In the Matter of the

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

and the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

and

UMBER (AMBER) ZAHRA GILANI
(the "Licensee")

ORDER

As Council made an intended decision on December 10, 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 Licensee with written reasons and notice of the intended decision dated January 14, 2025; 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's general insurance licence is cancelled;

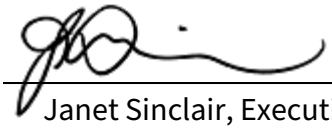
2) The Licensee is fined $7,500 to be paid by May 5, 2025;

3) The Licensee is required to complete an ethics course, as acceptable to Council, prior to being licensed in the future;

4) The Licensee is assessed Council's investigation costs in the amount of $2,593.75, to be paid by May 5, 2025; and

5) Council will not consider an application for any insurance licence from the Licensee for a period of five years commencing on February 3, 2025 and ending at midnight on February 2, 2030, and until the fine and investigation costs are paid in full and the course has been completed.

This order takes effect on the **3rd day of February, 2025.**



Janet Sinclair, Executive Director
Insurance Council of British Columbia

INTENDED DECISION

of the

INSURANCE COUNCIL OF BRITISH COLUMBIA
("Council")

respecting

UMBER (AMBER) ZAHRA GILANI
(the "Licensee")

1. Pursuant to section 232 of the *Financial Institutions Act* (the "Act"), Council conducted an investigation to determine whether the Licensee acted in compliance with the requirements of the Act, Council Rules and Code of Conduct relating to allegations that the Licensee made fraudulent benefit claims with an insurer.

2. On November 6, 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, the Licensee, and the Licensee's legal counsel before the meeting. Although the Licensee and the Licensee's legal counsel were notified of the Review Committee meeting, the Licensee and the Licensee's legal counsel 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 investigation report were reviewed by Council at its December 10, 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 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 formal hearing. This intended decision operates as written notice of the action Council intends to take against the Licensee.

FACTS

5. The Licensee became licensed with Council as a Level 1 general insurance salesperson ("Level 1 Salesperson") on June 28, 2017, and held an authorization to represent ("ATR") an agency (the "Agency") from May 6, 2021, to December 15, 2023. The Licensee is currently inactive.

6. On November 23, 2023, the Agency's health insurance provider (the "Insurer") advised the Agency that 47 registered massage therapist ("RMT") claims were improperly submitted in the names of the Licensee's family members. This resulted in a payout of $5,367.50 to the Licensee over a 12-month period between September 2022 and September 2023.

7. On December 15, 2023, the Agency terminated the Licensee's employment following its investigation into the Licensee and the fraudulent claims made with the Insurer. On December 18, 2023, Council received an End Authorization to Represent form from the Agency in which it informed Council that the Licensee's employment had been terminated due to her misconduct with the Insurer.

8. In November 2023, the Insurer carried out an investigation of the Licensee's benefit claims after identifying that there were services not provided as submitted. There were 47 RMT insurance claims, with discrepancies, submitted using the Insurer's app, in the names of the Licensee and the Licensee's family members.

9. On November 13, 2023, the Insurer requested that the Licensee provide receipts for 47 of the RMT services claimed. The Licensee was unable to provide receipts and stated that "a lot of places do not give receipts." On November 20, 2023, the Licensee emailed the Insurer stating that the massage therapist she went to was not a registered massage therapist, and that when her husband was unable to find the massage therapist's name, he submitted the claim under other providers' names that came up in the submission process. On November 22, 2023, the Insurer advised the Agency of this matter.

10. The Agency conducted an investigation, with Agency employee LD interviewing the Licensee on November 29, 2023, and December 12, 2023.

11. LD noted that the Licensee made inconsistent statements during the two interviews. Although she initially said that her spouse entered the claims on the Insurer's app, she later said that she and her spouse entered the claims. The Licensee also stated "that neither she or her spouse read the 'terms, conditions and authorization' statement. However, they attested to doing so by clicking the authorization radio/toggle button for each of the 47 claims."

12. On February 15, 2024, Council staff wrote to the Licensee requesting information relating to the Insurer's claims and requesting receipts for the RMT services.

13. On February 17, 2024, the Licensee responded, stating, "there was a misunderstanding in online claims submission, there is the incorrect provider information submitted in the claims was due to my husband inability to locate the intended provider, resulting in inadvertently selecting one from the list of providers we frequently used to visit for massages. It was never our intent to submit claims that did not align with the Insurer's policies or misrepresent the services received. it all happened because of lack of awareness of using the online claims submitting."

14. The Licensee provided 47 receipts for massage services performed at SB, which does not offer registered massage services. The massage receipts from SB showed that all services were paid with cash. However, the receipts provided by the Licensee had prices that did not match the pricing listed on SB's website, and no tax was noted on the receipts.

15. On March 8, 2024, Council's investigator interviewed the Licensee. In the interview, the Licensee stated that she was unaware that her health insurance plan would only cover registered massage therapy services. She said that her husband submitted all claims because she was going through health and mental health issues following the death of her father. The Licensee also stated that she did not obtain receipts after the massage services and only obtained them when Council staff asked her to provide them with receipts.

