

1 CALIFORNIA DEPARTMENT OF INSURANCE
2 LEGAL DIVISION

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9 California Department of Insurance

10 **BEFORE THE INSURANCE COMMISSIONER**
11 **OF THE STATE OF CALIFORNIA**
12 **SAN FRANCISCO**

13 In the Matter of the Certificate of Authority
14 of:

15 GLOBE LIFE and ACCIDENT
16 INSURANCE COMPANY;
17 AMERICAN INCOME LIFE INSURANCE
18 COMPANY;
19 LIBERTY NATIONAL LIFE INSURANCE
20 COMPANY;
21 UNITED AMERICAN INSURANCE
22 COMPANY;
23 UNITED INVESTORS LIFE INSURANCE
24 COMPANY,

25 Respondents.

CDI File No. UPA-2008-00017

ORDER TO SHOW CAUSE
(Insurance Code §§ 790.03, 790.05, and
790.06, and California Code of Regulations,
Title 10, Chapter 5, §§ 2695.1 et seq.);

ACCUSATION
(Insurance Code §§ 704, 790.02, 790.03,
790.05, 790.06, 1879.2, 10111.2(c), 10172.5,
10198.7(a), 10232.92, 10232.95, and California
Code of Regulations, Title 10, Chapter 5, §§
2695.1 et seq.);

NOTICE OF NONCOMPLIANCE AND
HEARING
(Insurance Code §§ 704, 790.02, 790.03,
790.05, 790.06, 1879.2, 10111.2(c), 10172.5,
10198.7(a), 10232.92, 10232.95, and California
Code of Regulations, Title 10, Chapter 5, §§
2695.1 et seq.);

DEMAND
(Insurance Code §§ 704, 790.035, 790.08,
10234.2, 10234.3, 10234.4, and 12976).

1 The Insurance Commissioner of the State of California ("Commissioner") in his official
2 capacity alleges that:

3 **JURISDICTION AND PARTIES**

4 1. Respondent, GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
5 ("GLOBE"), domiciled in Nebraska, holds a Certificate of Authority to transact the business of
6 life and disability insurance in the State of California, pursuant to § 700 et seq. of the California
7 Insurance Code¹; and,

9 2. Respondent, AMERICAN INCOME LIFE INSURANCE COMPANY
10 ("AMERICAN INCOME"), domiciled in Indiana, holds a Certificate of Authority to transact the
11 business of life and disability insurance in the State of California, pursuant to § 700 et seq. of the
12 California Insurance Code; and,

14 3. Respondent, LIBERTY NATIONAL LIFE INSURANCE COMPANY
15 ("LIBERTY"), domiciled in Nebraska, holds a Certificate of Authority to transact the business of
16 life and disability insurance in the State of California, pursuant to § 700 et seq. of the California
17 Insurance Code; and,

18 4. Respondent, UNITED AMERICAN INSURANCE COMPANY ("UNITED
19 AMERICAN"), domiciled in Nebraska, holds a Certificate of Authority to transact the business of
20 life and disability insurance in the State of California, pursuant to § 700 et seq. of the California
21 Insurance Code; and,

23 5. Respondent, UNITED INVESTORS LIFE INSURANCE COMPANY ("UNITED
24 INVESTORS"), domiciled in Nebraska, holds a Certificate of Authority to transact the business
25 of life and disability insurance in the State of California, pursuant to § 700 et seq. of the
26 California Insurance Code; and,

28 _____
¹ Unless otherwise stated, all references are to the California Insurance Code.

1 6. GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and
2 UNITED INVESTORS are or were, during the relevant time period, principal subsidiaries of
3 TORCHMARK CORPORATION, a holding company incorporated in Delaware (collectively
4 “TORCHMARK COMPANIES”).
5

6 7. On or about September, 2006, the California Department of Insurance’s
7 (“Department”) Field Claims Bureau commenced a Market Conduct examination of the claims
8 practices and procedures in California of GLOBE, AMERICAN INCOME, LIBERTY, UNITED
9 AMERICAN and UNITED INVESTORS, pursuant to California Insurance Code §§ 730, 733 and
10 735.5, to determine whether the TORCHMARK COMPANIES’ denial of claims and claims
11 handling practices during the period from July 16, 2005 to July 15, 2006 conformed to its
12 contractual obligations and applicable law. The examination occurred at the offices of the
13 TORCHMARK COMPANIES in Oklahoma City, Oklahoma, McKinney, Texas, and Waco,
14 Texas. The investigation included an examination of claims files and related records involving
15 Individual and Group disability insurance products, including Medicare Supplements, Cancer,
16 Individual and Group life insurance products, including annuities; and
17 and Long-Term Care, and Individual and Group life insurance products, including annuities; and
18 an examination of the companies’ guidelines, policies and procedures, training plans, and forms
19 adopted by the companies for use in California.
20

21 8. The Department’s Public Report of the Market Conduct Examination As of July
22 15, 2006 stated the manner and extent to which GLOBE, AMERICAN INCOME, LIBERTY,
23 UNITED AMERICAN, and UNITED INVESTORS’ noncompliance with Insurance Code
24 §790.03 and California Code of Regulations, title 10, §§ 2695.1 et seq. (attached hereto as Exhibit
25 1) is alleged, and specified a reasonable time thereafter in which such noncompliance may be
26 corrected.
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1 9. The Department's Report of the Market Conduct Examination As of July 15, 2006
2 stated the manner and extent to which GLOBE, AMERICAN INCOME, LIBERTY, UNITED
3 AMERICAN, and UNITED INVESTORS' noncompliance with violations of laws other than
4 § 790.03 and California Code of Regulations, title 10, §§ 2695.1 et seq. is alleged (attached hereto
5 as Exhibit 2), and specified a reasonable time thereafter in which such noncompliance may be
6 corrected.
7

8 10. The Department's Claims Services Bureau has also undertaken an investigation of
9 consumer complaints involving the TORCHMARK COMPANIES, pursuant to California
10 Insurance Code §§ 735.5 and 12919, reviewed by the Department between July 16, 2005 and July
11 16, 2006, regarding claims handling for the lines of business covered in the examination reports
12 As of July 15, 2006.
13

14 11. The Department's Field Claims Bureau had previously conducted an examination
15 of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and UNITED
16 INVESTORS regarding its claims practices and procedures in California during the period of
17 April 1, 2001 through March 31, 2002. The examination was conducted in company offices in
18 Oklahoma City, Oklahoma and Waco, Texas. The Department's reports of the previous
19 examination, denominated As of March 31, 2002, detailed the manner and extent to which
20 GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and UNITED
21 INVESTORS' noncompliance with Insurance Code § 790.03 and California Code of Regulations,
22 title 10, §§2695.1 et seq. (attached hereto as Exhibit 3), and other provisions of the Insurance
23 Code (attached hereto as Exhibit 4), is alleged. The previous examination covered the same lines
24 of business as the subsequent examination in the Department's reports denominated As of July
25 15, 2006.
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1 12. California Insurance Code § 700(c) provides that, after the issuance of a certificate
2 of authority, the holder must continue to comply with all requirements set forth in the Insurance
3 Code and all other applicable laws of this State.

