IN THE MATTER OF THE *FINANCIAL INSTITUTIONS ACT*
(RSBC 1996, c.141)
(the "Act")

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

KAMNA SURI
(the "Licensee")

ORDER

As Council made an intended decision on September 22, 2020, pursuant to sections 231, 236 and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Licensee with written reasons and notice of the intended decision dated October 8, 2020; and

As the 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. The Licensee is fined $1,000;

2. The Licensee is assessed investigation costs of $1,543.75;

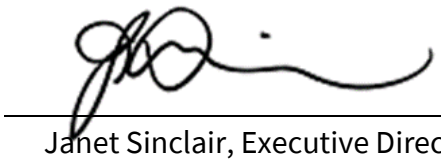
3. A condition is imposed on the Licensee's life and accident and sickness ("Life Agent") licence that she be supervised for a period of six months of active licensing by a Life Agent supervisor, as approved by Council, commencing from the date of Council's order;

4. A condition is imposed on the Licensee's Life Agent licence that requires her to complete the Council Rules Course;

5. A condition is imposed on the Licensee's Life Agent licence that requires her to complete an ethics course, as approved by Council; and

6. A condition is imposed on the Licensee's Life Agent licence that failure to pay the fine and investigation costs or complete the required courses by February 15, 2021 will result in the automatic suspension of her Life Agent licence and she will not be permitted to complete her annual filing until the fine and investigation costs are paid in full and the courses are completed.

This order takes effect on the **17th day of November, 2020**.



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

KAMNA SURI
(the "Licensee")

1. Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation respecting allegations that the Licensee:

   a) processed an insurance policy contrary to a client's instructions;

   b) falsely indicated that she had conducted a financial needs analysis with regard to a policy and inaccurately reported a client's annual income;

   c) failed to deliver a policy to a client; and

   d) used an inaccurate illustration on a policy application.

2. On August 11, 2020, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met with the Licensee via video conference to review an investigation report prepared by Council staff and provide the Licensee an opportunity to make submissions or provide any further information. A copy of the investigation report was forwarded to the Licensee in advance of the meeting.

3. Staff's investigation report and the Committee's report to Council were reviewed by Council at its September 22, 2020 meeting where it was determined the matter should be disposed of in the manner set out below.

PROCESS

4. Pursuant to section 237 of the Act, Council must provide written notice to the Licensee of the action it intends to take under sections 231, 236 and 241.1 of the Act before taking any such action. The 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 Licensee.

THE COMPLAINT

5. The Licensee has been licensed with Council as a life and accident and sickness insurance agent ("Life Agent") since September 2013.

6. On March 13, 2019, Council received a complaint about the Licensee. The Complainant stated that, on or around August 16, 2016, she determined that her coverage on a 2015 insurance policy of $50,000 ("Policy 1") was insufficient and the monthly premium of $88.56 was too high. She contacted the Licensee about increasing to $100,000 and, on September 18, 2016, they met to complete the paperwork. However, the Complainant stated that the Licensee, unbeknownst to her, facilitated the issuance of a new policy for $100,000 instead ("Policy 2").

7. The Complainant claimed she discovered Policy 2 approximately two years later when she reviewed her bank statements and realized that she was paying premiums for two policies. She advised she attempted to contact the Licensee to demand return of the Policy 2 premiums but was unsuccessful.

8. The Complainant also alleged that the Licensee failed to deliver Policy 2 to her. However, the Complainant admitted to signing a policy delivery confirmation but advised she did not know what she was signing at the time.

9. During staff's investigation, it was determined that it appeared the Licensee did not conduct a financial needs analysis with regard to Policy 2 and that she inaccurately reported the Complainant's income on the application.

10. It was also determined that the Licensee had used an illustration for a different client for the Complainant's purchase of a critical illness and disability policy in 2015. However, the correct information appeared in that policy's application form, including the monthly premium of $37.38. The Complainant claimed that, as a result, she was overcharged for more than two years. She complained to the insurer and was refunded the overpayments.

