

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

BANKERS LIFE and CASUALTY INSURANCE COMPANY

NAIC # 61263

11825 N. Pennsylvania Street (Executive Office)

Carmel, IN 46032

111 East Wacker Drive, Suite 2100 (Home Office)

Chicago, IL 60601-4508

As of

October 31, 2013

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Honorable Karen Weldin Stewart CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in Certificate of Examination Authority Number 61263-13-782, and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

Bankers Life and Casualty Insurance Company

The examination was performed as of October 31, 2013. Bankers Life and Casualty Insurance Company, hereinafter referred to as the "Company" or as "Bankers," and is domiciled in the State of Illinois and licensed in every state except New York. The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

11825 N. Pennsylvania Street
Carmel, Indiana 46032

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

Bankers Life and Casualty Company is domiciled in the State of Illinois and licensed in every state except New York. The Company sells long-term care insurance, life insurance and fixed-rate annuity and fixed index annuity products through a career agency sales force. The Company discontinued issuing new Medicare supplement business effective June 1, 2010. Currently, the Company assumes Medicare supplement insurance from an affiliate.

The Company's home office is located at 111 East Wacker Drive, Suite 2100, Chicago, Illinois and, the executive office is located at 11825 N. Pennsylvania Street, Carmel, Indiana 46032.

In the 2012 Annual Statement filed with the Department, Bankers reported total life premiums (group and individual) \$3,038,934, annuity considerations (group and individual) \$9,105,353 and long-term care (group and individual) \$2,243,146 was written in Delaware.

The examination focused on the Company's life, annuity and long term care business in the following areas of operation: Company Operations and Management, Complaint Handling, Producer Oversight, Underwriting and Rating, and Claims.

The following exceptions were noted:

COMPLAINT HANDLING:

Complaints:

- 3 Exceptions – 18 Del. CODE §2304 (17) Unfair methods of competition and unfair or deceptive acts or practices defined. Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title.
- 2 Exceptions – 18 Del. CODE §2304 (26) Unfair methods of competition and unfair or deceptive acts or practices defined. Failure to respond to regulatory inquiries within 21 calendar days of such inquiry.
- 1 Exception – 18 Del. Admin. Code 902 §1.2.1.2 Prohibited Unfair Claim Settlement Practices. Failure to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

UNDERWRITING AND RATING:

Long-Term Care – In Force New Business:

- 1 Exception 18 Del. CODE. § 2708 Consent of insured; life, health insurance. Failure to recognize that a single application was used to issue two policies. The original application was photocopied, and the photocopied application was used to issue a second policy. Failure at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefore or has consented thereto in writing to the issuance of the second policy.

Life Policies Issued:

- 86 Exceptions - 18 Del. Admin. Code 1203 §4.0 Definitions
The Company failed to provide to Delaware insureds a recent version of the Life Insurance Buyer's Guide, which contains language that is currently approved by the National Association of Insurance Commissioners.
- 24 Exceptions - 18 Del. Admin. Code 1203 §4.0 Definitions
The Company failed to revise the Policy Summary contained in 24 of the files reviewed to correspond with the language of the Life Insurance Buyer's Guide that is currently approved by the National Association of Insurance Commissioners.

Long-Term Care Issued:

- 12 Exceptions-18 Del. Admin. Code 1404 Long-Term Care Insurance §24.0 §24.1.6. The long-term care policyholders were not provided the written information about the state's ElderInfo Program, and a physical address, as required by regulations.

Annuities Issued:

- 2 Exceptions - 18 Del. Admin. Code 1204 §7.1 Replacement of Life Insurance
The Company failed to provide written communication to two insurers advising of the replacement to the existing insurer as required by 18 Del. Admin. Code 1204 §7.1.
- 2 Exceptions - 18 Del. Admin. Code 1204 §7.3 Replacement of Life Insurance
The noted files did not contain evidence of the Notice Regarding Replacement, the Policy Summary, or any required Ledger Statements. These replacements are considered qualified replacements, which the Company should have sent a communication to the administrator of the existing qualifying plan. The Company provided no evidence that it sent any documentation to whomever was in charge of the existing plan that was to be

replaced.

