In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

RANDEEP KAUR BHULLAR
(the "Former Licensee")

ORDER

As Council made an intended decision on January 27, 2026, pursuant to sections 231 and 241.1 of the Act; and

As Council, in accordance with section 237 of the Act, provided the Former Licensee with written reasons and notice of the intended decision dated February 10, 2026; and

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

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

1) The Former Licensee is fined $10,000, to be paid by August 31, 2026;

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 Challenge of Documenting Nothing course available through Advocis; and

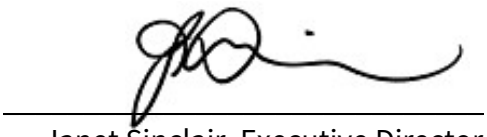
    ii. Making Choices I, II & III: Ethics and Professional Responsibility in Practice courses available through Advocis

(collectively, the "Courses");

3) The Former Licensee is assessed Council's investigation costs in the amount of $2,875, to be paid by August 31, 2026; and

4) Council will not consider an application for any insurance licence from the Former Licensee for a period of five years, commencing on March 2, 2026, and ending at midnight on March 1, 2031, and until the fine and investigation costs are paid in full and the Courses have been completed.

This order takes effect on the **2nd day of March, 2026**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA

("Council")

respecting

RANDEEP KAUR BHULLAR

(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 created fictitious clients to submit insurance policy applications to generate commissions.

2. On November 21, 2025, as part of Council's investigation, a Review Committee (the "Committee") comprised of Council members met via video conference to discuss the investigation and to allow the Former Licensee an opportunity to provide additional information or make further submissions. An investigation report prepared by Council staff was distributed to the Committee and the Former Licensee before the meeting. A discussion of the investigation report took place at the meeting, and 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 was reviewed by Council at its January 27, 2026, 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 and 241.1 of the Act before taking any such action. The Former Licensee may then accept Council's decision or, within 14 days, request a formal hearing. This intended decision operates as written notice of the action Council intends to take against the Former Licensee.

FACTS

5. The Former Licensee was licensed with Council as a Life and Accident & Sickness Insurance Agent ("Life Agent") from November 17, 2020, to August 1, 2025. The Former Licensee was authorized to represent an agency (the "Agency") from October 1, 2021, to September 11, 2024. On August 19, 2024, an insurer (the "Insurer") provided Council with a Life Agent Reporting Form stating that the Former Licensee created "fictitious clients" on insurance applications to generate commissions.

6. On August 7, 2024, the Insurer wrote to the Former Licensee advising that it had noted irregularities in the Former Licensee's business. The Insurer advised that its preliminary review suggested that the Former Licensee submitted applications with incorrect, misleading and potentially false information relating to different clients. The Insurer notified the Former Licensee that it was suspending her advisor code pending the outcome of its investigation.

7. On August 8, 2024, the Insurer wrote to the Former Licensee noting that its investigation "revealed that all filed applications either lapsed after 60 days due to non-payment of premium or remain active with incorrect bank details and unpaid premiums" and that within the previous six months, 29 of the 30 policies written by the Former Licensee had resulted in failed premium retrievals, with financial institutions reporting "cannot trace, account closed or incorrect account number" messages. The Insurer requested that the Former Licensee provide, by August 15, 2024, a copy of any Financial Needs Analysis ("FNA"), Reason Why Letter, proof of each client's identity with a copy of their identification, and proof of banking information with the client's name.

8. When the Agency became aware of the Insurer's investigation and suspension of the Former Licensee's advisor code, the Agency wrote to the Former Licensee on August 14, 2024, requesting that all documents requested by the Insurer also be sent to the Agency by the due date. The Agency also requested that the Former Licensee confirm her relationship with BB, who was also a Life Agent at the Agency.

9. On August 15, 2024, the Former Licensee sent an email to the Agency and the Insurer stating that "clients first understand the benefits of whole life with dividends and then they cancel the policies" and advised that she had sent a cheque to the Agency for $80,000 (which was already cashed by the Agency) to cover the chargeback. The Former Licensee also stated that she would cover the chargeback for BB.

