

**[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  
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY  
NAIC # 62049 CDI # 1910-9**

**AS OF APRIL 15, 2014**

**ADOPTED MARCH 23, 2016**

**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.**

**TABLE OF CONTENTS**

**SALUTATION ..... 1**  
**FOREWORD..... 2**  
**SCOPE OF THE EXAMINATION..... 3**  
**EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED..... 4**  
**RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND  
INQUIRIES, AND PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT  
ACTIONS ..... 5**  
**DETAILS OF THE CURRENT EXAMINATION ..... 6**  
**TABLE OF TOTAL ALLEGED VIOLATIONS ..... 7**  
**TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS ..... 10**  
**SUMMARY OF EXAMINATION RESULTS ..... 12**

**DEPARTMENT OF INSURANCE**

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



March 23, 2016

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:

**Colonial Life & Accident Insurance Company  
NAIC # 62049**

**Group NAIC # 0565**

Hereinafter, the Company listed above also will be referred to as CLAIC 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](http://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 Life, and Accident and Disability claims closed during the period from April 16, 2013 through April 15, 2014. 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.

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. While this report contains violations of law that were cited in this report by examiners, additional violations of CIC §790.03, or other law, not cited in this report may also apply to any or all of the non-complaint or problematic activities that are described herein.

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 April 16, 2013 through April 15, 2014; a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the Company in Columbia, South Carolina.

## **EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED**

The Accident and Disability and Life claims reviewed were closed from April 16, 2013 through April 15, 2014, referred to as the “review period”. The examiners randomly selected 200 claim files for examination including nine (9) life rescissions and 12 disability rescissions. The examiners cited 143 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination include a failure to maintain all documents, notes and work papers; a failure to conduct and diligently pursue a thorough, fair and objective investigation; a failure to effectuate prompt, fair and equitable settlements of claims; and a failure to disclose all benefits, coverage, time limits or other provisions of the insurance policy.

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

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

The Company was the subject of 22 California consumer complaints and inquiries closed from April 16, 2013 through April 15, 2014, in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI determined none of the complaints were justified. There was no specific area of concern identified in the complaint review.

The previous claims examination reviewed a period from September 2001 through August 31, 2002. The most significant noncompliance issues identified in the previous examination report was the Company's failure to provide an explanation of the computation of benefits; the failure to provide written basis for denial of a claim; the failure to adopt and implement reasonable standards for the prompt investigation and processing of claims, and the failure to respond to communication within 15 days. These issues were 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:

<b>CLAIC SAMPLE FILES REVIEW</b>			
<b>LINE OF BUSINESS / CATEGORY</b>	<b>CLAIMS IN REVIEW PERIOD</b>	<b>SAMPLE FILES REVIEWED</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
Accident and Disability / Individual Supplemental Health	72,125	42	13
Accident and Disability / Group Supplemental Health	2,512	16	10
Accident and Disability / Individual Supplemental Health Rescissions	45	12	41
Accident and Disability / Individual Disability Income	2,219	50	17
Accident and Disability /Group Disability Income	12	10	1
Life / Individual Life	212	60	33
Life / Group Life	2	1	0
Life / Individual Life Rescissions	9	9	28
<b>TOTALS</b>	77,136	200	143

## TABLE OF TOTAL ALLEGED VIOLATIONS

Citations	Description of Allegation	CLAIC Number of Alleged Violations
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	38
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.  The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute	26  3
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.	14
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	13
CIC §10380 *[CIC §790.03(h)(3)]	The Company barred the right to recovery under the policy for alleged false statements in the application without establishing that the statements were false. The Company used statements made in the application to rescind coverage without showing that the insured had knowledge of such facts of his or her medical history at the time of the application or appreciated the significance of the information related to him or her. Alternatively, if the Company barred recovery under the policy for making false statements in the application with actual intent to deceive, the Company failed to provide evidence that the applicant had such intent.	11
CCR §2695.11(b) *[CIC §790.03(h)(13)]	The Company failed to provide a clear explanation of the computation of benefits.	8
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	7

