**In the Matter of the**

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

**and the**

**INSURANCE COUNCIL OF BRITISH COLUMBIA**
("Council")

**and**

**HARPAL KAUR SANDHU**
(the "Licensee")

# ORDER

As Council made an intended decision on August 3, 2022, 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 August 3, 2022; 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's life and accident and sickness insurance agent license is suspended for a period of one year, commencing on August 25, 2022 and ending at midnight on Friday August 25, 2023.

2) The Licensee is fined $7500.00, to be paid by November 23, 2022;

3) The Licensee is required to complete the following courses, or equivalent courses as acceptable to Council by February 21, 2023:

    a. Council Rules Course for life and/or accident and sickness insurance; and

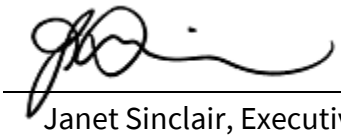
    b. The Disability Income Insurance Course, Individual and Group Course.

4) The Licensee is assessed Council's investigation costs of $1,687.50, to be paid by November 23, 2022;

5) A condition is imposed on the Licensee that requires her to pay the above-ordered fine and investigation costs in full and complete the Courses prior to the Licensee's suspension being lifted.

6) A condition is imposed on the Licensee's life and accident sickness insurance agent license that requires the licensee to be supervised by a qualified Life Agent, as approved by Council, for a period of two years, commencing from when the Licensee has completed the above conditions and the suspension is lifted.

This order takes effect on the **25th day of August, 2022**.



Janet Sinclair, Executive Director
Insurance Council of British Columbia

**INTENDED DECISION**

**of the**

**INSURANCE COUNCIL OF BRITISH COLUMBIA**
("Council")

Respecting

**HARPAL KAUR SANDHU**
(the "Licensee")

1. Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether the Licensee acted in compliance with the requirements of the Act, Council Rules, and Code of Conduct, and in particular to determine whether the Licensee breached section 3 ("Trustworthiness"); section 4 ("Good Faith"); section 5 ("Competence"); and section 8 ("Usual Practice of Dealing with Insurers") of the Code of Conduct by filing fraudulent insurance claims for total disability.

2. On June 28, 2022, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met with the Licensee via video conference to discuss the investigation. An investigation report prepared by Council staff was distributed to the Committee and the Licensee prior to the meeting. A discussion of the investigation report took place at the meeting and the Licensee was given an opportunity to make submissions and provide further information. Having reviewed the investigation materials and discussed the matter with the Licensee, the Committee prepared a report for Council.

3. The Committee's report, along with the aforementioned investigation report, were reviewed by Council at its July 26, 2022, 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.

**FACTS**

5. The Licensee first became licensed with Council as an accident and sickness insurance agent ("A&S Agent") in July 2011 and became a life and accident and sickness insurance agent ("Life Agent") in March 2015.

6. The Licensee held an independent sales representative agreement with an insurer until it was terminated by the insurer on September 27, 2019.

7. On October 3, 2019, Council received an email from the insurer regarding the termination of the contract between the insurer and the Licensee. In the email, the insurer alleged that the Licensee made three fraudulent insurance disability claims on her own policies.

8. The wording of the definition of the insurer's total disability policy at the material time that the disability claims in question were made was: "*Totally disabled or total disability means the inability to perform each of the substantial and material duties of your business or occupation (usual activities if not employed). If you are able to perform any of the substantial and material duties of your business or occupation (usual activities if not employed), you are not Totally Disabled. You must be under the care of a Physician.*"

9. The insurer provided a form dated August 29, 2017, signed, and completed by the Licensee. The form has a section titled "complete for accident or sickness," and in this section there is a part for "dates during which you were unable to do all the duties pertaining to your usual occupation or perform your usual daily activities," as well as a part for "dates which you were able to perform part of the duties pertaining to your usual occupation or perform part of your usual daily activities." The Licensee claimed that during the period of March 22, 2017, to June 4, 2017, she was unable to do all the duties pertaining to her usual occupation or perform her usual daily activities. The insurer paid a total of $3,993.33 for this claim.

