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 Sasha Butts
(the "Agent")

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

This case involved an allegation made pursuant to s. 480(1)(a) and, in the alternative, s. 509(1)(a) of the Act. Specifically, it is alleged that the Agent submitted a signed application for a life insurance policy when the insured was in the Intensive Care Unit with a brain injury and all insurability questions were answered "no". In so doing, it is alleged that the Agent is guilty of misrepresentation, fraud, deceit, untrustworthiness, or dishonesty as set out in s. 480(1)(a) of the Act. In the alternative, it is alleged that the Agent made false or misleading statements or representations or advertisements in violation of 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 the Council dated February 27, 2024 (the "Report"). The Report was forwarded to the Agent to review and provide further evidence or submissions to support her position.

The Agent currently holds Life and Accident and Sickness ("A&S") certificates of authority and has held these certificates continuously since May 18, 2021.

On May 18, 2023, the AIC received a Life Agent Reporting Form ("LARF"), from [I.A.I.A.F.S.I.] [redacted] (hereinafter the "Complainant"). The LARF provided the following:

Life Agent Reporting Form Date: 2023-05-18
Agent Name: Sasha Butts
Life Insurance and/or A&S Agent's License Number: […] Province/Territory: Alberta

Evidence that suggests: (refer to Guideline G8 Appendix 1 for explanation)

[…]	☐ Inducements ☐ Licensing Violation	☐ Product – Client Suitability ☐ Replacements

	☐ Misappropriation of Client Funds ▪ Misrepresentation to Company ☐ Misrepresentation/Disclosure ☐ Money Laundering/Terrorist Financing ☐ Premium Rebating ☐ Privacy or Confidentiality	☐ Tied Selling ☐ Trafficking In Insurance ▪ Trustworthiness ☐ Twisting ☐ Undue Influence ☐ Other Signature Discrepancies

Agent contract has been terminated: ▪ Yes

[…]
[Emphasis added in original document]

On June 19, 2023, the Complainant provided the following information to the AIC investigator:

[…]
Please find enclosed herewith the following documents:

- Copy of the investigation file – [redacted]
- Documents relating to contract – 986-[redacted];
- Copy of the claim file – [redacted]

As per the termination letter, the explanation provided by the agent are directly contradicted by the evidence on the client's file, furthermore, the documents provided by the agent were insufficient.
[…]

The Complainant's investigation file contained the following information:

1. A request for information letter to the Agent, dated April 25, 2023 (hereinafter the "Request for Information"),
2. An email from the Agent, dated May 2, 2023, providing the Agent's version of events (hereinafter the "Agent's Version"),
3. The Complainant's Application – Simplified Issue Products (P2) and Client Notes (hereinafter the "Application"),
4. Termination Letter to the Agent dated May 12, 2023 (hereinafter the "Termination Letter"), and
5. A letter from the Complainant to the beneficiary of the Policy, dated January 5, 2023 (hereinafter the "Reassessment Letter").

The Request for Information stated, in part:

[…]
We have initiated a market conduct investigation into your business practice following the receipt of a reporting related to an application that you carried out for the above-mentioned client.

I. SUMMARY OF EVENTS

On October 11th, 2022, you completed an application for an Access Life product, a simplified issue product, with the above-mentioned client as the insured and [redacted] as the policyholder.

On the application, all the insurability questions were answered by "No". [Redacted], the policyholder, was also indicated as the [in-law] [redacted] (hereinafter the "Policyholder") of the insured and was designated as beneficiary.

On October 11th, 2022, the policy was issued with the following features:

Contract n˚986-[redacted]	
Policyholder	[redacted]
Insured	[redacted]
Coverage	Access Life – Immediate Plus Whole Life Insurance [redacted]
Monthly Premium	[redacted]

On [date] [redacted], the insured passed away.

On October 31st, 2022, you completed the *Death Claim Declaration* with the policyholder and beneficiary [the Policyholder] [redacted] and transmitted it to [the Complainant] [redacted].

On November 6th, 2022, to analyze the death claim received, [the Complainant] [redacted] requested the documents below:

- Death Authorization to provide personal information to third parties form […]
- Attending physician's statement form [redacted] signed by the family physician.
- Confidential information disclosure form for the Provincial health insurance.
- Last will and testament (copy).
- Statutory declaration – If unable to provide the last will and testament.
- Name of the family physician of the insured between 2017 and 2022.