10. The Insurer terminated the Former Licensee's contract on August 19, 2024. In its termination letter, the Insurer stated that the Former Licensee had failed to provide any substantiating evidence to verify the existence of the clients and that the Former Licensee had "simply asserted that some clients requested to cancel their policies." The Insurer concluded that without any proof that these clients existed, the Former Licensee had fabricated client profiles solely to generate commissions.

11. The Agency wrote to the Former Licensee on August 22 and 23, 2024, requesting that the Former Licensee provide the applications, FNAs, illustrations, disclosures, Reason Why Letter, meeting notes and delivery receipts for the 30 policies specifically flagged by the Insurer.

12. The Insurer flagged 30 policies, of which the majority were terminated for “non-payment” or “outstanding requirements.”

13. The Former Licensee emailed the Insurer on August 23, 2024, stating that “unfortunately I didn’t print out [the client files]. I have no Access to [the] files.”

14. On August 27, 2024, the Former Licensee emailed the Agency, stating that she had made a “huge mistake” and had written policies with the Insurer using the names of friends and family members, and that she had not stolen anyone’s identification or bank information. The Former Licensee further stated that she “did this only for the Point and commission” and that she “understand[s] this is not a small mistake, but this is my first and last mistake.” The Former Licensee requested the Agency put restrictions on her such as supervision or withholding upfront commissions, and asked for one more chance to continue working for the Agency.

15. On September 4, 2024, Council’s investigator emailed the Former Licensee advising her of Council’s investigation into the matter and requesting that the Former Licensee provide her version of the events.

16. On September 11, 2024, the Agency terminated its contractual agreement with the Former Licensee following its investigation of the matter.

17. On September 12, 2024, the Agency advised the Former Licensee that she had a balance owing of $96,542.58 and that “this balance could increase subject to any additional chargebacks and/or earn reversals processed in future cycles.”

18. On September 19, 2024, the Former Licensee sent an email to the Insurer, the Agency and Council’s investigator in which she stated, “I know that I am 100 percent in the wrong I take full responsibility of my actions, I was under so much financial stress and I made a wrong decision, never in my imagination thought that I will do any fraudulent act and I still don’t have those intentions that’s why I already returned $80,000 and I am willing to return the rest of the premium.” The Former Licensee attached various conversations and emails she had exchanged with other Life Agents in the Agency, in which she sent drafts of her emails to the Agency and the Insurer and requested commentary from other Life Agents. The Insurer responded on September 20, 2024, to advise that its decision had not changed.

19. The Former Licensee attended an interview with Council’s investigator on October 16, 2024. The Former Licensee stated that the situation was not her fault, saying that some clients no longer wanted the policies and would cancel them. The Former Licensee stated that all the clients were real and that she had not completed the paperwork, including the reason why letter or needs analysis. The Former Licensee further described being pressured by other Life Agents in the Agency to write the emails to the Insurer and the Agency during their investigation.

20. In an email dated October 21, 2024, the Former Licensee responded to Council’s investigator’s questions and stated that she “never created any client profile for commissions” and “I sent an email

to [The Agency] DO not pay me any commission policies, the ones clients don't want to proceed on there[sic] insurance. [The Agency] still sent the commission."

21. On November 19, 2024, the Insurer responded to Council's investigator's inquiries. The Insurer stated that for all 30 of the policies in question, the Former Licensee declared that she had validated the identification documents with her clients, however none of the identification documents or the FNAs were provided to the Insurer.

22. The Former Licensee was unable to produce any documentation to substantiate the identities of the clients associated with the policies in question. A total of 11 identification documents submitted in the insurance applications could not be authenticated as they were foreign passports or lacked the identification details needed to verify their authenticity. Council's investigator contacted the Insurance Corporation of British Columbia ("ICBC") to verify the authenticity of 19 BC driver's licence details documented on the clients' applications.

23. On December 3, 2024, and March 27, 2025, ICBC provided information indicating that none of the 19 driver's licence details recorded on the insurance applications could be authenticated. ICBC reported that either the name and date of birth and driver's licence number did not match or that there was no record of the individual.

