

**[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
ATHENE ANNUITY & LIFE ASSURANCE COMPANY
NAIC # 61492 CDI # 0452-3**

AS OF AUGUST 31, 2014

ADOPTED APRIL 27, 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.

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FOREWORD

This 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 by the examiner, 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’s responses, if any, have not undergone a formal administrative or judicial process.

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).

SCOPE OF THE EXAMINATION

Under the authority granted in Part 2, Chapter 1, Article 4, Sections 730, 733, and 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 claim handling practices and procedures in California of:

Athene Annuity & Life Assurance Company
NAIC # 61492

Group NAIC # 4734

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

This examination covered the claims handling practices of the aforementioned Company on Accident and Disability claims, Life claims, and Annuity death claims closed during the period from September 1, 2013 through August 31, 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.

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 claim files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; and if any, a review of consumer complaints and inquiries about these Companies closed by the CDI during the period September 1, 2013 through August 31, 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 claim files was conducted at the offices of the California Department of Insurance, Sacramento, California.

EXECUTIVE SUMMARY

The Accident and Disability, Life, and Annuity death claims reviewed were closed during the period of September 1, 2013 through August 31, 2014, referred to as the “review period”. The examiner randomly selected 58 Athene claim files for examination. The examiners cited 39 alleged claims handling violations of the California Insurance Code (CIC) and the California Code of Regulations (CCR) from this sample file review.

Findings of this examination included the failure to provide written notice of the need for additional time within 30 days, the failure to pay the appropriate interest on life claims paid beyond 30 days from date of death, and the failure to provide a clear explanation of the computation of benefits.

DETAILS OF THE CURRENT EXAMINATION

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

ATHENE SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accidental Death / Paid; Declined; Closed without Pay	57	15	15
Disability Income / Group Short Term Disability Income	1	1	1
Life / Group and Individual Life	95	24	12
Annuity / Fixed and Variable	68	18	11
TOTALS	221	58	39

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	Athene Number of Alleged Violations
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice every 30 days of the additional time needed to determine whether the claim should be accepted or denied.	16
CIC §10172.5(a) *[CIC §790.03(h)(5)]	The Company failed to include the appropriate interest on a claim paid beyond 30 days from date of death.	7
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of the computation of benefits.	5
CCR §10172.5(c) *[CIC §790.03(h)(3)]	The Company failed to notify the beneficiary that interest will be paid.	4
CCR §2695.3(b)(2) *[CIC §790.03(h)(3)]	The Company failed to record in the file the date the Company received relevant documents.	3
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	2
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge a claim and provide necessary forms and assistance within 15 calendar days.	1
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed to provide the necessary forms, instructions, and reasonable assistance within 15 calendar days.	1
Total Number of Alleged Violations		39

***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 ALLEGED VIOLATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY (Accidental Death / Disability Income) 2014 Written Premium: \$2,331,392 AMOUNT OF RECOVERIES: \$4,392.15	NUMBER OF ALLEGED VIOLATIONS
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	10
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	3
CIC §10172.5(a) [CIC §790.03(h)(5)]	2
CIC §790.03(h)(1)	1
SUBTOTAL	16

LIFE 2014 Written Premium: \$5,570,662 AMOUNT OF RECOVERIES \$4,190.45	NUMBER OF ALLEGED VIOLATIONS
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	6
CIC §10172.5(a) [CIC §790.03(h)(5)]	3
CCR §2695.5(e)(1) [(CIC §790.03(h)(2)]	1
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	1
CIC §790.03(h)(1)	1
SUBTOTAL	12

ANNUITY 2014 Written Premium: \$13,324,356 AMOUNT OF RECOVERIES \$14,811.17	NUMBER OF ALLEGED VIOLATIONS
CCR §2695.11(b) [CIC §790.03(h)(3)]	5
CIC §10172.5(c) [CIC §790.03(h)(3)]	4
CIC §10172.5(a) [CIC §790.03(h)(5)]	2
SUBTOTAL	11

TOTAL	39
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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 should address corrective action for other jurisdictions when applicable.

Money recovered within the scope of this report was \$3,796.99 as described in sections 3, 6, 9, and 12 below. Following the findings of the examination, closed claim surveys were conducted by the Company as described in sections 3, 6, and 12 below resulting in additional payments of \$19,596.78. The instances identified in the examination were included in the surveys and are referenced in the corresponding summary sections. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$23,393.77.

ACCIDENT AND DISABILITY (Accidental Death / Disability Income)

1. **In 10 instances, the Company failed to provide written notice every 30 days of the additional time needed to determine whether the claim should be accepted or denied.** 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 that the status letters were not sent within the 30-day requirement of the code. To ensure future compliance, the Company conducted training with all claims handling personnel, contact center personnel, and Third Party Administrators on June 23, 2015, June 24, 2015 and July 2, 2015.

In addition, the Company is transitioning the claims handling of its Accidental Death business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claims will no longer be handled by Third Party Administrators. The claims department utilizes an automated system that ensures the status letters are sent timely.

