in a verbal statement made to the SFE, [Client 1] claimed that Mr. Nethercott never visited her at her property and she always attended meetings with him at his office in [redacted]. [Client 1] reviewed her calendar from the date November 10, 2017, and could find no instance of any appointment with Mr. Nethercott on that day. Review of [the Insurer] email records do not reveal any instance of Mr. Nethercott emailing the policy documents and the amendments to [Client 1] […]

[Client 3]

RE: 400*** – 19***** Alberta Ltd. O/A [redacted]**

The policy referenced is a Commercial General Liability policy. […] An email from Mr. Nethercott to [Client 3] containing the policy declarations provided to [Client 3] was identified. […] In addition to the coverage amounts, of note is the premium amount of $1,293.00

[Client 3] references a "Certificate of Insurance" in his statement. […] This document was prepared on February 19, 2018, and contains the coverage limits […] note that the premium amount is $1,994.00 and coverage amounts are significantly different from the document that [Client 3] received on March 9, 2018,

[…] Mr. Nethercott should have been fully aware of the coverage amounts and premium requirements on policy 400***** on February 19, 2018, the date of issue. By sending fictitious policy documents to [Client 3] on March 9, 2018 and by his failure to immediately explain the document that [Client 3] sent to him on March 24, 2018, Mr. Nethercott demonstrated that he wanted to withhold the actual coverage and premium amounts for policy 400***** from [Client 3] for some reason known only to Mr. Nethercott.

In addition, [Client 3] received a "Payment Schedule" (noted as his attachment 3) dated July 20, 2018. [Client 3] claims that, upon explanation of this document by [redacted – an employee of the Insurer], he discovered that the coverages had been reduced to the point of him incurring a significant risk in the event of a claim.

[Client 3] claims that he did not authorize or request these changes and no email record of such a request was located. As these changes essentially reduced the coverage on the policy to the point where a claim would have placed undue hardship on [Client 3], it is unlikely that he requested that these policy changes be made. The effect of these changes was to reduce the required premium substantially.

RE: 400***3 – [redacted] Ltd.**

[Client 3] explained that this policy was intended to include Errors and Omissions insurance coverage. Such coverage was required by himself/[redacted] Ltd. in order to meet the contractual requirements of a client and this need was made known to Mr. Nethercott.

Policy 400*****3 is a Commercial General Liability policy and was never an Errors and Omissions insurance policy.

While Errors and Omissions policies are issued by [the Insurer], they are a separate product and these coverages are not included in a Commercial General Liability policy issued by [the Insurer]. This product knowledge would have been known by Mr. Nethercott.

Re: Life Insurance Policy 00***** – [Client 3] [sic] and [Client 4]**
This policy is a Versatile Term 10 Year – Multiple Life policy issued on March 16, 2018, based upon an application dated February 27, 2018. The policy was originally issued with a Disability Premium Waiver (DPW) and subsequently re-issued at the request of Mr. Nethercott without a DPW on April 23, 2018. […]
Review of the illustration shows that both Mr. and Mrs. [Client 3 and 4] were quoted non-smoker 1 (N1) rates. Upon subsequent underwriting, it was determined that only [Client 4] qualified for this risk class and [Client 3] qualified for the non-smoker 4 (N4) rate class. The reason for this is clearly explained to Mr. Nethercott in the Agent Information Sheet. The policy itself clearly outlines the premium expectations.
[The Insurer] requires agents to deliver the policy (via email or in person) and completely explain the policy, including differences between the illustration and issued policy, including premium requirements. Had this policy been delivered properly, [Client 3] would have been aware of the increased premium requirements from the illustration and the rating increase.
[…]A review of the client file, obtained from Mr. Nethercott's former office, identified a completed policy delivery checklist. There is no record that the policy documents were reviewed with [Client 3]. […]

[Client 3 and 4]
RE: [Client 4] – 007*** – Critical Assist – [Client 4] Document Forgery**
These policies, while not specifically mentioned in [Client 3's] statement, were discussed. [Client 3] claims that he did not apply for or want a Critical Assist policy. He explicitly states this in an email to Mr. Nethercott on April 19, 2018, […]
Critical Assist Policy *****4 – [Client 4] was issued on May 11, 2018 effective that day. […] The application was the Critical Assist Special Offer made available to [Client 4] due to her risk rating on life policy *****4 and this was included in the package sent to the agent with that policy. […] Note that the date of the signature is April 18, 2018.
[Client 3] received a collection of life insurance documents for signature in an email from Mr. Nethercott on April 19, 2018. This email and the documents included for signature […] Neither the Critical Assist application document, nor the signature portion, are included as an attachment to this email. [Client 3] denies seeing this document.
[…] It should be noted that digitized signatures are included on the application document, not pen/ink signatures. […]

RE: [Client 3] – 007*** – Critical Assist – [Client 3]**
Fictitious Policy Application Altered/Forged Document
Contrary to his wishes (and expressed via email in Attachment 6), knowledge and consent, Mr. Nethercott inquired of CLIC the requirements for issuing a Critical Assist policy on [Client 3]. […]
On May 15, 2018, an application was received by CLIC for Critical Assist policy 007***** – [Client 3] […]
[The Insurer] issued Critical Assist policy 007***** – [Client 3] on May 28, 2018. […]
Due to the underwriting requirements, [Client 3] was required to sign a Declaration of Good Health (DOGH) in order to put the policy in force. This declaration was included in the policy package sent to Mr. Nethercott on May 28, 2018. The policy documentation was not provided to [Client 3] and the DOGH was not immediately signed. As a result, the policy was placed as outstanding and not put into force. […]
In his statement, [Client 3] mentions a phone call where Mr. Nethercott told him that a Declaration of Good Health was required to be completed for policy ********4 in order to reduce premiums. In fact, this document was not required and this policy was already in force. […]
[Client 3] promptly returned the signed DOGH to Mr. Nethercott as an email attachment in an email dated July 17, 2018. In addition to his signature, [Client 3] had included the policy number "*********4" on the form as being the only life related policy that he was aware that he owned. […]

