In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

JUDY LABAN
(the "Licensee")

ORDER

As Council made an intended decision on June 18, 2024, 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 June 27, 2024; and

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

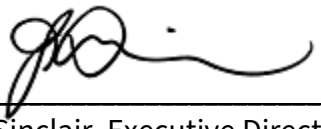
Under authority of sections 231, 236, and 241.1 of the Act, Council orders that:

1. The Licensee is fined $6,000, to be paid by October 16, 2024;

2. The Licensee is assessed Council's investigation costs of $2,312.50, to be paid by October 16, 2024; and

3. A condition is imposed on the Licensee's life and accident and sickness insurance agent licence, and general insurance agent licence that failure to pay the fine and investigation costs by October 16, 2024, will result in the automatic suspension of the Licensee's licences, and the Licensee will not be permitted to complete the Licensee's 2026 annual licence renewal until such time as the Licensee has complied with the conditions listed herein.

This order takes effect on the **18th day of July, 2024.**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

JUDY LABAN
(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, relating to allegations that the Licensee misled an insurer by providing an alternative address for a client to misdirect policy documents, the Licensee engaged in excessive rebating, and that the Licensee relied on instructions from a third party regarding the client's insurance policy and needs.

2. On April 10, 2024, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met via video conference to discuss the investigation. An investigation report prepared by Council staff was distributed to the Committee, the Licensee and the Licensee's legal counsel prior to the meeting. A discussion of the investigation report took place at the meeting and the Licensee and the Licensee's legal counsel were given an opportunity to make submissions and provide further information. After the meeting, the Licensee provided additional information for the Committee's consideration. Having reviewed the investigation materials and after discussing the matter, the Committee prepared a report for Council.

3. The Committee's report, along with the aforementioned investigation report and subsequent submissions from the Licensee, were reviewed by Council at its June 18, 2024, 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 has been licensed with the Insurance Council as a life and accident and sickness insurance agent ("Life Agent") since March 28, 2011, and has held the authority to represent ("ATR") an agency (the "Agency") since April 1, 2016. The Licensee also holds a level 2 general insurance agent licence.

6. The Licensee is contracted to conduct both life insurance and general insurance business with an insurer.

7. On January 24, 2021, a client of the Licensee, the "Complainant", wrote to the Insurance Council with a complaint relating to two life insurance policies (the "Policies") purchased through the Licensee. Policy one was a Versatile Term 30 years, $250,000 single life coverage policy, with an annual premium of $1,042.50 ("Policy 1"). In the application for Policy 1, the stated purpose of the insurance was for coverage of the Complainant's mortgage. Policy two was a Versatile Term 30 years, $200,000 single life coverage policy, with an annual premium of $925 ("Policy 2"). In the application for Policy 2, the purpose of the insurance was for "Personal" coverage.

8. The Complainant raised concerns that the Licensee convinced the Complainant to purchase Policy 2 by paying the premiums for it and that the Licensee failed to advise the Complainant that she ceased paying for the premiums on Policy 2, which caused the policy to lapse. Additionally, the Complainant had concerns that the Licensee used a mailing address where the Complainant could not receive policy documents.

9. In a letter to Council dated January 24, 2021, the Complainant claimed that in October 2016, the Complainant purchased life insurance coverage of $450,000 from the Agency. The Complainant alleged the Licensee advised the Complainant to split the policy into two with coverages of $250,000 and $200,000. The Licensee offered to pay the premium for the $200,000 coverage policy for the Complainant. The Complainant further alleged the Licensee used the Complainant's seasonal cottage address as the mailing address for the Policies instead of the Complainant's address so the insurer would not link the Policies to the Complainant's household policies. In August 2019, the Complainant was "*shocked*" when advised by Agency staff that Policy 2 had lapsed in May 2019. The Complainant found out that the insurer mailed the policy renewals to the Complainant's seasonal cottage address.

10. The Complainant further alleged that the Licensee ceased to pay the premiums for Policy 2 after the Licensee's persistency goals were met.

11. Insurance Council staff requested information from the Licensee regarding this complaint on January 28, 2021. On February 18, 2021, the Licensee provided a response and various documents as submissions.