4 13. California Insurance Code § 704(b) provides that the Commissioner may suspend
5 an insurer's certificate of authority, after hearing, for not carrying out its contracts in good faith.
6

7 14. California Insurance Code § 704(c) provides that the Commissioner may suspend
8 an insurer's certificate of authority for a period not exceeding one year, after hearing, for
9 habitually and as a matter of ordinary practice and custom compelling claimants to either accept
10 less than the amount due under terms of the policies or resort to litigation against such insurer to
11 secure the payment of the amount due.

12 15. California Insurance Code §§ 730, 733, 734, and 790.04 authorize the
13 Commissioner access to all records of an insurer and the power to examine the affairs of every
14 person engaged in the business of insurance to determine if such person violated certain
15 provisions of the Insurance Code.
16

17 16. California Insurance Code § 790.02 prohibits any insurer from engaging in this
18 State "in any trade practice which is ... an unfair method of competition or an unfair or deceptive
19 act or practice in the business of insurance."
20

21 17. California Insurance Code § 790.03 defines unfair methods of competition and
22 unfair and deceptive acts or practices in the business of insurance. Section 790.03(h) enumerates
23 sixteen (16) claims settlement practices that, when either knowingly committed on a single
24 occasion, or performed with such frequency as to indicate a general business practice, are
25 considered to be unfair claims settlement practices, and are thus prohibited.

26 18. California Insurance Code §790.03(e) prohibits any insurer from making a false
27 statement with intent to deceive any examiner or any public official who has authority to examine
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1 into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material
2 fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

3 19. California Insurance Code § 790.035 provides that any person who engages in any
4 unfair method of competition or any unfair or deceptive act or practice defined in § 790.03 is
5 liable to the state for a civil penalty not to exceed five thousand dollars (\$5,000) for each act, or,
6 if the act or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for
7 each act. The commissioner shall have the discretion to establish what constitutes an act.

9 20. California Insurance Code § 790.06 provides for the prosecution of unfair methods
10 of competition and unfair and deceptive acts or practices in the business of insurance that are not
11 defined in §790.03.

12 21. California Insurance Code § 790.08 states that "The powers vested in the
13 commissioner in this article shall be additional to any other powers to enforce any penalties, fines
14 or forfeitures, denials, suspensions or revocation of licenses or certificates authorized by law with
15 respect to the methods, acts and practices hereby declared to be unfair or deceptive."

17 22. California Insurance Code § 1879.2 requires an insurer to include a statutory fraud
18 warning on its insurance claims forms.

19 23. California Insurance Code § 10111.2(c) requires that "When the insurer has
20 received all information needed to determine liability for a claim, and the insurer determines that
21 liability exists and fails to make payment of benefits to the insured within 30 calendar days after
22 the insurer has received that information, any delayed payment shall bear interest, beginning the
23 31st calendar day, at the rate of 10 percent per year. Liability shall, in all cases, be determined by
24 the insurer within 30 calendar days of receiving all information set out in the insurer's written
25 notification to the insured."
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1 24. California Insurance Code § 10172.5 requires an insurer to pay interest on a claim
2 under any policy of life insurance that remains unpaid longer than 30 days from the date of death
3 of the insured. If interest becomes payable, an insurer is required to notify the named beneficiary
4 that interest will be paid on the proceeds of the policy and the rate of interest.
5

6 25. California Insurance Code § 10198.7(a) prohibits an insurer from excluding
7 coverage on the basis of a preexisting condition provision for a period greater than six months
8 following the individual's effective date of coverage.

9 26. California Insurance Code § 10232.92 requires that all expenses incurred while
10 confined in a residential care facility for long-term care services that are necessary diagnostic,
11 preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance
12 or personal care services needed to assist the insured with the disabling condition shall be covered
13 and payable up to the maximum daily facility benefit of the policy.
14

15 27. California Insurance Code § 10232.95 provides that every long-term care policy
16 that provides reimbursement for care in a nursing facility shall cover and reimburse for per diem
17 expenses, as well as the costs of ancillary supplies and services, up to the maximum lifetime daily
18 facility benefit of the policy.

19 28. California Insurance Code § 10234.2 authorizes the commissioner, in addition to
20 all other powers and remedies vested in the commissioner, to assess administrative penalties for
21 violation of any provision in Chapter 2.6 Long-Term Care Insurance (commencing with § 10231
22 of the Insurance Code). California Insurance Code § 10234.3 provides that any insurer that
23 violates the chapter is liable for an administrative penalty of not less than five thousand dollars
24 (\$5,000) for each first violation and not less than ten thousand dollars (\$10,000) for each
25 subsequent or knowing violation. The penalty for violating this chapter in a manner indicating a
26 general business practice shall reflect the magnitude of the violation against the public interest
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1 and shall be not less than ten thousand dollars (\$10,000) and not more than five hundred thousand
2 dollars (\$500,000).

3 29. California Insurance Code § 10234.4 provides that, upon determination of a
4 violation of this chapter, in addition to the assessment of penalties and other applicable remedies,
5 the commissioner may suspend an insurer's certificate of authority to transact disability insurance
6 and/or order the insurer to cease marketing a particular policy form of long-term care insurance or
7 any long-term care insurance.
8

9 30. California Code of Regulations ("CCR"), title 10, chapter 5, subchapter 7.5,
10 Article I contains Fair Claims Settlement Practices Regulations "to promote the good faith,
11 prompt, efficient and equitable settlement of claims." These regulations delineate certain
12 minimum standards for the settlement of claims which, when violated knowingly on a single
13 occasion or performed with such frequency as to indicate a general business practice, shall
14 constitute an unfair claims settlement practice within the meaning of Insurance Code § 790.03(h).
15 Other acts or practices not specifically delineated in this set of regulations may also be unfair
16 claims settlement practices subject to Insurance Code § 790.03. All licensees are required to have
17 thorough knowledge of such regulations.
18

19 31. California Code of Regulations, title 10, § 2695.1(f), provides that "Policy
20 provisions relating to the investigation, processing and settlement of claims shall be consistent
21 with or more favorable to the insured than the provisions of these regulations."
22

23 32. California Code of Regulations, title 10, § 2695.3(a) requires an insurer to
24 maintain in its claim files "all documents, notes, work papers (including copies of all
25 correspondence) which reasonably pertain to each claim in such detail that pertinent events and
26 the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can
27 be determined."
28

1 33. California Code of Regulations, title 10, § 2695.3(b)(1) requires an insurer to
2 maintain claim data that are accessible, legible, and retrievable for examination so that an insurer
3 shall be able to provide the claim number, line of coverage, date of loss and date of payment of
4 the claim, date of acceptance, denial or date closed without payment.

