ALBERTA INSURANCE COUNCIL
(the "AIC")

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

And

In the Matter of Sean Ronson Nethercott
(the "Agent")

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

This case involves an alleged violation of s. 480(1)(a) of the Insurance Act or, in the alternative, s. 509(1) of the Insurance Act. Specifically, that the Agent made changes to a client's insurance policies and personal information without the client's knowledge or consent. In so doing, it is alleged that the client's insurance policies lapsed due to non-payment, due to the Agent's dishonest, deceitful, fraudulent or untrustworthy conduct as contemplated by s.480(1)(a) of the Insurance Act. In the alternative, it is alleged that the Agent made false or misleading statements as contemplated by s. 509(1)(a) of the Insurance Act, and, in so doing, that the Agent subsequently violated s. 480(1)(b) of the Insurance Act.

Facts and Evidence

This matter proceeded by way of a written Report to Council dated October 30, 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 an addendum which was considered by the Council.

The Agent is the former holder of certificates of authority which authorized him to act in the capacity of a life and accident and sickness ("A&S") insurance agent. The Agent held both certificates of authority intermittently between the period of April 4, 2007 to September 24, 2019.

This matter commenced in response to a complaint received from the Agent's former client, (the "Client") on August 14, 2019 (the "Compliant"). The Complaint alleged that fluctuations in his life insurance premium amounts, his wife's premium amount, and his daughter's policy details prompted the Client to review his policy details. On August 14, 2019 the Client advised;

> I contacted [the Agent] about this and he assured me it would be checked into and straightened out.

> So, my premiums on Life Insurance amount to $139.55 monthly from January 1, 2018 and I was assured by [the Agent] that this paid for all three of our Policies. […]
> The $139.55 only pays premiums for my Wife's Policies is what I found out yesterday.
> My Daughter's premiums are deducted from the accumulated Value of her Policy.
> My coverage is lapsed. I AM NOT INSURED AT ALL.
> [Emphasis provided in source document]

In response to the Complaint, the AIC Investigator contacted the Insurer to ascertain the details of each insurance policy. On December 12, 2019 the Sr. Distribution Services & Market Conduct Manager of the Insurer provided a system entry regarding the Client's Complaint to the Insurer;

> August 2019: Client contacted new advisor, he was furious yesterday and confused so I don't even know exactly what happened [… He wanted $50,000 permanent insurance. […] He said after he talked to Sean several times to get it sorted out, he was then told that his payment was $139 for all policies.

Insurer's Sr. Distribution Services & Market Conduct Manager commented that;

> From what we can speculate, Mr. Nethercott kept [redacted][Client's wife's] policy active as that was the amount [of premium], we believe he gave to [redacted][Client] as the withdrawal amount.
>
> [Daughter's][redacted] policy – Mr. Nethercott emailed our internal life billing department to change the client to annual billing, so that the $27 monthly payment was no longer coming out. It also appears that Mr. Nethercott changed their mailing address in our internal system so they would not get the notices. This policy stayed active as the premium payments came out of the cash value of the policy.
>
> [Client][redacted] policies – all lapsed, as they were changed to annual billing as well. Address was changed so they did not get any notices. [Client][redacted] was unaware.

In response to the AIC's request for information, the Insurer's Sr. Distribution Services & Market Conduct Manager corresponded with the AIC between the period of December 2019 and July 30, 2020 and provided information relating to the Insurer's internal investigation, which included all correspondence between the Agent, the Insurer and the Client. Through July 30, 2020 to August 14, 2020 the Insurer's Sr. Fraud Examiner provided all policy documentation, applications, change requests and relevant documents related to the Client and his policies.

The Insurer's Sr. Fraud Examiner provided copies of the following documentation;

Documentation regarding the Daughter's Policy;

- Life Insurance Policy bearing the number ****174, issued July 16, 2005, owned by the Client which insured the Client's Daughter (the "Daughter's Policy");
- Correspondence dated October 24, 2017 between the Agent and the Insurer's billing department, wherein the Agent asked that the billing statements on the Daughter's Policy be changed to semi-annual;
- Insurer's response dated October 26, 2017 advising that semi-annual billing was not available on the Daughter's Policy type. Agent accepted that the billing be amended to annual statements;
- Email correspondence dated June 28, 2018, between the Client and the Agent regarding the Daughter's Policy stating that the Client received a billing notice despite "*paying monthly premiums already on this policy";*

- Correspondence reverting the Daughter's Policy to monthly billing by an unrelated Insurance representative with the notation that *"the previous advisor removed it and should not have".*

Documentation regarding the Wife's Policy:

- Life Insurance Policy bearing the number ****784, issued July 16, 2017, owned by the Client which insured the Client's Wife, with a premium amount of $139.55 (the "Wife's Policy"); and
- Correspondence dated January 3, 2018 between the Agent and the Insurer's billing department, wherein the Agent asked that the billing statements on the Wife's Policy be changed to annual.