10. The insurer provided internal reports that list policy applications submitted by the Licensee to the insurer. These reports showed a list of numerous policy applications submitted by the Licensee to the insurer during the period of May 22, 2017, to May 29, 2017. This demonstrated that the Licensee continued to work during her total disability period. The Licensee earned approximately $1,200 for each policy, spread out over a 12-month period, on the policy applications submitted during her total disability claim.

11. The insurer provided a form dated September 28, 2018, signed and completed by the Licensee. The form had the same section titled "complete for accident or sickness" as the previously mentioned form. The Licensee claimed that during the period of June 22, 2018,

to September 10, 2018, she was unable to do all the duties pertaining to her usual occupation or perform her usual daily activities. The insurer paid a total of $3,971.67 for this claim.

12. On March 13, 2019, the Licensee submitted a claim to the insurer for total disability for the period of November 20, 2018, to February 24, 2019, stating that she was unable to do all the duties pertaining to her usual occupation or perform her usual daily activities. The insurer determined this claim was fraudulent as during this time frame the Licensee travelled to India in January 2019 and attended a sales convention in Las Vegas in December 2018. The total disability claim was denied by the insurer.

13. The Licensee was interviewed by the insurer's representatives on August 27, 2019. The insurer provided the audio recording and a summary of this interview to Council. In the interview, the Licensee expressed confusion regarding the insurer's definition of *total disability*. The Licensee stated to the insurer's representatives that she did not think making a telephone call while on disability was problematic. She stated that she was totally disabled during the periods she made claims, but she felt that making telephone calls to service her clients was important to help her clients.

14. It was determined by the insurer through the Licensee's statement in the interview that she continued to make telephone calls and service clients during the three periods in which she claimed or applied for total disability.

15. The Licensee provided a written response to inquiries from Council staff on October 18, 2021, wherein she stated her understanding of total disability is if "you do not perform any physical work" and stated, "under total disability, you are not talking on the phone?"

16. The Licensee provided the insurer with medical records and doctor notes that supported a claim for total disability, indicating that the Licensee was unable to work or perform daily activities for the dates claimed in the three total disability periods.

17. During the Review Committee meeting, the Licensee failed to acknowledge her wrongdoing. The Licensee accused her district manager of pressuring her to continue to work and complete sales and policy applications, even though she was on a total disability claim. The Licensee did admit that she should not have completed the policy applications even with the pressure from her district manager, but it was apparent that the Licensee blamed her district manager for her own mistake in continuing to work while under total disability. The Licensee could not appropriately acknowledge that even if she felt pressured by her district manager to continue to work, it is the Licensee's responsibility to adhere to

the usual practice of the insurance business and Council's Code of Conduct by not partaking and defrauding an insurer by continuing to complete substantial and material duties of her business while under total disability. The Licensee was questioned regarding her work activity and whether she continued to call and service clients during the periods in which she claimed total disability. The Licensee admitted to servicing clients and taking phone calls during this time frame and that she was not under any pressure from her district manager to conduct those specific tasks.

18. The Licensee was unaware of any formal policy in place to advise her district manager or human resources of her periods of total disability. Furthermore, the Licensee was unable to provide any documentation that supported her claim that her district manager knew she was on total disability. Council believes there was likely some conflict or tension between the Licensee and her district manager during the relevant time periods. However, Council found it difficult to understand why there was no documented communication to show that the Licensee's district manager was advised of the Licensee's total disability claims yet allegedly continued to pressure the Licensee to work and submit applications during those periods.

19. At the Review Committee, the Licensee was able to recite the appropriate definition of total disability; that while on total disability one should not be able to perform all the duties pertaining to your usual occupation or perform your usual daily activities. However, this evidence was contrary to the information the Licensee provided to the insurer in the interview on August 27, 2019, and the Licensee's letter to Council staff on October 18, 2021, wherein the Licensee provided her understanding of total disability to mean not being able to complete the physical tasks of her occupation.

