

**[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**

**PAVONIA LIFE INSURANCE COMPANY OF MICHIGAN
NAIC # 93777 CDI # 3272-5**

AS OF OCTOBER 31, 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.

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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



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:

Pavonia Life Insurance Company of Michigan
NAIC # 93777
Group NAIC # 4725

Hereinafter, the Company listed above also will be referred to as PLICOM 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 Term Life, Credit Life and Credit Disability claims closed during the period from November 1, 2013 through October 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 November 1, 2013 through October 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 California Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Term Life, Credit Life and Credit Disability claims reviewed were closed from November 1, 2013 through October 31, 2014, referred to as the “review period”. The examiners randomly selected 96 PLICOM claims files for examination. The examiners cited 80 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 include the California fraud warning on beneficiary and claimant statement claim forms; a failure to notify the beneficiary of the specified rate of interest paid on the death benefit; and a failure to provide an explanation of benefits and/or a clear explanation of the computation of benefits.

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

The results of the market analysis review revealed that during 2010 and 2013, enforcement actions were taken in the states of Virginia and Maryland respectively. The market analysis showed the Company was fined \$20,000.00 in the state of Virginia for claims handling and unfair insurance practice violations on May 22, 2013. The market analysis also showed the Company was fined \$33,000.00 in the state of Maryland as a result of a market conduct examination on November 16, 2010.

The Company was the subject of one California consumer complaint and inquiry closed from November 1, 2013 through October 31, 2014, in regard to the lines of business reviewed in this examination. The CDI alleged one violation of law including an unsatisfactory settlement offer. The CDI determined the complaint was not justified.

The previous market conduct examination reviewed the period from October 16, 2009 through October 15, 2010. The most significant noncompliance issue identified in the previous examination report and within the scope of this report was the Company's failure to include the California fraud warning on insurance forms and failure to notify the beneficiary of the specified rate of interest paid on the death benefits. These issues were identified as problematic in the current examination. The prior examination was conducted under the Company's former legal name of "Household Life Insurance Company". The Company changed its legal name to Pavonia Life Insurance Company of Michigan effective October 29, 2013.

PLICOM has not been the subject of a prior CDI enforcement action.

DETAILS OF THE CURRENT EXAMINATION

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

PLICOM SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Credit Disability	132	45	28
Life /Group Credit Life	67	34	27
Life / Individual Term Life	23	17	25
TOTALS	222	96	80

TABLE OF TOTAL ALLEGED VIOLATIONS

Citations	Description of Allegation	PLICOM Number of Alleged Violations
CIC §1879.2(a) *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance forms	25
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.	22
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide an explanation of benefits.	15
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of the computation of benefits.	7
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time or information every 30 calendar days.	5
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.	2
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)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	1
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.	1
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed to begin investigation of the claim within 15 calendar days.	1
Total Number of Alleged Violations		80

***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

ACCIDENT AND DISABILITY 2014 Written Premium: \$550,166	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$1,905.00	
CCR §2695.11(b) [CIC §790.03(h)(13)]	15
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	5
CIC §1879.2(a) [CIC §790.03(h)(3)]	5
CCR §2695.3(a) [CIC §790.03(h)(3)]	1
CIC §790.03(h)(5)	1
CIC §790.03(h)(1)	1
SUBTOTAL	28

LIFE 2014 Written Premium: \$4,801,975	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$429.29	
CIC §10172.5(c) [CIC §790.03(h)(3)]	22
CIC §1879.2(a) [CIC §790.03(h)(3)]	20
CCR §2695.11(b) [CIC §790.03(h)(3)]	7
CIC §10172.5(a) [CIC §790.03(h)(5)]	1
CCR §2695.3(a) [CIC §790.03(h)(3)]	1
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	1
SUBTOTAL	52

TOTAL	80
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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 \$2,334.29 as described in section numbers 5 and 10 below.

ACCIDENT AND DISABILITY

1. In 15 instances, the Company failed to provide an explanation of benefits.

In 12 instances, the Company failed to issue an explanation of benefit (EOB) notice to the claimants on credit disability payments. In the remaining three instances, the notices failed to specify the maximum amount of benefits that were paid under the credit disability policies. 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 and states that its procedure is to issue an explanation letter when benefits are initially approved, and when benefits are due to end. As a result of the Department's findings, the Company has amended its process and will transmit payment notices with each monthly payment, with a clear explanation of the amount of payment and the benefit period covered. The benefit letter will also be revised to inform claimants of the amount of benefits paid when the maximum benefit coverage is reached. The first stage of enhancements to allow multiple system reminders with each payment was completed November 20, 2015. The Company states the new template settlement letter/text is scheduled for implementation January 2016. The Company also states it will continue to provide a full payment history to a claimant upon request.

2. In five 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 timely status letters within regulatory guidelines on credit disability claims. 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 understands that continuing disability benefits may extend beyond the anticipated end period. As a result of the examination, the Company will send disability claim forms and a request for evidence of continued disability at least 30 days prior to the end of the scheduled disability period. Prior to claim closure, another 30-day follow-up letter will be sent to ensure no additional claims will be made. The Company anticipates implementation of these changes effective January 2016.

