In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

ROBIN SINGH KHOSA
(the "Former Licensee")

ORDER

As Council made an intended decision on September 16, 2025, pursuant to sections 231 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 October 15, 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 and 241.1 of the Act, Council orders that:

1. The Former Licensee is fined $5,000, to be paid by February 23, 2026;

2. The Former Licensee is required to be supervised by a life and accident and sickness insurance agent, as approved by Council, for a period of two years of active licensing, should the Former Licensee be licensed in the future;

3. The Former Licensee is required to complete the following courses, or equivalent courses as acceptable to Council, prior to being licensed in the future:

    i. The Council Rules Course for Life and/or Accident & Sickness Insurance Agents;

    ii. Advocis' "Compliance Toolkit: Know Your Client and Fact-Finding" course;

    iii. Advocis' "Compliance Toolkit: Know Your Product and Suitability" course; and

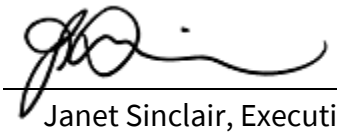
iv. Advocis' "Making Choices I, II, & III: Ethics and Professional Responsibility in Practice" courses;

(collectively, the "Courses")

4. The Former Licensee is assessed Council's investigation costs of $2,125, to be paid by February 23, 2026; and

5. Council will not consider an application for any insurance licence from the Former Licensee until the Courses have been completed and the fine and investigation costs are paid in full.

This order takes effect on the **24th day of November, 2025.**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

ROBIN SINGH KHOSA
(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 sold a client an unsuitable insurance policy by failing to conduct an adequate financial needs analysis and consider alternative insurance products that were more suitable for the client. The Former Licensee was also alleged to have failed to follow the client's instructions to cancel the insurance policy.

2. On June 24, 2025, 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 and the Former Licensee before the meeting, and the Former Licensee was given an opportunity to make submissions and provide further information. The Former Licensee did not attend the meeting. A discussion of the investigation report took place at the meeting.

3. After reviewing the investigation materials and discussing the matter at the June 24, 2025, meeting, the Committee prepared a report for Council that was reviewed by Council at its September 16, 2025, meeting. Council determined that 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 and 241.1 of the Act before taking any such action. The Former Licensee may then accept Council's decision or, within 14 days, 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 first licensed with Council as a life and accident and sickness insurance agent ("Life Agent") on June 11, 2019. His Life Agent licence was cancelled on August 2, 2023, due to non-renewal.

6. The Former Licensee had an authorization to represent an insurance agency (the "Agency") from June 11, 2019, to August 2, 2023.

7. On February 18, 2023, a client of the Former Licensee (the "Complainant") submitted to Council a complaint against the Former Licensee, alleging that he had recommended and sold her an unsuitable insurance policy and failed to cancel it in a timely manner when instructed to do so.

8. The Complainant stated that she met the Former Licensee in June 2021. The Former Licensee told the Complainant he could offer her a savings plan with a universal life insurance policy and critical illness benefits for $180 per month. The Complainant agreed, and in August 2021, the Complainant purchased a universal life insurance policy (the "Policy"). At the time, the Complainant, who was 21 years old, paid $180 per month for $350,000 in life insurance coverage and $100,000 in critical illness insurance coverage.

9. The application for the Policy was dated August 22, 2021. According to the Complainant, the application for the Policy was approved *"quite fast"* and the Former Licensee did not review the application with the Complainant.

10. The Complainant's financial needs analysis, prepared by the Former Licensee, was dated August 23, 2021. This document was not signed by the Complainant. Although an insurable need of $240,000 was listed, no rationale was provided for this amount. There was also no rationale provided for the $350,000 of life insurance coverage that was taken by the Complainant.

11. In November 2022, after deciding that the Policy was not appropriate for her, the Complainant contacted the Former Licensee to inquire about options for cancelling or pausing the Policy. The Former Licensee explained to the Complainant that she could lose all of the contributions she had made to the Policy if it were cancelled, and he referred the Complainant to his manager at the Agency (the "Manager"). At this time, the Former Licensee suggested to the Complainant that she should stop making Policy payments and let the Policy *"keep running for possibly up to another year"* by using the existing fund value to cover the premiums. In this way, the Complainant would still have coverage for a while but would not be contributing to the Policy.

