In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

CYNDAL IRENE TAYLOR
(the "Former Licensee")

ORDER

As Council made an intended decision on January 28, 2025, 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 February 18, 2025; 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) The Former Licensee is fined $10,000, to be paid by June 9, 2025;

2) The Former Licensee is assessed Council's investigation costs of $2,312.50, to be paid by June 9, 2025; and

3) Council will not consider an application for any insurance licence from the Former Licensee for a period of five years, commencing on March 10, 2025, and ending at midnight on March 9, 2030, until the Former Licensee has complied with the conditions listed herein.

This order takes effect on the **10th day of March, 2025**

Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

CYNDAL IRENE TAYLOR
(the "Former Licensee")

1. 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 relating to allegations that the Former Licensee submitted 77 fraudulent insurance claims for health benefits.

2. On December 18, 2024, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met to discuss the investigation. An investigation report prepared by Council staff was distributed to the Committee and the Former Licensee prior to the meeting. The Former Licensee was provided with the opportunity to make submissions at the Committee meeting; however, she explained she could not attend due to illness. The Former Licensee was then provided the opportunity to provide written submissions in lieu of her attendance, but she did not do so.

3. Having reviewed the investigation materials, the Committee prepared a report for Council. The Committee's report, along with the investigation report, were reviewed by Council at its January 28, 2025, 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 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

5. The Former Licensee was licensed with Council as a life and accident & sickness insurance agent ("Life Agent") from September 14, 2015, to August 7, 2024.

6. The Former Licensee was employed as an advisor with an agency from July 23, 2015, until December 7, 2023.

7. On March 12, 2024, an agency representative (the "Complainant") sent a Life Agent Reporting Form to Council indicating that the Former Licensee's employment had been terminated on December 7, 2023, for conducting fraud.

8. The Former Licensee did not advise Council that her authority to represent the agency had been terminated due to allegations of conduct in the nature of fraud.

9. The Complainant submitted that the agency determined the Former Licensee had submitted 77 fraudulent insurance claims, resulting in a total of $9,073 paid to the Former Licensee under the Former Licensee's benefit plan.

10. In a meeting with Council's investigator on July 12, 2024, the Former Licensee stated that she had been experiencing severe physical and mental health issues during the time period in which she submitted the 77 insurance claims. The Former Licensee further stated that she had receipts for some of the benefit claims that were determined to be fraudulent. However, she never provided copies of those receipts to either the Complainant or to Council's investigator.

11. The Former Licensee advised Council's investigator that she intended to repay the funds received from the benefit claims in full and had begun doing so.

12. The Former Licensee relocated to Alberta and became licensed with the Alberta Insurance Council on May 21, 2024.

ANALYSIS

13. Council found that the Former Licensee submitted false insurance claims to her employer, in violation of Council Rule 7(8) and Code of Conduct section 3 ("Trustworthiness"), section 4 ("Good Faith") and section 6 ("Financial Reliability"). Council also found that the Former Licensee failed to notify Council that her authority to represent an insurance agency had been terminated within five business days, contrary to Council Rule 7(3).

14. Council took into consideration the following precedent cases. 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.

PRECEDENTS

15. *Martin Hroch* (February 2020): A former licensee submitted at least 76 fraudulent insurance claims through his agency's employee health and wellness program. The amount claimed in each instance ranged from $25 to $75, leading to a total of $3,045 received fraudulently. Council ordered that no application for a licence would be considered from the former licensee for five years, fined him $5,000 and assessed investigation costs.

16. *Mahin Heidari* (June 2015): Following a hearing, a licensee was found to have 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 behaviour 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 assessed hearing and investigative costs.

MITIGATING AND AGGRAVATING FACTORS

17. Council considered relevant mitigating and aggravating factors in this matter. Council determined that the Former Licensee's efforts to remedy the breach and minimize the consequences to the Complainant by repaying the funds is a mitigating factor. However, Council found several aggravating factors, including the volume and quantum of the fraudulent claims completed, especially as she was a licensed life insurance agent at the time of the misconduct. Council found that the Former Licensee was not forthright with Council's investigator when she advised that she could prove the claims were legitimate by providing receipts but never did provide receipts. Finally, Council found the Former Licensee failed to take accountability for her conduct by suggesting that everything had been a mistake and not admitting to the misconduct and potentially attempting to evade discipline by registering in another province rather than porting her licence.

CONCLUSIONS

18. Council considered a fine of $10,000 to be appropriate. Additionally, Council determined that it was appropriate to prohibit the Former Licensee from applying for a licence from Council for a period of five years.

19. With respect to investigation costs, Council believes that these costs should be assessed to the Former 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

20. Pursuant to sections 231, 236 and 241.1 of the Act, Council made the following intended decision that:

    a) The Former Licensee be fined $10,000, to be paid within 90 days of Council's order;

    b) The Former Licensee be assessed Council's investigation costs of $2,312.50, to be paid within 90 days of Council's order; and

    c) Council will not consider an application for any insurance licence from the Former Licensee for a period of five years, commencing on the date of Council's order, and until the Former Licensee has complied with the conditions listed herein.

21. 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.

ADDITIONAL INFORMATION REGARDING FINES/COSTS

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

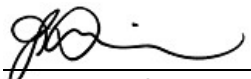
RIGHT TO A HEARING

23. 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 in 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 14 days of receiving this intended decision, the intended decision of Council will take effect.**

24. 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 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 https://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 **18th day of February, 2025.**

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director