3. In five instances, the Company failed to include the California fraud warning on insurance forms.

The Company failed to include the California fraud warning on credit disability insurance claim forms. The Department alleges these acts are in violation of CIC §1879.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings. The Company states there were changes to the systems workflow which inadvertently circumvented the system's ability to recognize and apply certain state-required language on claim forms. The Company further states this issue was self-disclosed to the Department prior to the commencement of the field claims examination.

The Company implemented a procedural change on November 24, 2014 to ensure the California fraud language is included on all claim forms provided to claimants and beneficiaries.

4. **In one instance, 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 this instance, the claimant's statement and the Attending Physician's Statement were missing from the claim file. The Department alleges this act is in violation of CCR §2695.3(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the finding and believes this was an isolated incident due to a misfiling of the forms. The Company has addressed this matter with pertinent staff for reinforcement.

5. **In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** In one instance, the Company discontinued credit disability benefits when it misapplied a maximum benefit amount. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the finding and has contacted the insured's creditors to reinstate coverage. As a result of the examination, additional credit disability benefit payments were issued in the amount of \$1,905.00.

6. **In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.** The Company misrepresented to the claimant that the maximum amount of benefits was paid and exhausted on a credit disability contract when the policy did not contain a maximum benefit amount provision. The Department alleges this act is in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges the finding and agrees that its claims handler inaccurately terminated benefits when there was no maximum benefit amount limit. This matter has been resolved as the Company has made additional settlement to the creditor and claimant and benefits have already resumed.

LIFE

7. **In 22 instances, the Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit.** The Company failed to disclose to the beneficiaries the specific rate of interest that the Company applied to the settlement proceeds. 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 the findings. The Company discovered that procedures for its manually-generated settlement letters were not updated to comply with the requirements of this statute. The Company indicates that this issue came up in a separate CDI audit, thus it has self-disclosed this matter prior to the commencement of the field claims examination. On November 20, 2014, procedures were revised and claims staff received reinforcement training. Effective July 2, 2015, the Company also implemented a senior level secondary review and sign-off process to ensure manual life benefit letters will specify the rate of interest paid on death claim settlements.

8. In 20 instances, the Company failed to include the California fraud warning on insurance forms. The Company failed to include the fraud warning on its term life claim forms and credit life forms. The Department alleges these acts are in violation of CIC §1879.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges these findings. The Company states there were changes to the systems workflow which inadvertently circumvented the system's ability to recognize and apply certain state-required language on claim forms. The Company further states this issue was self-disclosed to the Department prior to the commencement of the field claims examination. The Company implemented a procedural change on November 24, 2014 to ensure the California fraud language is included on all claim forms provided to claimants and beneficiaries.

9. In seven instances, the Company failed to provide a clear explanation of the computation of benefits. The Company failed to explain how death benefits were calculated in instances wherein an amount less than the maximum allowable amount of insurance were paid under a credit life insurance claim. The benefit provision states that the amount of life insurance will be a percentage of the scheduled unpaid balance of the loan on the date of the borrower's death. However, the Company failed to explain the calculation for the eligible percentage amount in its Explanation of Benefit (EOB). 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 and indicates that its procedure is to refer claimants to their insurance certificate for a definition of the liability and payable benefits. As a result of the examination, the Company has revised its credit life benefit letter to explain the calculation of benefits in these instances. The Company implemented the new template letter on May 27, 2015.

10. In one instance, 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 include interest on a credit life claim settlement when proceeds were unpaid longer

than 30 days after the date of death. The Department alleges this act is in violation of CIC §10172.5(a) and is an unfair practice under CIC §790.03(h)(5)

Summary of the Company's Response: The Company acknowledges the finding and states that this was an inadvertent adjuster error when interest was miscalculated from the date of proof of loss. The Company has addressed this matter with pertinent staff to reinforce the requirement to pay interest from the date of death. As a result of this examination, the Company reopened the claim and issued additional interest owed to the beneficiary for \$429.29.

11. In one instance, 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. A claim file revealed a conflict among the beneficiaries on the distribution of life settlement proceeds. In this instance, the Company failed to produce an official signed copy of a beneficiary change request form allegedly submitted online by the insured. The Department alleges this act is in violation of CCR §2695.3(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states that beneficiary changes were previously allowed through its secure self-service website. The Company believes it has provided evidence of an electronic system record as the beneficiary change was completed online and documented. This documentation is an internal electronic entry on the Company's system. The Company is however unable to produce a signed copy of the change of beneficiary form from the insured, or the actual online submission for the change in beneficiary request.

This practice was terminated in March 2013. The Company has revised its practice of accepting online change of beneficiary designation requests and now requires beneficiary changes to be submitted in paper format which is retained with the policy file.

12. In one instance, the Company failed to begin investigation of the claim within 15 calendar days. The Company failed to begin its contestable death investigation of a term life insurance claim within regulatory guidelines. The Department alleges this act is in violation of CCR §2695.5(e)(3) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges this finding. The Company indicates that it was aware of the deficiencies during the summer of 2013 following a decrease in staffing and a simultaneous change in its workflow management system. The Company has since hired an additional life insurance examiner to address this compliance issue.