

**BEFORE THE INSURANCE COMMISSIONER  
FOR THE STATE OF ARKANSAS**

**IN THE MATTER OF  
VICTOR TIMOTHY PESCE, Jr., LICENSE NO. 260994  
and  
JONESBORO LIFE INSURANCE AGENCY  
d/b/a GUARDIAN INSURANCE PROTECTORS**

**A.I.D. NO. 2008- 033**

**CONSENT ORDER**

On this day Julie Benafield Bowman, Arkansas Insurance Commissioner (“Commissioner”), and Victor Timothy Pesce, Jr., (“Respondent”) and Jonesboro Life Insurance Agency d/b/a Guardian Insurance Protectors (“Agency”), reached an agreement concerning the resident insurance producer’s license issued to Respondent by the Arkansas Insurance Department (“Department”). The Commissioner was represented by Nina Samuel Carter, Associate Counsel. The Respondent voluntarily and intelligently waived his right to a hearing and consented to the entry of this Consent Order. The parties agreed as follows:

**FINDINGS OF FACT**

1. Respondent is currently licensed in Arkansas as a resident life and accident and health insurance producer. Respondent holds Arkansas resident producer license number 260994 and has been licensed since October of 2003. He is the sole owner and operator of Jonesboro Life Insurance Agency d/b/a Guardian Insurance Protectors, an Arkansas resident insurance agency with an expired license as of September 30, 2007. Respondent’s last address of record at the Department is 4203 Forest Hill Road, Jonesboro, AR 72404. From information given to the Department by

the Respondent, it appears that Respondent has moved to Indiana although the License Division of the Department has not received a change of address notification from the Respondent in violation of Ark. Code Ann. § 23-64-507(f).

2. Respondent was terminated by Bankers Life Insurance Company (“Bankers”) for cause because Bankers alleges that Respondent forged an applicant’s signature.

3. According to a complaint received by the Department, on or about December 2005, Respondent signed Jennifer Wessell up with Humana. In April 2006, an agent from Respondent’s agency contacted Ms. Wessel to sign her up with Humana Gold Choice, which became effective on May 1, 2006. In June or July of 2006, Ms. Wessell received a different drug card in the mail and contacted Respondent about it in August 2006. Respondent told Ms. Wessell to discard the card and continue using the Humana drug card, which she did. In December 2006, after trying to fill a prescription, Ms. Wessell discovered that her Humana plan was cancelled as of May 1, 2006, and the Centers for Medicare and Medicaid Services (“CMS”) showed that she was currently signed up with Unicare. When Unicare was contacted, they stated that Ms. Wessell was not in their system and that in August 2006, Respondent’s son had called to cancel Ms. Wessell’s Unicare drug plan. Ms. Wessell later learned that a letter, purportedly signed by Jennifer Wessell, had been sent in August 2006 confirming cancellation of the Unicare drug plan. Ms. Wessell states that she has no knowledge of any such letter or a phone call made on her behalf because she did not know that she had a Unicare drug plan as Humana had been paying her claims for medication. Between September 2006 and December 2006, Respondent sent two different agents to enroll Ms. Wessell with

different plans, but Ms. Wessell did not qualify for those plans. It is alleged that the signature on the letter, purporting to be the signature of Jennifer Wessell, sent to Unicare was forged. Investigation into the matter revealed that the letter was faxed from Respondent's agency immediately following the phone call Respondent's son made to Unicare.

4. Around November 2007, the Department received information from Unicare as a result of a complaint by Richard Shelton on behalf of his aunt, Doris Shelton. Mr. Shelton complained to Unicare that his aunt was signed up with Unicare without her knowledge or consent. Ms. Shelton had been a member of Blue Cross MediPack Plus for several years and was happy with the plan. Ms. Shelton realized that there was a problem when she started receiving Unicare bills. Ms. Shelton lives at an Assisted Living Facility. Mr. Shelton discovered that the agent involved was the Respondent and that he serviced the Facility. An investigation by the Legal Division revealed that residents at the Facility were enrolled with either Humana or UniCare without their knowledge or consent by the then Director who claimed to have Power of Attorney for the residents. Respondent claims that his name is on the applications only for payment purposes as he was not at the Facility when the applications were filled out. Respondent sent one of his agents, Pat Davis, out to the Facility to get the paperwork completed. In a statement made under oath, Pat Davis stated that he went to the Facility and obtained the residents' personal information and filled out applications under Respondent's direction. The applications were signed either by the then Director claiming to have power of attorney or by the resident. Respondent did sign the

applications as the responsible insurance producer, although he did not witness the consumers' signatures.

5. According to a complaint filed by Tommy Tate around November 15, 2007, the Tates received a call from Respondent informing them that Respondent was in charge of helping local seniors with their Medicare Prescription enrollment and asked if Respondent could stop by since he would be in their neighborhood. During the visit, Respondent spoke to the Tates about their investments and asked whether they had any annuities. They had one annuity with Bankers, which they had for many years. Most of their investments were with Fidelity National in mutual funds. Respondent recommended that they sell their mutual funds with Fidelity and purchase an EquiTrust annuity. Respondent explained that the EquiTrust annuity would allow them to take their distributions as required by IRS without penalty. However, Respondent failed to explain that the EquiTrust annuity had a market rate value adjustment and that it only earned interest every other year. Respondent advised the Tates to put all of their savings into those annuities, which left them no money for emergencies. The Tates did not know about the market rate value until they needed extra money and were informed that there would be a 27.5% penalty for withdrawal. Respondent also advised that it would be in their best interest to transfer the Bankers annuity to EquiTrust because he used to work for Bankers and had inside information on their financial strength. That Respondent also advised the Tates that Respondent had quit due to Banker's poor ratings and that Bankers was about to file bankruptcy. This information scared the Tates, so they opted to move without further research. Respondent claimed to be a Senior Medicare Specialist and would take care of all their Medicare needs, concerns, and problems. Respondent

changed Mr. Tate's Medicare Supplement four times in one year. Mr. Tate was left with Care Improvement Plus, which was not what they expected. Respondent failed to tell them that the plan has co-pays that are out of pocket. When Mr. Tate was admitted to the hospital and required surgery, Respondent said after co-pay, everything else would be taken care of. The Tates now have a bill for \$17,000 from the hospital. The Tates were misled and misinformed about the policies by Respondent. Respondent was sent a letter on December 20, 2007, requesting information in regards to this complaint, but failed to respond.