24. As of November 19, 2025, the Agency advised that the total amount owing by the Former Licensee was $120,884.70.

25. In June 2025, Council's investigator requested that the Former Licensee attend a Review Committee meeting on August 28, 2025; however, the Former Licensee requested a date after September 2025 when her children would be back in school. The Review Committee date was scheduled for October 15, 2025, and on July 2, 2025, the Former Licensee confirmed that she would attend the meeting. On October 14, 2025, legal counsel for the Former Licensee requested an adjournment of the October 15, 2025, Review Committee date advising that they had just been retained for the matter. The same day, the legal counsel advised that they had withdrawn from the case and were no longer representing the Former Licensee. Council staff adjourned the October 15, 2025, Review Committee meeting, to allow the Former Licensee additional time to retain legal representation. The Review Committee meeting was rescheduled to November 21, 2025, and on October 26, 2025, the Former Licensee confirmed that she would attend.

26. At the Review Committee meeting, the Former Licensee became emotional when discussing the situation. She stated that she is suffering from a medical condition as a result of this situation, which has been very difficult for her. The Former Licensee stated that she did not make any false applications and explained that her mistake was failing to complete a needs analysis or maintaining the appropriate documentation for the policies in question. The Former Licensee explained her perspective on the working environment at the Agency and explained that she would sell products that other Life Agents had recommended or told her to sell. The Former Licensee admitted that she did not rely on her own expertise or the needs of her clients but relied on other Life Agents in the Agency to decide which products she should sell. The Former Licensee further stated that she did not

verify all identification or banking information, explaining that clients would sometimes share their ID numbers or banking information afterwards on the phone. When asked how the Former Licensee would describe the difference between a universal life policy and a whole life policy, the Former Licensee was only able to say that the difference is that universal life works with the market, whereas whole life stays on the dividend.

27. The Former Licensee was not able to articulate or state any information about the benefits of each kind of policy. When questioned about the specific policies at the Review Committee meeting, the Former Licensee stated several reasons as to why the clients no longer wanted the policies, including health issues, being in the process of buying homes, or intending to travel back to India. However, the Former Licensee could not explain why she had sold the policies to these individuals if she knew that their circumstances meant that the policies were not needed. The Former Licensee explained that when the Agency became aware of the Insurer's investigation she felt pressured by other Life Agents to admit wrongdoing. The Former Licensee stated that none of the emails she wrote admitting to creating the false identities for the policies were written by her, and that the other Life Agents either told her what to write or wrote the emails and she simply sent the email because they told her to do so. At the Review Committee meeting, the Former Licensee stated that she has worked hard to obtain her licence and that her lack of paperwork was an honest mistake. The Former Licensee requested that she be allowed to continue working in the insurance industry.

ANALYSIS

28. Council determined that on a balance of probabilities and the totality of the information and documentation within the investigation that the Former Licensee created fictitious clients to generate commissions for 28 of the 30 transactions flagged. One of the 30 transactions was for the Former Licensee's husband, and this policy had been terminated for non-payment. Additionally, one other policy remained in force, which Council did not believe to be a fictitious client. Council reviewed the information provided by ICBC for 19 of the clients associated with the policies in question and noted that none of the clients' driver's license numbers provided by the Former Licensee in those insurance applications matched ICBC's records. Further, numerous clients' date of birth on the insurance applications also do not match ICBC's records. If the clients were legitimate, their dates of birth and identification numbers would be expected to match official ICBC records. Council also did not believe it was likely that in addition to such a high number of clients having incorrect identification information, that 28 of the 30 policies in question would also have incorrect banking details, information, resulting in cannot trace responses, or non-payment resulting in the termination of the insurance policies. None of the submissions provided by the Former Licensee explained the discrepancies in the clients' banking information, identification numbers or dates of birth.