**ANALYSIS**

20. Council has concluded that the Licensee failed to engage in the usual practice of the business of insurance by submitting fraudulent total disability claims, which she knew, or ought to have known, were fraudulent. The claim forms submitted by the Licensee to the insurer requested information regarding the period in which the Licensee was either unable to do *all* the duties pertaining to their usual occupation or the period in which the Licensee was unable to perform *part* of their usual occupation. The Licensee should have a level of competency to complete an insurance claim form accurately and to understand the difference between total and partial disability.

21. The evidence demonstrates that during the periods in which the Licensee claimed for total disability, she continued to submit numerous insurance applications. Additionally, the Licensee admitted that she continued to make phone calls and service clients during her periods of total disability. While Council believes there was some legitimacy and medical documentation supporting a disability claim, the Licensee did not make the appropriate disability claim. The Licensee claimed for total disability, as opposed to partial disability. Had the Licensee claimed partial disability, she could have continued to complete part of her usual occupational duties and received partial disability payments from the insurer. However, in these instances the Licensee made claims for total disability yet continued to work during the disability period.

22. Council expressed concerns regarding the Licensee's credibility. The Licensee was unable to answer questions directly and would tend to answer in a roundabout fashion providing narratives on topics that were not directly relevant to the question being asked. Further, the Licensee provided information that was inconsistent from what was contained in the investigation report and what was said by the Licensee at the Review Committee meeting. Council felt there was some disconnect between what the Licensee was stating throughout the Review Committee meeting and what had transpired.

23. Council concluded that the Licensee made fraudulent insurance claims for total disability by claiming for periods of total disability and continuing to complete work duties and submit insurance applications in the relevant time frame. Whether intentional or not, the Licensee should have known that by providing information stating that she was unable to perform all the duties related to her occupation, she should not have continued working during that relevant time.

24. Given the credibility concerns, Council is unable to conclude whether there was intent to commit fraudulent claims by continuing to work, or if the level of competency and understanding of total disability was the issue.

25. Council has concluded, based on the seriousness of the Licensee's misconduct, that the Licensee poses a potential harm to the public. The Licensee's actions brought into question her trustworthiness and her ability to act in good faith and in accordance with the usual practice of the business of insurance as set out in sections 3 and 4 of the Code of Conduct.

26. Council considered the impact of Council Rule 7(8) and Council's Code of Conduct guidelines on the Licensee's conduct, including section 3 ("Trustworthiness"), section 4 ("Good Faith"), and section 5 ("Competence"). Council has concluded that the Licensee's

conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

27. Prior to making its recommendation in this matter, Council took into consideration the following precedent cases. While it is recognized that Council is not bound by precedent and that each matter is decided on its own facts and merits, Council found that these decisions were instructive in terms of providing a range of sanctions for similar types of misconduct.

28. *Paramjeet Kaur Johal* (June 2022) concerned a licensee who submitted two total disability claims with an insurer but continued to work during the total disability periods. The Licensee completed the appropriate total disability claim forms and claimed that she was unable to do all the duties pertaining to her usual occupation, but internal reports from the insurer demonstrated that the Licensee continued to work and submit policy applications during the relevant time frames. Council determined that the licensee knew or ought to have known that her conduct resulted in fraudulent total disability claims and that the Licensee has a duty to disclose any information fully and accurately to an insurer. Council determined that the misconduct brought into question the Licensee's trustworthiness and ability to act in good faith. Council ordered that the licensee be fined $5000, that the licensee's life and accident and sickness insurance agent licence be suspended for one year, that the Licensee be required to take courses, assessed investigation costs, and be supervised for a period of two years when the Licensee's suspension is lifted.

29. In *Martin Hroch* (February 2020), a former licensee submitted 74 false insurance claims for physiotherapy services through the employee health and wellness program during the period of May 2017 to June 2018. This resulted in a payment to the former licensee of $2570. The physiotherapy clinic and former licensee admitted that the physiotherapy sessions did not take place. Additionally, the former licensee admitted to making two false vision claims in June 2018, for which he received $475. The former licensee agreed to repay the insurer for the fraudulent claims but only ended up paying $425. Given the misconduct, Council determined that the former licensee did not meet the standards of trustworthiness and good faith. Council ordered that the licensee not be eligible to reapply for a licence for five years, fined $5,000, and assessed investigation costs. Council further ordered that until the insurer is paid back for the fraudulent claims, Council will not consider any applications from the former licensee.