2. In three instances, the Company failed to record in the file the date the Company received relevant documents. There was no documentation as to when the first notice of loss was received. The Department alleges these acts are in violation of CCR §2695.3(b)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges that the file does not contain documentation as to when the claims were received. To ensure future compliance, the Company conducted training with all claims handling personnel, contact center personnel, and Third Party Administrators on June 23, 2015, June 24, 2015 and July 2, 2015.

In addition, the Company is transitioning the claims handling of its Accidental Death business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claims will no longer be handled by Third Party Administrators. The claims department requires that the claim representatives complete a telephone template that records pertinent information regarding the notice of claim, including the date the claim is first received.

3. In two instances, the Company failed to include the appropriate interest on a claim paid beyond 30 days from date of death. Interest is due from the date of death through the date of payment. Of the two instances,

a. One involved the failure to include the date of death in the calculation of the interest due.

b. One involved the failure to apply the appropriate interest rate. Between the date of death and the date of payment the interest rate went down. However, in calculating the interest due, the Company utilized the lower interest rate for the entire period. The Company should have utilized the higher interest rate until the rate changed, then the lower interest rate until payment was made.

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 that the appropriate interest was not paid in these instances. The claim was reopened and on March 26, 2015 a payment of \$2,545.52 was sent representing \$24.54 for the date of

death that had been omitted, and \$2,520.98 for the interest rate that had not been calculated correctly.

The Company is transitioning the claims handling of its Accidental Death business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claims will no longer be handled by Third Party Administrators. The claims department utilizes an automated system that includes the date of death in the statutory interest calculation, and accounts for multiple interest rates if a rate change occurs between the date of death and date of payment.

To ensure compliance in the interim, on May 1, 2015 the Company started conducting monthly reviews of paid claims to determine if these specific issues are still problematic. In the event of further miscalculations, the Company will issue supplemental payments.

In addition, the Company conducted internal surveys to determine whether payments were due to other consumers.

For 3.a., the issue involving the date of death that had been omitted from the interest calculation, the survey included claims that were closed from September 1, 2010 through August 31, 2015. The survey resulted in additional payments returned to consumers totaling \$1,846.63.

For 3.b., the issue involving the interest rate that was improperly calculated, the survey included the period of time during which settlements may have been affected by the miscalculation. The results of the survey determined that there were no other instances warranting additional payments.

4. In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. A procedure was established that was in conflict with the policy provision related to the distribution of settlement proceeds. Specifically, the policy states that any excess benefits over the amount owed to the primary beneficiary to pay off the mortgage will be sent to the secondary beneficiary. The procedure established was to send the excess amount to the primary beneficiary or the lienholder. In this instance, the excess amount was sent to the lienholder. The Department alleges that this act is in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that the procedure established was in conflict with the wording of the policy. To ensure future compliance, the Company amended its procedures on June 5, 2015. Any proceeds in excess of those payable to the primary beneficiary will be paid directly to the secondary beneficiary, or to the estate.

LIFE

5. **In six instances, the Company failed to provide written notice every 30 days of the additional time needed to determine whether the claim should be accepted or denied.** 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 that the status letters were not sent within the 30 day requirement of the regulation. To ensure future compliance, the Company conducted training with all claims handling personnel, contact center personnel, and Third Party Administrators on June 23, 2015, June 24, 2015 and July 2, 2015.

In addition, the Company is transitioning the claims handling of its Life business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claims will no longer be handled by Third Party Administrators. The claims department utilizes an automated system that ensures the status letters are sent timely.

6. **In three instances, the Company failed to include the appropriate interest on a claim paid beyond 30 days from date of death.** Interest is due from the date of death through the date of payment. Of the three instances,

a. Two involved the failure to include all of the days between the date of death and the date of payment. Specifically, the Company calculated the interest due from the date it received the Proof of Claim, not from the date of death.

b. One involved the failure to apply the appropriate interest rate. Between the date of death and the date of payment the interest rate went down. However, in calculating the interest due, the Company utilized the lower interest rate for the entire period. The Company should have utilized the higher interest rate until the rate changed, then the lower interest rate until payment was made.

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 that the appropriate interest was not paid in these instances. These claims were reopened and supplemental payments of \$2.98, \$121.95, and \$54.29 were made on February 9, 2015, February 12, 2015, and December 24, 2015, respectively.

The Company is transitioning the claims handling of its Life business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion,

claims will no longer be handled by Third Party Administrators. The claims department utilizes an automated system that includes the date of death in the statutory interest calculation, includes all days between the date of death and date of payment, and accounts for multiple interest rates if a rate change occurs between the date of death and date of payment.

To ensure compliance in the interim, on May 1, 2015 the Company started conducting monthly reviews of paid claims to determine if these specific issues are still problematic. In the event of further miscalculations, the Company will issue supplemental payments.

In addition, the Company conducted internal surveys to determine whether payments were due to other consumers.