12. The Licensee advised that the Complainant's spouse, JS, was the Licensee's former partner/co-shareholder in the Agency. JS was a licensed Life Agent at the time the Policies were issued. The Licensee further advised that there was no formal written agreement when the Agency co-partnership was formed. In late 2018, JS indicated he wanted to retire soon, and as there had been no formal business arrangement written down, it took some time for them to work out the terms of the Agency buy-out. In January 2020, the Licensee and JS formalized an agreement with the Licensee buying out JS' shares and interests in the Agency.

13. The Licensee stated that she did not persuade the Complainant to purchase the Policies. The Licensee stated that JS and the Complainant attended the Agency in October 2016 and that the Complainant already knew which policies they wanted to purchase. The Licensee presumed, as JS was a licensed Life Agent, that he had gone through the options and suggested the appropriate policies to the Complainant. The Licensee advised that she followed the instructions of the Complainant and JS. The Licensee also believed that Policy 1 was intended to cover the mortgage for the seasonal cottage property and Policy 2 was for the Complainant's family to be beneficiaries.

14. The Licensee stated that, to her knowledge, JS and the Complainant were not married or in a common-law relationship at the time the Policies were sold to the Complainant. The Licensee believed that the Complainant and JS lived in separate residences. The Complainant and JS had purchased the season cottage property together, and the Licensee states she was advised by JS to use that property's address for the Policies. The Licensee provided a screenshot of a text message where JS states "*I told you to use our lake address*" when discussing the medical exam for the Policies. Additionally, the Licensee stated that JS had access to the Agency's electronic client management system and would have been able to change the Complainant's primary address for the Policies had he wished to have done so.

15. The Licensee could not recall the exact conversation that took place at the time the Policies were purchased in October 2016 but believes there was an agreement that the Licensee would pay the premiums for Policy 2, while JS would pay for Policy 1 in which he was the beneficiary. The Licensee further advised that she and JS had many informal business dealings with each other. They owned properties together, and JS had conducted the renovations to those properties. The Licensee stated that paying the premiums for Policy 2 was a way of repaying the renovation work done by JS as well as other shared expenses between the Licensee and JS.

16. The Licensee provided a Statement of Understanding and Client Option of Advice Received on Product Suitability form dated October 11, 2016, which appears to show the Complainant signed to confirm she had declined to receive an insurance needs analysis from the Licensee. The Licensee advised that she did not find this unusual as the Complainant had access to insurance advice from JS.

17. The Licensee provided a Delivery Checklist form that was signed by the Complainant on November 7, 2016, for Policy 2.

18. The Licensee paid the premiums for Policy 2 until January 3, 2019. The Licensee stated she stopped paying the premiums for Policy 2 at that time as the business relationship with JS was already in the process of being dissolved. The Licensee did not state whether she advised the Complainant directly that she would be terminating payment of the premiums for Policy 2. However, the Licensee stated that the Complainant would have received notices from the insurer that the policy was in danger of lapsing due to non-payment. The Licensee advised that she notified JS in person that she ceased paying the premiums for Policy 2.

19. The Licensee stated that the Agency contacted the Complainant to advise her of the situation. The Licensee provided an email chain from August 16, 2019 to August 21, 2019 between the Agency and the Complainant. SN, an Agency employee, emailed the Complainant advising that Policy 2 had lapsed due to non-payment and asked if she wanted to reinstate it. Attached to the email were the insurer's Notice letters. The Complainant responded stating that she had never received any communication regarding Policy 2 and wanted an explanation as to why the Agency had tried to reinstate Policy 2. The Licensee responded to the Complainant to explain the process. The Complainant responded asking why she was not informed that Policy 2 had lapsed. The Complainant stated that the Licensee had assured her that she would take care of all premiums personally for as long as the Licensee was an agent of the insurer, and that the Licensee asked her to take Policy 2 to help the Licensee's sales quota. The Licensee responded by stating that her agreement with JS was that she would pay for Policy 2 for the first two years and that the policyholder would either cancel or continue with payments thereafter. The Licensee stated that the insurer had sent the Complainant notices to the address provided and that JS could have advised the Complainant at any time. The Licensee denied forcing or promising the Complainant anything or discussing sales quotas. The Licensee further advised that JS knew that the Licensee was paying for Policy 2 for only two years. The Licensee confirmed to the Complainant that there was no correspondence from the Agency to the insurer regarding a reinstatement of Policy 2.

20. A review of the persistency record for the Policies indicated that Policy 2 was paid for 30 months (the Licensee stated she paid for the 30 months) with an annual premium of $925. Although Policy 2 had lapsed, there was no chargeback from the insurer. Policy 1 is still active.

