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INSURANCE COUNCILS APPEAL BOARD OF ALBERTA

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In the Matter of the Appeal of Robert Arnold from the Decision of the General Insurance Council dated June 18, 2013

BETWEEN:

ROBERT ARNOLD

Appellant

- and -

GENERAL INSURANCE COUNCIL

Respondent

Heard on Wednesday, April 23, 2014

NANCY E. CUMMING, Q.C.	Chair of Panel
STEVE BOOKER	Panel Member
KEVIN PALMER	Panel Member

REASONS FOR DECISION AND ORDER

PROCEEDINGS TO DATE

The Appellant is the holder of a valid Certificate of Authority to act in the capacity of a general insurance agent. He has been a licensed general insurance agent since at least January 3, 1996. The Appellant is also the Designated Representative of Mitchell Insurance Brokers ("MIB") and thus was responsible for the supervision of MIB.

On January 4, 2012, the Alberta Insurance Council ("AIC") received a faxed letter of complaint from *E.S. attaching a number of documents and requesting an investigation by the AIC into the Appellant's actions and the business practices of MIB. *E.S.

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indicated in his letter of complaint that the Appellant submitted a premium without his knowledge or consent and also used threatening and abusive language towards him.

An AIC investigator wrote to the Appellant on January 30, 2012 and requested that the Appellant provide answers to a number of questions arising from *E.S. letter of January 4, 2012 and attachments.

The Appellant responded by sending two faxes, both dated January 31, 2012, and both of which included a number of attachments. The Appellant sent two further faxes to the investigator on January 31, 2012 and February 1, 2012.

The investigator wrote to the Appellant on February 7, 2012 raising further questions and requesting responses. The Appellant provided further replies by way of faxes to the investigator dated February 9, 2012, February 15, 2012, and February 22, 2012.

The Investigator again wrote to the Appellant on February 23, 2012 requesting further responses from the Appellant. The Appellant replied by way of letters dated February 17, 2012, March 2, 2012 (two letters), March 5, 2012, March 16, 2012, March 19, 2012, March 22, 2012, and January 27, 2013.

During the course of the investigation, the investigator also requested and received documents and information from Portage Mutual Insurance, Intact Insurance, and an employee of MIB, *R.J.

The Investigative Report to the General Insurance Council ("GIC") was completed on January 16, 2013. The Report alleged that the Appellant misrepresented *E.S. policy as one that automatically renewed, then forwarded premium to the insurer without the knowledge or consent of *E.S. who did not wish to renew the policy, and then attempted to collect the premium, along with late charges, which *E.S. had not consented to verbally or in writing, in addition to court filing fees for a "potential" lawsuit. The Report also alleged that the Appellant was deceptive or dishonest in his statements made to the AIC regarding *R.J. knowledge of the situation, having asked her to falsify a letter to the AIC regarding the matter which she had no knowledge of.

The Investigative Report thus alleged that the Appellant was guilty of misrepresentation and/or acted in a dishonest or untrustworthy manner, contrary to Section 480(1)(a) of the *Insurance Act*.

The Investigative Report stated that in addition, or in the alternative, the Appellant attempted to collect renewal premiums for a policy belonging to *E.S. which policy should have lapsed at

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the expiry of the previous term, made false or misleading statements and representations to the AIC during the course of the investigation, and attempted to coerce *E.S. to pay alleged outstanding premiums by utilizing threatening and/or abusive language in his communications with *E.S. contrary to Section 509(a) and (c) of the *Insurance Act*.

The GIC rendered its decision on June 18, 2013.

In coming to its decision, the GIC considered the Investigative Report to the GIC dated January 16, 2013, a letter written by the Appellant dated January 27, 2013 with attachments, as well as a memo from the AIC dated February 25, 2013.

The GIC concluded that although the Appellant's conduct surrounding *E.S. file and the investigation was deplorable, immature, and completely unprofessional, it was prepared to give the Appellant the benefit of the doubt concerning the allegation made under Section 480(1)(a) of the *Insurance Act* and find him not guilty.

The GIC also considered the allegation made under Section 509 of the *Insurance Act*. The GIC concluded that the Appellant acted in an unfair manner towards *E.S. and also made false and misleading statements to the AIC during the course of the investigation. The GIC thus concluded that the Appellant had contravened Section 509(1)(c) of the *Insurance Act*. The GIC ordered a civil penalty of $1,000.00 and ordered that the Appellant's general insurance Certificate of Authority be suspended for a period of six months.