16. When questioned about the discrepancy in pricing shown on the SB website and on the receipts submitted, the Licensee said that she had massages of 75 to 90 minutes in duration, and the pricing on the website was for 60-minute massages. The Licensee denied knowing the owner of SB.

17. The Licensee stated that she has offered to pay the Insurer back for the money that she received.

18. On April 25, 2024, the Council investigator corresponded with TN, SB's owner, to discuss the receipts submitted by the Licensee. TN confirmed that no one from the Licensee's family had attended SB for massage services. TN also stated that the 47 receipts submitted by the Licensee were not from SB.

19. Council's investigator completed a land title search of the address of SB, which revealed that the Licensee owns 25% of the property, even though she denied knowing the owner of SB.

20. On May 6, 2024, Council's investigator contacted the Licensee and requested an additional interview. On May 29, 2024, Council received an email statement from the Licensee, which was provided by the Licensee's legal counsel. The Licensee admitted that neither she nor her family received any massage

services for the 47 claims made with the Insurer. The Licensee stated that her husband had not submitted any of the claims to the Insurer, and that she had submitted all of the claims. The Licensee admitted that she made these claims for financial gains and stated that she created the false receipts because she was "scared and depressed at the thought of the false claims being discovered." The Licensee stated that since this investigation she has sought medical treatment. She further stated that her relationship with her family had become strained, and that she had lost her employment and the ability to provide for her family.

21. At the time of the investigation, the Licensee had not repaid the Insurer for any of the 47 fraudulent claims submitted.

22. The Licensee did not inform or notify Council within the required five business days that the Agency had terminated her ATR because of conduct that would affect her suitability to hold a licence.

ANALYSIS

23. Council concluded that the Licensee's actions constituted serious breaches of the fundamental licensing requirements of trustworthiness and the intention to carry on the business of insurance in good faith. Council noted that the Licensee made false statements to the Agency, the Insurer and Council in the initial investigation of this matter. Council was troubled that the Licensee made false insurance claims and that the Licensee had created falsified receipts to perpetuate the false claims. Council further determined that the Licensee, as a licensed insurance agent, would know how to make insurance claims and that in these circumstances, the Licensee knew the process for making a claim and knowingly made 47 fraudulent claims at the maximum rate for massage therapy. It was troubling to Council that the Licensee made 47 fraudulent claims over the course of one year.

24. Council also concluded that the Licensee demonstrated an inability to be financially reliable. It is critical that licensees can be relied upon to properly safeguard money and property entrusted to them and deliver them in accordance with the circumstances. By making fraudulent claims and creating 47 fictitious receipts, the Licensee does not demonstrate that she can be trusted with client or insurer money.

25. Council further found that the Licensee made material misstatements to Council staff during the investigation, which is a breach of the Licensee's requirements and duty as a licensee.

26. Council considered the impact of Council Rule 7(8) and Council's Code of Conduct sections 3 ("Trustworthiness"), 4 ("Good Faith"), 6 ("Financial Reliability") and 12 ("Dealing with the Insurance

Council of British Columbia"). Council concluded that the Licensee's conduct amounted to breaches of the above Council Rule and Code of Conduct sections, as well as the professional standards set by the Code of Conduct.

PRECEDENTS

27. 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.

28. *Aline Marie Jacob* (June 2023): concerned a licensee who submitted five fraudulent claims to an insurer and received a total of $1,500 as a result. The licensee admitted to falsifying medical treatment records and submitting fraudulent claims to the insurer. The licensee explained that she was experiencing difficulties at the time and felt unsupported by her agency. The licensee was remorseful for her actions and repaid the insurer the amount she received. However, given the seriousness of the misconduct, Council ordered a $5,000 fine and a suspension of the licensee's licence for one year, as well as assessing investigation costs and requiring the licensee to complete courses.

29. *Nicole Sonia Barabas* (June 2023): concerned a licensee who submitted eight fraudulent claims to an insurer and received a total of $2,000 as a result. The licensee had submitted medical notes in support of her claims, including a forged signature of a doctor. The licensee admitted to falsifying the records and advised that she did have a valid injury for the claim but was not sure why she decided to falsify the medical records instead of seeing a doctor. The licensee expressed regret and was remorseful for her actions and repaid the insurer the amount she received. The licensee explained personal circumstances that may have contributed to the misconduct. Council ordered a $5,000 fine and a suspension of the licensee's licence for one year, as well as assessing investigation costs and requiring the licensee to complete courses.

30. *Harpal Kaur Sandhu* (August 2022): concerned a licensee who submitted three different total disability claims with an insurer but continued to work during the total disability periods. Council concluded that the licensee made fraudulent insurance claims for total disability by claiming for periods of total disability and continuing to complete work duties and submit insurance applications during the relevant time period. Whether intentional or not, the licensee should have known that by providing information stating that she was unable to perform all the duties related to her occupation, she should not have continued working during that time period. Council ordered that the licensee be fined $7,500, that the licensee's life and accident and sickness insurance agent licence be suspended for

one year, and that the licensee be required to take courses, be assessed investigation costs and be supervised for a period of two years following the lifting of the licensee's suspension.

