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 made changes to a client's insurance policy without the client's knowledge or consent. Further, it is alleged that the Agent misrepresented premium amounts to his client. 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.

Facts and Evidence

This matter proceeded by way of a written Report to Council dated April 29, 2020 (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 is a former holder of 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 intermittently from April 4, 2007 to September 24, 2019.

The AIC commenced an investigation in response to correspondence received from the Agent's client, (the "Client") alleging that the Agent had modified her life insurance policy without her knowledge or consent.

On April 1, 2019, the AIC contacted the Agent for his response to the allegations, the correspondence sent to the Agent reads:

> […] We have received a complaint from [redacted] with respect to her life insurance policy, alleging that her coverages were reduced without her consent and knowledge. In order to assist in my investigation, I am writing to request the following:
>
> 1) A detailed summary of your discussion and chronology of events relating to the above complaint;
> 2) Copies of file notes and correspondence with respect to this matter;
> 3) An explanation regarding the reason you requested an amendment to [redacted] policy without her consent and knowledge. […]

In correspondence dated April 1, 2019, the Agent's former employer, [redacted] (the "Agency") provided copies of the documents issued by the Agency. (the "Insurer Documents"). The Agency advised:

> These are the real documents issued by our life department […]

Contained within the Insurer Documents was the following as it related to the Client:

(a) Financial Advisor Information Sheet dated March 15, 2018-face amount decreased to $40,000 effective March 1, 2018
(b) Policy Amendment, amendment date March 15, 2018- effective date March 1, 2018
(c) Policy Information- coverage date noted as June 01, 2017-face amount noted as $40,000, policy date noted as June 01, 2017 and an initial premium amount as $91.42
(d) Financial Advisor Information Sheet dated July 19, 2018- financial advisor noted as the Agent, withdrawals from the Client's account on August 1, 2018 for $47.28 and subsequent withdrawals for each month $69.35- face amount decreased to $30,000 effective July 1, 2018
(e) Policy Amendment, amendment date July 19, 2018- face amount decreased to $30,000 effective July 1, 2018
(f) Policy Information, policy date June 01, 2017- coverage amount $30,000, coverage date June 01, 2017 and initial premium amount as $69.35

On April 17, 2019, legal counsel for the Client provided the AIC with two written statements authored by the Client. The first statement ("Statement 1") dated April 15, 2019 reads:

> My name is [redacted] I reside at [redacted]. My cell phone number is [redacted].

This statement is freely given and concerns the documentation relating to the Insurer policy [redacted] as provided to me by Sean Nethercott and actions and statements made to me by Sean Nethercott as it relates to this policy and the documents.

The contents of this statement were discussed with [redacted], the Agency's Senior Fraud Examiner, the Agency, on April 2, 2019, over the telephone.

In May 2017, I was in Sean Nethercott's office in Strathmore. Among the things, I wished to obtain increased coverage on my life [sic]. It was determined that $50,000 of coverage would meet my needs and Sean completed an application with me for policy [redacted] with the Agency. The previous policy that I had was to be replaced with this one and I would not be required to make payments on ~~it~~ my old policy anymore.

At the time, Sean told me that the monthly premium for the new policy was $113.49 and I was comfortable with the coverage and premium amount. I paid no premium on this policy initially and made arrangements to have the monthly premium amount withdrawn directly from my bank account similar to the old policy.

At some point, after June 2017 and before December of that year, I spoke with him and asked if there was some way of reducing the premium I was paying while still keeping the $50,000 in coverage. He responded that due to the visit by the nurse, in June 2017, I qualified for a lower rate of approximately $69.00 per month. I agreed that that was acceptable, provided that the amount of the policy remained at $50,000.

In May or June, 2018, I met Sean at his office in Strathmore and he handed the documents, copies of which are included as **Attachment A** to this statement. I was told that these documents were my life insurance policy and they included a "Plan Summary" where it showed that my monthly premium was $69.71and that I had a $50,000 insurance amount. I was satisfied at that point that my insurance was correct.

Subsequent to this meeting, I was expecting the withdrawals from my account to be reduced to $69.71 but this did not happen until September 2018 when the premium amount withdrawn was $69.35. This amount has been withdrawn from my account monthly since then.

On March 29, 2019, I spoke with the [redacted] [Agency's agent] in Strathmore, Alberta on the telephone. I was calling for other reasons unrelated to my life insurance policy. At that time, I was informed that Sean Nethercott no longer worked for the Insurer and was also informed that the coverage on my life insurance policy was not $50,000 as I believed and instead it was $30,000. I was shocked and extremely concerned as I required $50,000 in coverage and thought that I had been paying premium for that amount of coverage since I took the policy.

> I told [redacted] [Agency's agent] this and informed her that I had documents obtained from Sean Nethercott confirming that I had a $50,000 policy. She said that I should take my documentation to a local agent in Lethbridge and have them sent to her.
>
> Shortly afterwards, I located the documents provided to me by Sean Nethercott and took them to [redacted]. [Agency's agent] in Lethbridge. He took copies of the documents and returned my originals.
>
> On April 2, 2019, [Agency's Senior Fraud Examiner] called me and we spoke about the documents and my life insurance policy. At that time, I agreed to provide a statement. [Agency's Senior Fraud Examiner] informed me that he would create one for my review.
>
> I have not been provided any incentive or inducement in exchange for providing this statement. The statement was created by [Agency's Senior Fraud Examiner], but I have reviewed it and agree that its contents are accurate to the best of my recollection.