The Appellant appealed by letter to the AIC dated July 15, 2013.

By letter dated August 6, 2013, the Superintendent of Insurance appointed the Panel to hear the Appeal. A Notice extending the time for the Hearing was served on the parties on September 6, 2013. A Notice of Hearing was served upon the parties on January 23, 2014 fixing the date of Wednesday, April 23, 2014 for the Hearing.

The Hearing proceeded as directed. There were no objections taken to the Panel's appointment, nor its composition or right to hear the Appeal.

At the outset of the Hearing, a number of Exhibits were entered as follows:

Exhibit 1 - Letter dated August 6, 2013 appointing the Appeal Panel
Exhibit 2 - Decision of the General Insurance Council dated June 18, 2013
Exhibit 3 - Record of Proceedings filed with the Panel pursuant to Section 20 of the *Insurance Councils Regulation*

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Exhibit 4 - Notice of Appeal dated July 15, 2013

Exhibit 5 - Notice of Extension of date for Hearing dated September 6, 2013

Exhibit 6 - Notice of Hearing dated January 23, 2014 setting the date of Hearing to April 23, 2014

During the presentation of oral evidence, further Exhibits were entered as follows:

Exhibit 7 - Certificate of Insurance from Rogers Insurance Ltd. dated December 22,2011

Exhibit 8 - Memo from Mitchell Insurance Brokers to *E.S. and *L.S. dated January 6, 2014

The Appeal Hearing was heard on April 23, 2014. The Panel had as evidence before it the above-noted Exhibits, as well as the *viva voce* evidence of *J.D.), *R.J. , and *E.S. on behalf of the AIC, as well as the *viva voce* evidence of the Appellant, Robert Arnold.

Written submissions were provided by both counsel following the Appeal Hearing. Written submissions were all received by July 21, 2014.

PRELIMINARY COMMENTS

The Appeal Panel heard *viva voce* evidence from *J.D. , E.S. , R.J. and the Appellant. In the opinion of the Panel, the Appellant was generally evasive, contradictory, and argumentative in giving his evidence.

FACTS

Based upon the evidence before it, the Panel finds the facts on this Appeal to be as follows:

The Appellant is the holder of a valid Certificate of Authority to act in the capacity of a general insurance agent. He has been a licensed general insurance agent since at least 1996. He is also the Designated Representative of MIB.

Stephen Harris Professional Corporation d/b/a Kensington Health Group ("SHPC") operated as a chiropractic clinic and had been a client of MIB for several years. However, on May 31, 2010, SHPC was purchased by *E.S. At that time, the clinic held a commercial insurance policy with Portage Mutual Insurance ("Portage"), which insurance had been placed through MIB. The term of the policy was from June 11, 2010 to June 11, 2011. On June 1, 2010, *E.S. changed the name of SHPC to *E.L.S. Professional Corporation ("E&L"). *E.S. t made

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a written request to MIB that MIB change the name on the insurance policy to *E.L.S. Professional Corporation. MIB complied with the request.

On May 31, 2011, MIB sent a renewal invoice to E&L, enclosing a renewal policy declaration with Portage for a policy period from June 11, 2011 to June 11, 2012. The renewal invoice indicated an amount due of $1,118.00. The bottom of the renewal invoice stated "Policies not required must be returned to effect cancellation. All late accounts are subject to a $50.00 late charge."

*E.S. had not requested that MIB renew the Portage policy. At no time did he return the renewal policy declaration to MIB or Portage.

The Portage policy was an agency-bill policy. Rather than billing the insured directly, an agency-bill policy would be paid by the broker, MIB. Portage would provide the renewal policy declaration to MIB. MIB was to then forward it on to the insured, together with an invoice for the required premium. It was MIB's responsibility to advise Portage whether the renewal was required or not. If the renewal documents or a signed request for cancellation were not returned within 30 days of renewal date, but MIB advised Portage that the insured had paid nothing, then Portage would issue a "registered letter" of cancellation allowing a "flat" (full refund) to the broker. This was different from a direct-bill policy whereby the insurer would collect the premium directly from the insured.

MIB did not receive payment for the June 11, 2011 invoice from E&L within 30 or 60 days. MIB did not notify Portage that payment had not been received and that the Portage policy should be cancelled. MIB did not at that time attempt to contact *E.S. directly to discuss the renewal policy or the non- payment of the invoice.

