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 Mital Joshi
(the "Agent")

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

This matter involves an alleged violation of s. 480(1)(a) of the Act. It is specifically alleged that the Agent initiated one (1) critical illness insurance application which included falsified client addresses, phone numbers and banking information. As such, it is alleged that the Agent acted contrary to s. 480(1)(a) of the Act and is guilty of fraud, deceit, dishonesty, untrustworthiness, and/or misrepresentation.

Facts and Evidence

The matter proceeded to Council by way of a written Report to Council dated April 8, 2024 (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. In arriving at their conclusion, the Council carefully weighed all evidence presented.

The Agent held an Accident and Sickness (A&S) certificate of authority from July 29, 2021, to October 19, 2021.

The AIC commenced an investigation in response to information received in the course of an investigation to the conduct of another agent.

On January 14, 2022, the AIC investigator received an email dated November 30, 2021 (the "November 30, 2021 Email"), from the [W.F.G.I.A.C.I.] [redacted] (hereinafter the "Former Agency"). The November 30, 2021 Email stated:

> […]
> Below is an summary [sic] of the findings that were provided to the Agent Conduct Committee.

> The Advisors knowingly used false addresses and phone numbers on applications for Proposed Insureds, which each Advisor should have realized was not permitted.
>
> A review of the books of business for these [redacted] Advisors noted that there were multiple applications submitted where their office address or Mital Joshi's home address were stated as the Proposed Insured's home address. Additionally, there were phone numbers that were used across multiple applications for Proposed Insureds who did not appear related to each other or living at the same addresses.
>
> For many of these Proposed Insureds, a new application would be submitted for them around the time their previous policy would lapse. Invalid banking information was provided on the new applications. [The Insurer] [redacted] advised that when they would reach out to the Advisors regarding the banking information on these applications, they would not receive a response from them.
>
> Mital Joshi explained, "Some of the clients work more than one job, and they may not pick up their phones. So, I entered my phone number. Some of the clients were thinking to sell their home, so I entered my address". Regarding the bank account issues, she stated, "Some of the clients might have changed their banking information, and some of the clients were thinking to cancel their policy".
> […]

On February 7, 2024, the AIC investigator received the following information from [F.F./C.P.P.] [redacted] (hereinafter the "Insurer"):

1. Email between employees of the Insurer, undated (hereinafter the "Insurer Email"),
2. Email between employees of the Insurer, dated October 6, 2021 (hereinafter the "October 6, 2021 Email"),
3. Email from the Insurer to the Agent, dated November 3, 2021 (hereinafter the "November 3, 2021 Email"),
4. Email from the Agent to the Insurer, dated November 5, 2021 (hereinafter the "November 5, 2021 Email"), and
5. Timeline of events from the Insurer, undated (hereinafter the "Timeline").

The Insurer Email stated:

> […]
> Following our discussion yesterday, I have attached the spreadsheets with our findings for applications submitted by [the Former Agency] [redacted] advisors […]:
>
> As you will notice from the reports:
>
> 1. Out of 424 policies that were settled, 172 policies are either in Overdue/Lapsed/Not Proceeded With/NOT TAKEN status (i.e. Billing Status 4/7/8)
>   a. Of those 172 policies, we collected ZERO premiums on 86 cases.
>   b. Recently, we've experienced the initial premiums being returned by the bank as Invalid Banking Information, and when we would reach out to [not legible] receive any response back.
>   c. Instead we noticed a new application would be submitted for the same client around the time of the previous policy being lapsed [not legible].
>
> 2. Applications for multiple clients are being submitted with the same phone number and/or address:
>   a. The spreadsheet attached "**Copy of WF*** [redacted] business summary with address**

2.xlsx" has examples of cases where either the phone number or [not legible] same for multiple clients.

b. […]

3. In connection with the point above, one of the addresses being used is the WF*** [redacted] office address *as indicated above*.
    a. We've received 14 policies (for different clients) with the Insured/Policy Owner address listed as [Former Agency Address] [redacted].

