

**[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**

**TRANSAMERICA LIFE INSURANCE COMPANY
NAIC # 86231 CDI # 2000-8**

**MONUMENTAL LIFE INSURANCE COMPANY
NAIC # 66281 CDI # 2302-8**

AS OF AUGUST 31, 2011

ADOPTED JUNE 17, 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



June 17, 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:

**TRANSAMERICA LIFE INSURANCE COMPANY
NAIC # 86231**

and

**MONUMENTAL LIFE INSURANCE COMPANY
NAIC # 66281**

Group NAIC # 0468

Hereinafter, the Companies listed above also will be referred to as TLIC, MLIC or the Company or, collectively, as the Companies.

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 Companies on Individual Life, Group Life, Accident and Disability, and Long Term Care claims closed during the period from September 1, 2010 through August 31, 2011. The examination was made to discover, in general, if these and other operating procedures of the Companies 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 insurers’ 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 insurers’ 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 Companies’ 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 Companies for use in California including any documentation maintained by the Companies 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 these Companies closed by the CDI during the period September 1, 2010 through August 31, 2011, and a review of previous CDI market conduct claims examination reports on these Companies; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the Companies in Cedar Rapids, Iowa.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Individual Life, Group Life, Accident and Disability, and Long Term Care claims reviewed were closed from September 1, 2010 through August 31, 2011, referred to as the “review period”. The examiners randomly selected 148 TLIC claims files and 35 MLIC claims files for examination. The examiners cited 54 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination included the Companies’ failure to reference the California Department of Insurance in their claims denial; failure to provide a clear explanation and/or computation of benefits; failure to disclose all benefits, coverage, time limits or other provisions of the insurance policy; failure to conduct and pursue a thorough, fair and objective investigation of claims; and failure to pay interest at a rate of 10% per annum on delayed settlements of long term care claims.

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

The results of the market analysis review revealed that during 2009 and 2011, Transamerica Life Insurance Company was the subject of enforcement actions in the states of Minnesota and Pennsylvania as a result of market conduct examinations. The Company's failure to acknowledge claims timely was one of the allegations. The examiners focused on these issues during the course of the file review.

The Companies were the subject of 52 California consumer complaints and inquiries closed from September 1, 2010 through August 31, 2011, 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 July 1, 2003 through July 1, 2004. The most significant noncompliance issues identified in the previous examination report were the Companies' failure to reference the California Department of Insurance in its claims denial, and failure to conduct and diligently pursue a thorough, fair and objective investigation of a claim. These issues were likewise identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

TLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Long-Term Care /Group Long-Term Care	2,727	5	0
Long- Term Care / Individual Long-Term Care	11,152	58	42
Life/ Individual Life	3,488	38	0
Life/ Group Life	142	6	0
Life/ Rescissions - Individual Life	26	26	5
Accident & Disability / Individual Accidental Death and Dismemberment (AD&D)	285	13	3
Accident & Disability/ Group Accidental Death and Dismemberment (AD&D)	40	2	0
TOTALS	17,858	148	50

MLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Long- Term Care / Individual Long-Term Care	263	7	2
Life/ Individual Life	1,588	11	0
Life/ Group Life	1,089	3	0
Life/Rescissions - Individual Life	2	2	0
Accident & Disability/ Group Accidental Death and Dismemberment (AD&D)	542	12	2
TOTALS	3,484	35	4

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	TLIC	MLIC
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its claims denial.	12	2
CCR §2695.4(a) *[CIC §790.03(h)(3)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	11	1
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of benefits or failed to provide a clear explanation of the computation of benefits.	8	1
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.	5	0
CIC §10235.95(b) *[CIC 790.03(h)(5)]	The Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due.	5	0
CIC 790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	4	0
CCR §2695.7(g) *[CIC 790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	2	0
CIC 790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.	2	0
CCR §2695.5(e)(1) *[CIC 790.03(h)(2)]	The Company failed to acknowledge notice of claim within fifteen (15) calendar days.	1	0
Total Number of Citations		50	4

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

- CIC §790.03(h)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- 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