THE LICENSEE'S SUBMISSIONS

Policy 2

11. The Licensee submitted that the Complainant's version of events is false. She advised that the Complainant called her and specifically asked for a second policy in the amount of $100,000 which, combined with Policy 1, would result in total coverage of $150,000.

12. The Licensee stated the Complainant's allegation that she was unaware of Policy 2 is also false. She referred to the signed policy delivery confirmation and the Complainant's signature on the application as evidence. The Licensee was adamant that Policy 2 was processed with the Complainant's knowledge and consent.

13. The Licensee further submitted that it makes no sense that the Complainant would pay monthly premiums of $88.56 starting in July 2015 for Policy 1 and then additional monthly premiums of $171.72 for Policy 2 starting in October 2016, and then, two years later, allege she was unaware of Policy 2 and demand her money back. The Licensee advised that when she told the Complainant that return of the premiums was impossible, the Complainant became very upset and threatened to complain. At this point, the Licensee advised her to contact the insurer and she stopped taking the Complainant's calls.

14. It was brought to the Licensee's attention during the Committee meeting that the Policy 2 application indicates it was a replacement policy. The Licensee advised this was her error and reiterated that Policy 2 was an additional policy that the Complainant wanted. On further questioning by the Committee, the Licensee advised that if Policy 2 was meant to have been a replacement, she would have written to the insurer to advise as such. On further questioning, the Licensee admitted to making another error on the Policy 2 application by failing to list all of the Complainant's existing insurance policies.

Financial Needs Analysis

15. The Licensee advised the Committee that she did not do a written financial needs analysis for the Complainant's purchase of Policy 2 because, in her mind, since the Complainant contacted her and advised she wanted the policy and since she had already done a written needs analysis for Policy 1 in 2015, she did not need to ask the Complainant the same questions over again. The Licensee further reiterated that the Complainant advised she could afford the Policy 2 premiums. On questioning as to why the application for Policy 2 indicates that a financial needs analysis was performed, the Licensee advised that she ticked "yes" to this question because she considered her verbal analysis sufficient.

Delivery of Policy 2

16. The Licensee stated the Complainant's allegation that she did not receive Policy 2 is false. The Licensee adamantly advised she hand-delivered Policy 2 to the Complainant, as confirmed by the signed policy delivery confirmation. In addition, a sales illustration for Policy 2 was also signed by the Complainant which sets out Policy 2's details, including the insured sum of $100,000 and the required monthly premium of $171.72.

Inaccurate Illustration and Income

17. The Licensee advised the Committee that she was working on another client's policy at the same time as the Complainant's 2015 critical illness and disability application and that, as a result, she mistakenly sent the wrong illustration to the Complainant. She advised, however, that all of the information in the application was the Complainant's. She further advised that she was not aware that the insurer had charged the Complainant the incorrect premium amount. Of note, the correct monthly premium of $37.38 appeared on the policy's application form.

18. The Licensee also advised the Committee that, at the time the application for Policy 2 was completed, the Complainant reported a second job and a significant increase from her 2015 income. The Licensee did not attempt to verify the income, nor did she ask the Complainant what that second job was.

ANALYSIS

19. Council considered staff's investigation report and the Committee's report to Council.

Regarding Policy 2

20. With regard to the Complainant's claim that the Licensee placed Policy 2 without her knowledge or consent, Council agreed that the evidence tends not to support this allegation. It was peculiar that the Complainant would pay monthly premiums of $88.56 for Policy 1 and $171.72 for Policy 2 and then, after two years, claim that she was unaware there were two ongoing payments or of the existence of Policy 2. Further, the Complainant's signature appears not only on the application for Policy 2 but also on the sales illustration and the policy delivery confirmation. Council agreed that it is implausible that the Complainant was unaware of Policy 2 or its details including the premium amount which was clearly set out in the signed sales illustration.

21. Council accepted the Licensee's submission that the Complainant contacted her to demand a refund and that, when advised a refund was not possible, began to be verbally abusive toward the Licensee.

22. Council found that, more likely than not, the Complainant wanted Policy 2 as an addition to Policy 1. That being said, Council agreed that the Licensee's notes with regard to her discussions with the Complainant were woefully inadequate and did not properly document their communications.

