In the Matter of the

***FINANCIAL INSTITUTIONS ACT*, RSBC 1996, c.141**
(the "Act")

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

MARTIN HROCH
(the "Former Licensee")

ORDER

As Council made an intended decision on December 10, 2019, pursuant to sections 231, 236, and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Former Licensee with written reasons and notice of the intended decision dated January 27, 2020; and

As the Former Licensee has not requested a hearing of Council's intended decision within the time period provided by the Act;

Under authority of sections 231, 236, and 241.1 of the Act, Council orders that:

1. Council will not consider an application for any insurance licence from the Former Licensee for a period of five years, commencing February 19, 2020 and ending at midnight on February 19, 2025;

2. The Former Licensee is fined $5,000;

3. The Former Licensee is assessed Council's investigative costs of $1,875.

This order takes effect on the **19th day of February, 2020.**

Lesley Maddison
Chairperson, Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

MARTIN HROCH
(the "Former Licensee")

Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether the Former Licensee acted in compliance with the requirements of the Act, Council Rules, and Code of Conduct, and in particular whether the Former Licensee breached the duties set out in sections 3 ("Trustworthiness") and 4 ("Good Faith") of the Code of Conduct.

As part of Council's investigation, the Former Licensee was provided the opportunity to respond to the allegation that he had submitted over 70 false insurance claims through his employee health and wellness program. An investigation report, prepared by Council staff, was sent to the Former Licensee for his review.

The aforementioned investigation report, which included submissions provided by the Former Licensee, was considered by Council at its December 10, 2019 meeting, where it was determined that the matter should be disposed of in the manner set out below.

PROCESS

Pursuant to section 237 of the Act, Council must provide written notice to the Former Licensee of the action it intends to take under sections 231, 236, and 241.1 of the Act before taking any such action. The Former Licensee may then accept Council's decision or request a formal hearing. This intended decision operates as written notice of the action Council intends to take against the Former Licensee.

FACTS

The Former Licensee was first licensed with Council as a Level 1 general insurance salesperson (Level 1 Salesperson") in November 2012. His licence was terminated for non-filing in August 2019.

The Former Licensee was employed by and authorized to represent an agency (the "Agency") from September 2014 until he was terminated in November 2018 as a consequence of the misconduct described below.

As an employee of the Agency, the Former Licensee was able to submit insurance claims through the Agency's employee health and wellness program. Between May 2017 and June 2018, the Licensee submitted 74 separate false insurance claims for physiotherapy services through the employee health and wellness program. The amount claimed in each instance varied from $25 to $75, resulting in an overpayment to the Former Licensee of $2,570. The physiotherapy clinic named in the claims has confirmed that 74 of the treatment sessions claimed by the Former Licensee did not take place, and the Former Licensee has admitted that the claims were made fraudulently.

In addition to the 74 false physiotherapy claims, the Former Licensee has admitted to having submitted two fraudulent vision claims in June 2018, for which he received $475.

In total, the Former Licensee submitted at least 76 false claims through his Agency's employee health and wellness program, resulting in his fraudulent receipt of $3,045. Additional false claims may have been made, but have not been confirmed.

The Former Licensee agreed to a payment plan in October 2018, the terms of which required him to pay back the insurance company (the "Insurer") in installments for the overpayment of $2,570 he received for the false physiotherapy claims. The Former Licensee has failed to pay back the funds in accordance with the payment plan agreement, despite a revision of the agreement that occurred in February 2019 in order to accommodate the Former Licensee. Ultimately, the Former Licensee ceased making payments altogether after having repaid the Insurer only $425.

The Former Licensee cooperated with Council staff throughout the investigation, and provided a written statement in which he expressed remorse about his misconduct and described the personal circumstances that had led him to submit the numerous false claims.

ANALYSIS

Council concluded, based on the seriousness of the Former Licensee's misconduct, that the Former Licensee is unsuitable to hold a licence.

Although the value of each claim was small, the sheer volume of illegitimate claims submitted by the Former Licensee – at least 76 within a 13 month period – demonstrates that he had

established a pattern of routine and egregious disregard for the standards of trustworthiness and good faith required of a licensee, as set out in sections 3 and 4 of the Code of Conduct.