5 34. California Code of Regulations, title 10, § 2695.4(a) requires an insurer to disclose
6 all benefits, coverage, time limits or other provisions of the insurance policy that may apply to the
7 claim presented by the insured.

8 35. California Code of Regulations, title 10, § 2695.5(b) requires an insurer to respond
9 to any communication from a claimant regarding a claim within fifteen (15) calendar days after
10 receipt of the communication, furnishing the claimant with a complete response.

11 36. California Code of Regulations, title 10, § 2695.5(e)(2) requires an insurer, upon
12 receiving notice of a claim, to immediately, but in no event more than fifteen (15) calendar days
13 later, provide the insured with necessary forms, instructions, and reasonable assistance.

14 37. California Code of Regulations, title 10, § 2695.6(b) requires all insurers to
15 “provide thorough and adequate training regarding the regulations to all their claims agents” and
16 requires annual certification of such training.

17 38. California Code of Regulations, title 10, § 2695.7(b) requires an insurer to accept
18 or deny the claim within forty (40) calendar days upon receiving proof of claim.

19 39. California Code of Regulations, title 10, § 2695.7(b)(1) requires an insurer to
20 provide, in writing, the reasons for denial of a claim and the factual and legal basis for each
21 reason.

22 40. California Code of Regulations, title 10, § 2695.7(b)(3) requires an insurer to
23 include a statement in its claim denial that, if the claimant believes all or part of the claim has
24 been wrongfully denied or rejected, he or she may have the matter reviewed by the California
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1 Department of Insurance, and shall include the address and telephone number of the unit of the
2 Department which reviews claims practices.

3 41. California Code of Regulations, title 10, § 2695.7(c)(1) requires an insurer, if more
4 time is required to make a claim determination than allotted in §2695.7(b), to provide written
5 notice of the need for additional time specifying any additional information the insurer requires to
6 make a determination and state any continuing reasons for its inability to make a determination.
7 Thereafter, the written notice shall be provided every thirty (30) calendar days until a
8 determination is made.

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10 42. California Code of Regulations, title 10, § 2695.7(d) provides that every insurer
11 must conduct and diligently pursue a thorough, fair and objective investigation and shall not
12 persist in seeking information not reasonably required or material to the resolution of a claim
13 dispute.

14
15 43. California Code of Regulations, title 10, § 2695.7(g) prohibits an insurer from
16 attempting to settle a claim by making a settlement offer that is unreasonably low.

17 44. California Code of Regulations, title 10, § 2695.7(h) requires an insurer, upon
18 acceptance of the claim, to tender payment within thirty (30) calendar days.

19 45. California Code of Regulations, title 10, § 2695.11(b) requires an insurer to
20 provide a clear explanation of the computation of benefits.

21
22 **FACTUAL ALLEGATIONS**

23 46. On or about September 2006, the Department conducted a Market Conduct
24 examination of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and
25 UNITED INVESTORS' claims handling practices during the period of July 16, 2005 to July 15,
26 2006. The examination focused primarily on whether the TORCHMARK COMPANIES' claims
27 handling and claims settlement practices were effectuated promptly, fairly, and equitably, in
28

1 conformance with contractual obligations and California law. The Department's examination
2 reports As of July 15, 2006 stated the manner and extent of alleged noncompliance.

3 47. On or about June 2002, the Department had previously commenced a Market
4 Conduct examination of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN,
5 and UNITED INVESTORS' claims handling practices during the period of April 1, 2001 through
6 March 31, 2002. The examination focused primarily on whether the Companies' claims handling
7 and claims settlement practices were effectuated promptly, fairly, and equitably, in conformance
8 with contractual obligations and California law. The Department's examination reports As of
9 March 31, 2002 stated the manner and extent of alleged noncompliance. The examination
10 covered the same lines of business as covered in the Department's subsequent examination report
11 As of July 15, 2006.
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14 48. During the Market Conduct examination As of July 15, 2006, the examiners
15 reviewed six hundred seventy-four (674) claims files of the TORCHMARK COMPANIES
16 involving Individual and Group disability insurance products, including Medicare Supplements,
17 Cancer, and Long-Term Care, and Individual and Group life insurance products, including
18 annuities.

19 49. Based on the examination, the Department alleged that GLOBE, AMERICAN
20 INCOME, LIBERTY, UNITED AMERICAN, and UNITED INVESTORS engaged in the
21 following six hundred ninety-seven (697) unfair or deceptive acts or practices, in violation of
22 California Insurance Code § 790.03 and/or the Fair Claims Settlement Practices Regulations, as
23 more fully described in the Market Conduct Reports as of July 15, 2006 (Exhibits 1 and 2):
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1 benefits, in violation of California Code of Regulations (“CCR”), title 10, § 2695.11(b). As
2 examples of deficiencies, the report cited the failure to identify and explain unpaid invoices, the
3 failure to explain reduction of benefits as a Medicare offset, the failure to clarify maximum
4 benefit limits, and inadequate or mismatched description of benefits and incurred amounts. The
5 deficiencies involved disability and Long-Term Care policies and an annuity contract.
6

7 TORCHMARK COMPANIES were previously cited for such violations in the Department’s
8 Market Conduct examination As Of March 31, 2002. Out of the 130 instances alleged, the
9 violations were allocated, as follows:

- 10 a. The Department alleged that UNITED AMERICAN failed to provide an
11 explanation of benefits with a clear explanation of the computation of
12 benefits in seventy-six (76) instances, in violation of CCR, title 10, §
13 2695.11(b). These alleged violations involved Long-Term Care policies;
14
- 15 b. The Department alleged that AMERICAN INCOME failed to provide an
16 explanation of benefits with a clear explanation of the computation of
17 benefits in fifty-two (52) instances, in violation of CCR, title 10, §
18 2695.11(b);
- 19 c. The Department alleged that GLOBE failed to provide an explanation of
20 benefits with a clear explanation of the computation of benefits in one (1)
21 instance, in violation of CCR, title 10, § 2695.11(b);
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- 23 d. The Department alleged that UNITED INVESTORS failed to provide an
24 explanation of benefits with a clear explanation of the computation of
25 benefits in one (1) instance, in violation of CCR, title 10, § 2695.11(b).