CIC §10172.5(a) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death.	6
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	5
CCR §2695.7(c)(1) *[CIC §790.03(h)(5)]	The Company failed to provide written notice of the need for additional time or information every 30 calendar days.	4
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	2
CIC §10111.2.(b) *[CIC §790.03(h)(5)]	The Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim, and failed to accrue interest on the benefit payment beginning the 31st day after receipt of the claim.	2
CIC §10384 *[CIC §790.03(h)(3)]	The Company failed to complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy	1
CIC §1872.4(a) *[CIC §790.03(h)(3)]	The Company failed to report a claim that appeared to be fraudulent to the Department of Insurance Fraud Division within 60 days after determination by the insurer that the claim appears to be fraudulent.	1
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	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.	1
<b>Total Number of Alleged Violations</b>		<b>143</b>

**\*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)(4)      The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
- CIC §790.03(h)(5)      The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
- CIC §790.03(h)(13)     The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

**TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS**

<b>ACCIDENT AND DISABILITY</b> 2014 Written Premium: \$115,182,312  <b>AMOUNT OF RECOVERIES: \$20,311.01</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
CCR §2695.7(d) [CIC §790.03(h)(3)]	19
CCR §2695.3(a) [CIC §790.03(h)(3)]	13
CIC §790.03(h)(5)	12
CIC §10380 [CIC §790.03(h)(3)]	11
CCR §2695.11(b) [CIC §790.03(h)(3)]	8
CCR §2695.7(b)(1) [CIC §790.03(h)(3)]	7
CIC §790.03(h)(1)	4
CIC §790.03(h)(3)	2
CIC §10111.2(b) [CIC §790.03(h)(5)]	2
CIC §10384 [CIC §790.03(h)(3)]	1
CCR §2695.7(b) [CIC §790.03(h)(3)]	1
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	1
<b>SUBTOTAL</b>	<b>82</b>

<b>LIFE</b> 2014 Written Premium: \$27,864,686  <b>AMOUNT OF RECOVERIES: \$114,091.45</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
CCR §2695.3(a) [CIC §790.03(h)(3)]	25
CCR §2695.4(a) [CIC §790.03(h)(3)]	14
CCR §2695.7(d) [CIC §790.03(h)(3)]	10
CIC §10172.5(a) [CIC §790.03(h)(5)]	6
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	3
CIC §790.03(h)(1)	1

CIC §790.03(h)(5)	1
CIC §1872.4(a)	1
<b>SUBTOTAL</b>	<b>61</b>

<b>TOTAL</b>	<b>143</b>
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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 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 where applicable.

Money recovered within the scope of this report was \$102,976.28 as described in sections number 3, 9, 16, 17, and 20 below. Following the findings of the examination, a closed claims survey as described in section 17 below was conducted by the Company resulting in additional payments of \$31,426.18. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$134,402.46.

## **ACCIDENT AND DISABILITY**

### **1. In 19 instances, the Company failed to comply with the requirements of 2695.7(d) as described below:**

**1(a). In 16 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.** In 12 instances, the Company failed to obtain agents' statements during the rescission investigation of supplemental health claims. In two instances, the Company failed to clarify inconsistencies in the medical records, claimant's and physician's statements, and other relevant information which warranted additional review prior to the denial of claims. In one instance, the Company failed to review its systems database for coordination of all applicable benefits on eligible policies owned by the same insured. In the last instance, the Company failed to conduct diligent claim activities for the prompt resolution of a claim from December 17, 2013 to March 10, 2014.

**1(b). In three instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.** In three instances, the Company requested duplicative and/or unnecessary information which were already available or were previously submitted.

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 Company acknowledges the findings. As a result of the examination, the Company provided multiple training sessions on August 6, 2014, August 19, 2014, and August 21, 2014 to the various claims units and its management team. The training emphasized regulatory compliance including the importance of conducting a diligent investigation, complete file documentation; securing agents' statements and pertinent information, and evaluation of conflicting information. Effective August 21, 2014, the Company also implemented new procedures to address claims for multiple lines of coverage and coordination of all applicable benefits. The Company provided the Department with a copy of these revised procedures on August 21, 2014.