- 1 Exception - 18 Del. CODE §2708. Consent of insured; life, health insurance. One file contained an application without the insured's written consent.
- 1 Exception - 18 Del. CODE §1214 Senior Protection in Annuity Transactions. Based on the facts disclosed by the senior consumer at the time of application, the producer failed to ascertain that the senior consumer understood her tax status prior to execution of the annuity contract.

Life, Long-Term Care, and Annuities – Declined/Not Taken

- 6 Exceptions – 18 Del. CODE §320 (c) Conduct of examination; access to records; correction. The Company failed to retain and provide information relating to the subject of the examination.

CLAIMS:

Long-Term Care Appeals:

- 2 Exceptions - 18 Del. Admin. Code 1408 §4.0 Prompt Payment of Clean Claims and §8.0 Effective Date. Failure to pay a long term care claim or send written notice acknowledging the date of receipt of the claim within 30 days.
- 1 Exception - 18 Del. Admin. Code 902 §1.2.1.2 Prohibited Unfair Claim Settlement Practices. Failure to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.
- 2 Exceptions - 18 Del. Admin. Code 1301 §4.0 Mediation Services. Failure in two instances to provide written notice of the Insured's right to seek review of a claim denied on appeal through the Delaware Insurance Department.

Life Claims:

3 Exceptions – 18 Del. Admin Code. 902 §1.2.1.2. Prohibited Unfair Claim Settlement Practices. The Company failed to acknowledge and respond within 15 working days, upon receipt, to communications with respect to claims by insureds arising under insurance policies.

2 Exceptions - 18 Del. Admin Code. 902 §1.2.1.3. Prohibited Unfair Claim Settlement Practices. The Company failed to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss.

1 Exception - 18 Del. Admin Code. 902 §1.2.1.5. Prohibited Unfair Claim Settlement Practices. The Company failed to affirm or deny coverage or a claim or advise the person presenting the claim, in writing within 30 days after

proof of loss statement was received.

Long-term Care Claims and Short-term Care Claims:

- 9 Exceptions - 18 Del. Admin. Code 902 §1.2.1.3. Prohibited Unfair Claim Settlement Practices. The Company failed to implement prompt investigation of claims within 10 working days upon receipt of the notice of loss.
- 6 Exceptions - 18 Del. Admin Code. 902 §1.2.1.2. Prohibited Unfair Claim Settlement Practices. The Company failed to acknowledge and respond within 15 working days, upon receipt of communications with respect to claims by the insured.
- 3 Exceptions - 18 Del. Admin Code. 902 §1.2.1.5 Prohibited Unfair Claim Settlement Practices. The Company failed to either affirm or deny a claim in writing within 30 days after receipt of proof of loss statements.
- 2 Exceptions - 18 Del. CODE. §2304 Unfair methods of competition and unfair or deceptive acts or practices defined. The Company failed to effectuate prompt, fair, and equitable settlement of the claim by misrepresenting pertinent facts related to the coverage in correspondence sent to the policyholder.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. CODE §318-322 and covered the experience period of January 1, 2013 through October 31, 2013.

The examination was a target market conduct examination of the Company's life, annuity and long term care business in the following areas of operation: Company Operations and Management; Complaint Handling, Producer Oversight, Underwriting and Rating, and Claims.

METHODOLOGY

This examination was performed in accordance with market regulation standards established by the Department and examination procedures suggested by the NAIC. While examiners report on errors found in individual files, the examiners also focus on general business practices of the Company.

The Company identified the universe of files for each segment of the review. Based on the universe sizes, random sampling was utilized to select the files reviewed during this

examination.

Delaware market conduct examination reports generally note only those items to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the report may result in imposition of penalties. In general, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the report if no improprieties were noted. However, the examination report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of exceptions identified during the examination and to review written summaries provided in regard to the exceptions found.

COMPANY HISTORY

Bankers Life and Casualty Insurance Company is the consolidation of Illinois Standard Life Insurance Company, Chicago, a stock company formed in 1942; Hotel Men's Mutual Benefit Association of the United States and Canada, Chicago, a mutual assessment association incorporated in 1880; and Bankers Life and Casualty Company, Chicago, a mutual assessment company formed in 1932.