All these documents were provided to [the Complainant] [redacted] in the month of November 2022.

On December 14th, 2022, the death claim file was transferred to [the Complainant's] [redacted] department responsible of post-underwriting. They concluded that four questions in the application from October 11th, 2022, were inaccurately answered and that if this this information was known, [the Complainant] [redacted] would have declined to issue the Access Life product.

On January 5th, 2023, based on the reassessment of the insured's eligibility and the life insurance application submitted, [the Complainant] [redacted] sent their final decision to the claimant, stating that they could not consider the claim, since the application would not have been accepted initially.

II. [The Complainant's] [redacted] INQUIRIES

For us to move forward with our investigation, we are asking you to answer the following questions:

1. How were you introduced to the policyholder and insured?

2. At the initial meeting, when you gathered the information regarding the policyholder and insured, who was present?

3. Where and when did you meet with the insured and policyholder to complete the application?

4. Why did the policyholder need a life insurance on the insured's life? How did you ensure that there was a need for insurance?

5. Why did you recommend an Access Life product to the clients?

6. What means were used for the policyholder and insured to sign the application?

7. Who was present when the application was signed? Where and when was the application signed?

8. Were you made aware by the policyholder and/or the insured of any current medical issues that the insured might have?

9. Please provide your complete client file for this contract, including all of the documentation that was completed.

[…]
[Emphasis added in original document]

The Agent's Version stated, in part:

[The Complainant] [redacted] correspondence – Contract no# 986-[redacted]

1. How were you introduced to the policyholder and insured?
   We were connected on social media through networking. [The Policyholder] [redacted] had reached out to me.

2. At the initial meeting, when you gathered the information regarding the policyholder and insured, who was present?
   [The Policyholder] [redacted] was present at this time, as [the Policyholder] [redacted] was inquiring for coverage on behalf of [the Policyholder's] [redacted] [in-law] [redacted]. [The Insured] [redacted] was introduced after.

3. Where and when did you meet with the insured and policyholder to complete the application?
   October 11 2022 we met virtually.

4. Why did the policyholder need a life insurance on the insured's life? How did you ensure that there was a need for insurance?
   Policyholder was concerned about insurance coverage due to the insureds outstanding mortgage and debt.
   Due to this outstanding debt and payments, the need for life insurance was present.

5. Why did you recommend an Access Life product to the clients?
   Due to insureds age, and diabetes, they were searching for a non medical option.

6. What means were used for the policyholder and insured to sign the application?
   Electronically via text as per Assure and go platform.

7. Who was present when the application was signed? Where and when was the application signed?
   [Redacted] were present, application was signed electronically and virtually on October 11th 2022

8. Were you made aware by the policyholder and/or insured of any current medical issues that the insured might have?
   I was made aware that the insured had COVID twice in the past, which incurred hospitalization but had no serious implications.
   I was also aware that the client had diabetes and was advised It was medically controlled.

The Application provided, in part:

CLIENT NOTES Date of Meeting: OCTOBER 11 2022

[…]
INSURANCE

Product / Company Sold:

[…]

Explained Surrender Charges ☑

Notes
DISCUSSED NEEDS FOR ELDER [Insured] [redacted] FOR NON MEDICAL COVERAGE THAT IS SIMPLIFIED ISSUE.
WENT OVER COVERAGES TOGETHER, DUE TO DIABETES NON MEDICAL WAS OF MORE VALUE.
WENT THROUGH HEALTH QUESTIONS TOGETHER. […]

1 ELIGIBILITY – ACCESS LIFE

Summary of your answers to eligibility questionnaire, step 1 to 3.

STEP 1 – DEFERRED
Maximum $100,000 – Whole life protection only. Death benefit deferred for 2 years.

1 – In your lifetime, have you been diagnosed and/or treated for any of the following conditions:

a. […] **[…]**

b. Heart rhythm disorder (arrhythmias) which required the insertion of a pacemaker, heart failure or cardiomyopathy? **No**

c. […] **[…]**

4- Are you presently:

a. Hospitalized or in a nursing facility including a centre or a home for individuals with reduced autonomy? **No**

b. […] **[…]**

STEP 2 – DEFERRED PLUS
Maximum $350,000 – Whole life and/or term protection. Death benefits deferred for 2 years.

