In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

ANDREAS LAURI HINKKALA
(the "Licensee")

ORDER

As Council made an intended decision on June 18, 2019, pursuant to sections 231, 236, and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Licensee with written reasons and notice of the intended decision dated July 30, 2019; and

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

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

1. the Licensee be assessed a fine of $2,500;

2. the Licensee be assessed Council's investigative costs of $2,325;

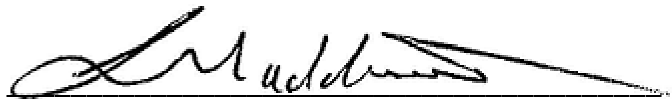
3. a condition be imposed on the Licensee's Life Agent licence requiring him to complete an ethics course, as approved by Council;

4. a condition be imposed on the Licensee's Life Agent licence requiring the Licensee to be supervised by a qualified Life Agent, as approved by Council, for a period of 24 months of active licensing commencing from the date of Council's order; and

5. a condition be imposed on the Licensee's Life Agent licence that failure to pay the fine and investigative costs and to complete the course within 90 days of

Council's order will result in the automatic suspension of the Licensee's Life Agent licence, and he will not be permitted to complete his annual filing until the fine and costs are fully paid and the course is successfully completed.

This order takes effect on the **30th day of August, 2019.**



Lesley Maddison
Chairperson, Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

ANDREAS LAURI HINKKALA
(the "Licensee")

Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether the Licensee and/or his insurance agency acted contrary to the duty to carry on the business of insurance in good faith, conduct all insurance activities in a competent manner, act in the usual practice of dealing with clients, and ensure that client interests are placed first, as respectively set out by sections 4.2, 5.2, and 7.2 of Council's Code of Conduct. Council also considered whether there was a breach of Council Rules 7(8) and 7(9) which respectively require compliance with Council's Code of Conduct and that licensees keep proper books, records, and other documents necessary for the proper recording of insurance transactions and related financial affairs. As no findings were made with regard to the Licensee's own insurance agency, this intended decision pertains only to the Licensee.

On January 16, 2019, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met with the Licensee respecting allegations that he recommended and facilitated insurance products for a client (the "Complainant") that were not in her best interests and brought into question his competency as a life and accident and sickness insurance agent ("Life Agent"). A copy of an investigation report prepared by Council staff was forwarded to the Licensee in advance of the meeting. A discussion of the report took place at the meeting and the Licensee was provided an opportunity to make further submissions. At the meeting and afterward, the Licensee provided the Committee with additional documents for consideration. Having reviewed all of these materials and after discussing this matter with the Licensee, the Committee prepared a report for Council.

The Committee's report, along with the aforementioned investigation report and documentation, were reviewed by Council at its June 18, 2019 meeting where it was determined the matter should be disposed of in the manner set out below.

PROCESS

Pursuant to section 237 of the Act, Council must provide written notice to the Licensee of the action it intends to take under sections 231, 236, and 241.1 of the Act before taking any such

action. The Licensee may then accept Council's decision or request a hearing. This intended decision operates as written notice of the action Council intends to take against the Licensee.

FACTS

Background

The Licensee has been licensed with Council as a Life Agent since 2003.

In 2009, the Complainant and her spouse (the "Spouse") began to attend recruitment meetings with a large, national insurance agency (the "National Agency"). The Complainant advised Council staff that, although she attended the meetings, she was not interested in obtaining an insurance licence. The Spouse, however, became licenced as a Life Agent that same year.

In 2009, through a licensed insurance advisor ("Advisor 1") they met through the National Agency, the Complainant and the Spouse purchased the following insurance policies:

1. a joint [redacted] policy with an annual premium of $[redacted] **("Policy 1")**;
2. for their son, a joint [redacted] policy with a minimum annual premium of $[redacted] **("Policy 2")**; and
3. for their daughter, a joint [redacted] policy with a minimum annual premium of $[redacted] **("Policy 3")**.

In 2011, the Complainant separated from the Spouse and became the primary caregiver to the children. There was differing evidence as to her annual income, [redacted]. At that time, she also held [redacted] mutual funds.

Following the separation, neither the Complainant nor the Spouse wished to continue contributing to the jointly held Policy 1. As such, it eventually lapsed in 2012 for non-payment of the premiums. The Spouse did not wish to continue to pay for Policies 2 and 3 either [redacted].