The Former Licensee's failure to reimburse the Insurer in accordance with the terms of the payment plan agreement was considered by Council to be an aggravating factor that further called his trustworthiness and good faith into question.

Although the Former Licensee's misconduct did not harm the public, Council nevertheless considers that the Former Licensee, given the lack of trustworthiness and good faith he has displayed, would pose a threat to the public if allowed to continue holding an insurance licence.

In determining a disposition in this matter, two previous cases were reviewed and considered by Council.

Mahin Heidari (June 2015) concerned a licensee who submitted at least 35 false personal health insurance claims through her group benefits insurance provider, including 18 claims for chiropractic services, 13 claims for masseuse services, and four claims for visits to a psychologist. The licensee received a total of $2,269 for these false claims. Despite all the evidence against the legitimacy of her claims, the licensee continued to justify her actions and displayed dishonest behavior throughout the disciplinary process. Council prohibited the licensee from holding an insurance licence for three years, fined her $10,000 (which could be reduced to $5,000 if the licensee reimbursed the insurance company for the full amount she received for her illegitimate claims), and required her to pay investigative costs of $2,025 and hearing costs of $2,500.46.

Yazdi & Associates Financial Services Inc. and Arvin Nazerzadeh-Yazdi (May 2017) concerned a former licensee who established a group health plan for a company for which he was director. The company had only six employees, yet 25 individuals were registered in the group health plan. During the time that the health plan was in effect, the former licensee submitted a number of invalid health claims on his own behalf, and also assisted others, including family members, with making false claims. The former licensee admitted to his misconduct when it was discovered, and cooperated with the insurance company's investigation. Council prohibited the former licensee from holding an insurance licence for five years and prohibited him from serving as an officer or director of an insurance agency for five years. Additionally, the former licensee was fined $10,000 and assessed investigative costs of $812.50.

Council considered that a lesser fine than the $10,000 issued in both precedents was appropriate in the present case, given that the Former Licensee's misconduct was somewhat less egregious than what had occurred in either precedent. However, Council was of the

opinion that it was in the public's interest for the Former Licensee to be prohibited from holding a licence for a lengthy period of time.

INTENDED DECISION

Pursuant to sections 231, 236, and 241.1 of the Act, Council made an intended decision to:

1. Not consider an application for any insurance licence from the Former Licensee for a period of five years from the date of Council's order;

2. Assess a fine of $5,000 against the Former Licensee; and

3. Assess Council's investigative costs of $1,875 against the Licensee.

The Former Licensee is advised that if the fine and/or investigative costs are still outstanding after the conclusion of the five year period in which the Former Licensee is prohibited from applying for a licence, no application from him will be considered by Council until such time as the fine and investigative costs have been paid in full.

Subject to the Former Licensee's right to request a hearing before Council pursuant to section 237 of the Act, the intended decision will take effect after the expiry of the hearing period.

Right to a Hearing

If the Former Licensee wishes to dispute Council's findings or its intended decision, the Former Licensee may have legal representation and present a case at a hearing before Council. Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Former Licensee must give notice to Council by delivering to its office written notice of this intention **within fourteen (14) days of receiving this intended decision**. A hearing will then be scheduled for a date within a reasonable period of time from receipt of the notice. Please direct written notice to the attention of the Executive Director. If the Former Licensee does not request a hearing **within fourteen (14) days of receiving this intended decision**, the intended decision of Council will take effect.

Even if this decision is accepted by the Former Licensee, pursuant to section 242(3) of the Act, the British Columbia Financial Services Authority ("BCFSA") still has a right to appeal this decision of Council to the Financial Services Tribunal ("FST"). The BCFSA has 30 days to file a Notice of Appeal, once Council's decision takes effect. For more information respecting appeals to the FST, please visit their website at fst.gov.bc.ca or contact them directly at:

Financial Services Tribunal
PO Box 9425 Stn Prov Govt
Victoria, British Columbia
V8W 9V1
Reception: 250-387-3464
Fax: 250-356-9923
Email: FinancialServicesTribunal@gov.bc.ca

Dated in Vancouver, British Columbia, on the **27th day of January, 2020**.

For the Insurance Council of British Columbia

Janet Sinclair
Executive Director