1- […]

2- Within the last five (5) years:

a. […]

b. Have you had or been treated for a chronic kidney disease or a chronic liver disease (including cirrhosis, fibrosis, hepatitis C or any other types of chronic hepatitis)? **No**

c. […]

4- Within the last twelve (12) months:
a. […]

b. […]

c. If you have diabetes, has your medication changed as advised by a physician (addition or replacement of a medication, increase or decrease of dosage)? **No**

[…]
[Emphasis added in original document]

The Termination Letter stated, in part:

> […]
> [The Complainant] [redacted] initiated a market conduct investigation following the receipt of a reporting involving your activities as an insurance advisor [sic]
>
> We have completed our review and wish to inform you of the outcome of our investigation.
>
> **1. Reporting**
>
> It was reported to [the Complainant] [redacted] that four questions were answered inaccurately on the application of October 11th, 2022, for the insured [redacted]. Consequently, the insured passed away [date] [redacted]. As part of the investigation, we reviewed the evidence on file and identified several irregularities.
>
> **2. ADVISOR'S VERSION**
>
> On April 25, 2023, we sent you a request for information asking for your explanations. A chronology of the events was included as well.
>
> You were given a reasonable delay to respond to our concerns and provide evidence in support of your version. On May 2, 2023, you submitted your Version of Events to [the Complainant] [redacted].
>
> Below is a summary of our understanding of your position as per the information that you have transmitted:
>
> - [Redacted], the policyholder, reached out to you through social media.
> - At the initial meeting, [the Policyholder] [redacted] was present and was inquiring for coverage on behalf of [the Policyholder's] [redacted] [in law] [redacted]. The insured, [redacted], was introduced later.
> - You met virtually with the policyholder and insured on October 11th, 2022.
> - The policyholder inquired about insurance because [the Policyholder] [redacted] was concerned due to the insured's outstanding mortgage and debt.
> - You recommended an Access Life considering the insureds age and [the Insured's] [redacted] diabetes. You mention that the policyholder and insured were searching for a nonmedical option.
> - The application was signed electronically via text as per Assure and go platform.
> - [Redacted] were present when the application was signed electronically and virtually on October 11th, 2022.
> - You were made aware that the insured had COVID twice in the past, which incurred hospitalization. However, according to you, there were no serious implications.
> - Furthermore, you were also aware that the client had diabetes, but was advised that it was medically controlled.
>
> **3. OBSERVATIONS**
>
> We do not retain your explanation related to the fact that you met with the insured on October 11th, 2022, and were not aware of any serious health conditions. The evidence on file directly contradicts these statements from your Version of Events. It is your duty as an advisor to provide every fact that is material to the insurance when you submit a life insurance application to an insurer, as per the obligation present in article 652(1) and (2) of the *Alberta Insurance Act:*
>
> > **"Disclosure of material facts**
> > **652(1)** An applicant for insurance and a person whose life is to be insured must each disclose to the insurer in the application, on a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within the applicant's or person's knowledge that is material to the insurance and is not so disclosed by the other.
> >
> > **(2)** Subject to section 653 and subsection (3), a failure to disclose, or a misrepresentation of, a fact referred to in subsection (1) renders the contract voidable by the insurer."

Furthermore, the documents provided in support of your Version of Events on May 2, 2023, were insufficient to justify the suitability of the sale completed. Multiple requirements were missing from the client file submitted, notably the Financial Needs Analysis and the Reason Why Letter. Additionally, signature discrepancies were identified in the same documentation that you transmitted.

4. CONCLUSION AND MEASURE(S)

Considering the foregoing, [the Complainant] [redacted] has taken the decision to terminate your advisor code effective as of the date of this correspondence. […]
[Emphasis added in original document]

The Reassessment Letter provided, in part:

[…]
While reviewing the claim the eligibility of the insurance application for [the Insured] [redacted] was reassessed.

About the insurance policy
When there is a death less than two years from the date the policy comes into force, the declarations made on the insurance application are confirmed before the claim can be considered.

Policy no. 986-[redacted]
The insurance application for was signed on October 11, 2022. Information was provided at the various steps of the process. Based on this information, the insurance policy came into force on October 11, 2022.