TLIC LIFE/ INDIVIDUAL AND GROUP 2010 Written Premium: \$502,558,938 AMOUNT OF RECOVERIES \$ 0.00	NUMBER OF CITATIONS
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	5
SUBTOTAL	5

TLIC INDIVIDUAL AND GROUP LONG-TERM CARE 2010 Written Premium: \$36,909,503 AMOUNT OF RECOVERIES \$3,450.43	NUMBER OF CITATIONS
CCR §2695.4(a) [CIC §790.03(h)(3)]	11
CCR §2695.11(b) [CIC §790.03(h)(3)]	8
CCR §2695.7(d) [CIC §790.03(h)(3)]	5
CIC §10235.95(b) [CIC §790.03(h)(3)]	5
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	4
CIC 790.03(h)(1)	4
CCR §2695.7(g) [CIC §790.03(h)(5)]	2
CIC 790.03(h)(5)	2
CCR §2695.5(e)(1) [CIC §790.03(h)(3)]	1
SUBTOTAL	42

TLIC INDIVIDUAL ACCIDENT & DISABILITY 2010 Written Premium: \$41,905,994	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$0.00	
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	3
SUBTOTAL	3

MLIC LIFE/ INDIVIDUAL AND GROUP 2010 Written Premium: \$25,562,954	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$0.00	
SUBTOTAL	0

MLIC LONG-TERM CARE INDIVIDUAL 2010 Written Premium: \$1,285,339	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$0.00	
CCR §2695.4(a) [CIC §790.03(h)(3)]	1
CCR §2695.11(b) [CIC §790.03(h)(3)]	1
SUBTOTAL	2

MLIC GROUP ACCIDENT & DISABILITY 2010 Written Premium: \$41,905,994	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$0.00	
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	2
SUBTOTAL	2

TOTAL	54
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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 Companies are required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Companies are obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Companies were asked if they intend to take appropriate corrective action in all jurisdictions where applicable. The Companies responded, "Where there are enhancements that can be reasonably implemented on a system-wide basis or through the training of personnel, some of the additional customer service initiatives we have agreed to provide for California policyholders may be extended to all customers regardless of the jurisdiction that governs their policy form. However, some of the enhancements the Company has implemented, such as the reference to the California Department of Insurance in supplemental communications that relate to an unfavorable benefit determination, are specific to concerns the examiner expressed relative to California law. The Company is considering whether changes are appropriate in other states based upon the laws of that jurisdiction."

Money recovered within the scope of this report was \$3,450.43 as described in sections number 3, 4, 7 and 8 below.

LONG TERM CARE

1. In 12 instances, the Companies failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In eight (8) instances the Companies failed to reveal an Ambulance Benefit. In two instances the Companies failed to reveal a Medical Alert Benefit. In one instance each, the Companies failed to reveal a Post Confinement Benefit and a Nursing Home Prescription Benefit. The Department

alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Companies' Response: The Companies state that they do not believe they violated CIC §790.03(h)(3). However, the Company acknowledges that in one (1) instance it should have requested the proof of loss documentation necessary for the Medical Alert benefit because the Assessor included in the assessment report an indication that Medical Alert was in place and, therefore, the benefit may have been payable. The Companies state that in eleven of the instances cited, given the nature of the claim and the information presented by the claimant, it was not reasonable to believe the ancillary benefits at issue might be available or payable. The Company is required to disclose benefits that may reasonably apply to the claim; however, this does not necessarily include all benefits of the policy in every claim. Moreover, all benefits are disclosed in the policy brochures and the policy's schedule page. .

Notwithstanding, the Companies state it is their desire to improve communications to insureds with respect to the ancillary benefits at issue in order to create a better customer service experience. To that end, the Companies have modified call center scripting for California policyholders to prompt the call center staff to inquire if the caller would like to discuss additional policy benefits available and/or make inquiry into additional services or dates of service. In addition, the Companies have modified the California claims package sent to claimants to include a copy of the policy schedule page and related endorsements listing all policy benefits as issued. The Companies also held training meetings with appropriate staff covering these enhancements.

2. In nine instances, the Companies failed to provide a clear explanation of benefits or failed to provide a clear explanation of the computation of benefits.