MIB sent an overdue notice to E&L on August 25, 2011 indicating that the previous invoice for $1,118.00 remained outstanding. Again, at that time MIB did not contact *E.S. directly to determine whether the insurance was required, nor why the invoice had not been paid. At no time did *E.S. request that the Portage renewal policy be issued or request that the premium be paid by MIB on E&L's behalf.

MIB paid the premium less its commission to Portage on August 31, 2011. At that time, MIB had not received any payment from E&L. MIB had not attempted to contact *E.S. to discuss the renewal or the invoice. MIB did not notify Portage that payment had not been received by E&L and that the Portage policy should be cancelled. MIB sent out a Final Notice on September 21, 2011 indicating that if the amount due of $1,118.00 was not paid, together with a late fee, that the policy would be cancelled. *E.S. had never signed a late fee agreement. *E.S. did not respond to the Final Notice as he felt he was being asked to pay for something that he had not

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requested and did not want. Again, no one from MIB attempted to contact *E.S. directly to discuss the invoice.

On October 5, 2011 and November 23, 2011, someone from MIB left messages for * E.S. to call.

It was MIB's policy to send out the initial renewal invoice, followed by an overdue notice 30 days after the expiry day and a further final notice 30 days thereafter. This policy allowed for three invoices to go out before MIB would have to pay the premium to Portage. In the case of E&L, MIB did not follow this policy. Rather, the invoices were sent out much later than as per the MIB policy.

An employee of MIB advised the Appellant of the E&L unpaid invoices in approximately November 2011. The Appellant contacted Portage on November 24, 2011 requesting that the policy be cancelled by registered letter. He also requested that the policy be back-dated for a FLAT as it was "lost in our system". On the same day, the Appellant sent an email to *E.S. demanding that he pay $1,318.00, and also provide a copy of * E.S. new policy.

The Appellant then sent a fax to E&L dated December 14, 2011 which included the following:

> "Amount past due including late charges $1,318.00. If this is NOT received by December 31, 2011 collection actions will be initiated."

On December 22, 2011 at 11:01 a.m., Portage sent a fax to the Appellant stating that return premium would be refunded totaling $477.00. On that same date, * E.S. provided the Appellant with a Certificate of Insurance from Rogers Insurance.

On December 22, 2011, at 1:03 p.m., the Appellant sent a fax to * E.S. stating that a lawsuit would be filed if the earned premium was not paid. A second fax was sent by the Appellant to [redacted] *E.S. on December 22, 2011 at 1:32 p.m. The Appellant stated that he expected the fully earned premium to be paid or he would pursue legal action. The letter stated that earned premium while on risk was "$841.00 including late charges". A third fax was sent by the Appellant on the same day at 2:51 p.m. This fax stated:

> "It is rather obvious you are not capable of telling the truth and you expect others to pay your bills. I have contacted INTACT your new insurer and have asked that they do not issue a new policy on your behalf until such time as the earned premium is PAID to our firm on your cancelled Portage policy."

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The Appellant sent a fax to Intact on December 22, 2011at 2:51 p.m. The fax did not ask Intact not to issue a new policy. The fax asked whether Intact took into consideration a registered letter of cancellation when considering new business.

*E.S. then called the Appellant later on the afternoon of December 22, 2011, as he felt that the tone of the faxes suggested to him that the Appellant was upset. *E.S. felt that there appeared to be a misunderstanding and he wanted to clear it up by offering to pay half the cost. During the course of the conversation, the Appellant accused *E.S. of lying and called him a "fucking liar" at least three times. The conversation then ended. The Appellant denied that he swore at *E.S. The Appeal Panel accepts the evidence of *E.S. regarding the content of the conversation and not the evidence of the Appellant.

A further fax was then sent by the Appellant to *E.S. on December 22, 2011 at 3:22 p.m. The letter included the following:

> "If you need further explaining I can drop by your office and discuss this with you. Please have a check prepared in the amount of $841.00 and have this certified. If the earned premium is NOT paid I will file a lawsuit against you. Do you understand, if not see a lawyer."

*E.S. considered the letter to be a threat.

Further letters were sent by the Appellant to *E.S. on January 3, 2012 and January 4, 2012. The last letter indicated that a Statement of Claim would be filed if the earned premium was not paid.

On February 22, 2012, Portage agreed to refund the premium and fully reimbursed MIB.