The medical record obtained during the claim process showed that [the Insured] [redacted] has been followed for congestive heart failure which requires multiple hospitalizations since 2017. It was also brought to our attention that [the Insured] [redacted] has been diagnosed with chronic kidney disease prior to the date upon which the policy was issued.

The insured was living with poorly controlled diabetes and [the Insured's] [redacted] treatment had changed numerous times over the past 12 months prior to October 2022. […]

Finally, at the time the insurance application was signed, the insured was hospitalized in the ICU (intensive care unit) since October 3, 2022 following a cardiac arrest.

This information should have been declared. However, in the declarations made on the insurance application signed on October 11, 2022, a negative answer was given for the following questions:

STEP 1 – DEFERRED
1. In your lifetime, have you been diagnosed and/or treated for any of the following conditions:
b. Heart rhythm disorder (arrhythmias) which required the insertion of a pacemaker, heart failure, or cardiomyopathy?

4- Are you presently:
a. Hospitalized or in a nursing facility including a centre or a home for individuals with reduced autonomy?

STEP 2 – DEFERRED PLUS
2- Within the last five (5) years:
b. Have you had or been treated for a chronic kidney disease or a chronic liver disease (including cirrhosis, fibrosis, hepatitis C or any other types of chronic hepatitis)?

4- Within the last twelve (12) months:
c. If you have diabetes, has your medication changed as advised by a physician (addition or replacement of a medication, increase or decrease of a dosage)?

Decision
The insurance application was reassessed. Based on this new information, this application would not have been accepted. Under the circumstances, we cannot consider the claim. The insurance policy has been cancelled.

> […]
> [Emphasis added in original document]

On September 10, 2023, the Agent provided the AIC investigator with the following explanation (hereinafter the "2023 Explanation"):

> […]
> On October 10, 2022 I was contact [sic] through social media by [the Policyholder] [redacted].
>
> [The Policyholder] [redacted] reached out to me because [the Policyholder] [redacted] was looking for a non-medical life insurance coverage on [the Policyholder's] [redacted] [in law] [redacted]. [The Policyholder] [redacted] advised me that [the Insured] [redacted] had an outstanding mortgage [amount] [redacted] and also some other debt that [the Policyholder] [redacted] wanted to try and cover in case of an emergency. [The Policyholder] [redacted] had also advised me that [the Insured] [redacted] had diabetes and that was why [the Policyholder] [redacted] was looking for a non-medical option.
>
> I looked into Assure and go for coverage, and gave [the Policyholder] [redacted] some coverage availabilities based on [the Insured's] [redacted] current age, […]. [The Policyholder] [redacted] wanted to try and get [the Insured] [redacted] coverage for as much was possible.
>
> I advised to [the Policyholder] [redacted], that I needed to go through the health questions with [the Insured] [redacted], for the application, [the Policyholder] [redacted] said okay, and I emailed [the Policyholder] [redacted] an illustration.
>
> The following day, on October 11 2022 [the Policyholder] [redacted] contacted me in the late morning, [the Policyholder] [redacted] wanted to proceed with the coverage. I knew that the premium was quite high and I confirmed that [the Policyholder] [redacted] realized the cost of this insurance was high.
>
> [The Policyholder] [redacted] confirmed that. I asked that we have a zoom call with both [the Policyholder] [redacted] and [the Insured] [redacted], [the Policyholder] [redacted] advised me that [the Insured] [redacted] does not speak English but that [the Policyholder] [redacted] can translate to [the Insured] [redacted] and will give answers on [the Insured's] [redacted] behalf. When we had our video call, there was an older [individual] [redacted] in the background that I was under the impression was [the Insured] [redacted]. [The Policyholder] [redacted] had brought up a concern, as [the Insured] [redacted] had contracted COVID 19 twice, which [the Policyholder] [redacted] had told me did not have any health impact but [the Policyholder] [redacted] seemed very concerned about the coverage being applicable if client had covid. There were no health questions that had asked about contraction of COVID19, so I confirmed with [the Policyholder] [redacted] that as long as the health questions stipulated were able to be answered 'no' then there should be no concern.
>
> After [the Policyholder] [redacted] confirmed questions with whom I thought was [the Insured] [redacted] we went forward with the application.
>
> I had an uneasy feeling after completing the application with the client, something hadn't felt right, but I tried to do my due diligence to ensure I was covering all necessary items.
>
> As it turned out, the client may have taken advantage of myself as an advisor, as I had recently found out that [the Insured] [redacted] was potentially hospitalized at time of application.
> I, in no means, had any bad intentions in regards to this application, I was mislead [sic] and given incorrect information – I have learned a lot from this event.
> […]

On September 19, 2023, the AIC investigator interviewed the Agent and produced a transcript. The transcript provided in part:

> […]
> **AIC Investigator**
> Ok, perfect. So now going into this particular case. Walk me through actually. What happened? Where did you meet [the Policyholder] [redacted]?