12. On December 21, 2022, the Complainant texted the Former Licensee stating that she had spoken with the Manager and had decided to cancel the Policy. The Complainant asked the Former Licensee to start working on the cancellation process. The Former Licensee responded, *"Sounds good, we'll get it moving."* On December 22, 2022, the Complainant asked the Former Licensee if there was any paperwork she needed to complete to cancel the Policy. The Former Licensee responded that she would not need to sign anything. The Complainant asked when she would get confirmation of the cancellation, and the Former Licensee replied that she should receive it in a few days. The Complainant asked to receive a copy of the cancellation document. On December 23, 2022, the Former Licensee apologized to the Complainant for the time it took to cancel the Policy and informed her that he had *"actually left the business a while back".*

13. On December 27, 2022, the Former Licensee texted the Complainant to say that the Policy was being cancelled. The Complainant asked the Former Licensee to send her confirmation via email. The Former Licensee told the Complainant that the insurer would send her a letter confirming that the Policy had been cancelled. On January 23, 2023, the Complainant contacted the Former Licensee to ask why she had not received a letter from the insurer. The Former Licensee responded that he would ask the Manager, and assured the Complainant that her premium payments had stopped. On January 27, 2023, and February 3, 2023, the Complainant asked the Former Licensee for an estimate of when she would receive her letter confirming that the Policy had been cancelled. On February 4, 2023, the Former Licensee responded that he did not know and advised the Complainant to contact the Manager.

14. The Complainant received a letter from the insurer, dated January 24, 2023, stating that she owed a $540 premium by February 23, 2023. The letter stated that she should contact her advisor, the Former Licensee, if she had any questions. The Complainant contacted the Former Licensee, asking why she had received the letter from the insurer when the Policy was cancelled in December 2022. The Former Licensee responded that it should not have happened. On February 8, 2023, the Former Licensee confirmed that the premium payments had stopped and that he had emailed a request for the Complainant's Policy cancellation letter. Later on February 8, 2023, the Former Licensee told the Complainant that the Policy had not been cancelled in December 2022, but that the premiums had been stopped. The Former Licensee did not explain why the Policy had not been cancelled in December 2022.

15. The Complainant received a letter from the insurer, dated February 6, 2023, confirming that pre-authorized premium withdrawals for the Policy had been stopped. A subsequent letter, dated February 21, 2023, confirmed that premium payments had been suspended and that the monthly insurance premiums would continue to be deducted from the Policy fund value.

16. In an email dated February 21, 2023, the Former Licensee sent the requested cancellation form to the Complainant. On February 27, 2023, the Complainant sent the signed cancellation form to the insurer.

17. On December 20, 2023, the Complainant provided further information to Council staff. The Former Licensee had told the Complainant that the Policy was a long-term savings and investment plan, and that purchasing the Policy through the Former Licensee rather than a bank would be more financially beneficial. The Former Licensee only discussed universal life insurance with the Complainant and did not provide her with any illustrations. Concerning the financial needs analysis, the Complainant stated that she was unaware of this document, that there were discrepancies in it, and that it was neither signed by her nor the Former Licensee. Further, she was unaware that her insurable need was listed as $240,000, as the Former Licensee did not explain this calculation to her. The Complainant confirmed that the Former Licensee did not review the Policy application with her.

18. On January 10, 2024, the Complainant told Council staff that from November 2022 to February 2023, she was led to believe that the cancellation of the Policy had been processed or was being processed, and that the Former Licensee's responses to her cancellation requests were often slow and seemed to be an afterthought.

19. The Former Licensee provided a response to Council staff on April 5, 2023. The Former Licensee stated that he had discussed different types of coverage with the Complainant and presented illustrations of them, and that the Complainant chose the universal life insurance option. The Former Licensee stated that he explained to the Complainant that the Policy was a long-term policy and that there were surrender charges in the first ten years. He further stated that the Complainant approached him in November 2022 about the concerns she had with the Policy. He reminded her of the surrender charges, but she demanded that her premiums be refunded.