The Companies Explanation of Benefits (EOB) fails to reveal the total number of days credited to satisfy the elimination period and current benefit rate and balance available. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Companies' Response: The Companies state that they do not believe they violated CIC §790.03(h)(3). The Companies agree that the EOB does not reflect the accumulated elimination days or a computation of the remaining benefits available, however, it disputes that the regulation requires an EOB to include this information. Notwithstanding the Companies belief the EOB satisfies the requirements of the regulation; the Companies are developing a system project to be able to provide an annual current benefits update for each insured that purchased a benefit increase option. The Companies undertook this project in advance of the examination as it identified the need for an annual update from a customer service perspective. Additionally, the Companies have begun sending letters to insureds under California-issued policies indicating when the elimination period has been satisfied and including a telephone number for insureds to call to request up-to-date information about benefit balances.

3. In five instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim. The Company (TLIC) failed to conduct a thorough and objective investigation in the following instances: a) in two instances, TLIC failed to investigate the eligibility period until the insured filed an appeal; b) in two instances, the Company failed to investigate a Post Confinement claim, and an eligibility for Waiver of Premium; and c) in one instance, the Company failed to consider prior care services applicable towards the elimination period. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Companies state that they do not believe they violated CIC §790.03(h)(3). However, Companies provided the following response and corrective action.

Regarding 3 a): The Company indicates that these were isolated errors and the Company will continue to provide additional training to its LTC claims handling staff to emphasize the conduct of a thorough and objective investigation. Additionally, the Company has reconsidered the dates of service for which the insured was confined and has applied the dates towards the elimination period and Waiver of Premium. As a result of the examination, the Company issued benefits of \$1,383.70 (representing \$1,300 towards elimination period benefits, plus \$83.70 in applicable interest). As a consequence of the incorrect application of the elimination period, the waiver of premium was also not calculated properly. Thus, a premium refund was also issued in the amount of \$44.53 for a total of \$1428.23 paid to the insured. In the other instance, the Company acknowledges that it could have processed a portion of the claim at an earlier date. The Company states that their claims management has reviewed this specific claim circumstance and will use this as a training example to assure that claims staff can appropriately identify this unique circumstance.

Regarding 3 b): The Company acknowledges that in one (1) instance it did not apply all dates of service (5/28/10 to 6/4/10) toward the Elimination Period because it believed, based on the bill from the facility, that the insured incurred no charges for those dates (the bill indicated the days were "free days"). Under the policy, only days for which charges are incurred count toward the Elimination Period. Nevertheless, as a result of the examination, the Company reached out to the facility to confirm there were no charges incurred for the dates in question. Upon further investigation, the Company determined the insured was charged a small room differential rate which was not reflected on the bill. The Company states any error was on the part of the facility in providing an inaccurate bill. The dates of service were applied towards the Elimination Period upon receipt of the additional information. In addition, the Company amended the Waiver of Premium dates.

In the other instance, the Company states that it appropriately paid the Post Confinement Benefit once it determined the new facility did not meet the definition of Nursing Home, however, it acknowledges that in this instance the investigation of the

facility's eligibility could have been conducted more efficiently. The Company states that it is continually looking for ways to improve its claims handling processes. A third-party vendor is used to perform assessments and assist insureds in the collection of proof of loss documents from providers and facilities. The Company also implemented a new workflow process to increase the efficiency of processing proof-of-loss documentation. Previously, when proof-of-loss documents obtained by a third-party vendor were transmitted to the Company, the documents were manually matched to paper claim files, a time consuming process. Beginning in February 2013, when proof-of-loss documents are received from the vendor, a notification is automatically generated in the work queue of the claims system for an Eligibility Specialist alerting them that proof-of-loss documents are ready for review. While the Company states that the delay experienced in this particular instance was an isolated and inadvertent error, it believes the new workflow process has increased the efficiency of its claims handling allowing it to adjudicate claims faster.