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1 yet the Companies failed to provide a basis for the denial, failed to address the specific charges
2 that were denied and/or failed to send a denial notice to the insured. TORCHMARK
3 COMPANIES were previously cited for violations of CCR, title 10, § 2695.7(b)(1) in the
4 Department's Market Conduct Examination As of March 31, 2002. Out of the 85 instances cited,
5 the alleged violations were allocated, as follows:
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- 7 a. The Department alleged that UNITED AMERICAN failed to provide a
8 written denial of a claim and the factual and legal basis for each reason
9 given for the claim denial in sixty (60) instances, in violation of CCR, title
10 10, § 2695.7(b)(1);
11 b. The Department alleged that AMERICAN INCOME failed to provide a
12 written denial of a claim and the factual and legal basis for each reason
13 given for the claim denial in twenty-three (23) instances, in violation of
14 CCR, title 10, § 2695.7(b)(1);
15 c. The Department alleged that GLOBE failed to provide a written denial of a
16 claim and the factual and legal basis for each reason given for the claim
17 denial in two (2) instances, in violation of CCR, title 10, § 2695.7(b)(1).
18

19 Failure to Effectuate Prompt, Fair and Equitable Settlement of Claims
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21 54. In five (5) instances, the Department alleged that AMERICAN INCOME
22 attempted to settle a claim by making a settlement offer that is unreasonably low despite evidence
23 submitted by the claimant to support the value of the claim, in violation of CCR, title 10,
24 § 2695.7(g). As a general business practice, AMERICAN INCOME unilaterally adopted a
25 practice not to pay for all surgical supplies covered under the insured's policy. Instead of paying
26 customary and reasonable charges for surgical supplies, AMERICAN INCOME limited payments
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1 for surgical dressings and supplies for the day of surgery only, in nonconformance with policy
2 provisions.

3 55. In twenty-seven (27) other instances, the Department alleged that TORCHMARK
4 COMPANIES attempted to settle a claim by making a settlement offer that is unreasonably low
5 despite evidence submitted by the claimant to support the value of the claim, in violation of CCR,
6 title 10, § 2695.7(g). The Companies underpaid and/or failed to pay benefits under Surgical,
7 Cancer, Long-Term Care, and Income Disability policies, as follows:
8

9 a. In seven (7) instances, the Companies failed to pay qualified cancer benefits and
10 defined benefits such as for EKG, hypodermics, drugs, surgical dressings and supplies,
11 and anesthesia;

12 b. In two (2) instances, the Companies failed to pay room charges under Long-Term
13 Care benefits, required by California Insurance Code § 10232.92 and/or § 10232.95. Such
14 violations are subject to additional penalties and remedies, pursuant to California
15 Insurance Code § 10234.2.
16

17 c. In eighteen (18) other instances, the Companies failed to pay maximum limits on
18 EKG and antibiotics, failed to pay physician call charges, underpaid disability benefits,
19 failed to pay eligible benefits such as surgical benefits, anesthesia, laboratory, x-rays, and
20 medicines, failed to apply a Good Risk provision benefit on a cancer policy, and
21 incorrectly bundled benefits for a lower settlement amount. Out of the 27 instances cited,
22 the alleged violations were allocated, as follows:
23

24 (1) The Department alleged that AMERICAN INCOME attempted to settle a
25 claim by making a settlement offer that is unreasonably low in twenty-two (22)
26 instances, in violation of CCR, title 10, § 2695.7(g);
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1 (2) The Department alleged that UNITED AMERICAN attempted to settle a
2 claim by making a settlement offer that is unreasonably low in four (4) instances,
3 in violation of CCR, title 10, § 2695.7(g);

4 (3) The Department alleged that GLOBE in at least one (1) instance attempted
5 to settle a claim by making a settlement offer that is unreasonably low, in violation
6 of CCR, title 10, § 2695.7(g).
7

8 As a result of these findings, the Companies paid an additional \$18,911.28 to policyholders
9 identified in the examination sample files.

10 56. In twenty-six (26) instances, the Department alleged that TORCHMARK
11 COMPANIES failed to effectuate prompt, fair and equitable settlement of claims in which
12 liability had become reasonably clear, in violation of CIC § 790.03(h)(5). As examples,

13 a. In sixteen (16) instances, UNITED AMERICAN unilaterally “re-priced” actual
14 charges and/or discounted charges for healthcare services, including charges for room and
15 board, by ten to twenty percent (10% to 20%) instead of paying reasonable and customary
16 charges as provided by policy provisions, resulting in reduced benefits to policyholders.
17 The Department alleged that TORCHMARK COMPANIES followed a general claims
18 processing practice of discounting charges by the same percentage as discounts it had
19 contracted for in non-insurance programs even though the discounts did not apply to the
20 insurance programs. In other instances, UNITED AMERICAN discounted charges in the
21 same amount as in contracts entered into by third party networks even though
22 TORCHMARK COMPANIES did not have direct contracts with the discounted
23 providers. TORCHMARK COMPANIES did not ensure that policyholders were not
24 responsible for the difference as a result of the discounts.
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1 b. In at least one (1) instance, and alleged as a general business practice,
2 AMERICAN INCOME failed to pay the usual and customary charge for knee prosthetic
3 implants and joint implants. Instead, the company utilized an informal, unverified, and
4 general internet search by an adjuster to come up with a price for the implant, without any
5 quality or suitability verification, rather than utilize standardized published medical data
6 and pricing guidelines. AMERICAN INCOME only paid \$4,050 for a joint implant rather
7 than the charge of \$33,804, without validating the actual cost of the implant device with
8 the correct model number and manufacturer's information.
9

10 c. In at least one (1) instance, AMERICAN INCOME denied payments using an
11 incorrect maximum limit.
12

13 d. In at least one (1) instance, UNITED AMERICAN reduced benefits on a Long-
14 Term Care policy claim for the first 20 days as a Medicare offset, without verifying that
15 Medicare had remitted payment. In this instance, and alleged as a general business
16 practice, UNITED AMERICAN failed to adopt procedures to consistently verify
17 Medicare remittances before reducing benefit payments for skilled nursing facility
18 expenses. Violations of California Insurance Code § 10232.92 and/or § 10232.95 covering
19 Long-Term Care policies are subject to additional penalties and remedies, pursuant to
20 California Insurance Code § 10234.2.
21

22 e. In six (6) other instances, UNITED AMERICAN deemed valid charges ineligible
23 as covered benefits, and delayed the application of premium benefits.

