

**[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**

**FIDELITY SECURITY LIFE INSURANCE COMPANY
NAIC # 71870 CDI # 2227-7**

AS OF MARCH 31, 2014

ADOPTED MAY 4, 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



May 4, 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:

**Fidelity Security Life Insurance Company
NAIC # 71870**

Group NAIC # 0451

Hereinafter, the Company listed above also will be referred to as FSLIC 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 Accident and Disability, Life, and Annuity claims closed during the period from April 1, 2013 through March 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.

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’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 from April 1, 2013 through March 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 claims files was conducted at the offices of the Company in Kansas City, Missouri.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Accident and Disability, Life, and Annuity claims reviewed were closed from period from April 1, 2013 through March 31, 2014, referred to as the “review period”. The examiners randomly selected 246 FSLIC claims files for examination. The examiners cited 51 alleged violations of the California Insurance Code and the California Code of Regulations (CCR) from this sample file review.

Findings of this examination included the failure to reference the California Department of Insurance in a claim denial; the failure to provide the claimant with a clear explanation of the computation of benefits; and the failure to provide the legal basis, including reference to applicable laws or policy provisions, for the denial of a claim.

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

The review of market analysis information and consumer complaints identified no specific areas of concern.

The previous claims examination reviewed a period from March 1, 2007 through February 29, 2008. The previous examination report cited the Company's failure to reference the California Department of Insurance in a claim denial. This issue was also identified as problematic in the current examination.

The Company was not the subject of any prior enforcement action by the California Department of Insurance.

DETAILS OF THE CURRENT EXAMINATION

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

FSLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Short Term Disability Income Individual & Group	169	64	15
Accident and Disability / Short Term Disability Income Individual & Group / Rescission	15	6	0
Accident and Disability / Dental & Vision / Group	207,555	70	22
Accident and Disability / Specified Disease / Cancer Individual & Group	234	35	10
Accident and Disability / Hospital Indemnity / Group	712	35	0
Life Insurance / Term Life and Whole Life Individual & Group	73	35	4
Annuity	1	1	0
TOTALS →	208,744	246	51

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	FSLIC Number of Alleged Violations
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 all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	22
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of the computation of benefits.	11
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions.	6
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	3
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.	3
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(a) *[CIC §790.03(h)(5)]	The Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability.	1
CIC §10172.5(c) *[CIC §790.03(h)(3)]	The Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit.	1
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days	1
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	1
Total Number of Alleged Violations		51

***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.
- 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

ACCIDENT AND DISABILITY 2013 Written Premium: \$ 46,674,776	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$271.97	
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	22
CCR §2695.11(b) [CIC §790.03(h)(3)]	11
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	6
CIC §790.03(h)(1)	3
CCR §2695.7(g) [CIC §790.03(h)(5)]	3
CIC §10111.2(a) [CIC §790.03(h)(5)]	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
SUBTOTAL	47

LIFE 2013 Written Premium: \$1,041,045	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$272.42	
CIC §10172.5(a) [CIC §790.03(h)(5)]	2
CIC §10172.5(c) [CIC §790.03(h)(3)]	1
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	1
SUBTOTAL	4

ANNUITY 2013 Written Premium: \$853,925	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$0	
SUBTOTAL	0

TOTAL	51
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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 \$271.97 as described in section number 5 below. Following the findings of the examination, a closed claim survey as described in section 8 below was conducted by the Company resulting in additional payments of \$272.42, including additional payments for the instances identified in the examination. Therefore, as a result of the examination, the total amount of money returned to claimants within the scope of this report was \$544.39.