30. *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 massage therapy 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 investigation costs of $2,025 and hearing costs of $2,500.46.

31. *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 with making false claims, including family members. The former licensee admitted to his misconduct when it was discovered and he 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 investigation costs of $812.50.

32. Council considered relevant mitigating and aggravating factors in this matter. The Licensee's failure to recognize and admit to her wrongdoing was considered by Council to be an aggravating factor that further called the Licensee's trustworthiness and good faith into question. Additionally, the Licensee filed multiple fraudulent claims for disability which showed a flagrant disregard for the rules governing the Licensee's conduct within the insurance industry. Council considered as a mitigating factor that the Licensee cooperated throughout the investigation.

33. Council considered that a fine of $7500 is appropriate in the present case. The facts of this case are similar to the *Johal* case. However, Council believes a higher penalty is appropriate in this case as the Licensee filed three fraudulent claims for total disability, as opposed to the two claims in Johal. Council concludes that a fine is appropriate in the circumstances to communicate to the Licensee, the insurance industry, and the public, that insurance agents are expected by Council to perform their roles and conduct insurance business competently and ethically.

34. Council is of the opinion that it is in the public's interest for the Licensee to be prohibited from holding a licence for one year, and to require mandatory supervision for two years by a supervisor approved by Council, following the suspension.

35. As Council has determined that a one-year suspension is appropriate, Council also feels it is important that if the Licensee enters the industry again, it would be appropriate that she be supervised by an approved supervisor, for two years.

36. Further, Council concluded that the Licensee be required to complete the Council Rules Course to apprise herself with the relevant duties and requirements of the usual practice of the insurance industry. Furthermore, Council determines that the Licensee be required to complete the "Disability Income Insurance, Individual and Group Course" currently available from Advocis, to address concerns regarding competency of disability products.

37. After weighing all of the relevant considerations, Council views the Licensee to be in breach of Council's Rules and the Code of Conduct and concludes that it is appropriate for the Licensee to be assessed the investigation costs of $1,687.50.

38. With respect to investigation costs, Council believes that these costs should be assessed against the Licensee. As a self-funded regulatory body, Council looks to licensees who have engaged in misconduct to bear the costs of their discipline proceedings, so that those costs are not otherwise borne by British Columbia's licensees in general. Council has not identified any reason for not applying this principle in the circumstances.

## INTENDED DECISION

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

    a. Fine the Licensee $7500, to be paid within 90 days of Council's order;

    b. Suspend the Licensee's life and accident and sickness insurance agent licence for one year, commencing on the date of Council's order;

    c. Assess Council's investigation costs in the amount of $1,687.50, against the Licensee, to be paid within 90 days of Council's order;

    d. Require the Licensee to complete the following courses, or equivalent courses as acceptable to Council: the Council Rules Course for Life and/or accident & sickness insurance, and the Disability Income Insurance, Individual and Group Course (collectively the "Courses") within 180 days of Council's order;

e. Impose a condition on the Licensee's life and accident and sickness agent licence that requires the Licensee to pay the fine and the investigation costs in full and complete the Courses prior to the licence suspension being lifted; and

f. Impose a condition on the Licensee's life and accident sickness insurance agent licence that requires the Licensee to be supervised for a period of two years by a supervisor, as approved by Council, commencing from when the Licensee has completed the above conditions and the suspension is lifted.

40. Subject to the 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.

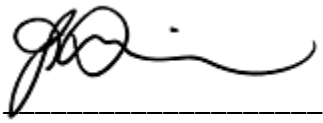
**RIGHT TO A HEARING**

41. If the Licensee wishes to dispute Council's findings or its intended decision, the Licensee may have legal representation and present a case in 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 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 Licensee does not request a hearing within 14 days of receiving this intended decision, the intended decision of Council will take effect.

42. 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 thirty (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 www.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 **3rd day of August, 2022**.

For the Insurance Council of British Columbia



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Janet Sinclair
Executive Director