31. *Paramjeet Kaur Johal* (June 2022): concerned a licensee who submitted two total disability claims with an insurer but continued to work during the total disability periods. Although the licensee completed the appropriate total disability form claims and stated that she was unable to do all the duties pertaining to her usual occupation, internal reports from the insurer demonstrated that the licensee continued to work and submit policy applications during the relevant time periods. Council determined that the licensee knew or ought to have known that her conduct resulted in fraudulent total disability claims and that the licensee had a duty to disclose any information fully and accurately to an insurer. Council determined that the misconduct brought into question the licensee's trustworthiness and ability to act in good faith. Council ordered that the licensee be fined $5,000, that the licensee's life and accident and sickness insurance agent licence be suspended for one year, and that the licensee be required to take courses, be assessed investigation costs and be supervised for a period of two years following the lifting of her suspension.

32. *Martin Hroch* (February 2020): concerned a former licensee who submitted 74 false insurance claims for physiotherapy services through his employee health and wellness program between May 2017 and June 2018. This resulted in a payment to the former licensee of $2,570. The physiotherapy clinic and former licensee admitted that the physiotherapy sessions did not take place. Additionally, the former licensee admitted to making two false vision claims in June 2018, for which he received $475. The former licensee agreed to repay the insurer for the fraudulent claims, but only ended up paying $425. Given the misconduct, Council determined that the former licensee did not meet the standards of trustworthiness and good faith. Council ordered that the former licensee not be eligible to reapply for a licence for five years, be fined $5,000 and assessed investigation costs.

33. *Mahin Heidari* (June 2015): concerned a licensee who submitted at least 35 false personal health insurance claims through her group benefits insurance provider, including 18 claims for chiropractic services, 13 claims for masseuse services and four claims for visits to a psychologist. The licensee received a total of $2,269 for these false claims. Despite all the evidence against the legitimacy of her claims, the licensee continued to justify her actions and displayed dishonest behaviour throughout the disciplinary process. Council prohibited the licensee from holding an insurance licence for three years, fined her $10,000 and required her to pay investigative costs of $2,025 and hearing costs of $2,500.46.

34. *Yazdi & Associates Financial Services Inc. and Arvin Nazerzadeh-Yazdi* (May 2017): concerned a former licensee who established a group health plan for a company for which he was director. The company had only six employees, yet 25 individuals were registered in the group health plan. During the time

that the health plan was in effect, the former licensee submitted numerous invalid health claims on his own behalf, and also assisted others, including family members, with making false claims. The former licensee admitted to his misconduct when it was discovered, and he co-operated with the insurance company's investigation. Council prohibited the former licensee from holding an insurance licence for five years and prohibited him from serving as an officer or director of an insurance agency for five years. Additionally, the former licensee was fined $10,000 and assessed investigative costs of $812.50.

MITIGATING AND AGGRAVATING FACTORS

35. Council considered relevant mitigating and aggravating factors in this matter. Council acknowledged that the Licensee had stated that she is now suffering from health issues and difficulties with her family as a result of this incident, which Council considered as a mitigating factor. However, Council identified several aggravating factors. The Licensee made 47 claims over a period of one year, and Council found the continuous and ongoing nature of this conduct to be an aggravating factor. Additionally, Council found the Licensee's misstatements and creation of falsified documents to support her fraudulent claims to be a flagrant disregard for the law governing licensee conduct, especially given the fundamental nature of trustworthiness that a licensee must possess. Council also found it aggravating that the Licensee, despite stating that she would repay the Insurer, has not done so.

CONCLUSIONS

36. 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.

37. Council concluded that the *Heidari* and *Hroch* cases were the most instructive, given the high volume of claims made and the Licensee's initial efforts to justify and legitimize her claims before finally admitting to making the fraudulent claims.

38. Council has concluded that it is appropriate for the Licensee's licence to be cancelled, that Council should not consider a licence application from the Licensee for a period of five years and that Council impose a fine of $7,500. Further, Council determined that the Licensee be required to complete an ethics course before being licensed in the future.

39. With respect to investigation costs, Council has concluded that these costs should be assessed to the 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

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

    a. The Licensee's general insurance licence be cancelled commencing on the date of Council's order;

    b. The Licensee be fined $7,500, to be paid within 90 days of Council's order;

    c. The Licensee be required to complete an ethics course, as acceptable to Council, prior to being licensed in the future;

    d. The Licensee be assessed Council's investigation costs in the amount of $2,593.75, to be paid within 90 days of Council's order; and

    e. Council will not consider an application for any insurance licence from the Licensee for a period of five years from the date of Council's order and until the fine and investigation costs are paid in full and the course has been completed.

41. Subject to the 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

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

RIGHT TO A HEARING

43. If the Licensee wishes to dispute Council's findings or its intended decision, the 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 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 14 days of receiving this intended decision, the intended decision of Council will take effect.**

44. Even if this decision is accepted by the 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 **14th day of January, 2025.**

For the Insurance Council of British Columbia

Per Janet Sinclair
Executive Director