On January 4, 2012, the AIC received the letter of complaint from *E.S. An investigation was then conducted by an AIC investigator, Carrie Graham.

During the course of the investigation, the Appellant provided a fax to AIC dated January 31, 2012. The Appellant stated in the fax: "My long time employee was here the day the insured called and she can confirm that I did not use any profane or abusive language."

A further fax was sent by the Appellant on February 1, 2012. The Appellant stated in the fax: "I have asked * R.J. to compose a letter with reference to my conversation with ES. Her office is next to mine and she has confirmed I returned his call and made mention of the earned premium and I needed verification that his new policy went into effect on the expiry of his old policy which was NOT the case. RJ will confirm in that conversation that I did not swear or use abusive language with

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this insured." *R.J. read this fax on February 1, 2012. She was extremely upset as she and the Appellant had never discussed the matter prior to *R.J. reading the fax. The Appellant had not discussed with *R.J. his conversation with *E.S. had not confirmed with her that he had not used abusive language, nor that she would write a letter confirming this information.

*R.J confronted the Appellant on February 1, 2012 and told him that she would not be writing a letter. She confirmed in an e-mail to the Appellant on February 2, 2012 that she had heard him swearing and yelling on the phone and that she had told him twice that she did not want to get involved.

*R.J. did overhear the Appellant on the phone that day. She did not know who he was speaking to. She heard the Appellant speak in a raised voice and use the "f" word.

During the course of the AIC investigation, the Appellant was asked to provide an explanation as to why his letter to *E.S. dated December 14, 2011 indicated an amount past due including late charges of $1,318.00. The Appellant responded that this comprised the premium plus a $200.00 filing fee for a Statement of Claim. The Appellant confirmed that a Statement of Claim had not been filed by that date.

The evidence before the Appeal Panel included a number of letters written by the Appellant to the AIC investigator. The tone of virtually all of the letters was harsh and rude, with some of the comments being threatening in nature.

On January 6, 2014, the Appellant sent a letter to * E.S. which included the following:

> "Trust me this is going to dig a deep hole into your bank account before this is over as your unethical actions have done to mine (sic)..."

The evidence before the Appeal Panel also included several letters and/or faxes from the Appellant to *E.S. . The tone of virtually all of the letters was harsh, rude, and threatening in nature.

REASONS FOR DECISION

1. Is the Appeal Panel restricted in law to an appeal of the Decision of the General Insurance Council concerning Section 509(1)(a) and (c) of the *Insurance Act* or can the Appeal Panel also consider whether the Appellant has contravened Section 480(1)(a) of the *Insurance Act*.

This matter initially proceeded by way of an Investigative Report to the General Insurance Council dated January 16, 2013. The Investigative Report recommended that the Appellant be charged with violations of Section 480(1)(a) and Section 509(1)(a) and (c) of the *Insurance Act*. The Decision of

the General Insurance Council dated June 18, 2013 found the Appellant not guilty of the allegation made under Section 480(1)(a) of the *Insurance Act*. However, the General Insurance Council did find the Appellant guilty under Section 509(1)(a) and (c) of the *Insurance Act*.

The Appellant appealed the finding of guilt under Section 509(1)(a) and (c) of the *Insurance Act*.

The question for the Appeal Panel is whether the Appeal Panel is restricted to an appeal of the conviction under Section 509(1)(a) and (c) of the *Insurance Act* or whether the Appeal Panel can also consider whether or not the Appellant has acted in contravention of Section 480(1)(a) of the *Insurance Act*.

Section 16 of the *Alberta Insurance Councils Regulation* provides for the appeal of the decision of the General Insurance Council. Section 13 of the *Alberta Insurance Councils Regulation* establishes the Board to hear the appeal. Sections 22 and 23 of the *Alberta Insurance Councils Regulation* are as follows:

> **Procedural fairness**
>
> **22(1)** Every panel is subject to the principles of procedural fairness.
>
> **(2)** A panel is not bound by the rules of evidence applicable to courts of civil or criminal jurisdiction.
>
> **(3)** A panel is confined in making its decision to the submissions and evidence submitted to it.
>
> **Panel orders**
>
> **23(1)** A panel may by order confirm, reverse or vary the decision of the council being appealed or make any decision that the council had the authority to make in the first instance.

Section 23(1) of the *Alberta Insurance Councils Regulation* provides that the "panel may...make any decision that the council had the authority to make in the first instance."