24 f. In at least one (1) instance, GLOBE failed to apply a Good Risk provision benefit
25 under a cancer policy.
26

27 Out of the 26 instances cited, the alleged violations were allocated as follows:
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1 (1) The Department alleged that UNITED AMERICAN failed to attempt in
2 good faith to effectuate prompt, fair and equitable settlements in twenty-
3 three (23) instances, in violation of CIC § 790.03(h)(5);

4 (2) The Department alleged that AMERICAN INCOME failed to attempt in
5 good faith to effectuate prompt, fair and equitable settlements in two (2) instances,
6 in violation of CIC § 790.03(h)(5);

7 (3) The Department alleged that GLOBE failed to attempt in good faith to
8 effectuate prompt, fair and equitable settlements in one (1) instance, in violation of
9 CIC § 790.03(h)(5).
10

11 Failure to Conduct Thorough, Fair, and Objective Investigation

12 57. In five (5) instances, the Department alleged that AMERICAN INCOME failed to
13 conduct and diligently pursue a thorough, fair and objective investigation of a claim, in violation
14 of CCR, title 10, § 2695.7(d). As examples, in three instances, the Company persisted in seeking
15 information from the claimant not reasonably required or material to the resolution of a claim
16 dispute or reasonably known by the claimant. AMERICAN INCOME required the claimants to
17 provide the surgical procedure code; produce verification that the hospital met hospital facilities
18 requirements; and required the claimant to provide the manufacturer and model information on a
19 prosthetic device. In determining payments for prosthetic devices, the Companies utilized an
20 unverified general Internet search for lowest pricing rather than matching models, geographic
21 region or other pertinent search parameters from a published medical database of reasonable and
22 customary charges, thus reducing benefit payments to the insureds.
23

24 Failure to Tender Payment Within Regulatory Requirements

25 58. In two (2) instances, the Department alleged that AMERICAN INCOME failed,
26 upon acceptance of the claim, to tender payment within thirty calendar days, in violation of CCR,
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1 title 10, § 2695.7(h). In two separate instances, the Companies failed to pay hospital confinement
2 benefits and emergency accident benefits within regulatory timeframes. AMERICAN INCOME
3 agreed with the findings and made additional payments to claimants in the amount of \$488.19.

4 Failure to Provide Written Notice of the Need for Additional Time to Make Determination

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6 59. In two (2) instances, the Department alleged that TORCHMARK COMPANIES
7 failed to provide written notice to the claimant/beneficiary, within the specified statutory
8 timeframe, of the need for additional time to determine whether a claim will be accepted or
9 denied, and thereafter every thirty calendar days, and failed to specify any additional information
10 the insurer requires to make a determination and state any continuing reasons for the insurer's
11 inability to make a determination, in violation of CCR, title 10, § 2695.7(c)(1). In one instance,
12 the Company failed to specify any additional information the Company required to make a claim
13 determination or state any continuing reason for its inability to make a determination. In another
14 instance, the Company failed to send a status notice to the life beneficiary stating the reason for a
15 48-day delay in determining coverage. TORCHMARK COMPANIES were previously cited for
16 violations of CCR, title 10, § 2695.7(c)(1) in the Department's Market Conduct Examination As
17 of March 31, 2002. Of the two instances cited, the Department alleged one violation of CCR, title
18 10, § 2695.7(c)(1) each against AMERICAN INCOME and GLOBE.

19
20 Failure to Accept or Deny Claim Within Regulatory Timelines

21
22 60. In one (1) instance, the Department alleged that GLOBE failed to accept or deny
23 the claim within forty (40) days of receiving proof of the claim, in violation of CCR, title 10,
24 §2695.7(b). Additionally, alleged as a general business practice, TORCHMARK COMPANIES
25 failed to accept or deny the claim within statutory timeframes each time its Explanation of
26 Benefits failed to indicate denial of each and every claim for services not paid, in violation of
27 CCR, title 10, §2695.7(b).
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Failure to Provide Necessary Forms, Instructions and Assistance

61. In three (3) instances, the Department alleged that GLOBE failed to provide necessary forms, instructions, and reasonable assistance to claimants/beneficiaries within 15 calendar days, in violation of CCR, title 10, § 2695.5(e)(2).

Failure to Respond to Claimant Within Regulatory Timelines

62. In one (1) instance, the Department alleged that AMERICAN INCOME failed to respond to a claimant within 15 calendar days upon receipt of a communication regarding a claim, in violation of CCR, title 10, § 2695.5(b).

Failure to Maintain Required Claim Documentation

63. In fifteen (15) instances, the Department alleged that TORCHMARK COMPANIES failed to maintain all documents, notes, correspondence, and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined, in violation of CCR, title 10, § 2695.3(a). As examples, in fourteen (14) instances, the Companies could not locate a copy of the application and declaration page of policies for verification of benefits, copies of claims denial letters, Medicare Remittance Summary/Advice, or documentation to support Medicare offsets. Out of the 15 instances cited, the alleged violations were allocated, as follows:

- a. The Department alleged that UNITED AMERICAN failed to maintain all documents, notes, correspondence, and work papers in claims files in eleven (11) instances, in violation of CCR, title 10, §2695.3(a);
- b. The Department alleged that AMERICAN INCOME failed to maintain all documents, notes, correspondence, and work papers in claims files in three (3) instances, in violation of CCR, title 10, §2695.3(a);

1 c. The Department alleged that GLOBE failed to maintain all documents,
2 notes, correspondence, and work papers in claims files in one (1) instance,
3 in violation of CCR, title 10, § 2695.3(a).
4

5 Failure to Adopt and Implement Reasonable Standards for Prompt Investigation
6 and Processing of Claims

7 64. In six (6) instances, the Department alleged that TORCHMARK COMPANIES
8 failed to adopt and implement reasonable standards for the prompt investigation and processing of
9 claims arising under its insurance policies, in violation of California Insurance Code
10 § 790.03(h)(3). As examples, a life settlement check was issued to an incorrect payee. In one
11 instance, the Company submitted an incorrect report of annuity settlement proceeds to the
12 Internal Revenue Service. In another instance, the Companies placed claims on its pending list
13 for up to 16 months without monitoring, follow-up, or appropriate closing procedures. In another
14 instance, the Company failed to investigate and pay a claim without any file activity for 58 days.
15 Out of the 6 instances cited, the alleged violations were allocated, as follows:

- 16 a. The Department alleged that AMERICAN INCOME failed to adopt and
17 implement reasonable standards for the prompt investigation and
18 processing of claims in four (4) instances, in violation of California
19 Insurance Code § 790.03(h)(3);
20
21 b. The Department alleged that UNITED AMERICAN failed to adopt and
22 implement reasonable standards for the prompt investigation and
23 processing of claims in one (1) instance, in violation of California
24 Insurance Code § 790.03(h)(3);
25
26 c. The Department alleged that UNITED INVESTORS failed to adopt and
27 implement reasonable standards for the prompt investigation and
28

1 processing of claims in one (1) instance, in violation of California
2 Insurance Code § 790.03(h)(3).