Respondent
[…] So I had gone through a [Marketing Specialist] [redacted] who did marketing, OK, [the Marketing Specialist] [redacted] did some leads through social media because I was just starting out and I wanted to just kind of getaway to get my name out there. I used [the Marketing Specialist] [redacted] as [the Marketing Specialist's] [redacted] service. So [the Policyholder] [redacted] was one of those. Leads. OK. And so I had reached out to [the Policyholder] [redacted] in regards to what [the Policyholder] [redacted] was looking for and [the Policyholder] [redacted] looked, [the Policyholder] [redacted] told me [the Policyholder] [redacted] was looking for a non medical insurance for [the Policyholder's] [redacted] [in law] [redacted] because [the in law] [redacted] had an outstanding mortgage [amount] [redacted]. And [the Insured] [redacted] was [the Insured] [redacted] just had a little bit of debt and you wanted to see what kind? Of coverage [the Insured] [redacted]. Could get, but [the Insured] [redacted] was [age] [redacted]. And so that's why [the Policyholder] [redacted] wanted a non-medical. [The Insured] [redacted] had diabetes. […]. And yeah, so I had given [the Policyholder] [redacted] the Max coverage price because [the Policyholder] [redacted] wanted to pretty much know [the Policyholder's] [redacted] Max. That could be covered for a [age] [redacted] with a non medical. And so I gave [the Policyholder] [redacted] the pricing on that. It was very high. […] It was very expensive. And so and you know and so I told them that and then we got off the phone it was. After that that [the Policyholder] [redacted] reached out to me the next day, [the Policyholder] [redacted] said. [The Policyholder] [redacted] wanted to put it in force. And and so I said, OK, Are you sure like this is a very large premium, right? And and so we ended up getting on a zoom call. I was aware that [the Policyholder] [redacted] was, I thought [the Policyholder] [redacted] was with [the Insured] [redacted]. Now [the Policyholder] [redacted] told me [the Insured] [redacted] didn't speak any English. And so [the Policyholder] [redacted] was going to translate it. I had sent [the Policyholder] [redacted] the application. So I'd actually screenshot. All the questions so that [the Policyholder] [redacted] could read them along with me so that we were there and I had never met [the Insured] [redacted] in person. And then and I know I had made it an incorrect issue with the signing because that was the first time I'd ever had somebody different own a policy than the insured. And so there was an error there and I'm aware of that. And and now I know how to how to properly do it because we did a test one and and yeah. And [the Policyholder] [redacted] turned out that [the Policyholder] [redacted] had that, the person that I was talking to or that [the Policyholder] [redacted] was translating to wasn't even [the Insured] [redacted]. Apparently [the Insured] [redacted] was in the hospital. And I wasn't aware of. This at all. I feel like [the Policyholder] [redacted] took advantage of me. And I I can't do anything. But you know, I didn't mean to misrepresent any information. I thought that, you know, [the Policyholder] [redacted] was translating properly. I I don't know. I don't speak…hmmm…

[…]
AIC Investigator
For the name actually, like…

Respondent
So it was. I didn't know and. And then, of course, there was the error and then I should have double checked and I did have a weird feeling in the pit of my stomach. I know that now I know to trust my gut.

AIC Investigator
Exactly. What? What? Stop you like to like to trust your gut, like you said?

Respondent
I can't. I can't say what made me kind of trust my gut instinct. I'm not sure. I like I might I I will be honest. You know, like there's a large Commission that comes along with a large premium like that. Maybe I was a little blindsided by that, that I am new. I'm not. It definitely did. Was not my intention. But but yeah, I made that mistake.

AIC Investigator
Now, at any point, do you ask for like ID?

Respondent
I had seen [the individual's] [redacted] ID.

AIC Investigator
And [the individual] [redacted] was the same person?