Regarding 6.a., the Company determined these instances to be aberrations and isolated instances. A survey was not necessitated.

Regarding 6.b., because this issue was found to be problematic in the Accidental Death and Annuity categories as well, the Company conducted a survey. The survey included the period of time during which settlements may have been affected by the miscalculation. The survey resulted in additional payments returned to consumers totaling \$894.65.

As a result of the findings summarized in Section 3 above, related to the Accidental Death business, and Section 12 below, related to the Annuity business, the Company also conducted a separate survey for the Life business. Those findings concerned the omission of the date of death in the calculation of interest. The survey included claims that were closed from September 1, 2010 through August 31, 2015. This survey resulted in additional payments returned to consumers totaling \$2,044.33.

7. In one instance, the Company failed to acknowledge receipt of the claim within 15 calendar days. 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 acknowledges that the first notice of loss was not acknowledged within the 15 day requirement of the code. To ensure future compliance, the Company conducted training with all claims handling personnel, contact center personnel, and Third Party Administrators on June 23, 2015, June 24, 2015 and July 2, 2015.

In addition, the Company is transitioning the claims handling of its Life business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claim will no longer be handled by Third Party administrators. The claims department

has implemented a quality assurance review process and the claim acknowledgement timeframe is included in that process.

8. In one instance, the Company failed to provide the necessary forms, instructions, and reasonable assistance within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges that the necessary forms, instructions, and reasonable assistance were not provided within 15 calendar days. To ensure future compliance, the Company conducted training with all claims handling personnel, contact center personnel, and Third Party Administrators on June 23, 2015, June 24, 2015 and July 2, 2015.

In addition, the Company is transitioning the claims handling of its Life business to its internal claims department operated by staff claim representatives. The transition will occur in phases and is expected to be completed by late 2016. Upon completion, claims will no longer be handled by Third Party administrators. The claims department has implemented a quality assurance review process and the claim acknowledgement timeframe is included in that process.

9. In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. Correspondence was sent to the insured's former husband indicating that the divorce disqualified him as a beneficiary under California law. According to California Family Code §2024, a divorce does not automatically cancel the spouse's rights as a beneficiary. The Department alleges this act is in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that the information provided to the insured's former husband was erroneous. As a remedial measure, the Company updated its claim handling procedure. During the claim investigation, if the claims representative discovers that a beneficiary is a former spouse of the insured, the claim will be sent to Compliance for review. Compliance will provide guidance to the claims representative as to how the claim shall be adjudicated.

As a result of this finding, on March 25, 2015 the claim was reopened and a payment of \$1,072.25 was sent to the insured's former husband.

ANNUITY

10. In five instances, the Company failed to provide a clear explanation of the computation of benefits. An explanation of how the statutory interest was calculated was not included on the Explanations of Benefits. 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 acknowledges that the Explanations of Benefits did not clearly explain how the interest was calculated. As a remedial measure the Company developed a letter that will be mailed separately from the remittance mailing. The letter will be implemented effective March 31, 2016 and will contain a clear explanation of how the interest was calculated.

11. In four instances, the Company failed to notify the beneficiary that interest will be paid. The Department alleges these acts are in violation of CIC §10172.5(c) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges that the beneficiaries were not notified that interest will be included in the settlement. As a remedial measure the Company developed a letter that will be mailed separately from the remittance mailing. The letter will be implemented effective March 31, 2016 and will contain a clear explanation of how the interest was calculated.

12. In two instances, the Company failed to include the appropriate interest on a claim paid beyond 30 days from date of death. Interest is due from the date of death through the date of payment. Of the two instances,

12.a. One involved the failure to include the date of death in the calculation of the number of days interest was owed;

12.b. One involved the failure to apply the appropriate interest rate in effect as of the date of death. Between the date of death and the date of payment, the interest rate went down. However, in calculating the interest due, the Company utilized the lower interest rate for the entire period, rather than apply the higher interest rate that was in effect on the date of death and then apply the lower interest rate until the payment was made.

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 that the interest payments were not calculated properly.

To ensure future compliance, the Company advises that, unlike the Accidental Death and Life claims, Annuity claims will continue to be handled by Third Party Administrators. On June 23, 2015, June 24, 2015 and July 2, 2015, the Company conducted thorough refresher training with all claim paying personnel and all Third Party Administrators. In addition, the system utilized to calculate statutory interest was updated on September 1, 2015, such that it now includes the date of death in the computations and also accounts for multiple interest rates if a rate change occurs between the date of death and date of payment.

Further, the Company conducted internal surveys to determine whether additional interest payments were owed to other consumers as described below:

For 12.a, the issue involving the date of death that had been omitted from the interest calculation, the survey included claims that were closed from September 1, 2010 through August 31, 2015. The survey resulted in additional interest payments returned to consumers totaling \$11,927.44.

For 12.b, the issue involving the interest rate that was improperly calculated, the survey included the period of time during which settlements may have been affected by the miscalculation. The survey resulted in additional interest payments returned to consumers totaling \$2,883.73.