20. The Former Licensee stated that he had advised the Complainant on December 11, 2022, that she could pause or cancel the Policy, and on December 27, 2022, the insurer was instructed to pause payments from the Complainant's account. The Former Licensee stated that the Complainant wanted her money back and that she became agitated when she did not receive it. The Former Licensee advised the Complainant to stop paying the premiums directly and have the current value in the fund pay for the premiums, as cancelling the Policy would trigger the surrender charges and she would get nothing back. Also, the Former Licensee advised the Complainant to contact the Manager for a second opinion, as she was more experienced and knowledgeable.

21. As part of the Former Licensee's response to Council, the Former Licensee provided a one-page document listing different types of insurance coverage: term, whole life and universal life. Also included in the response was the advisor disclosure form, dated August 23, 2021, and a handwritten note, dated December 11, 2022, which stated that the Complainant inquired about pausing or cancelling the Policy and that the Former Licensee discussed both options and explained that surrender charges would apply. The Former Licensee signed the note. There were no "Reason Why" letters.

22. On April 12, 2023, in response to Council staff's request for documents relating to the cancellation of the Policy, the Former Licensee stated that he was no longer an active agent and did not have access to his Agency email account. Thus, he could not retrieve copies of the instructions sent to the insurer for the premiums to be stopped and the Policy to be cancelled.

23. On April 20, 2023, the Former Licensee clarified his previous statement that he was no longer an active agent by stating that he meant he was not actively selling new life insurance policies. He confirmed that he was still licensed with the Agency. He stated that the protocol in the Complainant's situation is to advise her to stop paying premiums, and help her understand that cancelling the Policy would trigger surrender charges. The Former Licensee did not explain why he had instructed the insurer at the end of December 2022 to stop withdrawing the premiums instead of cancelling the Policy as per the Complainant's request.

24. In response to Council staff's request for documentation of the protocol previously mentioned by the Former Licensee, the Former Licensee stated that there was no documentation because this is common practice in the industry. The Former Licensee also stated that the Agency had recently changed its email hosting, and that his email inbox was lost in the process.

25. In a subsequent response to Council staff, the Former Licensee explained that the rationale for recommending $350,000 of life coverage was that *"more coverage is always better than not enough coverage"* and that the Complainant agreed with the coverage amount. With respect to the financial needs analysis, the Former Licensee stated that it was not in the Agency's training to review the analysis with the client. The Former Licensee confirmed that he had discussed other types of coverage and illustrations with the Complainant, but did not retain the illustrations. Lastly, the Former Licensee stated that he does not intend to continue working in the insurance industry in British Columbia.

26. On April 25, 2023, the Agency confirmed to Council staff that it had no record of the Former Licensee advising that he was inactive and stated that the Former Licensee remained active and authorized to represent the Agency at the time. However, the Former Licensee told the Agency that he was not actively working as an agent and was only handling old clients. The Agency stated that all active agents have access to their Agency email accounts.

27. In June 2024, the Former Licensee applied for a Life Agent licence with Council. After the Former Licensee failed to explain to Council why he answered *"no"* to whether he was under investigation in the licence application, Council staff closed his application in August 2024.

28. On May 1, 2025, the insurer confirmed to Council staff that commissions were paid and charged back directly to the Agency. The chargeback was charged due to the termination of the Policy after 18 months in force, at a rate of 70% for universal life insurance coverage.

ANALYSIS

29. Council considered the impact of Council's Code of Conduct (the "Code") on the Former Licensee's conduct, including section 3 ("Trustworthiness"), section 4 ("Good Faith"), section 5 ("Competence"), section 7 ("Usual Practice: Dealing with Clients"), section 8 ("Usual Practice: Dealing with Insurers") and section 12 ("Dealing with the Insurance Council of British Columbia"). Council concluded that the Former Licensee's conduct amounted to clear breaches of the aforementioned sections of the Code and the professional standards set by the Code. Licensees are required by Council Rule 7(8) to comply with the Code. Additionally, Council determined that the Former Licensee breached Council Rule 7(9).

