In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
(“Council”)

and

KENNETH DAVID THOM
(the “Former Licensee”)

ORDER

As Council made an intended decision on October 29, 2024, pursuant to sections 231, 236, and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Former Licensee with written reasons and notice of the intended decision dated December 3, 2024; and

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

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

1) The Former Licensee is fined $25,000, to be paid by June 10, 2025;

2) 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 agents;

   ii. the Insurance Needs Analysis course available through Advocis;

   iii. The Challenge of Documenting Nothing course available through Advocis; and

   iv. an ethics course

(collectively, the “Courses”);

3) The Former Licensee is assessed Council’s investigation costs in the amount of $2,875, to be paid by June 10, 2025;

4) The Former Licensee is required to be supervised by a qualified 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; and

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

This order takes effect on the **12th day of March, 2025.**

Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
(“Council”)

respecting

KENNETH DAVID THOM
(the “Former Licensee”)

1. Pursuant to section 232 of the *Financial Institutions Act* (the “Act”), Council conducted an investigation to determine whether the Former Licensee acted in compliance with the requirements of the Act, Council Rules, and Code of Conduct relating to allegations that the Former Licensee did not properly evaluate or assess the clients’ needs; sold an insurance policy that was inappropriate given the clients’ stated objectives and circumstances; failed to keep books, records and documents necessary for the proper recording of insurance transactions; failed to disclose to clients information relevant to the their needs, including information relating to market value guarantees and deferred sales charges; and failed to deliver insurance policies or evidence of insurance coverage within a reasonable time.

2. On August 28, 2024, 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 prior to the meeting. Although the Former Licensee was provided with advance notice of the August 28, 2024, meeting, the Former Licensee did not attend. Having reviewed the investigation materials and after discussing the matter, the Committee prepared a report for Council.

3. The Committee’s report, along with the aforementioned investigation report were reviewed by Council at its October 29, 2024, meeting, where it was determined the matter should be disposed of in the manner set out below.

PROCESS

4. Pursuant to section 237 of the Act, Council must provide written notice to the Former Licensee of the action it intends to take under sections 231, 236 and 241.1 of the Act before taking any such action. The Former Licensee may then accept Council’s decision or request a formal hearing. This intended decision operates as written notice of the action Council intends to take against the Former Licensee.

FACTS

5. The Former Licensee was licensed with the Council as a life and accident and sickness insurance agent ("Life Agent") on March 17, 1993. The Former Licensee's Life Agent licence was cancelled on August 2, 2023, due to non-renewal. The Former Licensee was a Council member from 1998 to June 30, 2012, including being a voting member from 2010 to 2012.

6. On July 1, 2022, Council received a complaint from RG and MG (the "Complainants") against the Former Licensee. The Complainants alleged that they were never provided with a proper explanation of their investments, such as the segregated fund guarantees, the terms and duration of their investments, or an explanation regarding resets. The Complainants further alleged that they were misled by the Former Licensee about the 100% market value guarantee and associated guaranteed value resets for segregated funds and were never informed about deferred sales charges ("DSC") or back-end load fees and were instead told that they had full access to their money at any time without penalty. The Complainants also stated that it was not until June 2022 that they were provided with copies of documents they had signed in October 2021.

7. The Former Licensee opened segregated fund investment accounts for the Complainants with insurer X. For RG, the Former Licensee opened the following segregated fund investments: a Registered Retirement Savings Plan ("RRSP"), Spousal RRSP and Registered Retirement Income Fund ("RRIF"). For MG, the Former Licensee opened the following segregated fund investments: an RRSP, Tax-Free Savings Account ("TFSA") and corporate non-registered account.

8. On August 16, 2022, about six weeks after their initial complaint, the Complainants sent an additional complaint to Council. The Complainants stated that the Former Licensee had recommended that they cancel their joint life insurance policy with insurer Z. The Complainants alleged that when they asked the Former Licensee for a reason, he told them that the agent who had sold them the policy only did so to generate commissions from the sale and that the policy was not beneficial to them in any way, but did not provide any further explanation. Based on the Former Licensee's recommendation, the Complainants cancelled their joint life insurance policy with insurer Z.

