

**[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**

**ASSURITY LIFE INSURANCE COMPANY
NAIC # 71439 CDI # 2003-2**

AS OF MAY 15, 2014

ADOPTED OCTOBER 22, 2015

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



October 22, 2015

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:

**Assurity Life Insurance Company
NAIC # 71439**

Hereinafter, the Company listed above also will be referred to as ALIC 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 Life and Disability claims closed during the period from May 16, 2013 through May 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 the examiners, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant 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 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 the Company closed by the CDI during the period May 16, 2013 through May 15, 2014; 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 California Department of Insurance in Los Angeles, California and the offices of the Company in Lincoln, Nebraska.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Life and Disability claims reviewed were closed from May 16, 2013 through May 15, 2014, referred to as the “review period”. The examiners randomly selected 164 ALIC claims files for examination. The examiners cited six alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination included a failure to pay interest on a claim that remained unpaid longer than 30 days from the date of death.

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

There were no specific areas of concern identified in the review of market analysis and consumer complaint information..

The previous claims examination reviewed a period from March 1, 2001 through February 28, 2002. There was no specific area of concern identified in the previous claims examination.

DETAILS OF THE CURRENT EXAMINATION

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

ALIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Life / Individual Life	170	40	2
Life / Group Life	16	4	0
Life / Life Rider	29	8	0
Disability / Supplemental Health	246	53	0
Disability / Individual Short-Term Disability Income	244	51	4
Disability / Individual Long-Term Disability Income	11	3	0
Disability / Medicare Supplement	19	5	0
TOTALS	735	164	6

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	ALIC Number of Alleged Violations
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.	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 31 st day after receipt of the claim.	1
CIC §10111.2(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.	1
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	1
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.	1
Total Number of Alleged Violations		6

*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 ALLEGED VIOLATIONS BY LINE OF BUSINESS

LIFE 2013 Written Premium: \$14,790,883 AMOUNT OF RECOVERIES \$929.96	NUMBER OF ALLEGED VIOLATIONS
CIC §10172.5(c) [CIC §790.03(h)(3)]	2
SUBTOTAL	2

DISABILITY 2013 Written Premium: \$5,170,109 AMOUNT OF RECOVERIES \$29,419.09	NUMBER OF ALLEGED VIOLATIONS
CIC §10111.2(b)[CIC §790.03(h)(5)]	1
CIC §10111.2(c)[CIC §790.03(h)(5)]	1
CIC §790.03(h)(5)	1
CIC §790.03(h)(3)	1
SUBTOTAL	4

TOTAL	6
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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.

Money recovered within the scope of this report was \$29,456.95 as described in section numbers 1, 3, 4 and 5 below. Following the findings of the examination, a closed claims survey as described in section 1 below was conducted by the Company resulting in additional payments of \$892.10. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$30,349.05.

LIFE

1. **In two instances, the Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death. The Department alleges these acts are in violation of CIC §10172.5(a) and are unfair practices under CIC §790.03(h) (5).** In two instances, the Company miscalculated the death benefit interest based on when the proof of claim was received. Thus, the Company failed to pay the correct interest owed on these claims from the date of death. 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 agrees with the findings. As of October 21, 2014, the Company completed training and updated its processing instructions for Company analysts to calculate interest on death claims according to regulatory or statutory requirements of the contract issue state. For California, interest will be calculated from the date of death. Further, the Company has updated its claim guidelines and procedures to comply with the law. The Company reopened the pertinent claims and paid a total of \$37.86 in additional interest.

As a result of the examination, the Company completed a self-survey of all life claim settlements paid beyond 30 days from the date of death for the window period January 1, 2011 – December 31, 2014. The results of the survey were completed on March 19, 2015. Out of the 46 claims included in the survey, the Company determined statutory interest was owed on 12 of the claims and had issued additional payments totaling \$892.10.

DISABILITY

2. **In one instance, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.** The Company received an individual short-term disability claim on December 3, 2013. During the period of February 1, 2013 through March 21, 2013, the Company failed to request additional information it required to complete the claim. The Department alleges this act is in violation of CIC §10111.2(b) and is an unfair practice under CIC §790.03(h) (3).