Documentation regarding the Client's Policies:

- Life Insurance Policy bearing the number ****052, issued May 16, 2017, owned by the Client insuring the Client (the "Client's Policy 1");
- "Change Request" regarding Client's Policy 1, dated January 3, 2018 completed by the Agent which amended the policy details to annual billing;
- Returned payment notification relating to Client's Policy 1, dated April 3, 2018 sent to an erroneous physical mailing address which was not the Client's;
- Life Insurance Policy Lapse Notice, dated May 16, 2018, relating to the returned payment on the Client's Policy 1, sent to an erroneous physical mailing address which was not the Client's;
- Life Insurance Policy, bearing the number ****798, issued July 16, 2017, owned by the Client, insuring the Client (the "Client's Policy 2");
- "Change Request" dated January 3, 2018 regarding Client's Policy 2, completed by the Agent which amended Client Policy 2 to annual billing;
- Returned Payment Notification dated April 13, 2018, regarding Client's Policy 2, sent to an erroneous physical mailing address which was not the Client's; and
- Life Insurance Policy Lapse Notice, dated May 16, 2018, relating to the returned payment on the Client's Policy 2, sent to an erroneous physical mailing address which was not the Client's.

The Insurer's Sr. Fraud Examiner also provided copies of email correspondence between the Client and the Agent, as follows;

- Email correspondence sent between the period of June 29, 2018 and June 30, 2018, wherein the Client expresses his concern of having received the Life Insurance Policy Lapse Notice with respect to Client Policy 2. The Agent advises *"sorry you should not receive any more notices I have put the up policy back on mpp and I think we are good going forward"*

- Email correspondence sent between the period of October 25, 2017, and January 25, 2018. In this email chain the Client advised;

> The Life Insurance Premium withdrawals debited from my account have been twice to triple per month from August through September and into October. The amounts have fluctuated.
> So I am wondering why this is occurring.[sic]
>
> | | |
> |---|---|
> | August 18 | $223.52 |
> | August 28 | $233.56 |
> | September 05 | $214.38 |
> | September 18 | $140.76 |
> | September 28 | $139.56 |
> | October 05 | $107.19 |
> | October 16 | $140.76 |
>
> […]

On January 25, 2018, the Agent responded, *"Hi [Client][redacted] I took a mother [sic] look today and the Billings are as they should be - for all the trouble with this we will get you a 50 dollar Canadian tire gift card tomorrow."*

- Email correspondence from the Client to the Agent dated February 13, 2018, wherein the Client stated;

> The [Insurer][redacted] sent another Bill for that Policy [redacted][Client Policy 2].
> Again they request payment of $626.69.
> When is this going to be straightened out?
> I am not impressed by the Accounting Staff at the [Insurer][redacted]. […]

To which the Agent responded *"I'll look into it tomorrow and call you I understood it was all resolved that may have been a problem from before the corrections last month but I'll let you know."*

- Email correspondence dated June 4, 2018 and June 5, 2018 wherein the Client stated; *"Had a message on my cell phone from the [Insurer][redacted] saying my mail has been returned as going to the wrong address. How can that be? It has been the same for 22 years."* The Agent and Client exchange emails and it is confirmed that the Client's address is incorrect. In response, the Agent stated, *"Your address is showing [redacted], something was returned a while back, it may have been mis-delivered by Canada post , as nothing else came back, ill have it resent."*

To gather further information and in light of the significant material submitted by the Insurer, the AIC Investigator emailed the Client on September 15, 2020 to corroborate the Insurer's information. On September 15, 2020, the Client responded and confirmed that his mailing address as recorded by the Agent was incorrect. The Client confirmed that he did however, receive mail regarding Client Policy 2 to his correct mailing address but that the Agent *"re-assured me the bill was just an annual statement but that I was paying monthly premiums on this policy"*.

