

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938,
THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT
EXAMINATION OF THE CLAIMS PRACTICES OF**

**HM LIFE INSURANCE COMPANY
NAIC # 93440 CDI # 2839-9**

AS OF DECEMBER 31, 2012

ADOPTED JANUARY 23, 2014

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



January 23, 2014

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

**HM Life Insurance Company
NAIC # 93440**

Group NAIC # 0812

Hereinafter, the Company listed above also will be referred to as HML or the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the claims handling practices of the aforementioned Company on Disability claims closed during the period from January 1, 2012 through December 31, 2012. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period January 1, 2012 through December 31, 2012; and a review of previous CDI market conduct claim examination reports on this Company.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Group Disability claims reviewed were closed from January 1, 2012 through December 31, 2012, referred to as the “review period”. The examiner randomly selected 120 HML claims files for examination. The examiner cited 38 alleged claims handling violations of the California Insurance Code from this sample file review.

Findings of this examination included failure to reference the California Department of Insurance in its claims denials, and failure to include the California fraud warning on insurance claim forms.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

Except as noted below, market analysis did not identify any specific issues of concern.

The Company was not the subject of any California consumer complaints and inquiries closed from January 1, 2012 through December 31, 2012, in regard to the lines of business reviewed in this examination. There was no specific area of concern identified in the complaint review.

The previous claims examination reviewed a period from March 1, 2001 through February 28, 2002. The most significant noncompliance issues identified in the previous examination report were the Company's failure to include the California fraud warning on insurance forms; the Company's failure to conduct business in its own name; the Company's failure to respond to communications within fifteen calendar days; the Company's failure to reference the California Department of Insurance in its claims denials; and the Company's failure to disclose all benefits, coverage, time limits or other provisions of the insurance policy. Two of these issues were identified as problematic in the current examination for failure to include the California fraud warning on insurance forms, and failure to reference the California Department of Insurance in its claims denials.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

HML SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Group Disability / Vision	28,368	50	0
Group Disability / Stop Loss Major Medical	1,473	25	6
Group Disability / Limited Medical Hospital and Sickness Indemnity	735	25	27
Group Disability / Accident	37	8	4
Group Disability / Critical Illness	32	8	1
Group Disability / Long Term Disability	7	4	0
TOTALS	30,652	120	38

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	HML Number of Alleged Citations
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its claims denial.	24
CIC §1879.2(a) *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance forms.	8
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days.	2
CCR §2695.7(h) *[CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	1
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to notify in writing, within 30 days after receipt of the claim, to the insured that the claim was contested.	1
CCR §2695.11(d) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days.	1
CIC §880 *[CIC §790.03(h)(3)]	The Company failed to conduct its business in its own name.	1
Total Number of Citations		38

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.

TABLE OF CITATIONS BY LINE OF BUSINESS

<p align="center">DISABILITY 2012 Written Premium: \$37,025,052 Recoveries: \$0</p>	<p align="center">NUMBER OF CITATIONS</p>
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	24
CIC §1879.2(a) [CIC §790.03(h)(3)]	8
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	2
CCR §2695.7(h) [CIC §790.03(h)(5)]	1
CIC §10123.13(a) [CIC §790.03(h)(3)]	1
CCR §2695.11(d) [CIC §790.03(h)(3)]	1
CIC §880 [CIC §790.03(h)(3)]	1
<p align="center">SUBTOTAL</p>	38
<p align="center">TOTAL 38</p>	

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

There were no recoveries discovered within the scope of this report.

DISABILITY

1. **In 24 instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.** In these limited medical hospital and sickness indemnity claims, reference to the California Department of Insurance was not included on the Explanation of Benefit (EOB) denial notices sent to claimants. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees and states "We acknowledge that the California notice was not on the Explanation of Benefits. However, as discussed, these members were erroneously covered in California under a Georgia sitused policy and the claims were administered under Georgia requirements as such. As previously advised, and incorporated into this response, we did advise California of the error and terminated the group effective 12/31/12. The entire group has terminated and there will not be further claims going forward."