Summary of the Company's Response: The Company agrees with the finding. The Company addressed the issue with pertinent staff for reinforcement. The Company's Law Division also conducted claims training on February 12, 2015, with emphasis on California's claims settlement practices, laws and regulations, and the importance of complying with notice timelines.

3. **In one instance, the Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.** The Department alleges this act is in violation of CIC §10111.2(c) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the finding. The Company has addressed the issue with pertinent staff and reopened the claim to issue additional interest owed in the amount of \$1.02. The Company also conducted claims training on February 12, 2015 and emphasized compliance with statutory payment of interest on disability claims.

4. **In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** The insured's policy provided for a \$75.00 wellness benefit for mammograms. The policy was in force at the time the services were rendered on a mammogram claim for \$75.00. However, the Company denied the claim due to a "Proof of Loss" policy provision requiring proof of loss to be submitted within 120 days of the date of service. The same proof of loss provision also qualifies that "we will not reduce or deny Benefits because proof is late". The Company failed to address the insurer's investigation to support its decision to deny the essential health benefit of a mammogram. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the finding and states that a mammogram is a covered benefit and should have been paid. The Proof of Loss provision in the relevant policy states "*However, You must give Us Proof within 12 months unless You lack legal capacity*" which sets forth a contractual one-year time limit for providing proof of loss. Assurity agrees that California case law on this subject requires a showing of prejudice before the Company may deny a claim under such provision. As a result of this examination, the Company has amended its process for policies issued in California to require that Assurity must have been prejudiced in order to deny a claim filed outside the "proof of loss" time period stated in the contract. Assurity also amended its process in all other jurisdictions, to comply with the particular jurisdiction's statutes or case law regarding the requirement to show prejudice before denying a claim based on late proof of loss.

The Company has also addressed this matter with pertinent staff for reinforcement. The Company reopened the claim on November 14, 2014 and issued payment in the amount of \$75.00.

5. **In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.** The insured's disability policies issued on October 1, 2013 were rescinded and the pertinent claim was denied due to an alleged material

misrepresentation on the policy application. The insured disputed the rescission and alleged that the agent specifically instructed the insured to exclude her complete medical history on the application.

The claim documentation on file disclosed the agent's potential conflict of interest, yet the agent misrepresented himself by acting as the Company's claims adjuster in the determination of the policy rescission. The agent's electronic mail to the insured contained detailed information including advising the insured of her right to appeal; explaining the reason for the denial; the interpretation of underwriting guidelines; and representing that the "decision is solid based on doctor's reports". When the insured appealed the denial and rescission, the agent intervened in the process by requesting the insured to submit all documentation to the agent instead of directly to the Company's claims adjuster. The Company failed to address the conflict of interest issue, and to refer the matter to its SIU Unit for investigation of a suspected fraudulent misrepresentation. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the Department's finding. As a result of this examination, the Company reopened its investigation and reinstated the insured's policies. On March 2, 2015, the Company issued payment on a critical illness policy in the amount of \$24,422.56. On April 20, 2015 the Company issued payment of \$4,920.51 on a disability income policy.

The Company's Law Division Unit conducted a meeting with its claims supervisors on February 12, 2015 to emphasize the importance of a thorough, fair and complete investigation. Supervisors were reminded that when the alleged statements or conduct of an agent are at issue in a claim or an appeal, a diligent and fair investigation includes providing complete and accurate information about the nature of the insured's claim or accusations, and for the Company to obtain a complete and detailed response from the agent. When appropriate, agents' statements should be obtained under penalty of perjury. If agents' statements do not answer all relevant questions, and/or create additional issues of fact, the analyst should conduct additional follow-up with the agent before denying the claim, or rescinding the policy.

The claims staff were also reminded that all instances of suspected claim fraud should first be reported to the supervisor, and elevated as appropriate to ALIC's Chief Investigator. When warranted based on the facts and relevant state law, suspected claim fraud will be finally reported to ALIC's third party SIU vendor and/or the Company's Law & Compliance Division for appropriate determination and reporting compliance.