The question as to whether Section 23(1) allows for a *de novo* hearing has been the subject of judicial decisions, as well as the subject of decisions by the Insurance Council's Appeal Board. Attached to these Reasons is a list of the decisions considered by the Appeal Panel on this issue.

It is the position of the Appeal Panel that the Hearing before the Appeal Panel is a hearing *de novo*. The Appeal Panel considered the following in coming to this decision:

1. In the current case, both parties led evidence under oath. *Viva voce* evidence was not heard by the General Insurance Council;

2. Section 16 of the *Alberta Insurance Councils Regulation* provides for the Notice of Appeal, but does not include any privative clause respecting the Decision of the General Insurance Council. In fact, the Decision of the General Insurance Council is suspended if it involves a suspension or revocation of a Certificate of Authority;

3. The composition of the Council and the Appeal Panel are essentially identical in respect of expertise represented by insurance agents and only the Appeal Panel has a majority of that qualification.

As a result, based upon the factors in *Newton* and *Dunsmuir* and in consideration of Section 23 of the *Alberta Insurance Councils Regulation*, it is the Panel's decision that the Hearing before it is a *de novo* hearing and it is not confined to a review of the General Insurance Council's Decision on reasonableness as defined in law alone.

The Appeal Panel has also considered Section 22(1) of the *Alberta Insurance Councils Regulation*, as well as the Decision of *Davidoff v. Law Society (Alberta)*, 2011 ABQB 668. Based upon a review of the *Alberta Insurance Councils Regulation* and this Decision, the Appeal Panel is of the opinion that the duty of procedural fairness prevents the Appeal panel from considering the charges under Section 480(1)(a) of the *Insurance Act* for the following reasons:

1. The Decision of the General Insurance Council included a dismissal of the charge under Section 480(1)(a) of the *Insurance Act*.

2. Section 22(1) of the *Alberta Insurance Councils Regulation* provides that the Appeal Panel is subject to the principles of procedural fairness and is confined in making its decision to the submissions and evidence submitted to it.

3. It was not the expectation of the Appellant that charges under Section 480(1)(a) would be revisited. Rather, the Appellant approached the Appeal as an Appeal with respect to Section 509(1)(a) and (c) of the *Insurance Act* only.

4. The General Insurance Council did not take the position during the Appeal that Section 480(1)(a) would be part of the Appeal Hearing.

In conclusion, it is the decision of the Appeal Panel that it is restricted to determining whether the Appellant is guilty under Section 509(1)(a) and (c) of the *Insurance Act*.

2. Did the Appellant commit an offence under Section 509(1) of the *Insurance Act*?

Section 509(1) of the *Insurance Act* states as follows:

> **Unfair practices**
>
> **509(1)** No insurer, insurance agent or adjuster may
>
> (a) make a false or misleading statement, representation or advertisement...
>
> (c) engage in any unfair, coercive or deceptive act or practice...

The Panel agrees with the standard of proof as set out in the decision of *Tenorlas v. Superintendent of Insurance* (1980), 32 O.A.C. 245 (Div. Ct.) and approved by Rowbotham, J.of this Court in *General Insurance Council v. Howatt*, 2000 ABQB 259 A.R. 33.

The test as described in *Tenloras* is as follows:

> "The law is clear that where a person's professional life or reputation are at stake, that disciplinary action should not be taken that would interfere with the professional life of the individual or seriously reflect upon his reputation without clear and cogent evidence."

The offences under Section 509(1) are public welfare offences. These offences are strict liability offences.

The Supreme Court of Canada in the case of *R. v. Sault Ste. Marie (City)*, [1978] 2 S.C.R. 1299, dealt with offences in which mens rea is required, strict liability offences, and absolute liability offences. Dickson J. held as follows:

> "I conclude, for the reasons which I have sought to express, that there are compelling grounds for the recognition of three categories of offences rather than the traditional two:
>
> 1. Offences in which mens rea, consisting of some positive state of mind such as intent, knowledge, or recklessness, must be proved by the prosecution either as an inference from the nature of the act committed, or by additional evidence.
>
> 2. Offences in which there is no necessity for the prosecution to prove the existence of mens rea; the doing of the prohibited act prima facie imports the offence, leaving it open to the accused to avoid liability by proving that he took all reasonable care. This involves consideration of what a reasonable man would have done in the circumstances. The defence will be available if the accused reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent, or if he took all reasonable steps to avoid the particular event. These offences may properly be called

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offences of strict liability. Mr. Justice Estey so referred to them in Hickey's case.