When Advisor 1 left the National Agency in 2011, the Complainant switched her insurance to another licenced advisor ("Advisor 2") and her mutual funds to the Licensee whom she had met through the National Agency. The Complainant wanted her own insurance policy to ultimately replace Policy 1 and so, in October 2011, Advisor 2 facilitated the purchase of a [redacted]

[redacted] policy with a [redacted] term rider and annual premium of $[redacted] **("Policy 4")**. At the same time, the Complainant elected to contribute an additional $[redacted] per year to Policy 4 in order to take advantage of tax deferred growth. Advisor 2 recommended that the Complainant use the yearly gains from her mutual fund investments to pay the total planned premium of $[redacted]. He advised Council staff that the Complainant agreed to the plan and that he discussed it with the Licensee who was, by then, the Complainant's mutual funds advisor. In contrast, however, the Licensee advised he was never advised of any arrangement to withdraw from the mutual funds for Policy 4's annual premium payment.

In January 2012, due to dissatisfaction with Advisor 2, the Complainant moved the management of all the insurance policies to the Licensee.

In October 2012, [redacted], Policy 4 lapsed due to non-payment.

In April 2013, the Complainant met with the Licensee to reinstate Policy 4. Also, on the Licensee's recommendation, the Complaint purchased the following:

1. a [redacted] policy with a first year premium of $[redacted] and $[redacted] annually thereafter until year 28 or age 65 **("Policy 5")**; and

2. a [redacted] policy for the children with a first year premium of $[redacted] and a minimum annual premium of $[redacted] thereafter; the annual planned premium was $[redacted] for 19 years **("Policy 6")**.

To pay for Policy 5, the Licensee recommended the Complainant redeem $[redacted] from her mutual funds, which she did. He also recommended and facilitated the cancellation of Policy 4's [redacted] term rider. The Complainant advised Council staff that she did not want or agree to cancel the term rider. However, from the documentary evidence, it is apparent she signed a form authorizing the cancellation.

The Licensee also advised the Complainant she could either cancel Policies 2 and 3 and use the cash surrender value to purchase Policy 6 or stop paying Policies 2 and 3 entirely and direct that premium money to Policy 6. However, given there were large surrender charges on Policies 2 and 3, it did not make financial sense to cancel them outright. Further, at that point, the Complainant had already paid [redacted] into Policies 2 and 3 and so she did not wish to let them lapse. Therefore, on the Licensee's recommendation, she withdrew $[redacted] from her mutual funds for Policy 6's first year premium and continued to pay Policies 2 and 3 until the surrender charges expired in 2015.

In October 2013, Policy 4 lapsed a second time for non-payment. The Complainant met with the Licensee in January 2014 to reinstate the policy.

In October 2014, Policy 4 lapsed a third time. In February 2015, the Complainant met with the Licensee to again reinstate it. At that time, the Licensee recommended she replace Policy 4 with a different whole life policy. The Complainant advised Council staff that, although she did a saliva test for a new policy, she told the Licensee not to submit the application as she was undecided given that she had already paid premiums of approximately $ on Policy 4. The new policy was issued anyway, which she declined. Policy 4 was eventually reinstated.

At that point, the Complainant held $ in insurance coverage for herself through Policies 4 and 5 and $ for each child from Policies 2, 3, and 6.

Licensee's Submission to the Committee

During his meeting with the Committee, the Licensee advised that the Complainant had attended the National Agency's training program to become a licensed Life Agent and that, therefore, she definitely had a degree of familiarly with insurance. The Licensee further submitted that the insurance products he recommended were appropriate for the Complainant and what she wanted. He stated that he fully explained the products to her and that she understood. However, the Licensee had no records to prove and demonstrate that the Complainant understood his recommendations.

The Licensee advised that, when the Licensee became the Complainant's agent of record, the Complainant had already separated from the Spouse. . The Licensee advised that, as such, his insurance recommendations had to take into account the likelihood that the Spouse might not financially provide for the children and their future education should anything happen to the Complainant. The Licensee advised the Committee that is why he recommended Policy 5 to the Complainant. The Licensee advised he recommended Policy 6 for the children over the existing Policies 2 and 3 because the premiums were nearly the same but the coverage was higher. He also recommended that the Complainant wait to cancel Policies 2 and 3 until the surrender charges expired. The Licensee advised that he spoke with the Complainant at length about his recommendations and that she understood and agreed with the plan.

The Licensee advised the Committee that, after Polices 5 and 6 were purchased, the Complainant continually contacted him with questions about her investments. He advised he met with the Complainant on multiple occasions to discuss and explain her investment

portfolio. He provided the Committee with a printed copy of numerous text messages between himself and the Complainant, his staff and the Complainant, and of voicemails and emails from the Complainant. He advised that he and his staff felt her behavior was inappropriate and that is why, in August 2015, he advised the Complainant by email that he could not give her any further time and that he would be happy to suggest another advisor for her if she wished. A few months later, the Complainant contacted Council.