23. Council agreed that the Licensee's failure to list all existing policies in Policy 2's application was a failure to provide full and accurate information to the insurer.

24. With regard to the Licensee having indicated on Policy 2's application that it was a replacement, Council accepted the Licensee's submission that this was an error on her part for the reason that, in order to have cancelled Policy 1, she would have had to provide the insurer with that specific request. That she did not tend to confirm the replacement indication was an error. Council agreed that the Complainant could have been misled by this error but this was negated by the implausibility that the Complainant did not notice two payments, one for the existing Policy 1 and the other for Policy 2, coming out of her account on a monthly basis for two years. However, Council agreed that the insurer reasonably expects, as does the client and Council, that full and accurate information will be provided in the application. As such, the Licensee failed in this regard.

Regarding Financial Needs Analysis

25. Council concluded that the Licensee did not conduct a financial needs analysis. Council recognized that the Licensee thought her verbal analysis was sufficient but Council agreed this was unacceptable and that insurers, and Council, expect the analysis to be in writing. By erroneously confirming in the application that a financial needs analysis had been done, she did not provide full and accurate information to the insurer.

Regarding Delivery of Policy 2

26. Council accepted the Licensee's submission that she delivered Policy 2 to the Complainant, along with the sales illustration, as evidenced by the Complainant's signatures. Council observed that the policy delivery confirmation form is brief and that the Complainant's signature appears directly below the words, "*The policy was delivered to me by: my advisor personally*". As such, Council agreed that it is highly unlikely that this straightforward form could be misunderstood.

Regarding Inaccurate Illustration and Income

27. With regard to the wrong illustration being sent to the Complaint for the critical illness and disability policy in 2015, Council concluded that this was carelessness and a breach of the other client's privacy.

28. Council accepted that the Licensee did not know that the insurer had charged the Complainant the incorrect premium. Council concluded that it appears the insurer made

an error on the Complainant's monthly automatic debit by withdrawing the wrong amount from the Complainant's account instead of $37.38 as originally documented.

29. Council also accepted that the Complainant told the Licensee she had two jobs at the time Policy 2 was completed. However, the Licensee ought to have documented the details, such as what the second occupation was.

Breaches

30. In light of all of the above findings, Council held that the Licensee breached the requirement under section 5.2 the Code of Conduct to conduct all insurance activities in a competent manner. Specifically, the Licensee failed to conduct a written financial needs analysis for Policy 2, failed to provide accurate information in the application for Policy 2, omitted information in the application for Policy 2, provided the Complainant with a copy of an illustration for another person, and failed to properly document her conversations with the Complainant.

31. Council also found that the Licensee breached section 7.2 of the Code of Conduct with regard to usual practice when dealing with clients. She violated the privacy of her previous client whom the critical illness and disability policy illustration actually pertained to by carelessly sending it to the Complainant and failing to provide the Complainant with her own illustration. She also failed in her duty to the client by failing to provide accurate information on the Policy 2 application and omitting to list all existing policies.

32. Further, Council held that the Licensee breached section 8.2 of the Code of Conduct with regard to the usual practice of dealing with insurers in failing to provide the insurer with full and accurate information on the Policy 2 application.

33. Lastly, it follows that the Licensee also breached Council Rule 7(8) which required her to comply with the Code of Conduct.

34. Council believed that the Licensee did not act with ill intent or fraudulent purpose. Rather, Council found that the Licensee's conduct was careless. Further, in rejecting the Complainant's specific allegations that the Licensee placed Policy 2 without her knowledge or consent and that Policy 2 was not delivered, Council concluded that there was no client harm.

35. As such, Council determined that a sanction is warranted for the purposes of specific and general deterrence, rehabilitation, punishment, denunciation of the Licensee's conduct

and the need to maintain the public's confidence in the insurance industry and Council's ability to govern insurance licensees.

INTENDED DECISION

36. In considering a penalty recommendation, Council reviewed two previous cases involving matters somewhat similar to the present case.