Established on January 17, 1879, in Chicago, Illinois, the predecessor, the Hotel Men's Mutual Benefit Association of the United States and Canada, began operating. In 1942, John D. MacArthur merged his companies, the Hotel Men's Mutual Benefit Association, the Illinois Standard Life Insurance Company and Bankers Life and Casualty Company, under the "Bankers" brand name. Bankers Life and Casualty Company focuses on the insurance needs of the retirement market; the nationwide company, a subsidiary of CNO Financial group, Inc. (NYSE: CNO). CNO is a holding company based in Carmel, Indiana with insurance subsidiaries, principally Bankers Life and Casualty Company, Colonial Penn Life Insurance Company and Washington National Insurance Company.

Bankers Life and Casualty Company is a direct subsidiary of Conseco Life Insurance Company of Texas, an indirect wholly owned subsidiary of CNO Financial Group, Inc. (CNO), formerly known as Conseco, Inc. The Company is domiciled in the State of Illinois and is licensed in every state except New York. CNO is a holding company for a group of insurance companies operating throughout the United States that develop market and administer supplemental health insurance, annuity, individual life insurance and other insurance products. CNO focuses on serving the senior and middle-income markets

through three distribution channels: direct marketing, career agents, and professional independent producers.

The Company primarily sells long-term care insurance, life insurance and fixed-rate annuity and fixed index annuity products through career agents. The Company discontinued issuing new Medicare supplement business effective June 1, 2010.

CONSUMER COMPLAINTS

The Company identified nine consumer complaints received during the experience period. All nine complaints were sampled and reviewed. The Company also provided a complaint log.

The complaint log was reviewed for compliance with 18 Del. CODE §2304 (17). This Section of the Code requires maintenance of a complete record of all complaints received since the date of its last examination. Written complaint files involving claims were also reviewed for compliance with 18 Del. CODE §2304 (26) and 18 Del. Admin. Code 902 §1.2.1.2.

The following violations were noted:

3 Exceptions – 18 Del. CODE §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

(17) Failure to maintain complaint handling procedures.—Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.

One complaint was filed with the Delaware Department of Insurance, but was not documented within the Company’s complaint log.

Two complaints were made directly to the Company by/on behalf of Delaware consumers, but were not documented within the Company’s complaint log.

Recommendation: It is recommended that the Company document all complaints within the Company’s complaint log.

2 Exceptions – 18 Del. CODE §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

(26) Failure to respond to regulatory inquiries. – No person shall, with such frequency as to indicate a general business practice, fail to provide preliminary substantive responses to inquiries from the Department of Insurance regarding the denial of claims, cancellation, nonrenewal, or refusal of benefits, refusal to pre-authorize benefits, or violations of this title, within 21 calendar days of such inquiry. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry.

The Company failed to respond to two inquiries from the Department of Insurance within 21 calendar days.

Recommendation: It is recommended that the Company respond to all inquiries from the Department of Insurance with 21 calendar days.

1 Exception – 18 Del. Admin. Code 902 §1.2.1.2

Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

The Company failed to issue a response to an insured's communication within 15 working days.

Recommendation: It is recommended that the Company issue a response within 15 working days in regard to an insured's communication.

UNDERWRITING AND RATING

Long-Term Care In Force New Business:

The Company provided a list of all long-term care policies in force during the experience period of January 1, 2013 through October 31, 2013. The Company identified a universe of 1,525 long-term care policies in force. Of the 1,525 policies, 29 were sampled for review.

One policyholder was issued 2 identical policies effective September 1, 2012. The file indicates that a single application was used to issue both policies. The original application was photocopied and used when issuing the second policy. Further review found the Company collected premiums for both policies.