**2. In 13 instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.** In these instances, the Company failed to fully document notes pertinent to telephone calls and other communications received from, or allegedly made to, claimants regarding the claims. The Company's Call Tracking system failed to identify the name of the caller, the purpose of the call or the information provided by the Company relative to any claim in question. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges the findings that pertinent information was not included, retained or documented in the Company's Call Tracking System notes. The Company's Legal Department provided in-person training to all Contact Center employees on July 30, 2014 regarding: 1) the importance of providing appropriate documentation of all communication with customers; 2) the responsibility to escalate calls to appropriate resources; and 3) the need to ensure that customer questions/concerns are routed to the proper Company resource for handling. Additionally, the Company enhanced and implemented call tracking procedures on September 12, 2014 regarding: 1) documentation philosophy of all customer interactions in the Contact Center; 2) call tracking job aid; and 3) acronyms and abbreviation terms for Colonial Life Contact Center.

The Company conducted claims training on August 6, 2014 and August 19, 2014 to reinforce regulatory compliance and emphasize the need for complete documentation.

**3. In 12 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** The Company failed to settle claims fairly and equitably in the following instances:

- In six instances, the Company did not pay eligible wellness and health screening benefits under disability income policies and/or supplemental health policies.
- In two instances, the Company did not accurately calculate disability benefits when it did not validate information from the insureds' employer and/or medical provider.
- In one instance, the Company improperly denied benefits under both an insured's Specified Disease Cancer policy and a disability income (DI) rider.
- In one instance, the Company denied emergency treatment for an accidental injury under a group accident policy.
- In one instance, the Company failed to pay a subsequent period of hospital confinement under a hospital indemnity policy.

The Department alleges these acts are in violation of CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company acknowledges that 12 claims on 11 policies benefits were overlooked thereby resulting in non-payment of eligible policy benefits. As a result of the examination, the Company reopened these claims and issued additional monies to policyholders in the amount of \$20,279.49.

The Company completed claims staff training on August 6, 2014 and August 19, 2014 for reinforcement and regulatory compliance.

**4. In 11 instances, the Company barred the right to recovery under the policy**

**for alleged false statements in the application without establishing that the statements were false. The Company used statements made in the application to rescind coverage without showing that the insured had knowledge of such facts of his or her medical history at the time of the application or appreciated the significance of the information related to him or her. Alternatively, if the Company barred recovery under the policy for making false statements in the application with actual intent to deceive, the Company failed to provide evidence that the applicant had such intent.** This pertains to the Company's handling of rescinded policies and denial of its supplemental health claims. The examination revealed that prior to the rescission of these claims, the Company did not conduct a complete investigation, nor secure pertinent and detailed applicant/insured statements to establish its allegations of material misrepresentation, including but not limited to what the applicant knew and understood regarding the alleged medical conditions at issue. The Department alleges these acts are in violation of CIC §10380 and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges that it failed to contact the insureds during its rescission investigation to determine what the insured knew about his/ her alleged medical condition. As a result of the examination, the Company enhanced its process and procedures for the investigation and review of supplemental health claims evaluated for rescission of coverage. The training and implementation of the new procedures were completed September 15, 2014. The Company also revised its standard rescission letter for notifying customers of the decision.

**5. In eight instances, the Company failed to provide a clear explanation of the computation of benefits.** Specifically, the Explanation of Benefit (EOB) statements failed to provide a clear explanation and calculation of benefits as described follow:

- a) The EOBs failed to identify the range and/or specific dates applied to the elimination period for disability income benefits and supplemental health benefits.
- b) The EOBs failed to differentiate or distinguish the benefit payments on multiple-owned policies by the same insured.

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 Company's Response:** The Company agrees with the findings and states that the Company's Explanation of Benefits (EOB) statements were already in the process of being improved prior to the Department's examination. As a result of the Department's findings, the Company implemented additional enhancements to its EOB template letters. As of September 30, 2014, the EOB template includes all policy numbers for which benefits are considered, and complete details or descriptions to provide a clear calculation and computation of benefits. The Company is continuing to consider a long-term solution to include the type of policy on the EOB.