3 Failure to Maintain Accessible Claim Data

4
5 65. In one (1) instance, the Department alleged that AMERICAN INCOME failed to
6 maintain claim data that are accessible, legible and retrievable for examination so that an insurer
7 is able to provide the claim number, line of coverage, date of loss and date of payment of the
8 claim, date of acceptance, denial or date closed without payment for all open and closed files for
9 the current year and the four preceding years, in violation of CCR, title 10, § 2695.3(b)(1).
10 AMERICAN INCOME was not able to produce a requested claim file for the review period.

11 Misrepresentation of Pertinent Facts or Insurance Policy Provisions to Claimants

12
13 66. In four (4) instances, the Department alleged that TORCHMARK COMPANIES
14 failed to represent correctly to claimants pertinent facts or insurance policy provisions relating to
15 a coverage at issue, in violation of California Insurance Code § 790.03(h)(1). Two instances
16 involved Long-Term Care insurance products, in which the Companies notified claimants that
17 policy benefits are to be reduced by Medicaid payments although this information contradicts the
18 actual policy language which excludes Medicaid payments from any offsets. Violation of
19 California Insurance Code § 10232.95, requiring reimbursement of per diem expenses, up to
20 policy limits, for every long-term care policy is subject to additional penalties, pursuant to
21 California Insurance Code §10234.2. In another instance involving Cancer insurance, the
22 Company indicated that none of the health services rendered were for the treatment of cancer,
23 thus disqualifying the claim. However, treatment of the bladder tumor qualified as a scheduled
24 benefit under the policy. In another instance, the insured was notified that the maximum period
25 and maximum limits were exhausted on a policy as of December 19, 2005 when actual benefits
26
27
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1 were not set to expire until February 25, 2006. Of the 4 instances, the alleged violations were
2 allocated, as follows:

- 3 a. The Department alleged that UNITED AMERICAN failed to represent
4 correctly to claimants pertinent facts or policy provisions in two (2)
5 instances, in violation of California Insurance Code § 790.03(h)(1);
6
7 b. The Department alleged that AMERICAN INCOME failed to represent
8 correctly to claimants pertinent facts or policy provisions in one (1)
9 instance, in violation of California Insurance Code § 790.03(h)(1);
10
11 c. The Department alleged that GLOBE failed to represent correctly to
12 claimants pertinent facts or policy provisions in one (1) instance, in
13 violation of California Insurance Code § 790.03(h)(1).

14 67. In one (1) instance, the Department alleged that UNITED AMERICAN knowingly
15 misrepresented to claimants pertinent facts or insurance policy provisions relating to any
16 coverages at issue, in violation of California Insurance Code § 790.03(h)(1). In this instance, the
17 Department alleged that UNITED AMERICAN misrepresented to the claimant in its claim denial
18 letter and in its policy provisions that the insuring clause of the policy provides that a loss due to a
19 pre-existing condition is not covered unless the loss is incurred *more than 2 years* after the
20 effective date of coverage. However, such statement does not conform to the Insurance Code.
21 For health policy coverage of three or more persons, California Insurance Code § 10198.7(a)
22 prohibits an insurer from excluding coverage on the basis of a pre-existing condition for a period
23 greater than *6 months* following the individual's effective date of coverage. The Department
24 alleges that UNITED AMERICAN'S misrepresentation in its policy language constitutes a
25 general business practice.
26

27 //
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1 death of the insured and failed to specify the rate of interest, as required by California Insurance
2 Code § 10172.5(c), in violation of California Insurance Code § 790.03(h)(5). TORCHMARK
3 COMPANIES were previously cited for violations of California Insurance Code § 10172.5(c) in
4 the Department's Market Conduct Examination As of March 31, 2002. Out of the 17 instances
5 cited, the alleged violations were allocated, as follows:
6

- 7 a. The Department alleged that UNITED INVESTORS failed to notify
8 beneficiaries that interest would be paid on settlement proceeds in sixteen
9 (16) instances, as required by § 10172.5(c), in violation of California
10 Insurance Code § 790.03(h)(5);
11 b. The Department alleged that AMERICAN INCOME failed to notify
12 beneficiaries that interest would be paid on settlement proceeds in one (1)
13 instance, as required by § 10172.5(c), in violation of California Insurance
14 Code § 790.03(h)(5).
15

16 Failure to Pay Interest on Income Disability Claims

17 71. In one (1) instance, the Department alleged that AMERICAN INCOME failed to
18 pay interest on a benefit payment that was not paid within 30 calendar days from receipt of all
19 information needed to determine liability for a claim, and the insurer had determined that liability
20 exists, as required by California Insurance Code § 10111.2(c), in violation of California Insurance
21 Code § 790.03(h)(5).
22

23 Failure to Provide Statutory Notice of Fraud

24 72. The Department alleged that, as a general business practice, the TORCHMARK
25 COMPANIES failed to provide the statutory fraud notice on claim forms, as required by
26 California Insurance Code § 1879.2, in violation of California Insurance Code § 790.03(h)(5).
27 TORCHMARK COMPANIES were previously cited for violations of California Insurance Code
28

1 § 1879.2 in the Department's Market Conduct Examination As Of March 31, 2002. The failure to
2 provide the fraud warning occurred on cancer claim forms in seventy-five (75) instances,
3 allocated as follows:

- 4 a. In fifty-four (54) instances, AMERICAN INCOME failed to provide the
5 statutory fraud notice, in violation of California Insurance Code § 790.03(h)(5);
6 b. In fourteen (14) instances, UNITED AMERICAN failed to provide the
7 statutory fraud notice, in violation of California Insurance Code § 790.03(h)(5);
8 c. In seven (7) instances, GLOBE failed to provide the statutory fraud notice,
9 in violation of California Insurance Code § 790.03(h)(5).
10

11 Making a False Statement to the Insurance Commissioner

12 73. In two (2) instances, the Department alleges that TORCHMARK COMPANIES
13 have made a false statement to an examiner or the Insurance Commissioner pertaining to the
14 business of the insurer during the course of the 2002 and 2006 Market Conduct examinations with
15 intent to deceive, in violation of California Insurance Code § 790.03(e). On two separate
16 occasions, officers of TORCHMARK COMPANIES made commitments, promises,
17 representations or other statements to the Department's Field Claims Bureau examiners relating
18 to improvement modifications to its claims processing computerized systems to correct
19 deficiencies in its Explanation of Benefits, which the Companies have failed to perform.
20
21