As a result, the following violation was noted:

1 Exception 18 Del. CODE § 2708 Consent of insured; life, health insurance.

No life or health insurance contract upon an individual, except a contract of

group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

- (1) A spouse may effectuate such insurance upon the other spouse*
- (2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to such minor;*
- (3) Family policies may be issued insuring any 2 or more members of a family on an application signed by either parent, a stepparent or by a husband or wife;*

The examiners notified the Company of this error and subsequently confirmed that on August 5, 2014, the Company provided a copy of a letter dated August 5, 2014, notifying the policyholder that duplicate policies were issued to her in error. The letter offers the policyholder two options: (1) void one policy with a return of all premiums paid on that policy plus interest, or (2) retain both policies. The customer elected to terminate the duplicate policy and requested all premiums paid since the effective date of September 1, 2012 be refunded with interest. The Company provided evidence that the payment of \$1,604.60, including interest, was made to the customer.

Recommendation: It is recommended that the Company implement policies and procedures to avoid the duplicate issuance of policies without the policyholder's consent. The procedures should include periodic audits.

Annuities In Force New Business:

The Company identified a universe of 1,856 in force annuity policies.

No exceptions were noted.

Issued Life Business:

The Company identified a universe of 571 life policies issued. A random sample of 86 life policy files was requested, received and reviewed. The files were reviewed to determine compliance with regulations and statutes in regard to issuance, underwriting, and replacement.

The following violations were noted:

86 Exceptions - 18 Del. Admin. Code 1203 §4.0 Definitions

*4.1 For the purposes of this regulation, the following definitions shall apply:
"Buyer's Guide" A Buyer's Guide is a document which contains, and is limited to, the language approved by the National Association of Insurance Commissioners*

in its Life Insurance Buyer's Guide or language approved by the Commissioner.

The Examiners reviewed the entire sample of 86 issued life policy files. In each instance, the Company failed to provide to Delaware insureds the correct version of the Life Insurance Buyer's Guide, which contains language that is currently approved by the National Association of Insurance Commissioners.

Recommendation: It is recommended that the Company provide its policyholders the current version of the Life Insurance Buyer's Guide, which contains language approved by the National Association of Insurance Commissioners.

24 Exceptions - 18 Del. Admin. Code 1203 §4.0 Definitions

§4.1 "Policy Summary" Policy Summary means a written statement describing the elements of the policy including but not limited to: ... A statement in close proximity to the Life Insurance Cost Indexes as follows: An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide.

Note: The Buyer's Guide currently approved by the National Association of Insurance Commissioners (NAIC) does not contain cost index information. Therefore, a current Policy Summary does not contain language that refers to the Buyer's Guide for a more detailed explanation of the use of cost indexes.

The Examiners reviewed the entire sample of 86 issued life policy files. Of the files reviewed, there were 24 instances in which the Company failed to revise the Policy Summary language to correspond to the language of the Life Insurance Buyer's Guide that is currently approved by the National Association of Insurance Commissioners.

Recommendation: It is recommended that the Company provide the policyholders a current Policy Summary that refers to the Buyer's Guide for a more detailed explanation of the use of cost indexes.

Long-Term Care Issued:

The Company provided a list of all long term care contracts issued during the experience period. The Company identified a total of 12 long term care contracts, all of which were reviewed.

The following violations were noted:

12 Exceptions-18 Del. Admin. Code 1404 Long-Term Care Insurance § 24.0 Standards for Marketing

§24.1.6 If the state of Delaware is the state in which the policy or certificate is delivered or issued for delivery, the insurer shall, at solicitation, provide written notice to the prospective policyholder or certificate holder that the Elderinfo

Program, a senior counseling program approved by the Commissioner, is available and the name, address and telephone number of the Elderinfo Program.

None of the long-term care policyholders provided the written information about the state's ElderInfo Program. The policyholders were provided the "Shopper's Guide to Long-Term Care Insurance" that referenced a "State Health Insurance Assistance Program." This Program includes contact information that is limited to phone numbers and a fax number. The files did not include the ElderInfo Program and a physical address, as required by regulation.

Recommendation: It is recommended that the Company provide its long-term care policyholders written information about the state's ElderInfo Program, and a physical address, as required by 18 Del. Admin. Code 1404 Long-Term Care Insurance § 24.0 Standards for Marketing, 24.1.6..