On July 19, 2018, Mr. Nethercott emailed the signed DOGH to CLIC. See Attachment 8 for this email and the document. Noteworthy about this document was that Mr. Nethercott had altered it by adding the policy number 007***** above [Client 3's] addition of policy number ********4.
[…] Mr. Nethercott then altered the document provided to him by the client to suit his needs and provided this false policy document to [the Insurer]. [The Insurer], believing that this document represented the true and expressed the wishes [sic] of the policyowner, placed the policy in force. During this entire time, the client was unaware of the existence of this policy.

Holding Out as an Agent for [the Insurer]
[…] During the period from July 19, 2018 to August 27, 2018, numerous clients contacted the [redacted location] and [redacted location] [the Insurer] agencies mentioning that they had contacted Mr. Nethercott or that he had contacted them.
[…] At no time was [Client 3] informed by Mr. Nethercott that he was not working for [the Insurer] any longer. […]
[SW], the Office Manager for the [location redacted] and [location redacted] [Insurer] Agencies provided a statement documenting her experiences with clients who were unaware that Mr. Nethercott was not employed by [the Insurer] […]
In summary, Mr. Nethercott was holding out as an insurance agent during the period July 19, 2018 to August 27, 2018, when he was not licensed to do so. These actions included providing product advice and claiming to act on behalf of [the Insurer] when he was unable to do so.

Additional Information:
It should be noted that during this investigation, a number of other instances relating to client complaints of premium discrepancies and potentially undelivered life insurance policies were identified. These instances are currently under review by agency staff and such details have not been included in this investigation due to time constraints.
It was also identified that Mr. Nethercott would routinely apply unauthorized discounts to policies in order to reduce the premium requirement. These discounts were typically not available to the client (such as Hybrid Vehicle discount for a non-hybrid vehicle) and would not have been applied for under typical circumstances. These discounts, as applied were used contrary to Company policy and would not have been available to the clients affected. These instances are currently being reviewed and any premium changes are being discussed with clients by agency staff.

Conclusion:
Based upon the above and the statements and documentation included in the attachments […]

- Mr. Nethercott made payments for client policies using his own credit cards, contrary to [the Insurer] policy;
- Mr. Nethercott submitted cheques in payment of premium for policies that were not his own;
- The cheques were written in such a way as to misrepresent the payee of the cheque and intended to deceive [the Insurer];
- Mr. Nethercott intentionally misrepresented premium requirements to clients on at least two life insurance policies (********* – [Client 1] and *******4 – [Client 3]);
- Mr. Nethercott failed to deliver and explain the premium requirements on, at minimum, these two life insurance policies;
- Mr. Nethercott submitted forged insurance applications on at least two occasions (007***** – [Client 4] and 007***** – [Client 3]);
- These applications were submitted without the knowledge of the clients and the required documents and signatures were obtained using trickery and deceit;
- These clients made premium payments on the insurance policies, issued in good faith by [the Insurer], without their knowledge or consent; and
- Mr. Nethercott continued to act as an insurance agent, contrary to licensing and employment, during the period of July 25, 2018 to August 23, 2018, when he was not licensed to do so.

On October 29, 2018, the AIC asked the Agent to respond to the allegations against him, and to and provide a chronology of events relating to the alleged activity. In an email dated November 9, 2018, the Agent responded:

> […] **Chronology leading up to Termination:**
> I was hired in February 2016 [...] I was rushed through training that did not include […], auto or home insurance training […] I was given 1 week of life training, 1 day of commercial training, a correspondence course from Home and farm insurance […]
>
> In May 2018, I believe, I was asked to come to the district office to review an audit of my personal lines policies that I had written. The audit showed that I had provided discounts and or deviation for personal lines that clients were not entitled to, not rated drivers or vehicle properly for the auto policies. I agreed on a course of action with Management to correct these issues […] I was also asked to improve my note taking […] and was given some training by the district coordinator […]
>
> […] in June we had a follow up meeting and it appeared that I had complied with all of the requirements as set out by management […]
>
> In July 2018 […] At that meeting, I was let go […] Management advised I was being let go without cause, that I would be paid severance in lieu […] Finally I asked why I was being terminated. They said it was an issue of trust and reputation, and that they were just exercising the right under my employment contract to terminate me […] I asked ha their being any complaints or other issues that I was not aware of related to clients, and they said no. Specifically, the District Manager said they did not expect any complaints since the clients were charged less then they should have been. The DM specifically said it was a really terrible situation, because I had made a small error and she regretted that I couldn't continue, but that her hands were tied.
>
> Over my time […], a large amount of discretion for deviation, applying discounts and management of customers was provided to the "Agents". For example most gents have substantial deviations on premiums across personal lines, Commercial and Farm lines which were used at their sole discretions, so I was fairly confused about the concerns from district about discounts and deviation.
>
> […]**Client Complaints:**
> […] I specifically asked at the time of my termination if it was related to any client complaints, and was told it was not, and that none had been filed that related to my termination. […] I do understand that [the Insurer] was very concerned about my solicitation of clients, and has spent significant time seeking to prevent clients leaving or contacting me. As noted, I have not been soliciting clients, but because I was not provided a company mobile phone, many clients contact me through my personal phone which was provided on my cards and other company communications, Several clients 3 months after my termination stated that I was still shown on the company website as their "agent" and contacted me as a result.
>
> **Misrepresentation, Rebating, Signatures:**
> Whilst at [the Insurer], I followed the best practices related to provision of binding sales of insurance products as provided by the company. With the exception of misquoting of personal lines polices […] I did not have an incidents of client or company concerns or complaints about sale practices. […] it was typical for independent [the Insurer] Agencies to "pay" premium balances, fees and other costs […]

In response to the Agent's version of events and the Investigation Report of the Insurer, the AIC contacted Client 1 to recount her interactions and experiences with the Agent.