9. On August 17, 2022, the Complainants forwarded an email to Council staff detailing their correspondence with MB, the licensee who had sold them their joint life insurance policy with insurer Z in 1999. In the email, dated the same day, MB reminded the Complainants of the reasons why they had originally purchased the life insurance policy, which included paying for their capital gains tax liability, creating a legacy for their children and accessing tax sheltering benefits.

10. On August 28, 2022, the Complainants sent an email to the insurer Z customer complaints department regarding the cancellation of their life insurance policy. In the email to insurer Z, the Complainants stated that the Former Licensee had strongly recommended that they cancel their policy, and that they then did so without proper consideration of their circumstances or taking enough time to consider the implications of the decision to cancel. The Complainants requested that insurer Z reinstate their policy.

11. In the correspondence with insurer Z, the Complainants also stated that the Former Licensee should have realized the importance of keeping the life insurance policy, given the Former Licensee's knowledge of the Complainants' ongoing health issues, including RG's cancer diagnosis and treatment history since April 2019 and MG's current conditions of osteoarthritis, rheumatoid arthritis and hypertension.

12. On November 4, 2022, insurer Z stated that since the Complainants had both signed the policy surrender form, insurer Z would not have questioned the reason for cancelling the policy. Insurer Z concluded that there was insufficient evidence that the Former Licensee had provided poor advice, citing the fact that the Complainants had both signed the policy surrender form. Insurer Z also informed them that in order to consider reinstating their policy, the Complainants would need to submit an application for reinstatement and provide evidence of insurability, write a cheque for $13,311.90 for all premiums due and agree to an increase in premiums. On December 3, 2022, the Complainants emailed another department at insurer Z to escalate their complaint, reiterating that the Former Licensee had failed to provide written advice about the pros and cons of cancelling their policy, particularly given RG's health issues and their children's lack of financial resources to pay for their taxes upon their death without the policy's death benefit payout. The Complainants also informed insurer Z that they would be seeking compensation through the Former Licensee's errors and omissions ("E&O") insurance policy for the loss of their life insurance policy benefits. As of March 2024, when Council staff inquired as to the status of this complaint, the Complainants stated that they had not received any compensation from the Former Licensee's E&O insurance in relation to the complaint with insurer Z.

13. On May 9, 2024, insurer Z's senior compliance officer provided documentation to Council staff confirming that insurer Z had received a complaint from the Complainants, indicating their disagreement with the decision made by insurer Z's escalated customer complaints office regarding the Complainant's file. Insurer Z had found no grounds for a different outcome and had sent a final letter to the Complainants dated December 6, 2022.

14. On July 25, 2022, the Former Licensee's assistant at the time, PM, informed Council staff that the Former Licensee's managing general agency ("MGA") and insurer X were investigating the Complainants' complaint. Between July 25, 2022, and May 3, 2023, PM provided information and documents on behalf of the Former Licensee in response to inquiries from Council staff.

15. On September 21, 2022, PM included an email with the Former Licensee's responses to Council staff inquiries. In response to a question asking why there was a delay between the signing of the Complainants' applications in October 2021 and their receiving copies of these documents in June 2022, the Former Licensee stated that there was no excuse for the delay. In response to a question asking, "how did you ensure the complainants understood and agreed with the funds," the Former Licensee stated that "we rely on body language, verbal and visual cues along with client responses. In this case, we were required to use our best judgement for their funds."

16. On June 16, 2023, PM informed Council staff that the Former Licensee's current associated general agency ("AGA") had terminated the authority to represent of the Former Licensee and the Former Licensee's agency.