Annuities Issued:

The Company identified a universe of 80 annuity contracts issued. Files for the entire universe of annuity contracts issued were requested, received, and reviewed. This documentation was reviewed to determine compliance with issuance and replacement statutes and regulations.

The following violations were noted:

2 Exceptions - 18 Del. Admin. Code 1204 §7.1 Replacement of Life Insurance

Each insurer that uses an agent of broker in a life insurance or annuity sale shall:

7.1.2 Where a replacement is involved:

7.1.2.2 Send to each existing insurer a written communication advising of the replacement or proposed replacement of the policy. The communication should include the information obtained pursuant to section 7.1.2.1 above and a Summary or Ledger Statement describing the proposed new policy. This written communication shall be made within 7 working days of the date the application is received in the replacing insurer's home office, or the date the proposed life insurance policy or annuity contract is issued, whichever is sooner.

The written communication advising of the replacement to the existing insurer was not provided as required.

Recommendation: It is recommended that the Company provide written communication advising of the replacement to the existing insurer as required by 18 Del. Admin. Code 1207 § 7.1.

2 Exceptions - 18 Del. Admin. Code 1204 §7.3 Replacement of Life Insurance

The replacing insurer shall maintain evidence of the "Notice Regarding

Replacement," the Policy Summary, and any Ledger Statements used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced. The existing insurer shall maintain evidence of Policy Summaries or Ledger Statements used in any conservation.

Evidence that all requirements were met shall be maintained for at least three years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state of domicile, whichever is earlier.

The two files did not contain evidence of the Notice Regarding Replacement, the Policy Summary, or any required Ledger Statements.

Recommendation: It is recommended that the Company provide evidence of the notice regarding replacement, the policy summary, or any required ledger statements.

1 Exception - 18 Del. CODE §2708. Consent of insured; life, health insurance.

No life or health insurance contract upon an individual, except a contract of group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefore or has consented thereto in writing.

One file contained an application without the insured's written consent.

Recommendation: It is recommended that all applications contain the insured's written consent.

1 Exception - 18 Del. CODE §1214 Senior Protection in Annuity Transactions

6.1 Duties of Insurers and Insurance Producers

6.2 In recommending to a senior consumer the purchase or exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the senior consumer on the basis of the facts disclosed by the senior consumer as to his or her investments and other insurance products and as to his or her financial situation and needs.

6.3 Prior to the execution of an annuity transaction resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

6.3.1 the senior consumer's financial status;

6.3.2 the senior consumer's tax status;

6.3.3 the senior consumer's investment objectives; and

6.3.4 such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the senior consumer.

The applicant answered “no” to Question 13 on the Suitability Form which reads “Except for 1035 exchanges or rollovers of qualified funds, do you understand that there may be tax consequences for the liquidation of your existing financial vehicle to purchase this annuity?” Thirty-two days later, the policyholder changed her answer to Question 13 to “yes”. The Company indicated an exception was made to issue the annuity prior to receipt of the corrected Suitability Form. Based on the facts disclosed by the senior consumer at the time of application, the producer failed to ascertain that the senior consumer understood her tax status prior to execution of the annuity contract.

Recommendation: It is recommended that the producers ensure that the senior consumers understand their tax status prior to executing an annuity contract.

Life, Long-Term Care, and Annuities Denied/Not Taken:

The Company identified a total of eight-nine (89) not taken contracts which represents seventy-one (71) Life, thirteen (13) Long-Term Care, and five (5) Annuities, all of which were sampled and reviewed.

The following violations were noted:

6 Exceptions – 18 Del. CODE §320 Conduct of examination; access to records; correction.

(c) Every person being examined, the person's officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination.

The Company failed to provide requested information for six files. In five files, the Company did not retain a copy of the denial of coverage letter and in one file the Company did not retain a copy of a check.

Recommendation: The Company shall ensure that all pertinent documentation, such as denial of coverage letters and scanned checks be retained in all files, in accordance with 18 Del. CODE. §320 (c).

CLAIMS

Long-Term Care Appeals:

The Company identified a universe of two (2) long term care appeals. Both files were reviewed.