On September 16, 2020, the AIC Investigator provided the Agent with a formal request that the Agent provide his version of events in relation to various allegations made by the Client. As no response was the AIC Investigator served a formal Demand for information pursuant to s. 481(2) of the Insurance Act (the "Demand"). The Demand provided a deadline of response of October 2, 2020.

The Agent partially responded to the Demand on October 7, 2020 by way of email correspondence, and advised, *"I don't remember much about this guy as it was 3 years ago but I'll respond to you by next week".* On October 20, 2020, the Agent corresponded with the AIC investigator via email and provided;

> […] [Client] asked about some life Insurance his family had. When we checked out the term policy his was due to expire in the next year or so, and no one had reviewed it in 20 years. They decided to convert some of it for last expenses, but since the wife was out of town much of the time, we ended up with two of the same policy for [Client][redacted] and none of the policies were joint as the term policy had been. I think that's what the refund was for, and the gift card for the mistakes made in [redacted]. I really don't remember anything further about this client.

In response to the entirety of the Report, the Agent emailed the AIC investigator on May 20, 2020;

> Please see attached response. As noted, please provide the original submission from June 2019 with this response, as this is only an addendum, and I really have nothing further to add. Further, Please send the response from the council by email, I fully consent to receiving all correspondence from the council by regular mail and email, and have no intention of contesting any of these decisions as was outlined to [Director of Legal and Regulatory Affairs at the AIC], so please send it via email and regular mail as the most efficient way to reach me. Thank you.

Discussion

The Council is cognizant that findings under s. 480(1)(a) of the *Insurance Act* can have long-lasting effects on those found guilty. The Council therefore applies stringent tests to weigh evidenced produced in Reports to Council, such as in this case, and all matters before Accordingly, in order to conclude that the Agent committed a violation 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 act(s) as alleged.

The elements of a violation of s.480(1)(a) of the Insurance Act 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 violating to s. 480(1)(a) of the Insurance Act. In Roy the agent falsely attested to completing the required continuing education credits ("CE") necessary to maintain his insurance certificates of authority when he did not, in fact, have the required CE. The Agent concurrently held a securities license and believed that the CE required to maintain his securities license was applicable to his CE as an insurance agent.

The Agent appealed the Decision of the Life Insurance Council to the *Insurance Councils Appeal Board* of Alberta. In their findings, the *Insurance Councils Appeal Board* set aside finding with respect to misrepresentation, fraud, deceit and dishonesty as contemplated by s. 480(1)(a) of the Insurance 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.

In his reasons for judgement, Mr. Justice Marceau reviewed the requisite test to find that a violation of s.480(1)(a) of the Insurance Act has been made, and expressed that reasoning 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]
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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.** [Emphasis added]
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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]
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> [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]

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 Council assessed the likelihood of the offence being committed, as alleged, based on the balance of probabilities. That being, was it more likely than not that the Agent committed the acts as alleged.

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 or not maintained, as is the case here. Due to the insurance industries high level of accountability, and an insurance agent's fiduciary duty to its' client, the Council found that it is not unreasonable to expect a high standard of due diligence be practiced by insurance agents when maintaining 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.

Negligence which causes loss, error, or lapse of such coverage, such as in this case, exposes the clients to undue risk. The Client's family was operating under significant risk as it was discovered that the Client's coverage had lapsed, leaving him unknowingly uninsured. Had the Client not researched the matter of his own inclination, his family could have shouldered a significant financial burden had the Client required coverage under Client Policy 1 and/or Client Policy 2.

In light of all the evidence, in particular, the Insurer's internal investigation, the Council is satisfied that there is sufficient, clear and cogent evidence that the requisite elements of a s. 480(1)(a) Insurance Act violation have been met and that the Agent's conduct was negligent, reckless, deceitful dishonest, or untrustworthy as contemplated by s. 480(1)(a) of the Insurance Act.

The Council agrees that a substantial civil penalty is warranted under the circumstances and reiterates that honesty and transparency are the hallmarks of a trustworthy insurance agent. Given the seriousness of the breach, the Council orders that a civil penalty in the amount of $5,000.00 be levied for each violation of s. 480(1)(a) of the Insurance Act, for a total civil penalty in the amount of $15,000.00, pursuant to the authority granted to the Council and in accordance with s. 13 of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001, Given that the Agent is not presently licensed, the Council had no ability to suspend or revoke his certificates of authority.

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: December 30, 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