Respondent
well, it looked like it. Yeah, it was. It was an ID from India or hmmm.
[…]

AIC Investigator
At anytime did you ask to, like, talk to [the Policyholder's] [redacted] [spouse] [redacted] like because [the spouse] [redacted] will be the [child] [redacted] of.

Respondent
[The Spouse] [redacted] would have been the [child] [redacted]. Yeah, no. I did not. OK, I I definitely I made an. Error in judgment, and I understand that.
[…]

AIC Investigator
Yeah, but again, like are you like? Allowing yourself like to trust your gut feeling because my question will be like. What stopped you to ask? Actually, your mentor. That like you, because you said, well, like have, like, the gut feeling. I mean, what stop you like I actually to double check on.

Respondent
No, I had. I had called [the mentor] [redacted] and [the mentor] [redacted] was like, as long as [the Insured] [redacted] gets through the health questions, you know, and and the I non medical there's only so many health questions together. They're not that hard. And as long as [the Insured] [redacted] was you know good and [the Insured] [redacted] hadn't changed [the Insured's][redacted] medication and. And then [the Policyholder] [redacted] was [the Policyholder] [redacted] brought up this concern about COVID, [the Policyholder] [redacted] said, well, [the Insured's] [redacted] had COVID twice. And. And you know what that could do to somebody? And and [the Policyholder] [redacted] was very. And that's really what kind of was weird because [the Policyholder] [redacted] was so concerned about COVID. But I was like, there's no questions about COVID, [Policyholder] [redacted]. I. I you know. I as long as you don't have any issues with the questions that they're being asked. Then you know. Then you can still get this insurance, right?
[…]

AIC Investigator
Like you settle the policy, and then like 10 days later, this [Insured] [redacted] dies.

Respondent
Yeah, and [the Policyholder] [redacted] didn't even contact me until about 8 weeks or 4 weeks later because that death claim didn't go in until about a month after [the Insured] [redacted] passed. Away. About like I can't remember the exact dates. But it was definitely a large gap in between where [the Policyholder] [redacted] had called me, and [the Policyholder] [redacted] didn't seem sad. [The Policyholder] [redacted] didn't seem upset, [the Policyholder] [redacted] it just seemed like it was like expected to happen. And then yeah.
[…]

AIC Investigator
Do you? Like, did you ask for a copy of the ID just to keep it on file or like just the fact that they show it through zoom. That was good. Enough. You just the number, yeah.

Respondent
I just used it through zoom. Yeah, OK, it's supposed to document the numbers.

AIC Investigator
Just the numbers. OK. And these were like? Pakistani documents so it wasn't even like Canadian.

Respondent
yeah, like wasn't Canadian.

AIC Investigator
OK.
AIC Investigator
So like you don't even know what they show you technically.

Respondent
Yeah…

AIC Investigator
[…]. So, is there anything that I should know?

Respondent
Not really, I just. I mean, I just want you to know that I'm I'm. I was not trying to trying to take advantage of anyone at all. I definitely have no link to this [Policyholder] [redacted]. And and anything like that. And I've stopped doing leads. I've completely stopped with that. I've just gone through referral system because I just can trust people more that way. […]

Respondent
[…] I mean it really every the whole transaction with [the Policyholder] [redacted] it happened very quickly. It was like 2 day process and that was. And then [the Policyholder] [redacted] called me the. Next day, talking about. COVID and [the Policyholder] [redacted] was concerned about [the Insured] [redacted] having past COVID. That was it. And so. And I know I made a mistake. I know there was errors on my end. I know that.

AIC Investigator
OK. So and then like [the Policyholder] [redacted] signed you submit this [Insured] [redacted], poor [Insured] [redacted]. [The Insured] [redacted] passed 10 days later and then you haven't heard from [the Policyholder] [redacted] like…

Respondent
Yeah. Like so, like, cause I think I submitted the death claim, like, right away. Once I heard from [the Policyholder] [redacted]. So there you should be able to find where the delay was in death to submit because I don't think I have [the Insured] [redacted] November. I don't think I sent it in till November and [the Insured] [redacted] passed away in October.

AIC Investigator
Yeah. Like it was, like, 10 days after [the Insured's] [redacted] birthday?