The following violations were noted:

2 Exceptions - 18 Del. Admin. Code 1408 §4.0 Prompt Payment of Clean Claims and §8.0 Effective Date

4.3 Within thirty (30) days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send written notice acknowledging the date of receipt of the claim and one of the following:

4.3.1 The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or

4.3.2 That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

8.0 This regulation becomes effective for all claims submitted for payment on or after July 1, 2010.

Within thirty (30) days after receipt of a claim for benefits under a long-term care insurance policy or certificate, the Company failed to send written notice acknowledging the date of receipt of the claim and that additional information was necessary to determine if all or any part of the claim was payable and the specific additional information that was necessary.

Recommendation: It is recommended that within thirty (30) days after receipt of a claim for benefits under a long-term care policy, the Company send written notice acknowledging the date of receipt of the claim and that additional information was necessary to determine if all or any part of the claim was payable and the specific additional information that was necessary.

1 Exception - 18 Del. Admin. Code 902 §1.2.1.2 Prohibited Unfair Claim Settlement Practices

Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

The Company failed to acknowledge and respond to a communication in regard to a claim within 15 working days.

Recommendation: It is recommended that the Company acknowledge and respond to a communication in regard to a claim within 15 working days.

2 Exceptions - 18 Del. Admin. Code 1301 §4

At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if the decision does not authorize payment of the claim in its entirety,

the carrier shall provide the covered person with a written notice of mediation services offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision. Any notice provided to a covered person shall, at a minimum, contain the following language:

"You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to review of this decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process. All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

In two instances the Company failed to provide written notice of the Insured's right to seek review of a claim denied on appeal through the Delaware Insurance Department.

Recommendation: It is recommended that the Company provide written notice of the Insured's right to seek review of a claim denied on appeal through the Delaware Insurance Department.

Life Claims:

The Company provided a list of claims for its life business. The Company identified a universe of 85 claims for the Life COMM business, and 24 claims for the Life PRO business, all of which were sampled for review.

As a result of the review, the following violations were noted:

3 Exceptions – 18 Del. Admin. Code 902 Prohibited Unfair Claim Settlement Practices

1.2.1.2 Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

The Company failed to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies. .

2 Exceptions - 18 Del. Admin. Code 902 Prohibited Unfair Claim Settlement Practices

1.2.1.3 Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.

The Company failed to implement a prompt investigation of two claims within 10 working days upon receipt of the notice of loss.

Recommendation: It is recommended that the Company implement a prompt investigation of claims within 10 working days upon receipt of the notice of loss.

1 Exception - 18 Del. Admin. Code 902 Prohibited Unfair Claim Settlement Practices

1.2.1.5 Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.

The Company failed to affirm or deny coverage or a claim or advise the person presenting the claim, in writing within 30 days after proof of loss statement was received.

Recommendation: It is recommended that the Company affirm or deny coverage or a claim or advise the person presenting the claim, in writing within 30 days after proof of loss statement was received.

Long-Term Care and Short-Term Care Claims:

The Company identified a universe of 202 Short-Term Care claims and 294 Long-Term Care claims. Random samples of 80 Short-Term Care claim files and 80 Long-Term Care claim files were requested, received, and reviewed. This documentation was reviewed to determine compliance in regard to claim settlement.

The following violations were noted:

9 Exceptions - 18 Del. Admin. Code 902 Prohibited Unfair Claim Settlement Practices

§1.2.1 The Following Claim Settlement Practices When Committed or Performed with such Frequency as to Indicate a General Practice are Prohibited:

§1.2.1.3 Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.

The Company failed to implement prompt investigations of claims within 10 working days upon receipt of the notice of loss for four short-term care claims and five long-term care claims.

Recommendation: It is recommended that the Company implement prompt investigations of claims within 10 working days upon receipt of the notice of loss for four short-term care claims and the five long-term care claims.