17. On January 26, 2024, Council staff sent the Former Licensee an email requesting additional information and documentation for this investigation. The Former Licensee did not respond by the requested deadline. Council staff sent a reminder email to the Former Licensee on February 6, 2024, and the Former Licensee replied to say that he no longer had access to the files and instructed Council staff to contact PM for the information. Council staff reminded the Former Licensee of his obligation to respond and asked him to specify the applicable questions for which he did not have access to the documents. On April 24, 2024, and May 3, 2024, Council staff tried to reach the Former Licensee by telephone with no success. Since April 24, 2024, the Former Licensee has not returned any calls or replied to any emails from Council staff.

18. On April 28, 2023, insurer X provided Council staff with information relating to this complaint. On June 21, 2022, the insurer X complaint handling team received a complaint through MGA regarding the Complainants' personal and corporate investment accounts. On October 19, 2022, insurer X issued a response to the Complainants and the Complainants accepted a settlement offer on October 26, 2022.

19. On May 9, 2023, an MGA representative confirmed that "this case resulted in an E&O claim and payout to the client, which was adjudicated by [the Former Licensee's] E&O in conjunction with the [insurer X] investigation team presiding over this case."

20. On May 15, 2023, insurer X provided a list of all of the commissions the Former Licensee had earned for products sold to the Complainants. Insurer X confirmed that the Former Licensee received total sales commissions of $65,427.46 and trailer fees of $5,328.44.

21. On January 26, 2024, insurer X provided Council staff with a copy of the investigation materials from its investigation of the Former Licensee. The investigation materials included information about the Former Licensee meeting with EW of the MGA on August 29, 2022, and providing a statement relating to the investigation. In his statement, the Former Licensee advised that the Complainants were reluctant to disclose all of their assets and holdings, so the Former Licensee could only proceed with the information provided at the time to complete the Complainants' know your client documents and determine their risk profile. The Former Licensee calculated that, at $1,300,000 with 10% redeemable units each year, the Complainants could easily withdraw $100,000 for their retirement cash flow needs. The Former Licensee stated that his agency has a standard practice of transcribing client meeting notes, including recording the day, date and time of the meetings. However, he also stated that "notes were not taken during our numerous cell phone conversations while using Bluetooth as required by law." In addition, the Former Licensee stated that if the markets had not declined, the Complainants would not have made their complaint.

22. Insurer X's market-based consultant found merit to the Complainants' complaint. It was noted that the Former Licensee did not provide the Complainants with the necessary sales and fee disclosures and the investments were not discussed with the clients. The Former Licensee did not discuss or deliver the information folder and fund facts documents to the Complainants. Copies of the contract applications were not provided at the time of signing and were emailed to the Complainants many months later, and the know your client assessment by the Former Licensee was inadequate, resulting in a more aggressive fund selection. The market-based consultant found evidence that the Former

Licensee had guaranteed an annual return of 7%-8% and assured the Complainants that they could withdraw funds without accessing the capital. The Former Licensee sold DSC funds to the Complainants without any explanation or discussion of other fee alternatives. The DSC fee structure was found to be unsuitable for some of the Complainants' accounts (RRIF, TFSA and non-registered), based on their need to access funds. Since the Complainants could not access any of the funds in their accounts without incurring a DSC penalty fee, they sold personal property, valued at $168,000, to obtain the funds needed to pay taxes and other personal expenses. The market-based consultant recommended switching the DSC funds into no-load or front-end load fee options at a current market cost of $19,175.28. The market-based consultant also recommended that the Former Licensee compensate the Complainants for their investment loss, calculated at $151,101.88, plus interest, as of June 27, 2022.