LEGAL FRAMEWORK

Council held that the following sections of Council's Rules and Code of Conduct are applicable to the facts of this case.

Council Rule 7(8)

A licensee must comply with the Council's Code of Conduct, as amended from time to time.

Council Rule 7(9)

A licensee shall keep books, records and other documents necessary for the proper recording of insurance transactions and related financial affairs.

Code of Conduct

Section 4. Good Faith

4.2 Requirement

You must carry on the business of insurance in good faith. Good faith is honesty and decency of purpose and a sincere intention on your part to act in a manner which is consistent with your client's or principal's best interests, remaining faithful to your duties and obligations as an insurance licensee.

You also owe a duty of good faith to insurers, insureds, fellow licensees, regulatory bodies and the public.

4.3 Guidelines

4.3.1 Conduct that would reflect adversely on your intention to practice in good faith includes:

...

f) taking advantage of a client's or insured's inexperience, ill health or lack of sophistication.

Section 5. Competence

5.2 Requirement

You must conduct all insurance activities in a competent manner. Competent conduct is characterized by the application of knowledge and skill in a manner consistent with the usual practice of the business of insurance in the circumstances.

You must continue your education in insurance to remain current in your skills and knowledge.

5.3 Guidelines

5.3.1 Your practice and level of service to clients should be consistent with that which a reasonable and prudent licensee in similar circumstances would exercise. Honest mistakes do not necessarily constitute a failure to adhere to the Code.

5.3.2 Conduct that would reflect on your competence includes:

…

c) failing to advise a client of a lapse or change in insurance coverage;

d) failing to conduct an adequate fact finding and assessment of a client's insurance needs…

Section 7. Usual Practice: Dealing with Clients

7.2 Requirement

When dealing with clients you must:

- *protect clients' interests and privacy;*
- *evaluate clients' needs;*
- *disclose all material information; and*
- *act with integrity, competence and the utmost good faith.*

7.3 Guidelines

…

Duty of Care

7.3.9 The client's interests take priority over your interests and should not be sacrificed to the interests of others. You must not engage in practices that place the interests of others ahead of the client's interests.

…

ANALYSIS

In considering this matter, Council reviewed the Report, the supporting evidence, the Licensee's oral submissions, and the documentation furnished to the Committee by the Licensee during and after the January 16, 2019 meeting. Despite the major differences in submissions as to the Complainant's comprehension and knowledge of insurance products, Council does not agree with the Licensee's assertion that the products he recommended to the Complainant were appropriate. Rather, Council found that, in fact, the products were grossly unsuitable considering her financial circumstances and needs. Council specifically found that $[redacted] of insurance for a person with an income such as the Complainant's is inappropriate. Council further found that $[redacted] in coverage (until Policies 2 and 3 were cancelled in 2015) for each of the Complainant's two children was also excessive [redacted]. As a result of the Licensee's recommendations to the Complainant, a disproportionate amount of the Complainant's [redacted] resources is tied up in insurance products.

Council noted that, even if it were to accept the Licensee's submission that the Complainant understood and wanted the products, it was still his responsibility to ensure they were appropriate for her. It was also his responsibility to keep records to demonstrate that the Complainant understood; however, he did not.

Council held that, on a balance of probabilities, the Licensee was motivated by insurance commissions when he redeemed and transferred a significant percentage of the Complainant's mutual funds to pay the initial premiums for Policies 5 and 6 respectively.

Council further found that the lapsing of Policy 4 in 2012, 2013, and 2014 while the Licensee was the Complainant's agent of record reflected poorly on his competency as a Life Agent. The Licensee should have ensured a system was in place to prevent a lapse.

Council finds the Licensee's actions were self-serving and without regard for the consequences to his client and that such conduct was contrary to the usual practice of the business of insurance.

As a result, Council finds the Licensee breached Council Rules 7(8), 7(9) and Council's Code of Conduct, particularly sections 4.2, 5.2 and 7.2, which requires licensees to carry on the business of insurance in good faith, conduct all insurance activities in a competent manner, and act in the usual practice of dealing with clients, specifically by protecting clients' interests, evaluating clients' needs, and acting with integrity, competence and the upmost good faith. As such, Council finds a sanction is warranted.