[…]
[Emphasis added in original document]

The October 6, 2021 Email stated:

[…] note below pretty well sums up what we know about the cases and where we are at with respect to holding business that has already been submit

I just want to add a few more points:

1. I have circled in [the Former Agency] [redacted] Compliance today and they confirm that [redacted] agents (Mital and [redacted]) had already been suspended […].
2. All [redacted] agents have had their E-Access suspended as of Monday Oct 4th.
3. We have 18 (or so) policies […] that has been submitted but not issued […]
4. The upline of all these agents has been made aware of some of the issues and is actively trying to get some of the pending lapse cases back on track
5. Some of the issues with multiple inactive cases on same clients, and multiple clients at same address may have been flagged by BQR […]

The November 3, 2021 Email stated:

[…]
We are reaching out to you today regarding 11 applications which were submitted by you and [redacted], using your home add[not legible] insureds. These Proposed Insureds don't appear to be related to you or residing at your residence. Also, all these people have the [not legible] ***-***-4299 [redacted] on their applications […].

[…]; then you submitted applications for [redacted] [not legible] 20, 2021, using your home address for them on their applications; […]

We've also noted that on application CS*****750 for [client name and address] [redacted], [client] [redacted] phone number on [client] [redacted] application is ***-***-[not legible] understand from your own insurance applications, is your phone number.

For many of these cases a new application would be submitted for the same client around the time of the previous policy being lap [not legible] information was provided on the new applications. [The Insurer] [redacted] has advised that when they would reach out to you regarding the banking [not legible] applications, they would not receive a response from you.

[The Insurer] [redacted] is concerned about this situation as there are applications being submitted by you […] for multiple Proposed [not legible] home address is your home address, or in the above-mentioned cases, a combination of your home and office. As I'm sure you can [not legible] several red flags for us regarding why their correct contact information was not used on the applications submitted for them, did [not legible] provide the answers to the questions, and if the Proposed Insureds were aware of and a party to their applications.

We are reaching out to you as the Adviser [sic] of record for these applications to explain this situation. With your explanation, please [not legible] following questions:

1. Did you personally meet with each Proposed Insured to complete each of their applications? If not, why not?
2. Did the go [sic] through each of the questions of the application with the Proposed Insured for each application and record the [not legible] Proposed Insured? If not, why not?
3. Why weren't the Proposed Insured's correct addresses and phone numbers disclosed on their applications?
4. Why were applications submitted with invalid banking information, and why did you not respond to [the Insurer] [redacted] when they asked [not legible]

[…]

The November 5, 2021 Email stated:

[…]
With reference to your email, I want to inform you the following:

1. Yes, I met them personally.
2. Yes, I did. Whatever information clients gave me, I entered it.
3. Some of the clients including [client] [redacted] work more than one job, and they may not pick up their phones. So, I entered my phone number. Some of the clients were thinking to sell their home, so I entered my address.
4. Some of the clients might have changed their banking information, and some of the clients were thinking to cancel their policy.

The Timeline stated:

[The Insurer's] [redacted] Timeline […]

- 2021-08-30 [The Insurer's] [redacted] Business Quality Review Department notifies [the Insurer's] [redacted] Special Investigations Unit (SIU) of […] advisors in Alberta agents where there appeared to be multiple, seemingly unrelated, proposed insureds using the same address on their applications.
- 2021-09-02 SIU opens investigation SIU-***042 regarding the address irregularities.
- 2021-09 Mid-month, additional applications were received. Attempts to reach the proposed insureds were unsuccessful due to incorrect contact information on the applications. [The Insurer] [redacted] notices that some applications they are receiving show the Advisors' office address as the home address of the Proposed Insureds.
- 2021-10-06 [The Insurer] [redacted] and informs [the Insurer's] [redacted] SIU of the applications where the Advisors' office address was used as the proposed insureds' address; [the Insurer] [redacted] places the Advisors' business on hold
- […]
- 2021-10-18 [The Insurer] [redacted] advises SIU that [the Former Agency] [redacted] has suspended advisor Mital Joshi.
- […]
- 2021-10-21 [The Insurer] [redacted] advises SIU that Mital Joshi has been terminated by [the Former Agency] [redacted].
- 2021-11-03 Notice of Investigations sent out to […] Agents
- 2021-11-05 Mital Joshi […] provide responses to the SIU, […]
- 2021-11-10 Advisors responses forwarded to their uplines
- […]