23. On September 1, 2022, insurer X's market-based complaint team shared their findings with the Former Licensee. They noted that there were significant errors and omissions in the manner in which the accounts were opened, and that the Complainants were not fully informed of the guaranteed investment funds they had invested in, were not fully informed of the investments purchased and their risk, and did not receive full disclosure of the fees. Further, the Former Licensee was advised that the products sold were not in the clients' best interest. There was no evidence that the Former Licensee discussed the advantages and disadvantages of the recommendation for the Complainants to surrender their other insurance products to purchase insurer X investments. It was further noted that the Former Licensee did not offer or discuss other fee options, including front-end load or no-load options, to ensure the clients made a fully informed decision. There was a lack of a needs analysis for all insurance sales.

24. On September 13, 2022, the complaint was escalated to insurer X's investigation team for further review of the Former Licensee's block of business. During this review, the risk governance team flagged the Former Licensee's business for mainly consisting of DSC accounts. It was noted that the Former Licensee told EW that he would sell DSC until DSC was removed from the industry. The results of the Advisor Practice Review that was conducted on the Former Licensee's block of business on November 30, 2022, indicated that the Former Licensee was rated "inadequate" for his sales practices based on the following: no evidence of needs analysis on know your client, fund selection, fee options and guarantee selection; no evidence of the Former Licensee's recommendations and rationale; and no evidence of clients receiving the reason why letter. Insurer X noted no additional client complaints were received. Insurer X further advised that the Former Licensee had retired, and his contract was terminated on April 13, 2023.

25. The Complainants received compensation through a claim made to the Former Licensee's E&O insurance policy, as a result of the complaint to insurer X.

ANALYSIS

26. Council has determined that the Former Licensee did not maintain sufficient documentation and records, especially documentation of communications and instructions from a client to ensure mutual understanding of the insurance transactions in question. There was no documentation in the Former

Licensee's file that was produced that explained why the Former Licensee had advised the Complainants to surrender their policy with insurer Z. In addition, there was no documentation that demonstrated that the Former Licensee had discussed with the Complainants the advantages and disadvantages of various products as well as the different types of fee options available through different policies. Insurer X, in its investigation, determined that the products sold to the Complainants were not in their best interest, as a needs analysis had not been completed. Council notes that the Former Licensee's failure to properly document instructions or document that he had provided full disclosure to the Complainants when selling the policies has brought into question the Former Licensee's competency.

27. When dealing with clients, a licensee must ensure that clients are informed about all aspects of the insurance products they purchase and that they are provided with full and fair disclosure of all facts to enable them to make informed decisions. Additionally, licensees must deliver insurance policies or evidence of insurance coverage within a reasonable time. The Former Licensee, by his own admission, stated that although the Complainants' applications were signed in October 2021, he did not provide them with copies until June 2022, and acknowledged that he had no excuse for the delay.

28. Council further determined that the Former Licensee was not acting in a manner consistent with the clients' best interests. Council notes that the way the Former Licensee assessed the Complainants' understanding by using "body language, verbal and visual cues" was not an appropriate measure of ensuring the Complainants fully understood the products or recommendations. It was troubling to Council that the Former Licensee had no documentation to support any discussions of the fees, especially the DSC fees associated with the products. Council concluded that the Former Licensee's failure to discuss the advantages and disadvantages of various products as well as the different types of fee options was misleading, or at least a misrepresentation of the products available to the Complainants. When important information relating to fees or a description of the products is not provided to a client, the client is not able to meaningfully evaluate their own needs and what is being offered to them.

29. When reviewing documentation provided by the Former Licensee, Council noted concerns relating to competency. In one of the insurer X applications for MG, the Former Licensee did not fill out the beneficiary designation and just wrote "TBD." Completing basic insurance forms is a fundamental task to the usual practice of the insurance business, and forms should be completed competently and accurately. The Former Licensee, in this instance, did not complete the application form competently by leaving the beneficiary designation as "TBD." Had something happened to MG after the policy was issued, there would be no named beneficiary to the policy. The Former Licensee also provided the Complainants with an expected rate of return based on past performance, which is not always indicative of future performance. Council found this to be misleading to the client, and also found that the way the Former Licensee calculated the rate of return was inconsistent with what a reasonable licensee in the circumstances would have assessed. The Former Licensee also provided the Complainants with the wrong information about the number of resets allowed within their policies.