6 Exceptions - 18 Del. Admin Code 902 Prohibited Unfair Claim Settlement Practices

§1.2.1 The Following Claim Settlement Practices When Committed or Performed with such Frequency as to Indicate a General Practice are Prohibited:

§1.2.1.2 Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

The Company failed to acknowledge and respond within 15 working days, upon receipt of communications with respect to claims by the insured.

Recommendation: It is recommended that the Company acknowledge and respond within 15 working days, upon receipt of communications with respect to claims by the insured.

3 Exceptions - 18 Del. Admin. Code 902 Prohibited Unfair Claim Settlement Practices

§1.2.1 The Following Claim Settlement Practices When Committed or Performed with such Frequency as to Indicate a General Practice are Prohibited:

§1.2.1.5 Failing to affirm or deny coverage on a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.

The Company failed to either affirm, deny, or to provide a reason for the inability to either affirm or deny a claim in writing within 30 days after receipt of proof of loss statements.

Recommendation: It is recommended that the Company either affirm, deny, or to provide a reason for the inability to either affirm or deny a claim in writing within 30 days after receipt of proof of loss statements.

2 Exception - 18 Del. CODE §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(16) Unfair claim settlement practices. — No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

In two instances, the Company failed to conduct a reasonable investigation into the current provisions contained within the insurance contract between the Company and the policyholder. As a result, the Company failed to effectuate prompt, fair, and equitable settlement of the claim. The Company misrepresented pertinent facts related to the coverage in correspondence sent to the policyholder.

In two (2) instances, the Company failed to pay the full amount of insurance proceeds due to the beneficiary(ies) according to the contract provisions set forth in the policy. In each of these instances, the contract language provided for an annual increase in the Daily Maximum Benefit and, accordingly, in the Lifetime Maximum Benefit. The Company failed to recognize these increased benefit amounts at the time of payment. In one instance, the Company accepted culpability and agreed to issue a benefit check, to the policyholder for the remaining amount of \$3,702.75. The issue of interest on the \$3,702.75 amount was not addressed by the Company.

Upon further investigation, the Examiners discovered that there were numerous policy forms issued by the Company that contain contract language specifying an annual increase in both the Daily Maximum Benefit and in the Lifetime Maximum Benefit (i.e., policy forms GR-N100, GR-N105, GR-N130, GR-N255, and GR-N540).

Recommendation: It is recommended that the Company make payments to the insureds, and conduct a reasonable investigation into the current provisions contained within the insurance contract between the Company and the policyholder in order to effectuate prompt, fair, and equitable settlement of the claim. Due to the large volume of policies issued by the Company that provide for these annual percentage increases, the examiners recommend the Company undergo a voluntary audit to ensure benefits are provided in accordance with approved contract language.

CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the exceptions noted in the Report. Location in the Report is referenced in parenthesis.

1. It is recommended that the Company document all complaints within the Company's complaint log, pursuant to 18 Del. CODE §2304 (17) (c).
2. It is recommended that the Company respond to all inquiries from the Department of Insurance with 21 calendars days, pursuant to 18 Del. CODE §2304 (26).
3. It is recommended that the Company issue a response within 15 working days in regard to an insured's communication, pursuant to 18 Del. Admin. Code §1.2.1.2. (Consumer Complaints).
4. It is recommended that the Company periodically perform internal audits of its long-term care policies for which duplicate long-term care policies may have been issued, pursuant to 18 Del. CODE §2708. (Long-Term Care In Force New Business Underwriting).
5. It is recommended that the Company provide its policyholders a recent version of the Life Insurance Buyer's Guide, which contains language that is currently approved by the National Association of Insurance Commissioners, pursuant to 18 Del. Admin. Code 1203 §4.0 (Issued Life Business – Underwriting).
6. It is recommended that the Company provide the policyholders, a current Policy Summary does not contain language that refers to the Buyer's Guide for a more detailed explanation of the use of cost indexes, but to contain language which corresponds to the language of the Life Insurance Buyer's Guide that is currently approved by the National Association of Insurance Commissioners, in accordance with 18 Del. Admin. Code 1203 §4.0. (Issued Life Business – Underwriting).
7. It is recommended that the Company provide its long-term care policyholders written information about the state's ElderInfo Program, and a physical address, as required by regulation, and pursuant to 18. Del. Admin. Code 1404 Long-Term Care Insurance § 24.0 Standards for Marketing §24.1.6. (Long-Term Care Issued New Business – Underwriting).
8. It is recommended that the Company provide written communication advising of the replacement to the existing insurer as required by 18 Del. Admin. Code 1204 §7.1.
9. It is recommended that the Company provide evidence of the notice regarding

replacement, the policy summary, or any required ledger statements, pursuant to 18 Del. Admin. Code 1204 §7.3.