Regarding 3 c): In this instance, the Company states that benefits are not owed because it is not able to approve benefits for periods of time for which policy conditions and eligibility requirements are not satisfied. However, as a result of the examination, The Company implemented a practice to obtain clarification from a treating physician, as necessary, where conflicting information arises during the course of a claim investigation. Further, the Company will provide additional training to its LTC claims handling staff regarding obtaining additional information whenever the proof of loss documentation presents materially conflicting information and it is determined that the opinion of the insured's treating physician would help provide a more comprehensive picture of the insured's care needs.

4. In five instances, the Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due. The Department alleges these acts are in violation of CIC §10235.95(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company (TLIC) states that it does not believe it violated CIC §790.03(h)(5). However, the Company acknowledges the five (5) instances cited and agrees interest was due and not paid in these instances. This was the result of individual processors' inadvertent oversights. The Company has provided additional training to claim staff on prompt payment of claims and interest due. Additionally, the Company, will be making modifications to its work distribution process in the near future. These changes will route claims similar to these to a more experienced staff member. As a result of the examination, the Company issued payments totaling \$162.20.

5. In four instances, the Companies failed to include a statement in the 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. The Companies failed to provide the appropriate reference to the California Department of Insurance on notices for claims denied in whole, or in part. 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 Companies' Response: The Companies disagree with the Department's findings. The Company states the Department of Insurance reference is provided on the Explanation of Benefit (EOB) which it considers to be a formal written denial of benefits as the EOB reflects what services or benefits have been accepted for payment or rejected. The Companies also send a separate letter to provide the insured with a more detailed understanding of the basis for the Companies' claim decision. However, the Companies acknowledge these supplemental letters did not contain the Department of Insurance contact information. As a result of the examination, the Companies revised their supplemental EOB letter template to include reference to the right to contact the Department.

6. In four instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company (TLIC) states that it does not believe it violated CIC §790.03(h)(1). However, the Company acknowledges that in one (1) instance a letter misstated the eligibility date, in another one (1) instance incorrect benefit amount information was given, in another one (1) instance inaccurate information regarding licensing of a care provider was given to the insured and in the final one (1) instance it failed to inform the caller of the dates considered for benefits and the available benefit amount. The Company has provided additional instruction and training to the individual claim handlers involved and communicated to the entire staff the importance of accuracy in all communications.

7. In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. In one instance the Company (TLIC) underpaid a claim. In the second instance, the Company determined the insured went to an alternative care facility following a hospital and skilled nursing stay. However, the Company failed to pay Post Confinement benefits until the issue was discovered in this examination. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company (TLIC) acknowledges that in one (1) isolated instance a human error occurred where the benefit amount was incorrectly entered by claim handler resulting in \$10.00 underpayment. The Company has now issued payment to the insured. The Company acknowledges that in the other instance the claim staff did not document that the insured received rehabilitation care in a skilled nursing facility which qualified toward satisfaction of the number of days required in order to be eligible for the elimination period. Additionally, the Company

provided additional Waiver of Premium benefits resulting from this revised date. As result of this exam, the Company issued payment of \$1,383.70 to the insured. The Company has provided additional training to claim staff on need for accuracy and documentation.

8. In two instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In the first instance, the Company (TLIC) determined the insured went to an alternative care facility following a hospital and skilled nursing stay. The Company failed to pay Post-Confinement benefits until the issue was discovered during the Department's examination. The Department issued an examination inquiry at which time the Company issued payment for \$1850.00 to the insured's estate. In the second instance, the Company received proof of claim and did not review the invoice until 17 days from receipt of invoice. As a result, The Company declined the incurred claim because the submission date was not in conformity with the Company's internal policy that requires the "timing" of submission of claims to be received at a certain date ["after the 1st of the month following care]. Furthermore, the Company required the insured to re-submit the same proof of invoice no earlier than the 1st day of the following month. This Company policy delayed again the reimbursement of benefits already incurred two months prior. The declination and requirement for re-submission of the same invoice copy resulted in settlement for the invoice five months later without applicable interest. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company' Response: In the first instance, the Company states that it appropriately paid the Post Confinement benefit (in the amount of \$1,850.00) once it received the necessary proof of loss documents indicating the new facility did not meet the definition of Nursing Home. However, the Company acknowledges that in this instance, the investigation of the facility's eligibility could have been conducted more efficiently. The Company states that while the claim activity coincided with the examination, it was not a direct result of the examiner's inquiry. The Company further states it has clear policies and procedures in place that ensure prompt, fair and equitable payment of claims, however, as described in its response to Criticism 3, the Company also implemented a new workflow process that has increased the efficiency of its claims handling allowing it to adjudicate claims faster. To ensure future compliance, the Company agrees to provide additional training regarding these policies and procedures, including the appropriate payment of Post Confinement Benefits, to its LTC claims handling staff.