30. Council found that the Former Licensee failed to follow the Complainant's instructions to cancel the Policy in a timely manner. When the Complainant requested updates on the cancellation, the Former Licensee lied to the Complainant that the Policy was being cancelled. Additionally, Council concluded that the Former Licensee withheld material information about the Policy during the application stage, as the Former Licensee did not adequately review the application with the Complainant. Council noted that the Former Licensee was not truthful in his licence application to Council when he answered *"no"* in response to a question about whether he was the subject of an investigation. Accordingly, Council found that the Former Licensee breached the principle of trustworthiness.

31. Council determined that by failing to follow the Complainant's instructions to cancel the Policy, the Former Licensee did not carry on the business of insurance in good faith. It was the Former Licensee's

responsibility as an insurance licensee to ensure that the Policy was cancelled and to follow up accordingly with both the insurer and the Complainant. Council was concerned that the Former Licensee repeatedly gave false information to the Complainant and misled her to think that the cancellation was being processed. Council also found that the Former Licensee did not conduct a proper needs analysis for the Complainant, and noted that this analysis was completed the day after the policy application and that it was not signed by the Complainant. For the same reasons, Council found that the Former Licensee breached the usual practice of dealing with clients principle. Council concluded that the Former Licensee failed to protect the Complainant's interests, evaluate her needs, disclose all material information, and act with integrity, competence and utmost good faith.

32. Similarly, Council found that the Former Licensee's actions demonstrated incompetence. Council determined that the Policy was unsuitable for the Complainant, given her insurable need. A competent insurance licensee would not apply for $350,000 of life insurance coverage based on an insurable need of $240,000 listed in the financial needs analysis without appropriate justification. In this case, the Former Licensee justified the higher coverage amount by simply saying that more coverage is always better than less coverage, and that the Complainant agreed with the amount. In addition, Council noted that there was no evidence of illustrations or "Reason Why" letters in the Complainant's file. Although the Former Licensee claimed that he informed the Complainant of different types of insurance coverage, Council noted that this one-page document did not contain a detailed comparison of the different coverages and that it was not specific to the Complainant. Given this, Council concluded that the Former Licensee breached Council Rule 7(9). Further, Council questioned the Former Licensee's claims that it was industry practice to pause the premium payment in the Complainant's case, and that the Complainant was not required to sign the financial needs analysis. Combined with the Former Licensee's failure to cancel the Policy in a timely manner, the Former Licensee did not act in a manner consistent with the usual practice of the business of insurance in the circumstances.

33. Council determined that the Former Licensee did not represent the insurer's products fairly and accurately, and therefore breached the usual practice of dealing with insurers principle. In addition to failing to provide full and accurate information about the Policy to the Complainant, the Former Licensee failed to provide information about the actual needs of the Complainant to the insurer in the policy application. The Former Licensee also failed to promptly communicate the Complainant's cancellation request to the insurer.

34. Council noted multiple instances where the Former Licensee made misstatements to Council staff, including in regard to his licence status, access to the Agency's email and systems, and his response in the licence application as to whether he was being investigated. As a whole, Council determined that the Former Licensee did not respond promptly and honestly to inquiries from Council.

PRECEDENTS

35. Before making its decision in this matter, 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.

36. *Andreas Lauri Hinkkala* (August 2019): concerned a life and accident and sickness insurance agent who recommended insurance products to a client and her two children who could not reasonably afford the premiums. In particular, the licensee redeemed and transferred the client's mutual funds to pay for the premiums on policies that the licensee sold. Additionally, the licensee let a policy lapse three times while he was the agent of record and did not maintain records of communication with clients. Council found that the insurance products the licensee recommended were grossly unsuitable considering the financial circumstances and needs of the client. Council also found that the licensee was motivated by insurance commissions in recommending the insurance products to his clients. Council determined that the licensee failed to carry on the business of insurance in good faith, conduct all insurance activities in a competent manner, and act in the usual practice when dealing with clients. Council ordered that the licensee be supervised for two years and be required to complete an ethics course. The licensee was also fined $2,500 and assessed investigation costs.

37. *Kamna Suri* (November 2020): concerned a relatively new life and accident and sickness insurance agent 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 the Council Rules Course and an ethics course, required the licensee to be supervised for six months and assessed investigation costs.