29. The Former Licensee stated that her mistake consisted of a lack of record keeping and not fully verifying all client identification. However, this does not account for the incorrect client identification numbers or dates of birth. Council did not find the Former Licensee's submissions credible. Council noted that the Former Licensee had sent two emails to the Insurer and the Agency admitting her "mistake" when the misconduct was brought to her attention. Council did not accept the Former

Licensee's later assertions that she did not write the emails and was forced to do so. One of the emails in question was dated September 19, 2024, and time stamped at 10:50 pm, although the Former Licensee had stated that she was forced to send these emails during a meeting with other Life Agents in the office. Additionally, the email included attachments of screenshots showing that the Licensee had asked another Life Agent, PJ to review the draft email sent on August 27, 2024. In the text it appears that the Former Licensee is asking for PJ's help to review the email before it is sent, and not that PJ is telling her what to send.

30. In light of Council's conclusion that the policies were fictitious and created solely to generate commissions, Council concluded that the Former Licensee did not act in a trustworthy manner and breached her duty of good faith to the Insurer. The Former Licensee made false declarations to an insurer by creating client information to submit policies to create commissions. Council found this conduct to be serious and a willful disregard of the Former Licensee's duties and obligations under the Act, Council Rules and Code of Conduct.

31. Council had concerns regarding the Former Licensee's financial reliability. The Former Licensee was accepting commissions that she knew were not earned. Regardless of whether the Former Licensee admitted to creating fictitious clients, the Former Licensee claimed that many of her clients told her they did not want the policies or that circumstances had arisen that made them want to cancel. The Former Licensee would have known that these commissions were not earned and would need to be repaid. However, the Former Licensee accepted the commissions and is currently unable to pay the Agency back the full chargebacks as she admitted that she has already spent the commissions she received for these policies.

32. Additionally, Council found that the Former Licensee did not conduct her insurance business in accordance with the usual industry practice. Based on the Former Licensee's own admissions, she did not complete any needs analysis or affordability checks and relied solely on other agents to advise her on which products to sell. All 30 of the policies in question were the same PAR Wealth 20-year policy. One of the clients listed on an application form was noted to be an Amazon manager requiring coverage of $961,111.00 and monthly premiums of $1,808.71. Council had serious concerns that the Former Licensee was unable to articulate or explain what a whole life policy is compared to a universal life policy. Council determined that the Former Licensee did not meet the competence standard required of a licensee.

33. Council considered the impact of Council Rule 7(8) and Council's Code of Conduct guidelines on the Licensee's conduct, including section 3 ("Trustworthiness"), section 4 ("Good Faith"), section 5 ("Competence"), section 6 ("Financial Reliability") and section 8 ("Usual Practice: Dealing with Insurers"). Council concluded that the Former Licensee's conduct amounted to breaches of the above Code of Conduct sections and the professional standards set by the Code.

PRECEDENTS

34. Before making its decision in this matter, Council took into consideration the following precedent cases. While Council is not bound by precedent and each matter is decided on its own facts and merits, Council found that these decisions were instructive in providing a range of sanctions for similar types of misconduct.

35. Manpreet Kaur Brar (April 2023): concerned a life agent where the insurer noted significant lapses of policies due to insufficient payments from the bank accounts used to pay the premiums for multiple clients. As a result of the commission reversals associated with the terminated policies, the licensee was charged back $146,000. Council concluded that the licensee failed to engage in the usual practice of the business of insurance by selling insurance products that were not appropriate or suitable to the clients' needs. The substantial volume of commission reversals by the insurers demonstrated that a large proportion of the insurance products sold by the licensee ultimately resulted in policy termination. Additionally, Council determined that the insurance products did not align with the clients' financial circumstances, given the high number of policies that lapsed due to non-payment. Council concluded that, given the high number of clients affected by the licensee's lack of competency, the licensee would pose a threat to the public if allowed to continue holding an insurance licence. Council ordered that the licensee's life agent licence be cancelled with no opportunity to apply for an insurance licence for two years.