Client 1

In an email dated January 10, 2019, Client 1 confirmed that she had engaged the Agent to obtain life insurance in August 2017. The Agent provided several insurance quotes by way of telephone. At the time, Client 1 advised the Agent that she was unable to afford the insurance rates as quoted. Further discussions were held, and various avenues explored until the Agent allegedly found a more suitable rate of $160-$170 per month. Client 1 consented to that amount. The life insurance application of Client 1 was written on August 10, 2017 with the initial monthly premium

noted as $242.19. Client 1 provided a cheque to the Agent in the amount of $163.00 on August 11, 2017 in accordance with what she believed had been secured as a policy payment. However, Client 1 discovered that $377.55 was being drawn from her account.

> […] In August, 2017 I took out a life insurance policy for $80,000 that I was quoted a premium of between $160 to $170 monthly. I did not realize or was ever informed my premium had been changed to $377.55. I have not seen the Application Amendment dated October 26, 2017 as shown to me by Peter Brand. I did not sign the signature portion of the Amendment dated November 10, 2017. The amended policy was never explained to me. […]

Client 1 provided supporting emails dated February 6, 2019, which enclosed several texts messages between Client 1 and the Agent, detailing their interactions regarding what she believed to be an overcharge of insurance payments:

> [iMessage] January 16, 2018
> [Client 1] Hi Sean. They took out too much again.
> [Agent] I'll look into it […]
>
> [Email] May 25, 2018
> [Client 1] Hi Sean, I hope you're doing well. The life insurance company took too much out in payment again and the trailer insurance was supposed to be taken off when I took semi off policy[…]
> [Agent] I'll take care of it [Client 1].
>
> [iMessage] July 20 [2018]
> [Client 1] Hi Sean. Life insurance took way more again. […]
> [Agent] I'll see and call you
> [Client 1] That's great Sean. I know this is a pain but it's well over a $1000 now I could really use it back right now […]
> [Agent] I understand
>
> [iMessage] July 21, [2018]
> [Client 1] Hi Sean the life insurance took an extra amount again Sorry
> [Agent] I'll get on it once I get back to the office sorry

Client 2

On November 21, 2018 and January 11, 2019, the AIC contacted Client 2 regarding his interactions with the Agent and response to the Investigation Report of the Insurer. To date, no response was received from Client 2. However, of note in the Investigation Report were receipts evidencing transactions from Client 2's credit card, as well as email correspondence between Client 2 and the Insurer inquiring as to those mistaken charges.

In an email dated September 12, 2018 Client 2 states:

> I'm sad to hear that Sean is no longer working with [the Insurer]. I believe Sean resolved the unauthorized charges by applying them to my home policy and I paid the remaining balance.

Client 2 verifies that the overcharges were remedied by the Agent by applying the erroneous charges towards his existing insurance products.

Client 3 and Client 4

On January 14, 2019, the AIC contacted Client 3 to obtain his version of the events, and to receive materials to support his claims. Client 3 provided the following statement:

> […] I would also like to state that at no time during my engagement with Sean, did we meet face to face to sign any physical/printed documents. Whilst most of our discussions happened via email, some of it was carried out via phone or text messages.
>
> **Regarding policy #*********
> […] He then sent me 'Retailers Package Policy Declaration' document […] The premium quoted on the document was $1,293. […]

I contacted Sean a few days after for an update and was told the policy was already in effect. I then asked for an "Confirmation of insurance" for the landlord so that I could cancel the existing insurance for the same business. I received that from Sean in a follow up email. The contents of this insurance confirmation were in line with our discussions, so I went ahead and cancelled the previous insurance. However, some time after I received a 'Certificate of Insurance' from [the Insurer], stating my premium to be $1994. On March 24, 2018, I sent an email with a photograph of the document to Sean at his [the Insurer] email address, raising my concerns about the increased premiums, but was told the company made a mistake and that he will take care of it. […]I also requested him for a meeting to deliver to me official copies of all my policies, terms, coverages, withdrawal schedules, source of funds etc. He agreed to meet with me on March 29, 2018. […]
he was late and said he forgot to bring the package but can pull up some of the information on his laptop. We exchanged details on the payments made to date and their allocations to the various policies issued for us. He promised to send me the other requested details in a follow up meeting, which never happened either.

I then received in the mail a "Payment Schedule" document from [the Insurer], stating that my premium for this policy had been changed to $98.67 per month and that I have 5 remaining payments for the current policy year. […] Subsequently, during Aug I contacted […] office […]. At that time, I was informed that the premium on this policy was not $1293 but was actually higher.

[…] Considering the gross inconsistencies in the communications from Sean and my understanding of our coverages, [SW] suggested that we meet to discuss my existing policies in detail. […] at that meeting I was informed, that the last adjustments made to this policy, that resulted in the new $98.67 premium payment, had actually reduced my coverage and altered other terms and compared to the original quotation and subsequent discussions with Sean. This was done without my knowledge or consent.