38. *Rosalie Abando Ninalga* (March 2024): concerned a life and accident and sickness insurance agent who failed to maintain documentation of client instructions, client notes and summaries related to the assessment of a client's needs. Council noted that without a properly documented needs analysis it is difficult to assess the suitability of the insurance products sold to the client. Council found that the licensee's practice did not align with the usual practice of the business of insurance and, as a result, there could be a risk to the public. Council ordered that the licensee be supervised for one year, required the licensee to complete the Council Rules Course and several courses through Advocis, and assessed investigation costs.

39. Council found *Hinkkala* to be most similar to the subject case due to the findings that the policies were unsuitable for the clients and that there was a lack of an adequate needs analysis.

MITIGATING AND AGGRAVATING FACTORS

40. Council considered relevant aggravating and mitigating factors. In terms of aggravating factors, Council noted that the Complainant was financially harmed by purchasing the Policy, as it was unsuitable for the Complainant's needs. Council was troubled that the Former Licensee repeatedly

lied to the Complainant by saying that he would cancel the Policy. In doing so, the Former Licensee did not act in the best interests of the Complainant. Council noted that the Former Licensee also lied to the Complainant about his licence status. Council found that the Former Licensee derived a financial benefit from the Policy, despite the chargeback from the insurer. Further, Council found that the Former Licensee was evasive and made material misstatements during Council's investigation. As a whole, Council determined that the Former Licensee's actions demonstrated a flagrant disregard for the laws governing the Former Licensee's conduct.

41. Council did not find any relevant mitigating factors. Council considered that the Former Licensee was licensed for about two years at the time of misconduct, but did not find this to be a mitigating factor. Council also considered that the misconduct involved only one client and one policy; however, the Committee believed that the absence of other complaints against the Former Licensee in this case was not a mitigating factor.

CONCLUSIONS

42. After weighing all of the relevant considerations, Council concluded that the Former Licensee should be fined $5,000 and supervised for a period of two years of active licensing should he be licensed again in the future. Council concluded that supervision is necessary for the Former Licensee to receive oversight and guidance in his practice.

43. Council also concluded that the Former Licensee be required to take courses on ethics, fact-finding and product suitability, as well as the Council Rules Course.

44. Council has determined that investigation costs should be assessed against the Former Licensee. As a self-funding regulator, the cost to investigate the misconduct of a licensee or former licensee should not be borne by members of the insurance industry unaffiliated with the investigation. This is particularly true when the evidence is clear that the actions of a licensee or former licensee have amounted to misconduct.

INTENDED DECISION

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

    a. The Former Licensee be fined $5,000, to be paid within 90 days of Council's order;

    b. The Former Licensee be required to be supervised by a life and accident and sickness insurance agent, as approved by Council, for a period of two years of active licensing, should the Former Licensee be licensed in the future;

c. The Former Licensee be required to complete the following courses, or equivalent courses as acceptable to Council, prior to being licensed in the future:

   i. The Council Rules Course for Life and/or Accident & Sickness Insurance Agents;

   ii. Advocis' "Compliance Toolkit: Know Your Client and Fact-Finding" course;

   iii. Advocis' "Compliance Toolkit: Know Your Product and Suitability" course; and

   iv. Advocis' "Making Choices I, II, & III: Ethics and Professional Responsibility in Practice" courses;

   (collectively, the "Courses")

d. The Former Licensee be assessed Council's investigation costs of $2,125, to be paid within 90 days of Council's order; and

e. Council will not consider an application for any insurance licence from the Former Licensee until the Courses have been completed and the fine and investigation costs are paid in full.

46. 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 COSTS

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

RIGHT TO A HEARING

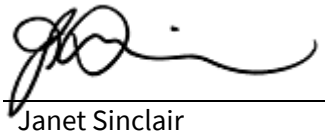
48. If the Former Licensee wishes to dispute Council's findings or its intended decision, the Former Licensee may have legal representation and present a case in a hearing before Council. Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Former Licensee **must give notice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

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

Dated in Vancouver, British Columbia, on the **15th day of October, 2025.**

For the Insurance Council of British Columbia



Janet Sinclair
Executive Director