36. Paul Brian Bradbeer (December 2018): an insurer's investigation concluded that the former licensee had submitted over 100 fictitious applications for life insurance certificates, accepted commissions for each of these fictitious applications, and then used part of the commissions he received to pay the monthly premiums. Approximately $650,000 in commissions was paid to the former licensee as a result of this fraud. Council ordered that the former licensee was unsuitable to hold an insurance licence, fined him $10,000, which was the maximum fine at the time, and assessed investigation costs of $1,000.

37. Virlie Aimendral Canlas (November 2020): in 2017, in response to financial problems, the former licensee began a scheme of convincing clients to obtain life insurance, even if they did not require coverage, with the agreement that he would pay their first-year premiums in full. He had also been conducting unlicensed securities activities with funds received from clients. 79 of the former licensee's clients terminated or lapsed their insurance policies between February 2017 and January 2019, which led to $258,940.93 in chargebacks. Council ordered that no insurance licence applications from the former licensee would be considered for five years; he was also assessed investigation costs of $1,500. Council considered fining the former licensee as well, as is usually done when a licensee perpetrates financially self-serving misconduct to the detriment of others. However, since the former licensee stated that he was currently attempting to repay clients who were financially harmed by his conduct, Council decided not to issue a fine, on the basis that such a fine might harm or delay the former licensee's attempts to repay his clients

38. Umber (Amber) Zahra Gilani (February 2025): concerned a licensee who made 47 fraudulent insurance claims for health benefits. Council noted that the licensee made false statements to her former agency, the insurer and Council in the initial investigation of this matter. Council was troubled that the

licensee not only made false insurance claims but that the Licensee had created falsified receipts to perpetuate the false claims. Council ordered that the licensee's licence be cancelled with no opportunity to reapply for five years and that the licensee be fined $7,500, assessed investigation costs, and be required to take an ethics course before being licensed in the future.

MITIGATING AND AGGRAVATING FACTORS

39. Council considered whether there were any mitigating and aggravating factors in this matter. Council noted the ongoing nature of the misconduct and the number of policies processed to be an aggravating factor. Council felt that the Former Licensee did not clearly answer the questions posed and found her responses to the investigation ambiguous and sometimes evasive, which Council found aggravating. Council found the conduct to be extremely egregious and potentially damaging to the insurance industry as a whole. Insurance companies would have likely incurred administrative costs to issue these fictitious policies. There is also a risk that this particular policy may not be available in the future or only be available at a higher cost to the public given the misuse of the products and loss suffered by the insurer. Additionally, the clients listed in the policies in question, if legitimate, may be prejudiced in the future when purchasing new insurance given the non-payment of these policies. Overall, Council found there to be several aggravating factors but did not identify any mitigating factors.

CONCLUSIONS

40. After weighing all of the relevant considerations, Council found the Former Licensee to be in breach of the Council Rules and the Code of Conduct.

41. Council considered the Gilani case to be the most relevant and determined that a five-year prohibition from the industry is warranted given the serious concerns relating to trustworthiness. As the Former Licensee's conduct resulted in more significant commission reversals compared to the fraudulent insurance claims made in the Gilani case, Council determined that a higher fine is appropriate in this case. As the Former Licensee has stated that she would like to repay the Agency for the chargebacks, Council has determined that it is appropriate to extend the time permitted for the Former Licensee to pay her fine and costs.

42. 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

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

    a. The Former Licensee be fined $10,000, to be paid within 180 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 Challenge of Documenting Nothing course available through Advocis; and
        ii. Making Choices I, II & III: Ethics and Professional Responsibility in Practice courses available through Advocis
        (collectively, the "Courses");

    c. The Former Licensee be assessed Council's investigation costs in the amount of $2,875, to be paid within 180 days of Council's order; and

    d. That Council will not consider an application for any insurance licence from the Former Licensee for a period of five years and until the fine and investigation costs are paid in full and the Courses have been completed.

44. 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

45. 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 180-day deadline.

RIGHT TO A HEARING

46. 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 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.**

47. 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 guidelines.pdf.

Dated in Vancouver, British Columbia, on the **10th day of February, 2026**.

For the Insurance Council of British Columbia

Janet Sinclair
Executive Director