21. On December 23, 2021, Insurance Council staff requested information from JS relating to the allegation made by the Complainant. On January 3, 2021, JS sent an email stating that only one policy was required, but the Licensee advised to do two policies, including a disability waiver that the Complainant did not need, and that the Licensee agreed to pay for the premiums for Policy 2 to meet life insurance goals for the 2016 year. JS advised "*My understanding from what [the Licensee] said and have come to learn was that using the remote address wouldn't link our household and other policies, because if it did then it would not count as a new policy for that year*".

22. TS, a senior manager of the insurer, telephoned the Insurance Council investigator to discuss the matter. TS advised that the client address provided on a new life policy did not affect whether the policy would be classed as new business or not.

23. The Licensee admitted that she should not have involved the payment of insurance policies in her sharing of expenses with JS. The Licensee additionally pointed out that the Complainant waived a financial analysis and fact-finding. The Licensee, as a result of this incident, has completed on her initiative, six different courses relating to ethics, compliance, and document management.

ANALYSIS

24. Council concluded that the Licensee engaged in excessive rebating of premiums for Policy 2. The Licensee should have been aware of her obligations under the Act, which states that a person must not directly or indirectly, pay or allow, or offer or agree to pay or allow, a rebate of a premium or part of it or other consideration or thing of value intended to be a rebate of premium, unless the rebate of premium is less than a prescribed amount or percentage, which is currently set at <25% of the premium. The Licensee should not have used the Complainant's Policy 2 premiums as an avenue to split business expenses or pay JS. In these circumstances, the Licensee paid 100% of the premiums for Policy 2 and therefore breached s. 79(1) of the Act. Council did not find sufficient evidence to support the Complainant's allegations that the Licensee paid the policy premium to hit insurance sales targets. Council did not find evidence the Licensee paid for the premiums for an ulterior motive and therefore did not find any breaches of trustworthiness or good faith on the Licensee's part.

25. Council has determined that the Licensee did not maintain sufficient documentation and records, especially documentation of communications and instructions from a client to ensure mutual understanding. Although JS was a licensed Life Agent and a shareholder of the Agency, the Licensee should not have relied on JS' advice or presumed JS provided the Complainant with advice, without further consultation with the Complainant. As a licensed Life Agent, the Licensee has an obligation to conduct insurance activities in a manner consistent with the usual practice, even if the client is someone who has a personal connection to them. Although the Complainant declined a needs analysis to be conducted, the Licensee should have still provided the Complainant with full disclosure of the Complainant's insurance needs. A needs analysis goes beyond collecting information from the clients but demonstrates why a product will provide value to a client and the benefits of the product. No documentation in the Complainant's file was produced that addressed why the Licensee sold two policies instead of one policy with coverage of $450,000, or whether any comparative quotes were provided outlining the difference between obtaining one policy versus two policies. Although the Licensee advises that JS provided the policy recommendations, the Licensee, as the Life Agent selling the policy, still has an obligation to ensure the Complainant understands what they are purchasing and that there is documentation of the instructions and conversation that took place. Council considers the Licensee's failure to properly document instructions and lack of documentation demonstrating that the Licensee provided full disclosure to the Complainant when selling the Policies, has brought into question the Licensee's competency.

26. When dealing with clients, a licensee must ensure that clients are informed about all aspects of the insurance products they purchase and that they are provided full and fair disclosure of all facts to enable the client to make informed decisions. Without documentation of these discussions, Council is unable to determine whether the Licensee provided the Complainant with all the material information necessary before the Complainant purchased the Policies.

27. Council considered the impact of s. 79(1) of the Act, Council Rules 7(8) and 7(9), and Council's Code of Conduct guidelines on the Licensee's conduct including section 5 ("Competence"), section 7 ("Usual Practice: Dealing with Clients"), and section 13 ("Compliance with Governing Legislation and Council

Rules"). Council concluded that the Licensee's conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

PRECEDENTS

28. Council took into consideration the following precedent cases regarding rebating and competency. While Council is not bound by precedent and each matter is decided on its own facts and merits, Council found that these decisions were instructive in providing a range of sanctions for similar types of misconduct.