10. It is recommended that all applications contain the insured's written consent, in accordance with 18 Del. CODE §2708.
11. It is recommended that the producers ensure that the senior consumers understand their tax status prior to executing an annuity contract, pursuant to 18 Del. CODE §1214. (Annuities Issued – Underwriting).
12. It is recommended that the Company provide the pertinent information relating to denial of coverage letters, etc. relating to the subject of the examination, in accordance with 18 Del. CODE §320 (c). (Life, Long-term Care, and Annuities Denied/Not Taken – Underwriting).
13. It is recommended that within thirty (30) days after receipt of a claim for benefits under a long-term care policy, the Company send written notice acknowledging the date of receipt of the claim and that additional information was necessary to determine if all or any part of the claim was payable and the specific additional information that was necessary, pursuant to 18 Del. Admin. Code 1408 §4.
14. It is recommended that the Company acknowledge and respond to a communication in regard to a claim within 15 working days, in accordance with 18 Del. Admin. Code 902 §1.2.1.2.
15. It is recommended that the Company provide written notice of the Insured's right to seek review of a claim denied on appeal through the Delaware Insurance Department, pursuant to 18 Del. Admin. Code 1301 §4. (Long-Term Care Appeals – Claims).
16. It is recommended that the Company provide written notice of the Insured's right to seek review of a claim denied on appeal through the Delaware Insurance Department, in accordance with 18 Del. Admin. Code 902 §1.2.1.2.
17. It is recommended that the Company implement a prompt investigation of claims within 10 working days upon receipt of the notice of loss, pursuant to 18 Del. Admin. Code 902 §1.2.1.3.
18. It is recommended that the Company affirm or deny coverage or a claim or advise the person presenting the claim, in writing within 30 days after proof of loss statement was received, in accordance with 18 Del. Admin. Code 902 §1.2.1.5. (Life COMM and Life PRO – Claims).

19. It is recommended that the Company implement prompt investigation of the claims within 10 working days upon receipt of the notice of loss, pursuant to 18 Del. Admin. Code 902 §1.2.1 and §1.2.1.3.
20. It is recommended that the Company acknowledge and respond within 15 working days, upon receipt of communications with respect to claims by the insured, in accordance with 18 Del. Admin. Code 902 §1.2.1 and §1.2.1.2.
21. It is recommended that the Company either affirm, deny, or to provide a reason for the inability to either affirm or deny a claim in writing within 30 days after receipt of proof of loss statements, pursuant to 18 Del. Admin. Code 902 §1.2.1 and §1.2.1.5.
22. It is recommended that the Company conduct a reasonable investigation into the current provisions contained within the insurance contract between the Company and the policyholder in order to effectuate prompt, fair, and equitable settlement of the claim.
23. It is recommended that the Company provide payment to the insureds, and conduct a reasonable investigation into the current provisions contained within the insurance contract between the Company and the policyholder in order to effectuate prompt, fair, and equitable settlement of the claim. Due to the large volume of policies issued by the Company that provide for these annual percentage increases, the Company undergo a voluntary audit to determine the magnitude of this error.
24. It is also recommended that the Company do not misrepresent pertinent facts related to the coverage in correspondence sent to the policyholder, in accordance with 18 Del. CODE §2304 (16) (a, d, f). (Long-Term, and Short-Term-Claims).

The examination, conducted by Shelly Schuman, Gwendolyn Douglas, Stephen Misenheimer, and Linda Armstrong, is respectfully submitted.

Gwendolyn J. Douglas, MCM, CIE,
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Examiner-in-Charge
Market Conduct
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