The reduced policy coverages that he had put in place […] put us at significant risk in the event of a claim and it is possible that we would not have been able to replace essential equipment, leasehold improvements, etc for us to continue operations after such an event.

[…]**Regarding policy ********** for [redacted] Ltd. Errors & Omissions policy**
[…] Sean asked me to confirm if I only required to add E&O policy or privacy breach as well. During a subsequent phone conversation, I had confirmed that I need the equal or greater E&O and CGL coverage as listed in the document that I had already provided a few times. […]

After another phone conversation, I sent him an email […] on June 28, 2018, again highlighting the required insurance and specifically requesting him to clarify which terms from the request are covered and which are not covered under the policy quotation he had provided. Although Sean responded to the email, saying he will look into it, I never received an answer for the query.

[…] I was told that the E&O would be listed under the detailed terms of the full policy document and that I should wait for the policy documents to arrive in regular mail.

Regarding Policy ******** Life Insurance for [Client 3] and [Client 4]**
[…] I had requested Sean for quotations on a few different options for Life Insurance […] On Feb 9, 2018 Sean sent me an email with the different quotations. None of these quotations included the Critical Assist add-on or a reference to the Disability Waiver option. During a follow up phone conversation, I had then confirmed to Sean that we would be interested in the […] policy option. He then ordered medical examinations for both me and my wife [Client 4]. […]

In an email dated March 9, 2018, I had informed Sean about the medicals and also required him to inform me once the underwriting was completed. Then around March 19 Sean asked me for a VIOD check to get the policy in effect. I then provided him the check in an email dated March 19, 2018 and once again asked for a confirmation on the premiums. I did not receive a response on that email.

On April 16, 2018 I saw a withdrawal from my bank account in the amount of $498.51[…] I sent him an email the same day trying to figure out what the payment was for. He initially suggested it was for the life

> insurance. I reminded him again that the life policy should have been around $102. He responded back saying it was for the business insurance (a separate policy) and that they had withdrawn 2 months upfront, a requirement for commercial policies.
> […]He got back to me suggesting that this was for the life insurance and that the premium was higher because 'they' had added the disability option as well. […] I am now finding that the Disability Waiver is a separate add-on to the life policy and that the Critical Assist is a totally separate policy, yet it was never explained to me at that point. The document that I was asked to sign at that time, had the Life Insurance and Critical Assist acceptance package attached to the Disability Cancellation request. I sent a signed copy of this documents via email on April 19, 2018., with an additional comment in the email stating that I did not want the disability/Critical Assist policies. […]
>
> During early Jul, during one of our follow up phone conversations, Sean notified me that [the Insurer] required me to sign the Good Health Declaration form in order to reduce the life insurance policy premiums to an amount in line with the original quote. I signed and returned this document on Jul 17, 2018. However, to date, that has not resulted in any change to the premiums. […]
>
> I was also notified […] that in addition to the life insurance policy, me and my wife still had two active Critical Assist policies that we weren't aware of and had never wanted, which had resulted in additional premium payments since inception.
>
> **Sean was representing [the Insurer] till about a month after leaving**
> […] On or around Aug 20, 2018 I finally decided to reach out for help from the local […] branch […] To my shock, I was told that Sean was no longer working with [the Insurer] and that I should talk to someone at the Strathmore branch, who would have access to my files. It was at this time, that I got in touch with [SW], who informed me that Sean had indeed left the company around July 19, 2018.[…]
>
> Further, on Aug 7, 2018, I sent him [the Agent] my bank details for switching the auto insurance policy for [Client 3] Business Analytics. Had I known he was no longer at [the Insurer], I would not have shared this confidential information with him. On August 8, 2018 I received a response from Sean stating that he will make the bank account changes. Now, I am really uncertain as to how he could have done that, since he was no longer working at [the Insurer]. […]

On September 20, 2018, Client 3 provided the Insurer with email correspondence and several text messages between himself and the Agent:

> [Cell phone message] August 13, [2018]
> [Agent] Refund 167.55 life and 141.69 comm I'll call you about the e&o payment
> [Client 3] According to the data I have life should be 337 and company should have been 296. So we are still off […] Please send the payment allocations up to now for me to check against my numbers. Thanks
> [Agent] Ok I'll look again
> [Client 3] And please sent it today. Thanks

Additional emails exchanged between Client 3 and the Agent in August 2018 were also provided:

> Email August 16,2018
> [Client 3] Hello Sean
>
> > We are planning a trip to the US in a couple of weeks and wanted to confirm what our coverage is there. We were thinking to be in Idaho, Washington and maybe Oregon […]
>
> Email August 17,2018
> [Agent] Yes just not into Mexico the continental us if fine.

Turning to the issue of unlicensed activity, the Insurer's Investigation Report included two staff member accounts of interactions with the Agent. In a statement dated September 14, 2018 the Office Manager, [SW], of the Insurer states:

> […] After Sean's termination, it was fairly common to receive phone calls from clients who were upset about premiums or coverages. Many of these clients expressed surprise when told that Sean was no longer working with [the Insurer], and some said they had been in contact with him recently and he had not told them that he was not with the company […]
> She advised me that she has called and messaged Sean several times and he had not informed her that he is not with [the Insurer], he assured her that everything was being taken care of. She had been in contact with Sean prior to his departure about coverage for jewelry, and advised that she had provided Sean with a copy of the appraisal. I apologized that there was no record of the document in our system and requested that she provide a new copy to keep on file. She stated that the appraisal was still in her safety deposit box and would be troublesome to get another copy of- requested I contact Sean to ask for a copy. I declined due to the fact Sean was no longer an employee. Later that day I received an email copy from Sean of the appraisal in question. […]

In furtherance of the Officer Manager's Statement regarding unlicensed activity an employee, [AF], of the Insurer submitted a statement dated September 14, 2018, which states:

> […] I worked with Sean Nethercott since 2016. During this time Sean issued multiple policies incorrectly and provided incorrect advice to clients when it came to their insurance. Sean was advised on numerous occasions by co-workers, management and myself that he was incorrectly writing new business, processing policy changes and advising clients. I have noted multiple files in ECM that the client's policy was incorrect, and I would ask Sean to correct it. Sean's response was "not to worry about it, he would take care of it". I also noted this in ECM. He never corrected the policies.