Attached to this Statement 1 were policy documents related to the same policy at issue.

The Council found the following documents and information of importance:

(a) Policy Information- policy date June 01, 2017- face amount $50,000, coverage date June 01, 2017 and initial premium amount as $113.49
(b) Application Amendment-policy effective date June 01, 2017- date of application for amendment: May 19, 2017
(c) Financial Advisor Information Sheet dated March 15, 2018-monthly premium amount being $69.35
(d) Plan Summary -monthly premium amount being $69.71, base insurance amount being $50,000

The Client provided a further statement ("Statement 2") dated April 15, 2019 which reads:

> My name is [redacted]. I reside at [redacted]. My cell phone number is [redacted].
>
> This statement is freely given and concerns the signatures on the Application for Policy Change documents relating to the Agency's policy [redacted].
>
> I have reviewed the signature on the Application for Policy Change documents dated February 18, 2018. It appears that the date has been changed from December 17, 2017 to February 18, 2018. I have never seen this document prior to April 5, 2019 and I did not ever sign the Application for Policy change document.

> I have reviewed the signature on the Application for Policy Change document dated June 18, 2018. It appears that the date has been changed from June 18, 2017 to June 18, 2018. I have never seen this document prior to April 5, 2019 and I did not ever sign the Application for Policy Change document.
>
> Copies of the above documents that I have reviewed have been attached to this statement and have been initialled [sic] by me for the purposes of inclusion in this statement.
>
> I have been offered no inducements or incentives for providing this statement.

Attached to Statement 2 were two applications for policy change documents as it relates to the Client. The Council found the following information of importance:

(a) Application for Policy Change of Individual Insurance- face amount decreased to $40,000. Date signed- unclear.
(b) Application for Policy Change on Individual Insurance- date signed by the Agent being June 18, 2018- face amount decreased to $30,000.

The position taken by the Client is that she neither saw nor signed off on any of the above two documents.

On April 23, 2019, the AIC received correspondence from the Agent, the Agent responded:

> RFI:
>
> I do not have any files, documents or notes related to this client, they would all be with the Insurer.
>
> It has been more than a year so I do not have a good recollection of the events requested. I will only discuss what I recall having happened. I did not have a lot of interaction with [redacted], so I have limited information about her concerns.
>
> [Redacted] came to see me about getting some life insurance. […] As I recall the policy was eventually issued after a fairly long underwriting process for a face amount of 40 or 50 thousand. She came to the office and saw me to take delivery of the policy, […] she came to see me some time later, saying that the premium was too high. I told her that the rate was the rate that had come from underwriting, and that was the premium. She asked if we could reduce the rate, and I said I would ask underwriting if there was anything they could do.
>
> There was nothing we could do to reduce the premium as she was rated standard. I told her that we would have to reduce the face amount to get the premium she said she wanted. I provided her with a quote for the reduced amount, and she

> signed the change form. The policy with the reduced amount was issued some time later, […] I do not recall the amounts involved or dates of the policy or any changes now.
> […]

On July 21, 2020 the Agent confirmed additional documents that he wished to be included within his Addendum. These documents stemmed over 150 pages and formed a part of his Addendum. Included within these documents is correspondence from the Agent dated May 11, 2020, which reads:

> […] **I take full responsibility of any miscommunication with [redacted], as I was clearly not providing the service that she required.** I cannot comment further on the documents or what [redacted] understood, as the policy was issued with a premium of $113, and it was only when we reduced the face amount did that change […]. **[emphasis added].**

Discussion

A finding under s. 480(1)(a) of the *Insurance Act* can have a long-lasting effect on those found guilty. Here, and in all cases of s. 480(1)(a) allegations, the Council applies stringent tests to weigh the evidence provided. Such evidence is assessed on s balance of probabilities. Accordingly, 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 act(s) 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 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). [Emphasis added]
>
> [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.** [Emphasis added]
>
> [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]
>
> [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 wilful[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]

Collectively, the Council is comprised of both industry and public members who are well-equipped to assess consumer risk and industry competence. The Council weighed the effects of the alleged actions, the evidence presented, and the accounts of all parties involved when arriving at their conclusion.

Insurance agents work in a profession which necessitates the accurate completion of forms and insurance documents. Clients can experience severe difficulties when 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 affect the discussed coverage. Loss, error, or lapse of such coverage exposes

the clients to undue risk. Had the Client in this matter not reached out to the Insurer and had the Insurer not investigated the Client's coverage, the Client and the Client's family would still remain at risk today.

In light of all the evidence, in particular, the Insurer Documents provided to the AIC directly from the Agency differ substantially when compared to the documents that the Agent provided the Client. 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's conduct was intentional, dishonest, or untrustworthy as contemplated by s. 480(1)(a) of the Act.

As the Council are not an authority on the authenticity of handwriting, they did not opine in this regard.

The Council agrees that a substantial civil penalty is warranted under the circumstances as honesty and transparency are the hallmarks of a trustworthy agent, especially when advising and presenting services to their clients. Given the seriousness of the offence the Council orders that a civil penalty in the amount of $5,000.00 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.

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: September 18, 2020

[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