**6. In seven instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.** In seven instances involving the rescission of supplemental health policies and denial of claims, the rescission notices failed to include claim information such as the name of the medical entity; the period of the rescission investigation; the dates of medical treatment considered in the rescission determination; and the factual and legal bases to support the policy rescissions for alleged material misrepresentation. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

**Summary of the Company's Response:** The Company agrees with the findings. On September 15, 2014, the Company implemented new policy rescission procedures on Contestable Claims to ensure that revised claim denial letters for rescission of coverage include the name of the medical provider and/or treating physician; the relevant medical condition relied upon in its decision; the dates of treatment for which the rescission was based; and other relevant information to support the alleged material misrepresentation during the policy's contestability period.

The Company also acknowledges that in two instances, it failed to notify the insured of the specific reason upon which the denial was based. As a result of the examination, the Company provided training to claims personnel and managerial staff pertaining to this issue. The Company also conducted general claims training with the claims units on August 6, 2014 and August 19, 2014 for compliance reinforcement.

**7. In four instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.** In three instances, the Company's denial and/or rescission letters contained inaccurate medical information for the alleged bases of the decision. In the last instance, the agent misled the insured during the application process regarding the medical information necessary to replace and upgrade the existing disability income (DI) coverage. The Department alleges these acts are in violation of CIC §790.03(h)(1).

**Summary of the Company's Response:** The Company acknowledges that correspondence to claimants were inaccurate in three instances. In the last instance, the Company reinstated the claimant's existing health insurance policy, and additionally offered to the insured a reinstatement of the new upgraded policy. Additionally, the Company reinforced compliance with staff and provided training to claims personnel and its management team on August 8, 2014.

**8. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.** In the first instance, the Company failed to validate the discrepancy on the start date of disability. The Company did not reconcile the verbal (telephonic) verification with the actual Employer's Statement form. In the second instance, the Company requested medical records without promptly paying the medical copy fees resulting in a delay of the rescission investigation of a supplemental health claim. The

Department alleges these acts are in violation of CIC §790.03(h)(3).

**Summary of the Company's Response:** In the first instance, the Company agrees that the telephonic information received from the insured's Employer conflicted with the information on the official Employer's Statement claim form. The Company agrees the claim handler should have clarified the dates of total disability in writing to ensure benefits were calculated properly. In the second instance, the Company agrees its delay in paying medical records fees. The Company addressed this issue with claims staff. As a result of the examination, the Company also conducted claims staff training on August 6, 2014 and August 19, 2014 for compliance reinforcement.

**9. In two instances, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim, and failed to accrue interest on the benefit payment beginning the 31st day after receipt of the claim.** The Company failed to request in writing any additional information needed to clarify inconsistencies on the October 9, 2013 and November 1, 2013 disability claim forms. The subsequent benefit payment issued on December 10, 2013 did not include applicable interest for the late payment of benefits. The Department alleges these acts are in violation of CIC §10111.2(b) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company acknowledges the deficiencies in the claims processing which resulted in a delay in the payment of disability income (DI) benefits. The Company addressed this issue with claims personnel. As a result of the examination, the Company issued interest payments in the amount of \$31.52. The Company also conducted claims staff training on August 6, 2014 and August 19, 2014 for compliance of statutory guidelines.

**10. In one instance, the Company failed to complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy.** During its rescission determination, the Company failed to thoroughly review prior claims history on coverages already in effect at the time of application. The insured's prior claims revealed a history of treatment for diabetes which would have resulted in a declination of the critical care illness coverage during the underwriting and pre-issuance review period. The Department alleges this act is in violation of CIC §10384 and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges there was existing information in its records that the applicant/insured had a diagnosis of diabetes which was overlooked by the underwriter. The Company states the application was subject to automated and systematic checks for existing coverage and a prior claims history. As a result of the examination, the Company reevaluated the rescinded policy and offered to reinstate the insured's critical illness policy. Further, the Company reinforced its Underwriting process and procedures to ensure complete underwriter review and documentation of claims history in August 2014. The Company is pursuing further enhancements to systematically capture prior claims history information that is expected to

be implemented by April, 2016.