30. Council determined that the Former Licensee did not make reasonable inquiries during the Complainants' client assessment to determine their risk tolerance and capacity. In turn, the Former Licensee did not comply with his duty to the insurer to make reasonable inquiries into the risk.

Council concluded that the Former Licensee also failed to provide full and accurate information and did not represent the insurer's products accurately, as he provided the wrong information about resets and failed to properly disclose the fee structure of the insurer's products.

31. The Former Licensee has not responded to any inquiries from Council since April 2024. Council notes that the Council's Code of Conduct and the *Financial Institutions Act* require that licensees and former licensees reply promptly to Council inquiries.

32. Council considered the impact of Council Rules 7(8) and 7(9) and Council's Code of Conduct guidelines on the Licensee's conduct, including 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 breaches of the above Council Rules and Code of Conduct sections, and the professional standards set by the Code.

PRECEDENTS

33. Before making its recommendation 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.

34. Sherlock Hsu (September 2023): concerned a life agent licensee who was alleged to have submitted applications for insurance products without the client's full understanding and failed to maintain proper and adequate books and records. The licensee was unable to provide sufficient evidence in the form of documentation for summaries of the discussions that the licensee had with the complainant, documentation of client instructions, client emails, notes or summaries related to the specific assessment of the client's needs or circumstances. Council determined that without documentation that illustrates the fact-finding or justification of the recommendations and/or strategy sent, it is very difficult for an outside party to assess the transaction in question and objectively verify if the products recommended were suitable for or understood by the client. Additionally, Council concluded that the licensee failed to engage in the usual practice of the business of insurance by witnessing a signature on the application form when the licensee had not, in fact, witnessed the signature. Council ordered that the licensee be fined $2,000, be required to be supervised for 24 months, be required to complete courses and be assessed Council's investigation costs.

35. Eunice Chew Hoon Gan (January 2021): concerned a life agent licensee who was found to have given unsuitable advice to an elderly client. The licensee encouraged and facilitated the client, a pensioner with modest assets, to borrow significant sums in 2007 and 2014 to leverage her investment portfolio. The hearing committee considered these investments to be objectively not suitable for the client, given her age and overall financial circumstances. The hearing committee further found a lack of documentation to support the licensee's recommendations or to confirm advice was given to the client. The hearing committee found that the licensee took advantage of an elderly client and put her own financial interests ahead of the client. Following a hearing, the licensee was fined $10,000 (the

legislated maximum at the time), was required to be supervised for 24 months of active licensing, was required to complete various courses, and was assessed Council's investigation and hearing costs.

36. Edraline Buetipo Borginia (June 2016): concerned a life agent licensee who 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 was 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 a course and be assessed Council's investigation costs.

37. Andreas Lauri Hinkkala (August 2019): concerned a life agent who had sold insurance products to a client that were "grossly unsuitable considering her financial circumstances and need." There was a lack of records showing that the client understood the products in question. Council found the life agent's conduct had been self-serving (motivated by commissions) and without regard for the consequences to his client. The life agent was fined $2,000, required to take an ethics course, required to be supervised for two years of active licensing and assessed Council's investigation costs.

38. Ismat Simo (September 2017): concerned a life agent licensee who made recommendations to an elderly client that were, based on the client's financial circumstances and risk tolerance, inappropriate and not in her best interests. In particular, the life agent's recommendation that the client cash in a Guaranteed Investment Certificate, held in a TFSA, only to invest it in a new TFSA that same year, was detrimental to the client and showed a lack of proper needs assessment. The life agent had also recommended that the client increase her debt by way of a refinanced mortgage, which Council determined was not in the client's best interests. Overall, Council considered the life agent (who only worked part time as a life agent) to lack competence. The life agent had his life agent licence suspended until he had completed four courses, was required to be supervised for two years of licensing following the suspension lifting and was assessed Council's investigation costs.