22 STATUTORY ALLEGATIONS

23 74. The facts alleged in Paragraphs 50 through 73 herein demonstrate that GLOBE,
24 AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and UNITED INVESTORS have
25 engaged in acts which constitute an unfair method of competition and/or unfair or deceptive acts
26 or practices in this State, in violation of California Insurance Code § 790.03 and/or the Fair
27 Claims Settlement Practices Regulations. The TORCHMARK COMPANIES' conduct
28

1 constitutes grounds for the Insurance Commissioner to assess a monetary penalty, pursuant to
2 California Insurance Code § 790.035; and,

3 75. The facts alleged in Paragraphs 50 through 73 herein demonstrate that GLOBE,
4 AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS have not
5 carried out its contracts in good faith, and constitute grounds for the Insurance Commissioner to
6 suspend for a period not exceeding one year, after hearing, the respective Certificates of
7 Authority of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED
8 INVESTORS, pursuant to California Insurance Code § 704(b); and,

10 76. The facts alleged in Paragraphs 53, 55, 56 and 66 herein demonstrate that
11 UNITED AMERICAN has violated any provision of Chapter 2.6, Part 2, Division 2 of the
12 California Insurance Code and constitute grounds for the Insurance Commissioner to assess an
13 additional monetary penalty, pursuant to § 10234.3(b), and suspend its Certificate of Authority
14 and/or order the insurer to cease marketing a particular policy form of long-term care insurance or
15 cease marketing any long-term care insurance in California, pursuant to California Insurance
16 Code § 10234.4; and,

18 77. The Insurance Commissioner hereby notifies GLOBE, AMERICAN INCOME,
19 LIBERTY, UNITED AMERICAN and UNITED INVESTORS that, based upon the facts alleged
20 herein, the TORCHMARK COMPANIES are in violation of California Insurance Code
21 §§ 700(c), 704(b), 790.02, 790.03, 790.06, 1879.2, 10111.2(c), 10172.5, 10198.7(a), 10232.92,
22 10232.95, and the Fair Claims Settlement Practices Regulations contained in California Code of
23 Regulations, title 10, Chapter 5, Subchapter 7.5, commencing with § 2695.1.

25 78. The Commissioner has alleged that each act identified in paragraphs 50 through 73
26 constitutes an unfair method of competition or unfair or deceptive act or practice within the
27 meaning of California Insurance Code § 790.03.
28

DEMAND PURSUANT TO
CALIFORNIA INSURANCE CODE §§ 704, 790.035, 790.05, 790.08, 10234.2, 10234.3,
10234.4, 10234.5 and 12976

79. PLEASE TAKE NOTICE that the Insurance Commissioner may, as a result of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS' actions as set forth hereinabove, and pursuant to California Insurance Code § 790.035, seek monetary penalties up to:

- a. Five thousand dollars (\$5,000.00) for each of the acts alleged above that is established, at hearing, as an act of unfair competition or unfair or deceptive act or practice and such acts are non-willful; or
- b. Ten thousand dollars (\$10,000) for each act of unfair competition or unfair or deceptive practice alleged above that is proved willful; and,

80. PLEASE TAKE FURTHER NOTICE that the Insurance Commissioner may, as a result of the actions of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS as set forth hereinabove, and pursuant to California Insurance Code § 704, seek to suspend the respective Certificates of Authority of GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS; and,

81. PLEASE TAKE FURTHER NOTICE that the Insurance Commissioner may, as a result of UNITED AMERICAN'S actions as set forth in Paragraphs 53, 55, 56 and 66, and pursuant to California Insurance Code §§ 10234.2, 10234.3 and 10234.4, seek to suspend UNITED AMERICAN'S Certificate of Authority and/or seek additional monetary penalties of not less than five thousand dollars (\$5,000) for each first violation and not less than ten thousand dollars (\$10,000) for each subsequent or knowing violation, and the penalty shall reflect the magnitude of the violation against public interest and shall not be less than ten thousand dollars (\$10,000) and not more than five hundred thousand dollars (\$500,000). PLEASE TAKE

1 FURTHER NOTICE that the Insurance Commissioner hereby notifies UNITED AMERICAN
2 that it has the right to elect any of the actions set forth in California Insurance Code
3 § 10234.5(b)(4); and,

4 82. PLEASE TAKE FURTHER NOTICE that, as a result of the actions of GLOBE,
5 AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS as set
6 forth hereinabove, and pursuant to California Insurance Code §§ 790.06, 790.08, 10111.2,
7 10172.5, 10198.7, 10234.2, 10234.5 and 12976, demand is hereby made for such other equitable
8 relief, including restitution, as may be necessary to redress GLOBE, AMERICAN INCOME,
9 LIBERTY, UNITED AMERICAN and UNITED INVESTORS' violations of enumerated
10 California statutory law and regulations and for such other and further relief as may be just and
11 proper.
12

13
14 **ORDER TO SHOW CAUSE**
15 **PURSUANT TO CALIFORNIA INSURANCE CODE §§ 790.03, 790.05 and 790.06**

16 83. WHEREAS, the Insurance Commissioner has reason to believe, based upon the
17 facts set forth herein, that GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN
18 and UNITED INVESTORS have engaged in or are engaging in unfair methods of competition
19 and/or unfair or deceptive acts or practices in this State as defined in California Insurance Code
20 §§ 790.03(e), 790.03(h) and/or the Fair Claims Settlement Practices Regulations; and,

21 84. WHEREAS, the Insurance Commissioner has reason to believe, based upon the
22 facts set forth herein, that GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN
23 and UNITED INVESTORS have engaged in or are engaging in a method of competition and/or
24 an act or practice in the conduct of its business in this State that is not defined in California
25 Insurance Code § 790.03, and that the method is unfair and/or the act or practice is unfair or
26 deceptive pursuant to California Insurance Code § 790.06; and,
27
28

1 85. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding
2 by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order
3 to Show Cause, pursuant to California Insurance Code § 790.05, containing a statement of the
4 charges and GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED
5 INVESTORS' potential liability; and,
6

7 86. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding
8 by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order
9 to Show Cause, pursuant to California Insurance Code § 790.06, containing a statement of the
10 methods, acts or practices alleged to be unfair or deceptive; and,
11

12 87. THEREFORE, the Insurance Commissioner hereby notifies GLOBE,
13 AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS that a
14 hearing shall be held at a time and place to be determined by the Commissioner which shall not
15 be less than 30 days after service of the herein Order to Show Cause to determine whether the
16 alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and
17 whether the Commissioner should issue an Order to pay the penalties imposed by California
18 Insurance Code §§ 790.035 and 10234.3 and to cease and desist from such acts or practices.
19