29. *Sherlock Hsu* (September 2023): concerned a life agent licensee who was alleged to have submitted applications for insurance products without the client's full understanding and for failing to maintain proper and adequate books and records. The licensee was unable to provide sufficient evidence in the form of documentation for summaries of the discussions that the licensee had with the complainant, documentation of client instructions, client emails, notes, or summaries related to the specific assessment of the client's needs or circumstances. Council determined that without documentation that illustrates the fact-finding or justification of the recommendations and/or strategy sent, it is very difficult for an outside party to assess the transaction in question and objectively verify if the products recommended were suitable or understood by the client. Additionally, Council concluded the licensee failed to engage in the usual practice of the business of insurance by witnessing a signature on the application form when the licensee had not, in fact, witnessed the signature. Council ordered that the licensee be fined $2000, required to be supervised for 24 months, complete courses, and be assessed Council's investigation costs.

30. *Eunice Chew Hoon Gan* (January 2021): concerned a life agent licensee who was found to have given unsuitable advice to an elderly client. The licensee encouraged and facilitated the client, a pensioner with modest assets, to borrow significant sums in 2007 and 2014 to leverage her investment portfolio. The hearing committee considered these investments objectively not suitable for the client, given the client's age and overall financial circumstances. The hearing committee further found a lack of documentation to support the licensee's recommendations or to confirm advice was given to the client. The hearing committee found that the licensee took advantage of an elderly client and put her own financial interests ahead of the client. Following a hearing, the licensee was fined $10,000 (the legislated maximum at the time), required to be supervised for 24 months of active licensing, required to complete various courses, and assessed Council's investigation and hearing costs.

31. *Edraline Buetipo Borginia* (June 2016) concerned a life agent licensee who 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 was 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 a course, and assessed Council's investigation costs.

32. *Patie Kaur Johl* (March 2017), concerned a life agent licensee who misled a client about the terms of an insurance policy, paid the policy premiums herself and had her client sign money orders to give the impression to the insurer that the clients were paying the premiums. Council was also concerned about the licensee's file management and storage practices and lack of understanding of industry tools such as how to generate a policy illustration. Council ordered the licensee to pay a $5,000 fine, required to be supervised for 24 months of active licensing, complete a course, and assessed Council's investigation costs.

33. *Kamna Suri* (November 2020) concerned a life agent licensee who failed to conduct a written financial needs analysis for a client's policy, failed to provide accurate information in the client's insurance application, provided the client with a copy of an illustration for another person, and failed to properly document her conversations with the client. Council determined that the licensee did not act with ill intent; rather, Council found that the licensee's conduct was careless. The licensee had no prior discipline history and there was no objective client harm. Council fined the licensee $1,000, required the licensee to complete courses, be supervised for six months, and assessed Council's investigation costs.

34. *Roel-Reyes Bernardino* (May 2015) concerned a life agent licensee who was found to have misrepresented or failed to adequately explain changes to a client's insurance coverage, and to have had the client sign a blank insurance transactional form. The Council found that the licensee was focused on the sale of insurance at the expense of the client's understanding of the products that the licensee was recommending. There was a finding that the licensee's competency as a Life Agent had been called into question. Council ordered that the licensee be supervised for 24 months of active licensing, required the licensee to complete a course, prohibited the licensee from acting as a supervisor for three years after the completion of his supervision, and assessed Council's investigation costs.

35. *Yanzhi (Carolyn) Jia* (November 2023) concerned a life agent licensee who was found to have misled an insurer by making attestations in client's applications that she had verified the client's identification documents, when the licensee admitted she checked the identification documents of only 20 of the 50 clients at issue. Council determined that the Licensee failed to engage in the usual practice of the business of insurance. Council considered that the licensee was a relatively new Life Agent at the time of misconduct; however, Council believed that the licensee showed a lack of basic understanding of insurance business, which was evident when she used her own banking information on the clients' applications. Council also believed that the licensee did not understand the significance of providing her attestation on the applications. Further, the licensee failed to properly document communications and instructions from clients as she was not able to provide a record of her

conversations with most of the clients. Council ordered the licensee be supervised for two years, complete various courses, and assessed Council's investigation costs.