3. Offences of absolute liability where it is not open to the accused to exculpate himself by showing that he was free of fault."

The Panel thus concludes that Section 509(1) is a strict liability offence. Thus, only the act itself need be proved to have occurred. The Appellant may avoid liability by showing that he took all reasonable care to avoid committing an offence.

The Panel finds that there is clear and cogent evidence that the Appellant breached Section 509(1)(a) and (c) of the *Insurance Act*. The Panel agrees with the findings of the GIC that the Appellant's conduct in relation to *E.S. was disgraceful. Many of his communications with *E.S. were unprofessional, inappropriate, insulting, aggressive, and threatening. The Panel also finds that the Appellant was in breach of Section 509(1)(a) of the *Insurance Act* as it relates to his dealings with the AIC investigator.

Despite the fact that Section 509(1) does not require proof of mens rea, if such proof was required, the Panel finds that the Appellant made statements that were false or misleading and/or that he made the statements willingly and/or recklessly.

MIB could have requested a cancellation of the Portage policy simply by contacting Portage within 30 days and indicating that the premium had not been paid by *E.S. or E&L. Had MIB proceeded in such a fashion, the subsequent events involving the Appellant would not have occurred.

The Panel finds that the Appellant was guilty of Section 509(1)(a) and (c) by virtue of the following:

(a) The Appellant initially advised *E.S. that the policy premium of $1,138.00 was outstanding. He subsequently advised *E.S. that the amount past due, including late charges, was $1,318.00. The Appellant admitted that MIB did not have a written agreement with *E.S. that late charges would apply. Further, the Appellant indicated to the AIC investigator that the amount of $1,318.00 included the cost of $200.00 for filing a Statement of Claim. The Appellant admitted that the Statement of Claim was not issued and that the $200.00 fee was never incurred. As a result, the Appellant's statement that $1,318.00 was the amount that was past due was misleading, unfair, and deceptive. The attempt to collect Court fees was misleading, unfair and deceptive.

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(b) The Appellant provided more than one letter to *E.S. wherein he used threatening language towards *E.S. . The use of this language was an unfair and coercive attempt to force *E.S. to pay the renewal premium.

(c) On December 22, 2011, the Appellant wrote to *E.S. indicating that he had contacted Intact and asked that they do not issue a new policy on his behalf until the earned premium was paid. This statement was false. The actual communication from the Appellant to Intact had been an inquiry as to whether issuance of a registered letter of cancellation for non-payment of premiums was something that Intact took into consideration for new business.

(d) Many of the Appellant's communications with *E.S. were unfair and coercive. Examples include the following:

i. The Appellant wrote to *E.S. on December 22, 2011 indicating:

"It is rather obvious that you are not capable of telling the truth and you expect others to pay your bill."

ii. The Appellant further wrote to *E.S. on December 22, 2011 indicating:

"As I explained to you and the IBC should have confirm these facts. The only way to cancel an insurance contract is in writing by the insured or by register letter from the insurer. Did we receive a letter from you to cancel your insurance? No. Did you receive a registered letter of cancellation? Yes.

If you need a further explaining I can drop by your office and discuss this with you. Please have a check prepared in the amount of $841.00 and have this certified. If the earned premium is NOT paid I will file a lawsuit against you. Do you understand, if not see a lawyer.

Your new policy went into effect December 19, 2011 our policy was in effect and the only valid insurance you had from June 11, 2011 to December 19, 2011 we were therefore on risk. Correct?

It is also nice to see you are receiving Faxes and we didn't have the wrong fax number. Did you not say you had never received notifications or correspondences over this past due account.

Simply put, I am not paying your bills."

These communications were threatening in nature, unfair, misleading, and coercive.

(e) The Portage policy only remained in effect as a result of the Appellant submitting payment for the premium, rather than requesting cancellation of the Portage policy. The Appellant

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then repeatedly demanded that *E.S pay the premium associated with the policy. The Panel finds that this was unfair.

(f) On December 22, 2011, the Appellant engaged in a telephone conversation with *E.S. During the course of that telephone conversation, the Appellant called *E.S. a "fucking liar" on more than one occasion. Immediately following this phone conversation, the Appellant sent a fax to *E.S. which included the following statement: "If you need further explaining I can drop by your office and discuss this with you." This behavior was entirely unprofessional and inappropriate. The Panel finds that such behavior and language was unfair and coercive.

