ALBERTA INSURANCE COUNCIL
(the "AIC")

In the Matter of the *Insurance Act*, R.S.A. 2000 Chapter I-3
(the "Act")

And

In the Matter of Richard (Rick) Charles Talbot
(the "Agent")

DECISION
OF
The Life Insurance Council
(the "Council")

This case involved allegations pursuant to ss. 480(1)(a) or (c) of the Act. Specifically, it is alleged that the Agent collected insurance premium funds from his client and did not pay the insurance premium to the insurer but instead retained the funds for his own use. In so doing, it is alleged that he is guilty of untrustworthiness or dishonesty in his dealings with his client, the insurer, and his MGA (Custom) and that this constitutes an offence pursuant to s. 480(1)(a) of the Act. In the alternative, it is alleged that the Agent failed to pay premium collected from his client to the insurer and instead used their funds without their consent. In so doing, it is alleged that he is guilty of an offence pursuant to s. 480(1)(c) of the Act.

Facts and Evidence

This matter proceeded by way of a written Report to Council dated August 21, 2015 (the "Report"). The Report was forwarded to the Agent for his review and to allow the Agent to provide the Council with any further evidence or submissions by way of Addendum. The Agent signed the Report on September 7, 2015 and did not adduce any further evidence.

The Agent was the holder of an Accident & Sickness Certificate of Authority, and was licensed since June 28, 2000. By letter dated March 23, 2015, Manulife's VP Compliance ("IM") wrote to the AIC to lodge a complaint against the Agent. In addition to the letter, Manulife provided the AIC with a copy of the compliance report it completed after discussions with the Agent and its investigation. The compliance report included a letter that Manulife wrote to the Agent that read, among other things:

> I would like to thank you for your cooperation in my investigation around the accepting of premiums due to Manulife and your failure to remit at least one of them when it was due. It

> is unfortunate that your financial pressures have caused you to make decisions that have affected your relationship with [Custom], the insurance carriers, insurance councils and of course the code of conduct of all concerned. …We are also going to cancel your contract with our MGA… We will work with you to assist in an orderly transition of your existing business ….

On April 8, 2015, an AIC investigator wrote to IM to request, among other things, a copy of his investigation file. IM responded on April 8, 2015 and April 10, 2015 and provided the information requested by the investigator. IM indicated this was the only complaint they had received on the Agent in 20 years. Custom thought there was another complaint from one of the Agent's clients ("SG"); however, this client provided a letter saying that he had no complaint or concern with the Agent and that he would recommend the Agent to prospective insurance clients without hesitation.

On May 9, 2015, IM provided additional information including copies of cheques written to the Agent's company that were cashed by the Agent. IM confirmed that the Agent did not subsequently pay the client's premiums to the insurer.

On June 15, 2015, the investigator wrote to the client ("AN") to gather more information about the events that led to his complaint to Manulife. AN responded by way of email dated June 18, 2015 as follows:

> 1. I came into contact with [the Agent] around 2006 through [a "Benefits Provider"]. [The Benefits Provider] was providing my holding company with insurance and health trust benefits. [The Agent] was introduced to handle my disability insurance.
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> 2. I was late with my 2014 premium (due in July) and mentioned it to [the Agent]. This had happened before and [the Agent] offered to expedite my premium to Manulife to prevent any potential lapse in coverage. However, this time he asked that I make the cheque ($3,677.23) dated July 20, 2014) out to his company, Abraxas, rather than Manulife as in the past. He also mentioned that I would be receiving a premium refund of about $7000 from Manulife for being claims-free a certain period (eight years, I think). Later he told me that he had a marketing allowance which allowed him to offer me a premium-free third year (2017) if I paid up front for two years (2015 & 2016). I thought I was being offered this promotion by the insurance company because of my claims-free record. However, I did ask him directly if this was normal policy and he claimed that it was so.
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> Around October 2014 I asked [the Agent] when I would be receiving my refund from Manulife. He mentioned that he would inquire from the insurer and responded that Manulife had not credited the account properly due to some difficulties in accounting systems due to integrating with another company. He claimed that he'd encountered this type of problem before. I contacted Manulife and they stated that they had not received any funds for my account. Again, I mentioned this to [the Agent] and again her (sic) reiterated that he was