36. *Yun-Wei (Erica) Niu* (March 2022) concerned a former licensee who faced multiple allegations including failing to act as instructed by clients, was responsible for and failed to inform clients of a life insurance policy lapse, forged signatures on life insurance applications, and rebated the entirety of the first-year premium on a life insurance policy. The investigation also reviewed concerns that the former licensee had conducted insurance business under a name that had not been registered with Council, that she had completed an application for a replacement life insurance policy for a client without adhering to the replacement disclosure statement requirements established by regulation, and that she had failed to notify Council of a lapse in her errors & omissions ("E&O") insurance of over 15 months, during which time she sold an insurance policy. Council determined that the licensee failed to maintain E&O coverage between January 2018 and April 2019, and failed to notify Council of the lapse as required. Council further concluded the former licensee forged the signature of the client's children on two insurance applications. Council found the licensee rebated the entirety of the first year's premiums for a life insurance policy and exceeded the rebating limits established. Council considered a total fine of $14,000 but due to the maximum fine amount as set out in the Act, Council ordered a fine of $10,000. Council further ordered the licensee to complete courses, assessed Council's investigation costs, and should the former licensee become licensed again that she would be required to be supervised for a period of 24 months.

37. *Virlie Aimendral Canlas* (November 2020) concerned allegations that the former licensee incentivized clients to apply for life insurance by offering them rebates for the entire first year's premiums; that he failed to conduct sufficient needs-based assessments for his clients, and was in fact knowingly selling insurance products to clients that went beyond their needs; and that he was conducting unlicensed securities activities. Council found that the former licensee engaged in egregious professional misconduct, for his own personal benefit, that included promising to rebate entire first-year premiums to clients, knowingly selling clients unsuitable insurance products, failing to perform needs analyses or keep sufficient records, and conducting unlicensed securities activities. Council ordered that no insurance application would be considered from the former licensee for a period of five years and ordered investigation costs.

MITIGATING AND AGGRAVATING FACTORS

38. Council considered relevant mitigating and aggravating factors in this matter. Council viewed the Licensee's cooperation throughout the investigation as a mitigating factor. A further mitigating factor Council considered was the Licensee's efforts to self-correct and learn from this incident, by admitting the Licensee's misconduct and by taking six courses on compliance and documentation management before the Review Committee meeting.

CONCLUSIONS

39. After weighing all of the relevant considerations, Council found the Licensee to be in breach of the Council's Rules and the Code of Conduct.

40. Council considered the precedents of the *Niu* and *Johl* case to be the most instructive and believes it is appropriate to fine the Licensee $6,000 for the Licensee's role in rebating contrary to the Act. As of 2020, the Act provides that the maximum fine that Council can order against an individual is $25,000. It is noted that the misconduct in the precedents *Niu* and *Johl* held a maximum fine of $10,000 as allowed by the Act at that time. Council concluded that a higher fine than the precedent *Johl* is warranted, especially given the higher fine threshold allowed in the Act.

41. Although Council had some concerns regarding the Licensee's competency, Council did not conclude that supervision was necessary in this matter. Council has determined that the misconduct resulted from the relationship between the parties and is satisfied this was likely an isolated incident. Additionally, the Licensee has taken the appropriate steps to rectify competency concerns through compliance and document management courses, which the Licensee took on her own initiative.

42. With respect to investigation costs, Council has concluded that these costs should be assessed to 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

43. Pursuant to sections 231, 236 and 241.1(1) of the Act, Council made an intended decision that:

    a. The Licensee be fined $6,000 to be paid within 90 days of Council's order;

    b. The Licensee be assessed Council's investigation costs in the amount of $2312.50, to be paid within 90 days of Council's order; and

    c. A condition be imposed on the Licensee's life and accident and sickness insurance agent licence, and general insurance agent licence that failure to pay the fine and investigation costs within 90 days of the date of Council's order will result in the automatic suspension of the Licensee's licences, and the Licensee will not be permitted to complete the Licensee's 2026 annual licence renewal until such time as the Licensee has complied with the conditions listed herein.

44. 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.

ADDITIONAL INFORMATION REGARDING FINES/COSTS

45. Council may take action or seek legal remedies against the Licensee to collect outstanding fines and/or costs, should these not be paid by the 90-day deadline.

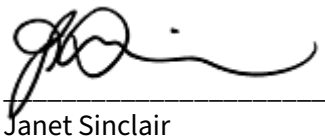
RIGHT TO A HEARING

46. 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.

47. 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.bcfst.ca or visit the guide to appeals published on their website at https://www.bcfst.ca/app/uploads/sites/832/2021/06/guidelines.pdf.

Dated in Vancouver, British Columbia, on the **27th day of June, 2024.**

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director