ACCIDENT AND DISABILITY

1. **In 22 instances, the Company failed to include a statement in its claim denial that, if the claimant believes all or part of 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 Company's Response: The Company acknowledges this issue. The Company sent out a compliance bulletin ("CB") to all Third Party Administrators (TPAs) instructing the TPAs to include the mandated language cited in CCR §2695.7(b)(3), including the address and telephone number of the California Department of Insurance Consumer Services unit. This CB is updated whenever a

state adds or amends mandated language. The current version of the CB, GN14-008, continues to include the California mandated language. Since this particular TPA was not complying with the CB, and as a result of the findings in this examination, the Company re-issued the above CB immediately advising all TPAs to advise providers that the provider may seek a review by the California Department of Insurance.

2. In 11 instances, the Company failed to provide a clear explanation of the computation of benefits. In all identified instances, the Explanation of Benefits (EOB) sent to the insured does not provide a clear explanation of the computation of benefits. Specifically, in seven of the instances, the reduction of benefits by 50% for an illness that begins after the age of 65 is not explained. In two instances, the EOBs do not explain the Company's computation for determining the benefit for a procedure not listed in the policy. In one instance, the deduction for taxes is not identified and is not explained on the EOB. In the final instance, the EOB does not explain the determination for payment of the minimum benefit. 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 the findings in all instances. To correct the errors identified in the seven instances, the Company added a remark code E0 (Benefits are reduced 50% at age 65) that now clarifies the benefit payment.

In two instances, the Company added a new remark code to be used when processing a claim for a surgical procedure not listed in the Policy. The new remark code states the following:

This procedure is not listed under the Schedule of Operations in your Policy, therefore a procedure in the 1964 California Relative Value Schedule or a comparable procedure was used. The procedure's Relative Unit Value was multiplied by the Surgical Conversion Factor in your Policy to determine the benefit (benefits may reduce at certain ages).

In one instance, the Company agrees the EOB does not provide a clear explanation of the computation of the benefits in regard to the FICA tax. As a result of this examination, the Company immediately added a remark code to advise the insured that FICA taxes have been withheld. In addition, the Company instructed its claim examiners to add a message to the "Memo" field of the EOB advising that the FICA tax was withheld.

In the final instance, the examiner's judgment was to pay the minimum benefit rather than pend the claim until itemized bills were received. The Company examiner should have sent a letter explaining the rationale behind paying the minimum benefit and asking for itemized bills. As a result of this finding, the Company re-opened the

claim and sent a letter of explanation to the insured. Additionally, the insured was contacted by telephone and the Company explained the need for the itemized bills in order to fully compensate the insured.

3. In six instances, the Company failed to provide in its written denial a reference to and an explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. In three of the instances, the rescission letter does not provide the applicable law, policy provision, and an explanation of such provision for the rescission of the policy and for the denial of the claims submitted by the insured. In two instances, the partial denial letter fails to reference the definition of total disability, fails to explain the reason benefits were not approved beyond a certain date, and fails to explain the specific findings of the independent medical review. In one instance, the Company received a facsimile from the claimant's treating physician placing the claimant on seven weeks of total disability. The Company allowed six weeks of disability and verbally advised the claimant of the reduction; however, it failed to send a partial denial letter explaining the reason one week was disallowed. 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 acknowledges the findings in all instances. To correct the error identified in three of the instances, the Company now references the Entire Contract - Changes provision of the policy along with an explanation of the provision in its rescission and denial letters.

To correct the error identified in two of the instances, the Company implemented procedures effective mid-2013 to reference the policy definition of total disability and other applicable policy provisions when benefits are being denied. Additionally, specific information will be included in denial letters to substantiate and explain why benefits are not approved.

To correct the error identified in one instance, the Company sent a partial denial letter to the claimant that explained the reason one week of total disability was disallowed. While it is the Company's normal procedure to send a written denial whenever benefits are denied, the Company discussed the procedure with the individual claims examiner in this instance and with all claims staff regarding adherence to the procedure.