(g) On February 1, 2012, the Appellant sent a fax to the AIC investigator stating that: "My long-time employee was here the day the insured called and she can confirm that I did not use any profane or abusive language." On February 1, 2012, the Appellant sent another letter to the AIC investigator stating that the employee "will confirm in that conversation that I did not swear or use abusive language with this insured." According to the testimony of *R.J., the Panel finds that the Appellant's statements were false and in contravention of Section 509(1)(a) of the *Insurance Act*. *R.J. was clear in her evidence that she did not provide such confirmation to the Appellant prior to the Appellant providing these letters to the AIC investigator. In fact, *R.J. indicated that the Appellant routinely spoke on the phone in a raised voice and used profane language in his conversations.

The Appellant was deceptive in his statements to the AIC investigator.

(h) The Appellant's statements to the AIC investigator concerning *R.J. involvement were misleading. The Appellant admitted that he had not confirmed with *R.J. the contents of his two faxes to the AIC investigator. Further, *R.J. also provided a number of emails to the AIC investigator indicating that any suggestion that she had overheard the conversations between the Appellant and *E.S. was false. The Appellant's communications with the AIC investigator both before and after his discussions with *R.J. were misleading and in contravention of Section 509(1)(a) of the *Insurance Act*.

In summary, the Panel finds that the Appellant contravened Sections 509(1)(a) and (c) of the *Insurance Act* with respect to his communications and dealings with *E.S.

Section 509 of the *Insurance Act* immediately follows a heading "Unfair Practices". Section 509 provides a means for ensuring consumer protection by setting rules to maintain both discipline and

fairness in the insurance market place. The AIC is empowered to undertake investigations to determine whether an individual has contravened Section 509 of the *Insurance Act*. The AIC investigation is meant to determine whether an agent or broker has acted in compliance with the *Insurance Act*. It is thus imperative that any individual under investigation by the AIC be honest and forthright with the AIC investigator. Thus, the Appellant must comply with Section 509 in his dealings with the AIC investigator. Section 509 is broad enough to include the Appellant's dealings with the AIC during its investigation. Thus, the Panel finds that the Appellant has also violated Sections 509 1(a) and (c) as it relates to his conduct during the AIC investigation.

The Panel concludes that the Appellant committed many acts in violation of Sections 509(1)(a) and (c) of the *Insurance Act*. The Appellant has not established that he reasonably believed in a mistaken set of facts, which, if true, would have rendered the act or omission innocent, nor that he took all reasonable steps to avoid the particular event.

If the Panel is in error with its ruling that Section 509(1) is a strict liability offence, then the Panel finds that the evidence establishes the requisite mens rea and that the Appellant intended to commit the offences as set out in Sections 509(1)(a) and (c) of the *Insurance Act*.

The Appellant requests that an adverse inference be drawn against the GIC as a result of its failure to call the investigator, Carrie Graham, to testify. The Panel declines to find that an adverse inference should be drawn against the GIC. As noted by the Supreme Court of Canada in *R. v. Jolivet*, a failure to call a particular witness does not automatically lead to an adverse inference. The Panel does not find that the *viva voce* evidence of Ms. Graham was necessary in order to determine whether the Appellant had violated Sections 509(1)(a) and (c) of the *Insurance Act*.

In conclusion, the Panel finds that there is clear and cogent evidence that the Appellant breached Section 509(1)(a) and (c) of the *Insurance Act*. As a result, the Panel orders a levy of a penalty in the amount of $1,000.00. The Appellant's conduct was of sufficient severity that the Panel also orders that the Appellant's General Insurance Certificate of Authority be suspended for a period of nine months.

Dated at Edmonton, Alberta this 7th day of August, 2015

INSURANCE COUNCIL APPEAL BOARD OF ALBERTA

Per:

NANCY E. CUMMING, Q.C., Chair of Panel

Cases

1. Alberta Insurance Council Appeal Board Decision of September 23, 2013
2. *Gilbert v. Alberta Insurance Council*, 2009 ABQB 673
3. *Newton v. Criminal Trial Lawyer's Association*, 2010 ABCA 399
4. Alberta Insurance Council Appeal Board Decision of March 19, 2014
5. *Dunsmuir v. New Brunswick*, [2008] I.S.C.R. 190