In considering an appropriate penalty, Council recognized it is not bound by precedent to follow the outcomes from prior decisions, but similar conduct should result in similar outcomes within a reasonable range depending on the particular facts of the case. Accordingly, Council reviewed the facts and disposition from four previous cases before Council involving similar or somewhat similar situations:

1. In *Sherry Lynn Matthews* (August 22, 2008), a licensee failed to act in the best interests of three clients and made unsuitable insurance recommendations when she had them each purchase similar insurance policies, regardless of their individual needs and financial circumstances. Council also determined that the licensee failed to keep adequate documentation and notes on client files. Council cancelled the licensee's licence for three years, fined her $10,000, and ordered her to complete courses in the Certified Financial Planner curriculum.

2. In *Edraline Buetipo Borginia* (June 7, 2016), a licensee was alleged to have sold life insurance policies to a client to replace existing policies, contrary to the client's best interests. Council found no evidence to suggest that the new policies were inferior to the existing ones. However, it did find that the process by which the licensee implemented the new policies less than satisfactory in that the policy comparison provided by the licensee was based on incomplete information. Council found that by providing comparisons without full information, the licensee failed to act in accordance with the usual practice of the business of insurance. Council also found it was inappropriate for the licensee to have had the client sign post-dated policy cancellation letters. While accepting that the licensee was attempting to act in the client's best interests, Council found that the licensee failed to demonstrate good judgment in dealing with the client, which brought into question her ability to act in a competent manner, and in accordance with the usual practice of the business of insurance. As a result, Council imposed conditions on the licensee's licence requiring her to be supervised for a period of 24 months, complete the Advocis Getting Established course, and pay Council's investigation costs of $1,112.50.

3. In *Patie Kaur Johl* (March 2, 2017), a licensee misled a client about the terms of an insurance policy, paid the policy premiums herself and had her client sign money orders to give the impression to the insurer that the clients were paying the premiums. Council was also concerned about the licensee's file management and storage practices and lack of understanding of industry tools such as how to generate a policy illustration. Council ordered the licensee to pay a $5,000 fine, undergo 24 months of supervision, complete the Advocis Getting Established course, and pay Council's investigation costs of $5,587.50.

4. In *Khamsouei Phovixayboulom* (February 16, 2018), a licensee intentionally misled clients for personal benefit and failed to place insurance as instructed; failed to provide information so as to allow the client to make an informed decision about a policy; used a third party to pay for the policy premium, without consent from either the third party or the client; and made a material misrepresentation to the insurer in the application with respect to the client's address. Council suspended the licensee for 12 months, ordered 24 months of supervision after completion of the suspension, and assessed a fine of $5,000 and Council's investigation costs of $637.50.

INTENDED DECISION

Based on the particular facts of this matter and in consideration of the aforementioned cases, pursuant to sections 231, 236, and 241.1 of the Act, Council made an intended decision to:

1. assess a fine of $2,500 against the Licensee;

2. assess Council's investigative costs of $2,325 against the Licensee;

3. impose a condition on the Licensee's Life Agent licence requiring him to complete an ethics course, as approved by Council;

4. impose a condition on the Licensee's Life Agent licence requiring the Licensee to be supervised by a qualified Life Agent, as approved by Council, for a period of 24 months of active licensing commencing from the date of Council's order; and

5. impose a condition on the Licensee's Life Agent licence that failure to pay the fine and investigative costs and complete the course within 90 days of Council's order will result in automatic suspension of the Licensee's Life Agent licence and he will not be permitted to complete his annual filing until the fine and costs are fully paid and the course is successfully completed.

RIGHT TO A HEARING

If the Licensee wishes to dispute Council's findings or its intended decision, the Licensee may have legal representation and present a case at a hearing before Council. Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Licensee must give notice to Council by delivering to its office written notice of this intention within fourteen (14) days of receiving this intended decision. A hearing will then be scheduled for a date within a reasonable period of time from receipt of the notice. Please direct written notice to the attention of the Executive

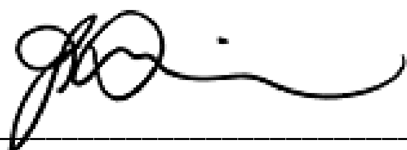
Director. If the Licensee does not request a hearing within fourteen (14) days of receiving this intended decision, the intended decision of Council will take effect.

Even if this decision is accepted by the Licensee, pursuant to section 242(3) of the Act, the Financial Institutions Commission still has a right to appeal this decision of Council to the Financial Services Tribunal ("FST"). The Financial Institutions Commission has 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 fst.gov.bc.ca or contact them directly at:

Financial Services Tribunal
PO Box 9425 Stn Prov Govt
Victoria, British Columbia, V8W 9Vl
Reception: 250-387-3464, Fax: 250-356-9923
Email: financialservicestribunal@gov.bc.ca

Dated in Vancouver, British Columbia, on the **30th day of July, 2019**.

For the Insurance Council of British Columbia



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