**11. In one instance, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.** The Company failed to accept or deny a claim for hospital indemnity benefits under a disability income (DI) policy within regulatory timelines. The Department alleges this act is in violation of CCR §2695.7(b) and is an unfair practice under CIC §790.03(h)(4).

**Summary of the Company's Response:** The Company acknowledges the finding. The claim was received on May 31, 2013 and accepted July 11, 2014, beyond the regulatory timeline requirement. The Company addressed this issue with the claims handler. As a result of the examination, the Company also conducted claims staff training on August 6, 2014 and August 19, 2014 for compliance reinforcement.

**12. In one instance, 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.** The Company failed to include the Department's required language on its rescission decision letter. The Department alleges this act is in violation of CCR §2695.7(b)(3) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company Response:** The Company agrees to the finding. Effective September 15, 2014, the Company revised its procedures to include the California Department of Insurance (CDI) language on all rescission letters.

**13. In one instance, the Company failed to provide written notice of the need for additional time or information every 30 calendar days.** The Company failed to provide a status letter to the claimant during the rescission investigation of a supplemental health claim. The Department alleges this act is in violation of CCR §2695.7(c)(1) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company agrees with the finding that a status letter was not sent to the insured from October 28, 2013 to December 3, 2013, a period exceeding the regulatory 30-day timeline. The Company provided reinforcement training to staff. The Company also conducted claims training on August 6, 2014 and August 19, 2014 to reinforce regulatory compliance.

## **LIFE**

**14. In 25 instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.** The Company failed to retain, document or maintain notes and related claim handling activities in the following instances:

- In 16 instances, the Company failed to document notes, telephone calls received from, or made to claimants on these claims. As to the Company's Call Tracking system, it also failed to identify the name of the caller, the purpose of the call and/or the information provided by the Company on these telephone inquiries.
- In nine instances, the Company failed to maintain complete notes of review and claim discussions relative to its adjudication and final determination to rescind these life policies. The Company held weekly "case study" meetings to decide on claims occurring during the two-year contestability period on individual life policies. However, the participants of this review group failed to maintain records regarding how the Company supported or reached its decisions to rescind these nine policies.

The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges the findings that pertinent information was not included, retained or documented in the Company's Call Tracking System notes. The Company states that its Tracking System uses general reason codes to capture what is discussed when a customer calls its Contact Center.

As a result of the examination, the Company's Legal Department provided in-person training to all Contact Center employees on July 30, 2014 regarding 1) the importance of providing appropriate documentation of all communications with customers; 2) the responsibility to escalate calls to the appropriate resources; and 3) the need to ensure that questions/concerns are routed to the proper Company resource for handling. The Company enhanced and implemented call tracking procedures on September 12, 2014 regarding: 1) documentation philosophy of all customer interactions in the Contact Center; 2) call tracking job aid; and 3) acronyms and abbreviation terms for Colonial Life Contact Center.

The Company conducted claims training on August 6, 2014 and August 19, 2014 to reinforce regulatory compliance and emphasize the need for complete documentation.

To address the issue of the failure to maintain complete documentation related to contestable life claims, the claim file will now document all the discussions, supporting information, recommendations, and the determination process by the Dedicated Legal Resource Unit (DLR) on the review of contestable claims. These procedures and guidelines were implemented as of September 1, 2014.

**15. In 14 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.** The Company failed to disclose settlement options to beneficiaries on death claims. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

**Summary of the Company's Response:** The Company agrees with the findings and acknowledges that claim forms did not provide beneficiaries with the settlement

options available under the policy. Effective September 5, 2014, the Company revised its electronic form available on the Company's website. The Loss of Life Notification form advises beneficiaries that life benefit proceeds may be paid by lump sum amount and/or other payment options. The Company completed its paper claim form revisions in April of 2015.