The Agent expressed a desire to stay in the industry and, on August 15, 2018, the AIC received a new application for a life insurance agent certificate of authority. Under the employment history section of the online Application the Agent disclosed that he had been employed as a "*Financial Advisor*" by the Insurer from January 22, 2016 to August 10, 2018. The date of August 10, 2018 is not in alignment with the Insurer's Employment Agreement which stated *"[the Insurer] has elected to terminate your 36 month Employment Agreement […] effective July 19, 2018 […]"*

The Agent in turn provided his response to the entirety of the Report, which addressed the issue of unlicensed activity, as well as his reasoning behind his conduct, on April 5, 2019:

> […] I have worked in insurance since 1992, without any complaints or concerns under multiple Licensing bodies […]
> […] When I left [the Insurer], I was inundated with calls from clients who could not get service from the office […]
>
> In my time with [the Insurer] we dealt with a number of similar complaints to these below, and referred them to District. The solution was always to work with the client to resolve the complaint, provide compensation or write offs for fees, gift cards, retroactive changes to policies, refunds. […] When I left [the Insurer], I was inundated with calls from clients who could not get service from the office. My personal cell phone was the main point of contact for me during my time with [the Insurer], and was on my business card, email signature, even the corporate website. [the Insurer] had made a big deal that I had to use my personal cell phone […] As per my email to [the Insurer] legal, I had changed my voice mail to state I did not work there and they should call the office for service. […] The suggestion of [Insurer] was that I should change my phone number […] In fact my name was listed on their website as the Agent with my personal cell phone as a contact until at least November 2018.
>
> […] I did forward a large number of texts, emails and communications to the chestermere office and they acted upon them until this had happened, and they were told to stop accepting communications. […] Therefore, I was put into an impossible position of having my personal phone as a published contact for them, staff at the agency telling

people that they should "Call Sean" when there was a problem […] Clearly [the Insurer] are hoping to escalate even minor complaints into the AIC complaints, without bothering to address or even listen to client complaints.

The Agent extrapolated details relating to each allegation, and client, as follows:

1. [Client 1]

[…] [Client 1] refinanced her property and contacted me to add a lienholder and asked about adding some life insurance. […] Since this was to be short term insurance to cover the mortgage, she asked for the lowest cost policy available, which was a 10 year term policy. Since she was in good health it was quoted at the amount she stated in her letter. The policy was underwritten and issued at the end of the year as I recall. I do recall speaking to [Client 1] that the premium was approximately double because she stated that she smoked occasionally during the telephone interview, which had caused the premium to go up approximately double, and that this was the reason for the change in premium at some point in 2017, 2018[…] With respect to texts presented, there had been changes in a number of her premiums so she had often contacted me by text about changes[…] and I would generally respond that I would have to get back to her about it.

2. [Client 2]

During the time in question he had called me about his renewal premiums with [Insurer], which were significantly higher than previously. We sought to set up policies that were more competitive than the renewal offer provided by the company. He had provided his credit card information presumably to pay the annual premium for the personal lines policies while the changes were being made. […] I recall it taking some time to get the changes completed for him, and that was why the CC information was stored for some time, and inadvertently used for the wrong policies. […] I do not have any knowledge of the transactions mentioned, other than that [Client 2] contacted me about them before I had left [the Insurer]. I had asked one of the staff to do a trace and determine why it happened, and was resolved to his satisfaction. […] We typically processed 50 or more transactions per day by credit card over the phone and through policy centre, and there were a number of errors on a regular basis.

3. [Client 3]

We originally wrote home and auto policies for [Client 3], and then added some commercial lines and life insurance policies […] [Client 3] had a very complicated structure for his policies that required vehicles on different companies, paid by different credit cards, a number of business names, numbers and payment sources […]

The Life insurance policy in question was written and underwritten normally. […] At that time I presented the policy, reviewed the Critical assist offer that came with the policy from Head Office, and the waiver of the premium. I suggested that the critical assist was a better option than the Waiver of premium, and that [Client 3] had been rated standard not preferred as his wife had been. I asked him to seek medical advice […] For a month or so we went back and forth on the medical and benefits to get the policies they wanted issued, including whether to have DWP or CA. In the end they decided to only have Life Insurance. […] **In addition, they did sign a number of forms both by scanning and emailing, and in person for various things as per the file.** […]

[Regarding Holding Out]

I did not hold myself out as an agent, or sell or service any insurance, only passed information between clients and staff sent by text, voicemail or email (to my gmail account) […] I continue to get 2-3 calls per week about [the Insurer] even now. I have had a message on my personal phone that I don't work there since August, 2018, and have worked with other brokers since then, with a valid AIC license.