The Insurer provided the AIC investigator with the insurance application in question, which provided the following information that was falsified:

Client	Policy Number	Falsified Information
[J.M.] [redacted] (hereinafter "Client 1")	CS*****750 [redacted]	- The phone number provided was found to be the Agent's personal phone number. - The address provided was found not to exist. - The banking information provided was found by the Insurer not to exist.

On August 10, 2023, the Agent provided the AIC investigator with the following information:

> […]
> I introduced all the clients to my upper line to provide them with the best products based on their needs and analysis to protect every family per the [Former Agency] [redacted] slogan. I had no license during my period of activity as I was only a trainee, meaning any clients I had were served to my upper line, [redacted]. I also do not have any data because without a license I cannot keep that data with me. I tentatively recall a few names that [upper line] [redacted] served during that period, however, I am not in contact with these people due to the situation at hand.
> […]
>
> In the letter, it states that two insurers were suspended because of me, but as I had previously said, I was only a trainee for my upper-line [redacted]. […]
>
> As per how I had met the clients, it was a mix of in-person, over call and some who I had not met but only had contact information for that I would transfer to my upper line.
> […]

On August 21, 2023, the Former Agency provided the following information to the AIC investigator:

> […]
> **Mrs. Joshi**
> […]
> Lastly, what was the reason Mrs. Joshi was terminated?
> Mrs. Joshi was terminated for cause on October 19, 2021, for improper recruiting practices and the suspension of her contract by [the Insurer] [redacted] for chargebacks and issues at the underwriting stage.
> […]
> [Emphasis added in original document]

On August 29, 2023, the Agent provided the following information to the AIC investigator:

> […]
> I understand the importance of cooperating fully with the investigation process, and I genuinely want to provide all necessary information to assist in the resolution of this matter. However, my current […] health condition has made it extremely challenging for me to engage in activities that involve additional stress or pressure.
>
> Given my circumstances, I kindly request your understanding and support in making reasonable accommodations to facilitate my participation in the investigation process. This might include rescheduling the questioning session to a date when I am better able to contribute meaningfully.

> I assure you that I am committed to resolving this matter and providing the required information for your consideration of my current health situation would be immensely helpful […]

On October 17, 2023, the Agent provided the following information to the AIC investigator:

> […] Firstly, I appreciate you educating me with what all irregularities happened with my accounts with my name. […]
>
> I would like to inform you that some of these irregularities were conducted in threatening pressure by my upline [redacted] and majority were done by [upline] [redacted] with my id as [upline] [redacted] used to keep my id and password stating that I am still a trainee and it is better that [upline] [redacted] handles all my clients and policies.
>
> To explain this, I would like to request a call or meet so I can exactly explain what all happened.
>
> Yes, I understand that as it has happened under my name and id, it is me who is in this troublesome situation. My only purpose right now is to solve this matter as soon as possible and prove to you that I was not involved in any such schemes. In fact, I was misguided a lot and at times mentally and socially threatened by my upline. If I denied a task given as a trainee. […]

By way of email dated the same, the AIC investigator provided the Agent with the following information:

> […]
> At this point, I suggest you write a letter to the council explaining the situation – while you were working under [upline] [redacted] and now ([health condition] [redacted]).
> […]

On October 18, 2023, the Agent provided the following information to the AIC investigator:

> […]
> In light of gravity of the alligations [sic] and to ensure a fair and thorough examination of the situation, I believe it would be beneficial to discuss this matter in person. This would allow me to clarify any potential misunderstandings and provide additional context before submitting my formal response.
>
> I kindly request permission for a one-on-one meeting at your convenience. I believe that such a meeting will facilitate a more productive and constructive exchange of information.
>
> Once we have had the opportunity to meet and discuss the matter, I will promptly provide a detailed written response, along with any supporting materials.
>
> I understand the important of adhering to the established timeline and will ensure that my response is submitted in accordance with the deadline. […]

On October 26, 2023, the AIC investigator conducted an interview with the Agent by way of Microsoft Teams. The AIC investigator provided the following summary of the interview:

- […]
- She cannot remember how many policies [upline] [redacted] submitted on her behalf and she only sent one.
- […]

Discussion

In order for the Council to conclude that the Agent has committed an offence pursuant to s. 480(1)(a) of the Act, the Report must provide, on the basis of clear and cogent evidence, that it is more likely than not that the Agent committed the act as alleged. The requirement of clear and cogent evidence reflects that the Council's finding 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 Queens's Bench of Alberta Decision, *Roy* v. *Alberta (Insurance Councils Appeal Board)*, 2008 ABQB 572 (hereinafter "*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.
>
> [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 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* 2008 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.

Contraventions of s. 480(1)(a) 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 initiated one (1) critical illness insurance application which included falsified client addresses, phone numbers and banking information.

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.

The insurance application, the November 5, 2021 Email, the Insurer's Timeline of Events and the summary of the October 26, 2023 interview with the Agent were of significance to the Council's decision. In the

Council's opinion, these materials demonstrated that the Agent acted in a dishonest, deceitful, fraudulent and untrustworthy manner as contemplated by the Act.

The Council took specific issue with the explanations from the Agent in the November 5, 2021 Email, which stated:

1. *[…]*
2. *[…]*
3. *Some of the clients including [Client 1] work more than one job, and they may not pick up their phones. So, I entered my phone number. […]*
4. *Some of the clients might have changed their banking information, and some of the clients were thinking to cancel their policy.*

Despite the explanation from the Agent that the Agent provided her phone number because the Client worked multiple jobs and wouldn't answer the phone, and the banking information was invalid because the client might have changed their banking information or was thinking of cancelling the policy, it is the Council's opinion that the Agent intentionally provided false information on the insurance application for a self-serving purpose.

Consumers who purchase insurance products expect that insurance agents will act with the utmost good faith while carrying out their work. Honesty and integrity are the hallmarks of a good insurance agent. An insurance agent owes a fiduciary obligation to act in the best interest of their clients. It is, therefore, not unreasonable to expect that a high standard of due diligence be practiced by insurance agents.

In light of the information provided by the Agent, the evidence submitted by the Former Agency, the Insurer and the October 26, 2023 summary of the Agent's interview confirms that the Agent initiated one (1) insurance application containing falsified information, the objective and subjective elements of the applicable legal test under s. 480(1)(a) are met. This was intentional conduct, and it is fraud, deceit, dishonesty, untrustworthiness and/or misrepresentation as contemplated pursuant to s. 480(1)(a) of the Act.

The *Insurance Act* and its Regulations act as a mechanism of public protection. It is the view of the Council that the Agent's deception was self-serving, as it was deliberate and without any consideration of the risk they were subjecting the former client and the Insurer to. Accordingly, a significant civil penalty is warranted under the circumstances.

In terms of 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 per demonstrated offence against an agent, in accordance with s. 36.1(1)(a)

of the *Insurance Agents and Adjusters Regulation*, AR 122/2001. Given the seriousness of the offence, the Council orders a civil penalty per demonstrated offence in the amount of $5,000.00 be levied against the Agent.

The civil penalty must be paid within thirty (30) days of receiving this notice. If the penalty is not paid within thirty (30) days, interest will begin to accrue at the rate of 12% per annum as prescribed by s. 36.1(2) of the *Insurance Agents and Adjusters Regulation*, A.R. 122/2001.

Pursuant to s. 482 of the Act (copy 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 11, 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*