> trying to resolve the issue. As I had worked with [the Agent] for nearly eight years, I trusted him and also agreed to to (sic) provide him with a cheque for the 2015 & 2015 premiums (cheque for $7,354.46 dated November 20, 2014 to Abraxas)
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> I then received a refund cheque from Manulife for $3,564.53 dated November 17, 2014 (so it would have been delivered after November 20, 2014). I called Manullife (sic) to ask about the sum being only half of the expected amount and they pointed at (sic) that they deducted the 2014 premium as it had not been paid. I then called [the Agent] and told him what happened and he claimed that Manulife had made an error. Then he offered to pay me my premium directly from his company so that I was not inconvenienced further. However, he never made good on his promise to refund my 2014 premium and always had an excuse when I called him to follow up on payment. November turned into December and 2014 turned into 2015.
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> Sometime in February (not sure if early March)2015 [the Agent] claimed that he was having difficulties in getting me my refund because he was short on cash due to ta (sic) legal matter involving his son. I thought this odd because I made the cheque out to Abraxas and not [the Agent] personally. I expect the business and individual to be separate and I had certainly not intended my money to be used as a personal loan. In any case he promised to get me my refund so I was still not overly concerned. In fact, I felt sorry for his predicament. However, on follow up calls he kept avoiding me and eventually failed to respond to my calls. I became concerned about what was going on.
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> In March I called ["DO"] of [the Benefits Provider] and asked him if he had recently had any contact with [the Agent] and he asked me what my concern was. I recounted my story as above and he promptly indicated that [the Agent's] conduct was unprofessional and that he recommended that I sanction an investigation. Shortly after [DO] pushed the matter forward to the proper individuals I received a call from [the Agent] indicating that he had some of my refund (not the full amount) and that he wanted to deliver it promptly. I did not respond to his call at that time or any other calls as [DO] recommended I refrain from any contact until the investigation was completed….

DO advised the investigator that he had referred AN to the Agent because the Agent specialized in disability insurance. DO also confirmed the information in AN's response and he provided proof of the cheques made out to Abraxas Insurance Inc. ("Abraxas") by AN. Abraxas is the name of the company of the Agent. DO also indicated that the Agent had offered to repay only a part of the monies to AN ($2,100 of the $11,031.69 that the Agent had taken from AN). In his response DO also stated:

> Spoke to [AN] March 20, 2015. This is when he told me about the incident. He relayed the following.
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> When [AN's] 2014 annual premium came due [the Agent] told [AN] to cut a cheque to [the Agent's] company [Abraxas] instead of Manulife and he would pay the premium for him. [AN] did.

> Then [the Agent] came back to [AN] and said if he paid his 2015 and 2016 premiums to [Abraxas] as well then he would pay the 2017 premium for him out of his marketing allowance. [AN] did.
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> [AN] was scheduled to have his return of premium [("ROP")] on his policy this year of roughly $7300. When he got his ROP it was half that amount as the 2014 premium (approx. $3600) remained unpaid and was deducted from his return of premium.
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> [The Agent] kept saying it was a clerical error on Manulife's end and he did send in the cheque. That was in October of 2014. Since then [the Agent] has been dodging [AN's] phone calls and correspondence regarding the issue. Now nearly 6 months later [AN] is still waiting to be reimbursed for his 2014 premium that was paid from his ROP.
> [AN] is not confident that [the Agent] will pay the 2015, 2016 or 2017 premiums either as agreed.
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> [AN] wants his money back (roughly $11,000), however it seems [the Agent] has spent it and does not have the money anymore."

To obtain the Agent's side of the story, the investigator wrote to the Agent on June 26, 2015. The Agent responded on July 10, 2015 and advised the investigator that this was the only complaint he had in his "21 years of practice". He also stated that he had made efforts to call AN in order to pay him but that his calls and text messages went unanswered. He claimed that a family member was charged with a serious criminal offence in February 2014 and that the pressure of funding the defence led to his actions in and around AN.

On July 13, 2015, the investigator spoke with the Agent and asked him when he would be able to repay AN. The Agent replied that it may take him a month or so and he could do it in two instalments. The Agent spoke to the investigator again on July 22, 2015 and he advised the investigator that he had acquired a loan from a family member to satisfy the amount outstanding to AN. On July 23, 2015, the Agent emailed the investigator to confirm that he had made arrangements to pay AN in full and settle the matter amicably and AN subsequently confirmed that the Agent reimbursed him.

Discussion

In order to conclude that the Agent has committed an offence pursuant to s. 480(1)(a) of the Act, the Report must prove, on the basis of clear and cogent evidence, that it is more likely than not that the Agent committed the act as alleged. The requirement of clear and cogent evidence reflects the fact that our findings can dramatically impact an insurance agent's ability to remain in the industry.