39. Kamna Suri (November 2020): concerned a life agent licensee 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 a policy 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 and required that the licensee complete courses, be supervised for six months and be assessed Council's investigation costs.

MITIGATING AND AGGRAVATING FACTORS

40. Council considered the relevant mitigating and aggravating factors in this matter. Council found the Former Licensee's conduct to be an ongoing problem, and not an isolated event. The results from insurer X's audit of the Former Licensee's book of business identified a trend in the Former Licensee's business of a lack of needs analysis and record-keeping, which demonstrated that this was not the experience first instance of non-compliance. Therefore, Council found the ongoing nature of the Former Licensee's misconduct to be aggravating. The Former Licensee was a Council member, and a voting member for a period of time, and should have knowledge greater than the average licensee relating to Council's processes and his obligations under Council's Rules and the Code of Conduct. Council found it aggravating that the Former Licensee should have had the knowledge to avoid this type of misconduct and that his conduct was a flagrant disregard for the Council's Rules and the Code of Conduct. In addition, Council found it to be aggravating that, although the clients were made whole due in part to the insurer X policy as a result of the Former Licensee's E&O insurance coverage, the process and experience of their interactions caused a degree of harm. Council found that there were no mitigating factors in this instance.

CONCLUSIONS

41. After weighing all of the relevant considerations, Council found the Licensee to be in breach of the Council's Rules and the Code of Conduct, and also found there to be many aggravating factors that made the Former Licensee's conduct more egregious.

42. Council considered the Gan precedent to be the most instructive and believes it is appropriate to fine the Former Licensee the maximum penalty. As of 2020, the Act provides that the maximum fine that Council can order against an individual is $25,000. It is noted that the misconduct in the Gan precedent held a maximum fine of $10,000, as allowed by the Act at that time. Council concluded that, given the similar circumstances to Gan and the aggravating factors, the maximum fine of $25,000 in this case is appropriate.

43. Should the Former Licensee decide to re-enter the industry in the future, Council has determined it is appropriate that the Former Licensee be required to take courses and be supervised to ensure the Former Licensee is conducting insurance business to the level that is expected of all licensees.

44. With respect to investigation costs, Council has concluded that these costs should be assessed to the Former Licensee. As a self-funded regulatory body, Council looks to licensees who have engaged in misconduct to bear the costs of their discipline proceedings, so that those costs are not otherwise borne by British Columbia's licensees in general. Council has not identified any reason for not applying this principle in the circumstances.

INTENDED DECISION

45. Pursuant to sections 231, 236 and 241.1(1) of the Act, Council made an intended decision that:

    a. The Former Licensee be fined $25,000, to be paid within 90 days of Council's order;

    b. 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 agents;

        ii. the Insurance Needs Analysis course available through Advocis;

        iii. The Challenge of Documenting Nothing course available through Advocis; and

        iv. an ethics course
        (collectively the "Courses");

    c. The Former Licensee be assessed Council's investigation costs in the amount of $2,875, to be paid within 90 days of Council's order;

    d. The Former Licensee be required to be supervised by a qualified 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; and

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

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 FINES/COSTS

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

RIGHT TO A HEARING

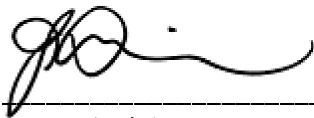
48. If the Former Licensee wishes to dispute Council's findings or its intended decision, the Former Licensee may have legal representation and present a case in a hearing before Council. **Pursuant to section 237(3) of the Act, to require Council to hold a hearing, the Former Licensee must give notice 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 https://www.bcfst.ca/app/uploads/sites/832/2021/06/guidelines.pdf.

Dated in Vancouver, British Columbia, on the **3rd day of December, 2024.**

For the Insurance Council of British Columbia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Janet Sinclair
Executive Director