37. In *Ismat Simo* (September 13, 2017), a Life Agent recommended that a client cash in a TFSA investment and then re-invest it in the same year in another TFSA. This led to a significant tax penalty for the client. Council determined that the licensee had not undertaken an appropriate needs analysis and that his failure to provide proper advice to his client raised concerns about his competency. The licensee was suspended until he had taken certain continuing education courses, was subject to a two year period of supervision by a qualified Life Agent, and assessed investigation costs of $1,650.

38. In *Edraline Buetipo Borginia* (June 7, 2016), a Life Agent was alleged to have sold life insurance policies to a client to replace existing policies, contrary to the client's best interests. Council found no evidence to suggest that the new policies were inferior to the existing ones. However, it did find that the process by which the licensee implemented the new policies less than satisfactory in that the policy comparison provided by the licensee was based on incomplete information. Council found that by providing comparisons without full information, the licensee failed to act in accordance with the usual practice of the business of insurance. Council also found it was inappropriate for the licensee to have had the client sign post-dated policy cancellation letters. While accepting that the licensee was attempting to act in the client's best interests, Council found that the licensee failed to demonstrate good judgment in dealing with the client, which brought into question her ability to act in a competent manner, and in accordance with the usual practice of the business of insurance. As a result, Council imposed conditions on the licensee's licence requiring her to be supervised for a period of 24 months, complete the Advocis Getting Established course, and pay Council's investigation costs of $1,112.50.

39. Council is not bound by precedent to follow the exact outcomes from prior cases, but similar conduct should result in similar outcomes within a reasonable range depending on the particular facts of the case. Council recognized that the facts of the *Simo* and *Borginia* cases are not directly on-point. In *Simo*, there was client harm, whereas none was found in the present matter; and *Borginia* pertained to replacement polices, an allegation rejected in the Licensee's case.

40. Council also considered the mitigating factors that the Licensee has not been the subject of discipline before, that there was no client harm, that at the material times she was a relatively new Life Agent, and that there was no ill intent or fraudulent purpose. There were no aggravating factors.

41. In consideration of the facts, the two somewhat similar cases, the mitigating factors, and that some of the Complainant's allegations were unsubstantiated, Council agreed with the Committee's recommendation that a fine of $1,000, investigation costs of $1,543.75, a six month period of supervision, and a requirement to complete the Council Rules Course and an ethics course is an appropriate penalty for the totality of the Licensee's misconduct.

42. With regard to the investigations costs, Council confirmed that, as a self-funded body, it should look to licensees who have engaged in misconduct to bear the costs of their disciplinary proceedings so they are not borne by other licensees in general.

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

    a) Fine the Licensee $1,000;

    b) Assess the Licensee investigation costs of $1,543.75;

    c) Require the Licensee to be supervised for a period of six months of active licensing by a Life Agent supervisor, as approved by Council;

    d) Require the Licensee to complete the Council Rules Course;

    e) Require the Licensee to complete an ethics course, as approved by Council; and

    f) Impose a condition on the Licensee's Life Agent licence that failure to pay the fine and investigation costs or complete the required courses within 90 days of Council's order will result in the automatic suspension of her licence and she will not be permitted to complete her annual filing until the fine and investigation costs are paid in full and the courses are completed.

RIGHT TO A HEARING

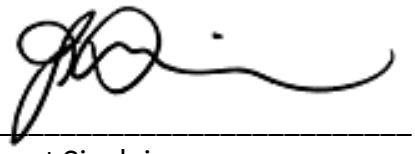
44. If the Licensee wishes to dispute Council's findings or its intended decision, the Licensee may have legal representation and present a case at a hearing before Council. Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Licensee must give

notice to Council by delivering to its office written notice of this intention within 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 Licensee does not request a hearing within 14 days of receiving this intended decision, the intended decision of Council will take effect.

45. Even if this decision is accepted by the Licensee, pursuant to section 242(3) of the Act, the British Columbia Financial Services Authority ("BCFSA") still has a right of appeal 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 visit the guide to appeals published on their website at www.fst.gov.bc.ca/pdf/guides/ICGuide.pdf.

Dated in Vancouver, British Columbia, on the **8th day of October, 2020**.

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director