[Client 1]: I disagree with the finding that the client was not informed of the change in her policy. I specifically discussed the effect of occasional smoking on her policy with her at issue. I did seek to help her reduce her substantial total monthly insurance costs during the spring of 2018, and advise her of those changes as they happened […]

[Client 2]: [..] [Client 2] had unauthorized transactions on his card. I was contacted by him and asked that they trace the payments, and refund him ASAP. He was mainly upset at the 100% change in his premiums that we were trying to fix, and eventually moved to another insurance company as a result of the rates. There is no evidence that this was intentional. His account was refunded the amounts charged or something. The charges were applied to life insurance policies for another party, as I was dealing with both policies at the same time and must have mixed up the card numbers.

[Client 3] […] I acknowledge that there was some miscommunication with the [Client 3 and 4] about their various policies, options and payments. I had worked with him to resolve these, and asked my staff to help him after I had left.

> However, there was nothing nefarious about the communications, they did request a large number of changes throughout the time I dealt with them, and were quite knowledgeable about the insurance they were buying. […] I believe that I was clear in advising them of their options, and agreed to remove the optional coverages once they asked me to […]
>
> I do not believe that the evidence presented in any of these cases demonstrates intentional dishonesty, only honest errors made in an agency that was severely short staffed and did not have reasonable controls set up for payments, policy deliveries, etc. […] **I am not clear on how the act defines "acting as an agent" since I did not bind, change or cancel any policies, or offer advise about coverage during that time. At the time, I was told by [the Insurer] that they had only elected to end my contract early, and that they wanted me to assist in the transition and pay for career advisory Services to help me find another role. Basically, I did everything I could to fend off all request for services and complaints from clients, by forwarding them to [the Insurer], and asking them to act, to try to retain the business for them. Therefore, I reject that I acted as an agent before starting with All City. I clearly took reasonable steps to inform clients I WAS NOT WORKING THERE, OR ANYWHERE, AND THAT THEY SHOULD CALL THE OFFICE FOR SERVICE. To the contrary, [the Insurer] did not, to my knowledge, email, mail or call the clients to advise them that I was not there, that my personal cell is a personal cell phone, or make any constructive steps to resolve this situation.** […] It should not have been my sole responsibility to inform 3000+ policyholders not to call me, particularly while all documents, website and other forms of communications continued to have my name and contact information all over them for at least 3 months. Sending a letter, email or even removing me from their website would have helped tremendously in this regard.
>
> […] Misrepresentation on the license application, I do not know why I put that date on the application, I can only surmise that I included the three week notice period provided to me as part of my employment, not the date my license had been terminated. I did not know the date my licenses with [the Insurer] had been terminated exactly until I looked at it in November. I continued to be paid by [the Insurer] as an AIT until the middle of August 2018. It was not intentional, and was clearly an error in dates. […]
> **[Emphasis added by Agent]**

Discussion

1. Preliminary Matters

In arriving at their conclusion, the Council remained mindful that findings under 480(1)(a) of the Act can dramatically impact an insurance agent's ability to remain in the industry, as these subsections speak to acts of misrepresentation, fraud, deceit, untrustworthiness and dishonesty. In order to conclude that the Agent committed an offence pursuant to s.480(1)(a) of the Act, the Report before the Council must prove, on the basis of clear and cogent evidence, that it is more likely than not that the Agent committed the acts as alleged.

The intent and requirement of clear and cogent evidence is reflected in the Act. Additionally, the elements of s.480(1)(a) offences are discussed in the Decision of the Court of Queen's Bench of Alberta in *Roy v. Alberta* (*Insurance Councils Appeal Board*), 2008 ABQB 572 (hereinafter referred to as "*Roy*"). In *Roy*, the Life Insurance Council found that an Agent was guilty of an offence pursuant to s.480(1)(a) of the Act as the Agent had falsely attested to completing the required insurance related continuing education credits ("CE") to maintain his insurance license when he did not, in fact, have the required CE. At the time the Agent concurrently held a securities license and believed that the CE to maintain his securities license was applicable to his insurance agent certificates of authority. The Agent advanced the decision of the Life Insurance Council to appeal before the *Insurance Councils Appeal Board* of Alberta.

In their findings, the *Insurance Councils Appeal Board* set aside the specific findings with respect to misrepresentation, fraud, deceit and dishonesty as contemplated by s. 480(1)(a) of the Act, but upheld the conviction of untrustworthiness, as contemplated by s.480(1)(a) of the Act. The Agent appealed the Decision to the Court of Queen's Bench of Alberta on a matter of judicial review regarding the findings of untrustworthiness under s.480(1)(a) of the Act.

In his reasons for judgement, Mr. Justice Marceau reviewed the requisite test to find that an offence pursuant to s.480(1)(a) of the Act has been made, and expressed it at paragraphs 24 to 27 as follows:

> [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 set out the two step approach, namely the court or tribunal **must first decide whether objectively one or more of the disjunctive elements have been proved. 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 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).
>
> [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.**
>
> [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".**
>
> [27] Clearly the false answer was one which the Alberta Life Insurance Council could not trust as a basis for renewing the Applicant's Life Insurance Certificate of Authority. That satisfies the objective element. Just as clearly the finding that "the best that can be said of the Appellant's approach to the required statements is that he did not know if he had the required credits or not and likely gave the form little or no thought" is a finding of willful[sic] blindness, of recklessness, and that is sufficient to prove intent in this context. The Board was aware that recklessness could satisfy the intent requirement and made no error on that score. Having read the transcript of the hearing, I find that it was not unreasonable for the Appeal Board to conclude that the evidence of the Applicant about vaguely thinking that among all the courses he took he believed there would be enough crossover from courses taken for his securities licence to the life insurance requirements **fell far short of the due diligence expected of someone entrusted with fiduciary and good faith obligations.**
> [Emphasis added]

2. Evidence

Collectively, the Council is comprised of both industry and public members who are well-equipped to assess

consumer risk and industry competence. As to the allegations, the Council generally agrees with the Agent's submissions that errors do not automatically attract professional sanctions pursuant to s. 480(1)(a) of the Act. However, the Council weighed the effects of the alleged actions, the evidence presented, and the accounts of all parties involved when arriving at their conclusion.