4. In three instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. Specifically, when a claim is submitted to the Company within the two year contestability period, a letter is sent to the named insured stating the Company must conduct a medical history investigation. The letter includes a specimen copy of the policy which provides details of the provisions and limitations of the coverage; however, the letter does not explain the pertinent fact that the Company is conducting an investigation that could result in the rescission of the policy. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: As a result of this examination, the Company changed the wording in the initial claim letter to the insured explaining that the medical investigation could result in the rescission of the policy. The letter now states the following:

Because you have filed a claim within the first 2 years of coverage it is necessary to perform a medical history investigation which may result in the rescission of your policy. Please provide the following information within 15 calendar days from the date of this letter.

5. In three instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Specifically, the Company miscalculated the period of disability by one day which resulted in an underpayment of benefits. 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 agrees with these findings. As a result of the examination, the Company issued payments to the three identified policyholders totaling \$271.97, including statutory interest. The Company counseled the claim representative associated with these claims and provided further instruction on the computation of disability payments.

6. In one instance, the Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability. The Department alleges this act is in violation of CIC §10111.2(a) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees the benefit payment was not made within 30 calendar days from the receipt of information. The payment that was to be issued on February 27, 2014, was not issued. The payment was subsequently issued with statutory interest on May 9, 2014, prior to commencement of this examination. The claims examiner received additional training on the system's "special pricing" procedures.

7. In one instance, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. In this instance, the Company was notified of the claim approximately two years post-loss after the deceased insured's brother discovered the policy. Specifically, the Company failed to conduct an investigation of the insured's legal capacity, as provided by the exception in the proof of loss clause in the policy. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this finding. In an effort to correct this error, the Company re-opened the claim and contacted the insured's brother to inform him the claim was being re-opened for

evaluation. The Company sent a letter to the policyholder's brother requesting the necessary documentation and followed up with multiple telephone calls and certified letters to the insured's brother over a four month period. The Company sent a third and final letter on October 10, 2014, advising the insured's brother the file would be closed if no response within 30 days. No response was received and the Company closed the file after 30 days.

LIFE

8. 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).

Summary of the Company's Response: The Company states its position, in all situations, is to pay interest based on the state of residency at the time of the named insured's death as verified on the death certificate. The Company's research does not find any California statutes or regulations that require the Company to pay interest to a claimant if the insured is a non-resident of California at the time of death. While California Insurance Code section 10172.5 provides for the payment of interest on death claims from the date of death to the payment date, it does not require California interest to be paid on non-California residents' claims where the policy was originally issued in California.

Nonetheless, in an effort to resolve the issue, the Company has created a new procedure as follows:

For policies that originated in California when the policyholder lived and worked in California:

- Insured was a resident of California at time of death (or presumed a resident of California) - Apply California Interest Regulations per CIC § 10172.5.
- Insured was a resident of another state at time of death – Apply California Interest Regulations per CIC § 10172.5.

To address past harm, the Company conducted an internal survey of all California life claims paid between January 1, 2012 and December 31, 2014, to determine if interest was owed and paid. If interest was paid, the Company used its new interest procedures outlined above to determine if there was an underpayment due to the Company's procedure to use another state's insurance law. The Company completed the survey and reported the results to the Department on January 9, 2015. The documentation provided to the

Department shows the Company reviewed 257 life claims in the survey and found a total of five claims with an underpayment of interest that exceeded \$5.00. A total of \$272.42 was paid to the beneficiaries of these five claims including the two instances identified in the examination.

9. In one instance, the Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit. The Department alleges this act is in violation of CIC §10172.5(c) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the interest rate should have been included in the memo section of the Explanation of Benefits. The Company reviewed this with the claims examiner to ensure this is not an issue in the future.

10. In one instance, the Company failed to acknowledge notice of 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 agrees that the acknowledgment letter was not sent within 15 calendar days. The letter was sent on the 13th business day following receipt of the claim. As a result of this finding, the Company reviewed the required practices and procedure with the examiner.

ANNUITY

There were no violations alleged or criticisms of insurer practices in this line of business within the scope of this report.