In the second instance, the Company states that liability only becomes reasonably clear after services are rendered and therefore, it cannot pay "advance bills". However, in order to provide a positive customer experience, the Company is implementing a new process for handling advance bills in California. The Company will dedicate five (5) examiners to a new team to handle the advance bills submitted by its customers and providers. These invoices will be sent to an "Advance Bill" work queue and its receipt will be acknowledged in writing. On the first day of the following month, the work queue will be verified with the provider as to confinement stay, accuracy of

charges, and that no out-of-facility days occurred during the period. The examiner will document its claim file with this review process and will issue appropriate benefit payment. The Company will comply with the California claims regulations in acknowledging communications from the insured and in processing benefits, and this process will mitigate complaints on handling of advance billings.

9. In one instance, the Company failed to acknowledge notice of claim within fifteen (15) calendar days. On February 19, 2009, the Company (TLIC) received a letter from the insured's signing agent advising that the insured was diagnosed with dementia. On March 10, 2009, the Company contacted the agent in an attempt to review policy language and obtain additional information. Although the agent was no longer an authorized company producer, he assisted the claimant with notification of claim to the Company. The Company failed to acknowledge the claim within the 15-day regulatory timeline. The Department alleges this act is in violation of CCR §2695.5(e)(1) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees with the Department that under ordinary circumstances a letter from a duly authorized agent would be sufficient notice of claim and, except that the agent in question was terminated as to all authority with regard to LTC, this agent's letter would have constituted a notice of claim. However, under the unique factual circumstances of this claim, the agent's LTC contract had been terminated for many years and the agent was not authorized to act in the capacity of an agent on behalf of the Company with respect to the insured's policy. Accordingly, the Company could not accept the agent's letter as a notice of claim. Notwithstanding, the Company contacted the former agent who requested that it contact the insured's daughter. The insured's daughter informed the Company that the insured was hospitalized and scheduled for surgery. Upon the insured's release from the hospital, the insured's daughter contacted the Company to initiate a claim which was opened and acknowledged in a timely manner. In addition, the Company agrees to provide additional training to its LTC claims handling staff to reinforce the importance of accepting notice of claim from duly authorized agents.

LIFE

10. In five instances, the Companies 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. 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 Companies Response: The Companies state that they do not believe they violated CIC §790.03(h)(3). However, the Companies acknowledge that in the five (5) instances cited their letters did not contain the Department of Insurance contact information. The Companies have procedures in place to comply with the

requirements CCR §2695.7(b)(3), however, the claim examiners who processed these particular claims inadvertently failed to include the disclosure. The Companies have provided additional guidance to its Claims administration staff clarifying that the statement of availability of the California Department must be included on all California claims that are denied in whole or in part.

ACCIDENT AND DISABILITY

11. In five instances, the Companies 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. 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 Companies' Response: The Companies state that they do not believe they violated CIC §790.03(h)(3). However, the Companies acknowledge that in the five (5) instances cited its letters did not contain the Department of Insurance contact information. The Companies have procedures in place to comply with the requirements of CCR §2695.7(b)(3) whenever a claim is denied in whole or in part. However, the claim examiners who processed these particular claims believed the claim was being closed without payment pending receipt of required documentation from the claimant that would prove a loss payable under the policy. The claim examiner did not include reference to the availability of the California Department of Insurance because the letter was not considered to be a denial letter. Based on the Department's feedback during the examination, the Company provided additional guidance to its Claims administration staff clarifying that the statement regarding the California Department's availability must be included on all California claims that are being closed without payment, regardless of the reason.