The extensive materials, in excess of 1,000 cumulative pages, were duplicated amongst the parties' responses. In that, the following facts were agreed upon:

- The Agent's termination was dated July 19, 2018;
- Insurance related communications did exist between the Agent and his clients past the date of the Agent's termination of July 19, 2018;
- Client 2's overcharges were ultimately rectified, and a response was never received from Client 2 with respect to the AIC's investigation; and
- The level of complexity was high with respect to Client 3's various insurance products.

3. Violations of s. 480(1)(a) of the Act or, in the alternative, s. 509(1)(a) of the Act

Client 1

With regards to the alleged violation of s. 480(1)(a) of the Act, or alternatively, s. 509(1)(a) of the Act; it was apparent that Client 1 and the Agent disagreed as to the history of insurance-related meetings between the parties. On one hand, Client 1 states that she often had to engage the Agent due to lack of response, and on the other, the Agent states that Client 1's involvement in her equestrian business made it difficult to find common availability. Client 1 also took issue with signatures collected on the insurance policy amendments which she denied were her own. As the Council are not handwriting experts, they did not opine as to the authenticity of the signatures collected from Client 1.

The Council therefore turned to the evidence provided. Client 1 produced text messages wherein she expressed to the Agent that she believed an "overpayment" towards her insurance policies had occurred. An opportunity was thereby presented to the Agent to clarify the payment responsibilities and structure of the insurance to Client 1. However, the Council found that the Agent's response of "*I'll take care of it*" only stood to reinforce to the client's mistaken understanding that the payments were taken in error. Further, the communications spanned over a number of months which offered ample time for the Agent to clarify Client 1's payment obligations.

Based on the evidence the Council is of the view that the test of clear and cogent evidence has been met, and a violation of s. 480(1)(a) of the Act has occurred. Turning to the intention of the Agent; the Council found that the Agent's failure to meaningfully investigate or explain to Client 1 the charges that had been taken was deceitful in nature or, at the very least, demonstrated untrustworthiness or dishonesty as contemplated by s. 480(1)(a) of the

Act. In consideration of all of the evidence the Council concluded that the objective and subjective elements of the applicable legal test under s.480 (1)(a) of the Act have been met, and that the Agent is guilty of violating s. 480(1)(a) of the Act.

Client 2

As noted, Client 2 did not respond to the AIC's request for comment. As such the Council relied on evidence submitted by the Insurer and the responses of the Agent. Client 2's credit card was used by the Agent without his knowledge and consent to pay premiums for two unrelated clients. Client 2 confirms through the Investigation Report that on July 12, 2018 the Agent reimbursed the overcharge by offsetting the withdrawn amount against his home insurance policy. The error extended to Client 3's credit card being charged for the Agent's personal insurance policy.

The Agent retorts that the errors were merely an administrative oversight and that Insurer lacked measures to verify and audit accounting related activities within the Agency. The procedures practiced within the Agency suggest that the Agent both had the power to sell insurance products and the ability to manage payments towards those accounts.

In making their determination the Council also noted that the Agent holds a Canadian Risk Management ("CRM") designation which, while having no binding or effect on the Agent's certificates of authority or on the determinations of the Council, did speak to the Agent's sophisticated understanding of loss prevention and risk mitigation. In considering the above, the Council contemplated whether the Agent's actions fell below the expected level of expertise of an agent under similar circumstances and if those actions could be considered a misrepresentation of facts, or were dishonest, untrustworthy, deceitful or fraudulent in nature.

In consideration of the facts, the Agent's experience, and the evidence presented to the Council, the Council concludes that the Agent's conduct was untrustworthy and that there is sufficient evidence that the elements of an offence under s.480(1)(a) have been met. Therefore the Council finds the Agent guilty of dishonesty, deceit and untrustworthiness as contemplated by s.480(1)(a) of the Act.

Client 3

Client 3 owns several companies and, as aforementioned, the degree of complexity relating to his insurance products was high. Client 3 relied on the Agent to facilitate both his personal, and business insurance coverage. The Agent's business extended by Client 3 through the insurance of his wife, referred to herein as Client 4. With

respect to Critical Assist coverage, the Council concurred that it is common professional practice to offer such a product when selling life and accident and sickness insurance. However, seeking such a product requires the expressed consent of the client. Here, Clients 3 and 4 deny having consented to such an addition. Further, the Council was troubled that the Commercial Errors and Omissions policy was not properly constructed which, if undiscovered by the Insurer, would have subjected Client 3 to significant risk. Product knowledge of this level would have, or ought to have, been known by the Agent.

Client 3 also questioned the Agent regarding the Errors and Omissions and company policies and another opportunity was presented to the Agent to probe, clarify and confirm the policies were correctly in force for Client 3. Instead, Client 3's questions remained unanswered and the insufficient coverage remained.

Insurance agents work in a profession which necessitates the accurate completion of forms and insurance documents. Clients can experience severe difficulties when incorrect forms or improper policies are put into force. Therefore, it is not unreasonable to expect that a high standard of due diligence be practiced by insurance agents when soliciting insurance products. The relationship between the agent and the client is such that the client relies on the agent's expertise, competency and integrity to effect the discussed coverage. Loss, error, or lapse of such coverage exposes the clients to undue risk. Had the Insurer not investigated Client 3's coverage Client 3's companies would still remain at risk today.