6. According to a complaint filed by Mae Dale and Roy David Jones on June 27, 2007, they were informed by their supplemental insurance carrier, Mutual of Omaha, that their plan would cost \$1400 more starting in 2007. The Joneses contacted Respondent and asked him to find something cheaper. Respondent sent "his young men" to their home with a plan from Care Improvement Plus that was described as being especially for people like Mrs. Jones who had diabetes and heart problems. Respondent told Mrs. Jones that the medications for her diabetes would be free, but that she would have to pay for other drugs. Mrs. Jones asked to read the paperwork and was told that it was not necessary because it was just like her other insurance and that she was still under Medicare, but it would pay better on her prescriptions. Mrs. Jones then went to her doctor and found out that neither her doctor nor her hospital accepted Care Improvement Plus. While at the doctor's office, Mrs. Jones also found out that they did not actually have Medicare Parts A and B, as they thought. The Joneses then went to Respondent's office and he assured them that they were still on Medicare. Respondent advised them to be patient and the doctor would be paid, but that they should change doctors if the doctor

did not care enough about them to accept their insurance. Mrs. Jones stated that she had been going to that doctor for over 12 years and would not change. The Joneses did not understand that the new Medicare Advantage plan took them out of Medicare. Mr. and Mrs. Jones were misled by the Respondent as the Medicare Advantage plans they were sold were not properly explained.

7. For the above actions, the Department alleges that Respondent is in violation of the Insurance Code for: Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance, in violation of Ark. Code Ann. § 23-64-512(a)(5); Forging another's name to an application for insurance or to any document related to an insurance transaction, in violation of Ark. Code Ann. § 23-64-512(a)(10); Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, lack of good personal or business reputation or financial irresponsibility, in violation of Ark. Code Ann. § 23-64-512(a)(8); Failing to provide a written response after receipt of a written inquiry from the Commissioner or her representative within thirty (30) days, in violation of Ark. Code Ann. § 23-64-512(a)(13); Churning of business by replacing an existing policy that is not for the benefit and betterment of the insured, in violation of Ark. Code Ann. § 23-66-206(2); Making false or fraudulent statements or representations in, or relative to, an insurance policy, in violation of Ark. Code Ann. § 23-66-206(8); Making false or fraudulent statements or representations in, or relative to, an application for insurance, in violation of Ark. Code Ann. § 23-66-305; Failing to provide reasonable and professional service to each insured or prospective insured, in violation of Ark. Code Ann. § 23-66-307(a)(1); Failing to exercise discretion and good faith in the insurance sales presentation or transaction, in

violation of Ark. Code Ann. § 23-66-307(a)(2); and Failing to improve upon existing insurance by providing better coverage or a more suitable product for the needs of the insured, their family, or business, in violation of Ark. Code Ann. § 23-66-307(a)(3).

8. Respondent desires to voluntarily submit his license for revocation by the Department. In so doing, Respondent neither admits any allegations contained herein, nor makes any admissions related to the allegations or complaints filed herein.

### **CONCLUSIONS OF LAW**

1. That the Commissioner has jurisdiction over the parties and over the subject matter herein pursuant to Ark. Code Ann. § 23-61-103.

2. That pursuant to Ark. Code Ann. § 23-64-512(a) and § 23-64-216(d)(1), if the Commissioner finds that one or more grounds exist for the suspension or revocation of any license under § 23-64-216(a)(1), the Commissioner in his or her discretion may impose upon the licensee an administrative penalty in the amount of up to one thousand dollars (\$1,000) per violation or up to five thousand dollars (\$5,000) per violation if willful misconduct on the part of the licensee is found.

3. That Respondent has been made fully aware of his right to a hearing and has voluntarily and intelligently waived said right and consents to the entry of this Consent Order.

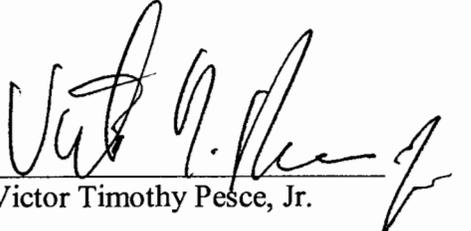
**THEREFORE**, in consideration of these Findings of Fact and Conclusions of Law, it is hereby ordered and agreed that:

A. Respondent's resident Arkansas Insurance producer's licenses, including the Agency license, are hereby voluntarily surrendered for revocation by the Arkansas Insurance Commissioner.

B. Pursuant to Ark. Code Ann. § 23-64-218(a)(1), Respondent shall immediately forward to the Insurance Commissioner all insurance producer and agency licenses.

C. Pursuant to Ark. Code Ann. § 23-64-216, Respondent shall also pay an administrative penalty of \$5,000. The administrative penalty shall be paid within 90 days from entry this Order.

IT IS SO ORDERED THIS 24th day of April, 2008.

  
Victor Timothy Pesce, Jr.

  
JULIE BENAFIELD BOWMAN  
INSURANCE COMMISSIONER  
STATE OF ARKANSAS