Additionally, the elements of s. 480(1)(a) offences were outlined by the Alberta Court of Queen's Bench in *Roy* v. *Alberta (Insurance Councils Appeal Board)*, 2008 ABQB 572 (hereinafter "*Roy*"). In *Roy*, the Council found that an Agent committed an offence pursuant to s. 480(1)(a) of the Act when he attested to completing the applicable CE when he did not, in fact, have the required CE. The Insurance Councils Appeal Board dismissed the appeal and also found the agent guilty of the offence. The agent subsequently appealed to the Court of Queen's Bench. In his reasons for judgment dismissing the agent's appeal, Mr. Justice Marceau reviewed the requisite test and wrote at paragraphs 24 to 26:

> [24] The Long case, albeit a charge under the Criminal Code of Canada where the onus of proof is beyond a reasonable doubt (not on a preponderance of evidence as in this case), correctly sets out the two step approach, namely the court or tribunal must first decide whether objectively one or more of the disjunctive elements have been proven. If so, the tribunal should then consider whether the mental element required has been proved. While the Appeal Board said it was applying the Long decision, it did not make a finding as to whether step 1 had been proved with respect to each of the disjunctive elements. Rather it immediately went into a step 2 analysis and found that the mental element required for untrustworthiness might be less than the mental element required for fraud (as a given example).
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> [25] I am of the view that statement was in error if it was made to convey a sliding scale of mens rea or intent depending on which of the constituent elements was being considered. In my view, the difference between the disjunctive elements may be found in an objective analysis of the definition of each and certainly, as demonstrated by the Long case, what constitutes fraud objectively may be somewhat different from untrustworthiness. However once the objective test has been met, one must turn to the mental element. Here to decide the mental element the Appeal Board was entitled, as it did, to find the mental element was satisfied by the recklessness of the Applicant.
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> [26] While the language used by the Appeal Board may be characterized as unfortunate, on this review on the motion of the Applicant I need not decide whether the Appeal Board reasonably could acquit the Applicant on four of the disjunctive elements. Rather, the only matter I must decide is whether the Appeal Board acting reasonably could conclude, as they did, that the Applicant's false answer together with his recklessness justified a finding of "untrustworthiness". (emphasis added)

In applying this test to the case before us, it is clear that the Agent misappropriated premium funds that AN provided him. It is equally clear that the Agent lied to the client about what he did with the premium payments and the reason that Manulife did not obtain them. On numerous occasions, the Agent told the client that the mistake was as a result of a clerical error on Manulife's part and that he would try to clear up the matter all the while the Agent knew that he took the client's funds and he was not in a position to reimburse the client. In doing this, the Agent compounded the original

untrustworthy conduct by covering up his actions and dishonestly blaming someone else. Given the facts in their entirety, we are satisfied that the Agent acted intentionally and that he was untrustworthy and dishonest as contemplated in s. 480(1)(a) of the Act.

As to the appropriate sanction for this conduct, we typically have the ability to levy civil penalties in an amount up to $5,000.00 for offences pursuant to s. 480(1)(a) and 13(1)(a) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. We also have the ability to order that certificates of authority be revoked for one year or suspended for a period of time. However, in this case the Agent no longer holds a certificate of authority and this option is; therefore, not open to us.

Based on the facts in this case, including the fact that this is the Agent's first offence under the Act and the length of time he has been licensed without incident, that he reimbursed the client and his cooperation in the investigation, we order that a civil penalty in the amount of $2,500.00 be levied against the Agent pursuant to ss. 480(1)(a) of the Act and 13(1)(a) of the *Certificate Expiry, Penalties and Fees Regulation*, A.R. 125/2001. The civil penalty must be paid within thirty (30) days of receiving this notice. In the event that the penalty is not paid within thirty (30) days, interest will begin to accrue. The Agent has thirty (30) days in which to appeal this decision by filing a notice of appeal with the Office of the Superintendent of Insurance.

This Decision was made by way of a motion made and carried at a properly conducted meeting of the Life Insurance Council. The motion was duly recorded in the minutes of that meeting.

Date: December 7, 2015

Original signed by
Jim Brownlee
Life Insurance Council

Extract from the *Insurance Act*, Chapter I-3

Appeal

482 A decision of the Minister under this Part to refuse to issue, renew or reinstate a certificate of authority, to impose terms and conditions on a certificate of authority, to revoke or suspend a certificate of authority or to impose a penalty on the holder or former holder of a certificate of authority may be appealed in accordance with the regulations.

Extract from the *Insurance Councils Regulation*, Alberta Regulation 126/2001

Notice of appeal

16(1) A person who is adversely affected by a decision of a council may appeal the decision by submitting a notice of appeal to the Superintendent within 30 days after the council has mailed the written notice of the decision to the person.

(2) The notice of appeal must contain the following:

a) a copy of the written notice of the decision being appealed;

b) a description of the relief requested by the appellant;

c) the signature of the appellant or the appellant's lawyer;

d) an address for service in Alberta for the appellant;

e) an appeal fee of $200 payable to the Provincial Treasurer.

(3) The Superintendent must notify the Minister and provide a copy of the notice of appeal to the council whose decision is being appealed when a notice of appeal has been submitted.

(4) If the appeal involves a suspension or revocation of a certificate of authority or a levy of a penalty, the council's decision is suspended until after the disposition of the appeal by a panel of the Appeal Board.

Address for Superintendent of Insurance:

Superintendent of Insurance
Alberta Finance
402 Terrace Building
9515-107 Street
Edmonton, Alberta T5K 2C3