The Company does not believe that these instances rise to a violation of CIC §790.03(h)(3), i.e. “(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices: (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.” The Company believes that the failure to include the required denial language does not demonstrate a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

2. In eight instances, the Company failed to include the California fraud warning on insurance forms. In four instances, a claim form applicable to another State Department’s fraud language requirement was used. In the remaining four instances, the claim forms did not include the specific California fraud warning. The Department alleges these acts are in violation of CIC §1879.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company agrees with the findings and will conduct additional training to ensure that proper claim forms are utilized in California, and/or that the specific California fraud warning is on its claim forms. In addition, the Company indicates that their Third Party Administrator’s (TPA) practice was to provide supplemental pages with the claim forms that state all state-specific fraud warnings. The supplemental pages were not attached to the claim forms. The Company anticipates this issue will be resolved as it will no longer use the TPA’s services. The Company will attach a supplemental page to include the required California fraud language to all claim forms utilized in California.

The Company does not believe that these instances rise to a violation of CIC §790.03(h)(3), i.e. “(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices: (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.” The Company believes that the incorrect fraud notice does not demonstrate a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

3. In two instances, the Company failed to provide written notice of the need for additional time or information every 30 calendar days. In these limited medical hospital and sickness indemnity instances, status letters were not provided as required within regulatory timelines. The Department alleges these acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company agrees that written notices of the need for additional time or information were not provided as required by this regulation. The Company indicates that these members were erroneously covered in California under a Georgia sitused policy and the claims were administered under Georgia requirements. The Company advised all appropriate California departments of the error in the group covering California residents when it came to their attention and

terminated the group effective 12/31/12. The group has terminated and there will not be any further claims from this group.

The Company does not believe that these instances rise to a violation of CIC §790.03(h)(3), i.e. “(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices: (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.”

4. In one instance, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. In this limited medical hospital indemnity and sickness instance, the claim was paid on the 97th calendar day after receipt of the claim. The Department alleges this act is in violation of CCR §2695.7(h) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company’s Response: The Company agrees and states that “This claim was on a billing hold. Claims are not released unless the group has a paid to date as of the claim date of service. The premiums are posted at the individual level so if we have not received premium for the individual to pay them through the claim date of service, the claim goes on hold until premium is paid through that date. A 30-day delay letter was sent. These members were erroneously covered in California under a Georgia sitused policy and the claims were administered as such. We advised all appropriate California departments of the error in the group covering California residents when it came to our attention and terminated the group effective 12/31/12. The group has terminated and there will not be any further claims from this group.”

5. In one instance, the Company failed to notify in writing, within 30 working days after receipt of the claim, to the insured that the claim was contested. In one stop loss major medical, the insured was not advised that the claim was contested for continuation of coverage information within regulatory timeframe. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company agrees with this finding. It is the Company’s standard practice to transmit the regulatory notice which shall identify the portion of the claim which is contested including the legal and factual basis known at that time by the Company for contesting the claim. The Company will conduct additional training to ensure compliance with this regulation.

6. In one instance, the Company failed to provide written notice of the need for additional time every 30 calendar days. In one stop loss major medical claim, the Company failed to provide a claim status letter within regulatory timelines. The Department alleges this act is in violation of CCR §2695.11(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this finding. It is the Company's standard practice to request any additional information and to provide the reason for the request. The Company will conduct additional training to ensure compliance with this regulation.

7. **In one instance, the Company failed to conduct business in its own name.** In this instance, the claim form used did not have the appropriate underwriting name. The Department alleges this act is in violation of CIC §880 and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that a claim form was inadvertently used with incorrect company information. The Company indicates this was an isolated instance of non-compliance. The Company will reinforce claims procedures to prevent these errors.

The Company however does not believe that this instance rises to a violation of CIC §790.03(h)(3), i.e. "(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices: (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies." The Company believes that the incorrect claim form used does not demonstrate a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims. In addition the Company indicates that this claim was handled by their TPA.