**16. In ten instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.** In eight instances, the Company failed to obtain agents' statements to validate its rescission investigation and claim conclusion. In two instances, the Company failed to review and/or clarify information in the medical records prior to rescinding coverage. 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 Company acknowledges that agent statements were not requested during the rescission investigation in these instances. During the course of the audit examination, the Company agreed to reopen the life claims and obtained agent statements to reevaluate the medical and other supporting documentation and evidence on the files. The results of the reevaluation review revealed the following:

- a) In one instance, the Company agrees that the agent had knowledge of a material fact and did not disclose it at the time of the application.
- b) In one instance, the Company agrees that policyholder/applicant may not have known or understood the spouse's medical condition for disclosure at the time of application.
- c) In one instance, the Company acknowledges it was unclear if the insured understood further medical questioning by the agent after disclosing a material diagnosis during the application process.

As a result of the examination, the Company reversed these three life rescission claims and paid death benefits with statutory interest in the amount of \$73,275.22. Additionally, the Company enhanced its process and procedures for the investigation and review of life claims, and the rescission of policies. The training and implementation of the new procedures were completed on September 15, 2014.

**17. In six instances, the Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death.** The Company failed to pay statutory interest on five (5) Life and Accidental Death and Dismemberment (AD&D) claims that were paid beyond 30 days from the date of death. In the last instance, the Company incorrectly paid statutory interest to a financial corporation which held an assignment for the death proceeds. The Department alleges these acts are in violation of CIC §10172.5(a) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company acknowledges the

findings and agrees that statutory interest was not paid on Life and AD&D claims when settlements were longer than 30 days from the date of death. As a result of the examination, the Company re-opened the claims and paid applicable interest on six policies in the amount of \$2,018.85. The Company also conducted training with claims staff for compliance and reinforcement on August 8, 2014.

Additionally, the Company conducted a voluntary self-survey to identify improper or inaccurate payments on AD&D and Life claim settlements for the period from February 1, 2012 through January 31, 2015. The Company identified 64 claims and issued additional payments in amount of \$31,426.18. The results of the survey, including supporting data and proof of payments were provided to the Department on August 6, 2015.

**18. In three instances, the Company failed to provide written notice of the need for additional time or information every 30 calendar days.** The Company failed to send regulatory status letters to claimants and beneficiaries. 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 acknowledges the findings and addressed the issue with the respective claims handlers. The Company believes these were isolated instances. As a result of the examination, the Company also completed reinforcement training to its claims staff and management team on August 8, 2014.

**19. In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.** The Company misrepresented the policy terms and provisions to a beneficiary regarding coverage of accidental bodily injury. The Department alleges this act is in violation of CIC §790.03(h)(1).

**Summary of the Company's Response:** The Company agrees with the finding and states that the accidental bodily injury information was erroneously included in a communication letter. The Company addressed this issue with the claims handler. As a result of the examination, the Company also provided reinforcement training to its claims personnel and management team on August 8, 2014.

**20. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** The Company failed to evaluate and pay all benefits on an insured's multiple policies. In this instance, the insured was entitled to additional disability income (DI) benefits until the date of death. The Department alleges this act is a in violation of CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees that additional disability income (DI) benefits were payable under a separate DI policy. As a result of the examination, the Company issued additional payments in the amount of \$7,371.20 including applicable interest. Further, the Company developed a new procedure to

address claims for multiple lines of coverage and these procedures were implemented on August 21, 2014. Further, the Company conducted training with claims staff for compliance reinforcement on August 8, 2014.

**21. In one instance, the Company failed to report a claim that appeared to be fraudulent to the Department of Insurance Fraud Division within 60 days after determination by the insurer that the claim appears to be fraudulent.** The Company discovered during its rescission investigation that the applicants misrepresented their marital status on an insurance application. The Company rescinded the policy based on this alleged material misrepresentation; however the Company did not report it to the CDI Fraud Division. The Department alleges this act is in violation of CIC §1872.4(a) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges this finding that the claim was not referred to the Special Investigation Unit (SIU) for appropriate reporting to the Fraud Division. As a result of the examination, the Company revised its rescission procedures and guidelines on contestable claims. The Company will refer claims to its SIU upon discovery of any potential fraud by omission or misrepresentation to comply with the statute. The Company provided its claim personnel with access to the Fraud Reporting Form and the applicable link to report suspected fraud. The Company will ensure compliance with regular ongoing audits.