In light of all the evidence, the Council is satisfied that there is sufficient, clear and cogent evidence that the requisite elements of an offence under s.480(1)(a) have been met, and that the Agent misrepresented information, was dishonest in order to deceive, and is therefore untrustworthy as contemplated by s.480(1)(a) of the Act.

The Council agrees that substantial civil penalties are warranted under the circumstances. Honesty and transparency are the hallmarks of a trustworthy agent, especially when advising and presenting services to their clients. Given the seriousness of the offences the Council orders the maximum civil penalty for each finding of guilt under s. 480(1)(a) of the Act, being 3 counts in the amount of $5,000.00 each, for a total civil penalty of $15,000.00, to be levied against the Agent pursuant to s. 480(1)(b) and 13(1)(b) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001.

Under findings of 480(1)(a) of the Act the Council also has the jurisdiction to suspend the Agent's certificates of authority for the period of up to 12 months or alternatively, to revoke the certificates of authority for the period of up to one year. Given the conduct of the Agent, the Council orders that of each finding of guilt under 480(1)(a) the Agent's certificates of authority shall be revoked for the period of one year. The 3 revocations shall be served concurrently.

4. Violations of s. 452(2)(a) and subsequently s. 480(1)(b) of the Act

The Council then turned to the alleged violation of s. 452(2)(a) of the Act that the individual acted as an insurance agent at a time when he did not hold valid certificates of authority to do so. The Agent was terminated from the Insurer on July 19, 2019 which was "*effective immediately*". The Agent states that the circumstances surrounding his termination were not made clear to him and he did not understand the termination was due to his misconduct. Further, the Agent maintains that the Insurer failed to remove his contact information from the Insurer's public website which caused clients to assume the Agent was still employed by the Insurer.

All parties evidenced communications that occurred between clients and the Agent after the date of termination of July 19, 2018. The Council observed clear opportunities for the Agent to respond to clients and advise them that he was not an employee of the Insurer. Notwithstanding the Agent's explanation, when clients contacted him beyond the date of termination the Agent's only obligation was to make clear that he was no longer licensed or able to act in the capacity of an insurance agent under the Insurer. Forwarding his clients' requests to contacts within the Insurer to enact changes to policies was an intermediate step in facilitating services for those former clients. Acting in the capacity of an insurance agent while not holding certificates of authority is prohibited by the Act. As such, the Council finds the Agent guilty of violating s. 452(2)(a) of the Act and subsequently has violated s. 480(1)(b) of the Act.

The Council has the ability to levy civil penalties in an amount not exceeding $1,000 pursuant to s.480(1)(b) of the Act and 13(1)(b) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. In the context and seriousness of the findings herein the Council orders the maximum civil penalty allowable under s. 480(1)(b) of the Act, levying a penalty of $1,000.00 against the Agent.

Under findings of 480(1)(b) the Council also has the jurisdiction to suspend the Agent's certificates of authority for a period of up to 12 months or alternatively, to revoke the certificates of authority for the period of up to one year. As such, the Council orders that the Agent's certificates of authority shall be revoked for the period of one year.

5. Violations of s. 467(1)(c) and subsequently 480(1)(b) of the Act

Finally, it is alleged that the Agent contravened s. 467(1)(c) of the Act when he failed to accurately complete the employment history section of his application for certificates of authority. In doing so, it is alleged that the Agent failed to deliver the information requested by the Minister, as contemplated by s. 467(1)(c) of the Act.

Section 467(1)(c) of the Act is considered a strict liability offence. In other words, when it is proven that the Agent gave a statement that was not correct, the essential elements of contravention of s. 467(1)(c) of the Act are proven. The onus then shifts to the Agent to prove that all reasonable steps were taken to avoid making the misstatement. In the Agent's words, the Agent realized his termination was dated July 19, 2018 retroactively after completing the applications. Based on his given statement the Agent has not demonstrated that he took steps to diligently, attentively and accurately complete his reapplications for certificates of authority. Therefore, the Council finds the Agent guilty of violating s. 467(1)(c) of the Act and subsequently s. 480(1)(b) of the Act.

In findings under s. 480(1)(b) allow the Council to levy civil penalties in an amount not exceeding $1,000.00 pursuant to s.13(1)(b) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. Given the circumstances the Council orders the maximum penalty of $1,000.00. Further, the Council has elected to exercise their authority under s. 480(1)(b) to order the revocation of the Agent's certificates of authority.

Conclusion:

The Council finds the Agent guilty of the following breaches of the Act and aforementioned Regulation:

- s. 480(1)(a) of the Act – 3 counts
- s. 452(2)(a) and subsequently s. 480(1)(b) of the Act – 1 count
- s. 467(1)(c) and subsequently s. 480(1)(b) of the Act – 1 count

and the Council has ordered the following penalties as a result of each finding of guilt:

- s. 480(1)(a) – $5,000.00 each for a total sum of $15,000.00;
- s. 452(2)(a) and subsequently s. 480(1)(b) of the Act – $1,000.00; and
- s. 467(1)(c) and subsequently s. 480(1)(b) of the Act – $1,000.00;

all of which, in their totality, amount to $17,000.00.

Under each finding the Council has ordered that the Agent's certificates of authority shall be revoked for the period of one year. Those 5 revocations shall be served concurrently, effective 30 calendar days following the mailing of this Decision to the Agent.

The civil penalties must be paid within thirty (30) days of receiving this written decision. In the event that the penalties are not paid within thirty (30) days, interest will begin to accrue at the prescribed rate. 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: July 31, 2019

[original signed by]

Michael Bibby, 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