Respondent
Yeah, Yeah, like it was very shortly after that application went through.
[…]
[Sic throughout for grammar]
[Emphasis added in original document]

Discussion

In order for the Council to conclude that an agent has committed an offence pursuant to s. 480(1)(a) of the Act, the Report must prove, on the basis of clear and cogent evidence, that it is more likely than not that the Agent committed the act as alleged. The Council is cognizant that findings of guilt under s. 480(1)(a) of the Act can dramatically impact an insurance agent's ability to remain in the industry. Therefore, the Council carefully weighs all evidence before it prior to reaching its' decision.

The applicable legal test to determine the Agent's guilt in violating s. 480(1)(a) of the Act is set out in the Court of Queen's Bench decision, *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 violated s. 480(1)(a) of the Act by attesting to completing the required continuing education hours when he did not, in fact, complete the required continuing education hours. The *Insurance Councils Appeal Board* also found the agent guilty on appeal. The agent advanced the decision to the Court of Queen's Bench of Alberta.

In his reasons for judgment dismissing the appeal, Mr. Justice Marceau wrote as follows at paragraphs 24 to 26:

> [24] The *Long* case, albeit a charge under the Criminal Code of Canada where the onus of proof is beyond a reasonable doubt (not on a preponderance of evidence as in this case), correctly sets out the two step approach, namely the court or tribunal **must first decide whether objectively one or more of the disjunctive elements have been proven. If so, the tribunal should then consider whether the mental element required has been proved**. While the Appeal Board said it was applying the *Long* decision, it did not make a finding as to whether step 1 had been proved with respect to each of the disjunctive elements. Rather it immediately went into a step 2 analysis and found that the mental element required for untrustworthiness might be less than the mental element required for fraud (as a given example).
>
> [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)

The Decision of the *Insurance Council's Appeal Board* (of Alberta) was subsequently upheld, its' findings confirmed, and the agent was found guilty of an offence pursuant to s. 480(1)(a) of the Act.

The evidence in these types of cases is based on the concept of *"clear and cogent"* evidence. In *The Matter of the Appeal of Arney Falconer*, Chairperson Hopkins dealt with this principal of clear and cogent evidence and provided as follows:

> The Life Insurance Council stated in the Decision that there is a requirement "for 'clear and cogent evidence' because our findings can dramatically impact an insurance agent's ability to remain in the industry". However, the requirement for clear and cogent evidence does not mean that the evidence is to be scrutinized any differently than it should be in any other civil case. **In all civil cases evidence must be sufficiently clear, convincing and cogent to satisfy the balance of probabilities**. In *F.H. v. McDougall* 20008 SCC) [sic]; [2008] 3 S.C.R. 41 the Supreme Court of Canada States:
>
> > [45] To suggest that depending upon the seriousness, the evidence in the civil case must be scrutinized with greater care implies that in less serious cases the evidence need not be scrutinized with such care. I think it is inappropriate to say that there are legally recognized different levels of scrutiny of the evidence depending upon the seriousness of the case. There is only one legal rule and that is that in all cases, evidence must be scrutinized with care by the trial judge.

> [46] Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge that the plaintiff satisfied the balance of probabilities test.
>
> [Emphasis added]

Contraventions of s. 480(1)(a) of the Act are *mens rea* offences that require proof of intent, knowledge, or recklessness on a balance of probabilities. Section 480(1)(a) of the Act reads:

> If the Minister is satisfied that the holder or a former holder of a certificate of authority has been guilty of misrepresentation, fraud, deceit, untrustworthiness or dishonesty, […]
>
> the Minister may revoke, suspend or refuse to renew or reinstate one or more of the certificates of authority held by the holder, impose terms and conditions provided for in the regulations on one or more of the certificates of authority held by the holder and impose a penalty on the holder or former holder.

The Report alleged that the Agent was guilty of fraud, deceit, dishonesty, untrustworthiness and/or misrepresentation as contemplated by s. 480(1)(a) of the Act when the Agent recklessly submitted a signed application for a life insurance policy when the insured was in the Intensive Care Unit and all insurability questions on the application were answered "no".

The Council was concerned by the lack of due diligence conducted by the Agent throughout the insurance application process. The lack of due diligence was highlighted in the 2023 Explanation and the AIC interview transcript.

The 2023 Explanation provided there was a lack of due diligence prior to a zoom call with the Policyholder, *"I asked that we have a zoom call with both [the Policyholder] [redacted] and [the Insured] [redacted], [the Policyholder] [redacted] advised me that [the Insured] [redacted] does not speak English but that [the Policyholder] [redacted] can translate to [the Insured] [redacted] and will give answers on [the Insured's] [redacted] behalf."* The Council is of the view that the Agent failed, in her role as an insurance agent, to ensure that the Insured understood the questions on the insurance application and that the answers being provided by the Policyholder where accurate to the responses provided by the Insured, as there was a language barrier present between the Agent and the Insured.

During the Agent's interview with the AIC, the Agent admitted the following:

> **Respondent**
> […] Now [the Policyholder] [redacted] told me [the Insured] [redacted] didn't speak any English. And so [the Policyholder] [redacted] was going to translate it. […] And [the Policyholder] [redacted] and it turned out that [the

Policyholder] [redacted] had that, the person that I was talking to or that [the Policyholder] [redacted] was translating to wasn't even [the Insured] [redacted]. […]

AIC Investigator
Now, at any point, do you ask for like ID?

Respondent
I had seen [the individual's] [redacted] ID.

AIC Investigator
And [the individual] [redacted] was the same person?

Respondent
well, it looked like it. Yeah, it was. It was an ID from India or hmmm. […]

AIC Investigator
[…] Like, did you ask for a copy of the ID just to keep it on file or like just the fact that they show it through zoom. That was good. Enough. You just the number, yeah.

Respondent
I just used it through zoom, yeah, OK, it's supposed to document the numbers.

AIC Investigator
Just the numbers. OK. And these were like? Pakistani document so it wasn't even like Canadian.

Respondent
yeah, like wasn't Canadian.

AIC Investigator
OK.

AIC Investigator
So like you don't even know what they show you technically.

Respondent
Yeah…
[…]

The Council is of the view that the Agent did not take appropriate steps to verify the identity of the individual present with the Policyholder during the October 11, 2022, zoom meeting.

Insurance agents work in a profession which necessitates the accurate completion of forms and insurance documents by the insured. Insurers rely on the honesty and due diligence of insurance intermediaries, such as brokerages, agents, and agencies, to complete forms and insurance applications accurately. If there was no responsibility on the insurance intermediary to ensure accuracy of information, then the insurer would presumably be assuming risk on which it had no basis of information, as is the case here. Therefore, it is not unreasonable to expect a high standard of due diligence to be practiced by insurance intermediaries when soliciting and finalizing insurance documents.

In light of the lack of due diligence conducted by the Agent, as outlined in the evidence, the objective and subjective elements of the applicable legal test under s. 480(1)(a) of the Act are met. As such, the Council finds that the Agent is guilty of misrepresentation pursuant to s. 480(1)(a) of the Act, as the Agent recklessly submitted a signed application for life insurance when the Insured was hospitalized and all insurability questions were answered "no". As a result of this finding, it is unnecessary for the Council to consider the alternative alleged offence pursuant to s. 509(1)(a) of the Act.

In terms of the available sanction, the Council may impose a civil penalty for a violation of s. 480(1)(a) of the Act not exceeding $5,000.00, pursuant to s. 36.1(1)(a) of the *Insurance Agents and Adjusters Regulation*, AR 122/2001. Given the evidence that the Agent has no previous discipline, fully engaged with the AIC, acknowledged guilt, was genuinely remorseful, took voluntarily active steps including undertaking relevant continuing education courses, and given the exceptional circumstances in this case, the Council orders that a civil penalty in the amount of $500.00 be levied against the Agent.

The civil penalty of $500.00 must be paid within thirty (30) days of receiving this notice. In the event that the penalty is not paid within thirty (30) days, interest will begin to accrue at the prescribed rate. 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: April 24, 2024

[Original Signed By]

Andy Freeman, 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.

Contact Information and Useful Links for Appeal:

Email: tbf.insurance@gov.ab.ca
Phone: 780-643-2237
Fax: 780-420-0752
Toll-free in Alberta: Dial 310-0000, then the number
Mailing Address: 402 Terrace Building, 9515 – 107 Street Edmonton, AB T5K 2C3
Link: Bulletins, notices, enforcement activities | Alberta.ca – *Interpretation Bulletin 02-2021 – Submitting Notices of Appeal of Insurance Council Decisions*