20 88. THEREFORE, the Insurance Commissioner hereby notifies GLOBE,
21 AMERICAN INCOME, LIBERTY, UNITED AMERICAN and UNITED INVESTORS that a
22 hearing shall be held at a time and place to be determined by the Commissioner which shall not
23 be less than 30 days after service of the herein Order to Show Cause to determine whether the
24 alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and
25 whether the Commissioner should issue a report so declaring.
26

27 WHEREFORE, the Insurance Commissioner prays for the following:
28

1 1. An Order to Cease and Desist against GLOBE, AMERICAN INCOME,
2 LIBERTY, UNITED AMERICAN and UNITED INVESTORS from engaging in unfair methods
3 of competition and unfair and deceptive acts or practices in the business of life and disability
4 insurance in violation of California Insurance Code §§ 790.03 and 790.06 and the Fair Claims
5 Settlement Practices Regulations contained in CCR, Title 10, Chapter 5, Subchapter 7.5,
6 commencing with § 2695.1 et seq.; and,

8 2. An Order to Cease and Desist against GLOBE, AMERICAN INCOME,
9 LIBERTY, UNITED AMERICAN and UNITED INVESTORS from engaging in activities in the
10 business of life and disability insurance in violation of California Insurance Code §§ 700(c),
11 704(b), 1879.2, 10111.2(c), 10172.5, 10198.7 and 10232.92 and 10232.95; and,

12 3. The suspension of GLOBE, AMERICAN INCOME, LIBERTY, UNITED
13 AMERICAN and UNITED INVESTORS' respective Certificates of Authority to act as a Life and
14 Disability insurer in the State of California for a period not exceeding one year, pursuant to
15 California Insurance Code § 704(b); and,

17 4. The suspension of UNITED AMERICAN'S Certificate of Authority to act as a
18 Disability insurer in the State of California, and/or to cease marketing in California a particular
19 policy form of long-term care insurance or cease marketing any long-term care insurance,
20 pursuant to California Insurance Code § 10234.4; and,

21 5. The imposition of a monetary penalty against UNITED AMERICAN as provided
22 by law, pursuant to California Insurance Code § 10234.3; and,

23 6. The imposition of monetary penalties against GLOBE, AMERICAN INCOME,
24 LIBERTY, UNITED AMERICAN and UNITED INVESTORS as provided by law, pursuant to
25 California Insurance Code § 790.035, of up to five thousand dollars (\$5,000) for each of the acts
26 of unfair competition or unfair or deceptive acts or practices alleged above that is established and
27
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1 such acts are non-willful; or up to ten thousand dollars (\$10,000) for each act of unfair
2 competition or unfair or deceptive practices alleged above that is established and such acts are
3 willful; and,

4 7. The imposition of Notice on GLOBE, AMERICAN INCOME, LIBERTY,
5 UNITED AMERICAN and UNITED INVESTORS that, after conclusion of the hearing, upon a
6 finding of violation of California Insurance Code § 704(b), GLOBE, AMERICAN INCOME,
7 LIBERTY, UNITED AMERICAN and UNITED INVESTORS will be subject to the possible
8 suspension of its Certificate of Authority; and,

9 8. The imposition of such other equitable relief, including restitution, as may be
10 necessary to redress the violations of GLOBE, AMERICAN INCOME, LIBERTY, UNITED
11 AMERICAN and UNITED INVESTORS as set forth above; and,

12 9. The imposition of such further relief as may be just and proper.

13 //

14 Dated: August 11, 2011

CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION

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By: 
Mary Ann Shulman
Senior Staff Counsel

Attorneys for California Department of Insurance

[THIS VERSION OF THE REPORT IS MADE AVAILABLE
IN ACCORDANCE WITH CIC SECTION 12938]

REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

NAIC # 91472 CDI # 2439-8

AMERICAN INCOME LIFE INSURANCE COMPANY

NAIC # 60577 CDI # 1908-3

LIBERTY NATIONAL LIFE INSURANCE COMPANY

NAIC# 65331 CDI# 1679-0

UNITED AMERICAN INSURANCE COMPANY

NAIC #92916 CDI# 2505-6

UNITED INVESTORS LIFE INSURANCE COMPANY

NAIC# 94099 CDI# 2493-5

AS OF JULY 15, 2006

ADOPTED ON November 12, 2008

STATE OF CALIFORNIA



DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

TABLE OF CONTENTS

SALUTATION.....	1
FOREWORD.....	2
SCOPE OF THE EXAMINATION.....	3
EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED.....	4
RESULTS OF REVIEWS OF CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS.....	5
DETAILS OF THE CURRENT EXAMINATION.....	6
TABLE OF TOTAL CITATIONS.....	9
TABLE OF CITATIONS BY LINE OF BUSINESS.....	11
SUMMARY OF EXAMINATION RESULTS.....	13

DEPARTMENT OF INSURANCE

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



November 12, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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 practices and procedures in California of:

Globe Life and Accident Insurance Company

NAIC # 91472

American Income Life Insurance Company

NAIC # 60577

Liberty National Life Insurance Company

NAIC# 65331

United American Insurance Company

NAIC #92916

United Investors Life Insurance Company

NAIC# 94099

Group NAIC # 0290

Hereinafter, the Companies listed above also will be referred to as GLAIC, AILIC, LNLIC, UAIC, UILIC, or the Company or, collectively, as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWORD

The examination covered the claims handling practices of the aforementioned Companies during the period July 16, 2005, through July 15, 2006. The examination was made to discover, in general, if these and other operating procedures of the Companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. The alleged violations of other relevant laws which resulted from this examination are included in a separate report.

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 resulted in 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. 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 Companies' 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 Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of 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) consumer complaints and inquiries about these Companies handled by the CDI during the same time period and a review of previous CDI market conduct examination reports on these Companies.

The review of the sample of individual claims files was conducted at the offices of the Companies in Oklahoma City, Oklahoma, McKinney, Texas, and Waco, Texas.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were closed from July 16, 2005 and July 15, 2006, referred to as the "review period". The examiners randomly selected 51 GLAIC claims files, 4 LNLIC claims files, 297 UAIC claims files, 22 UILIC claims files, and 300 AILIC claims files for examination. The examiners cited 501 alleged claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample file review.

Findings within the scope of this report included: failure to provide an explanation of benefit with claim payment; failure to include a written basis for the denial; failure to include a statement in the written denial advising the claimant that he or she may have the matter reviewed by the California Department of Insurance; failure to disclose benefits that may apply to the claim presented; attempting to settle a claim by making a settlement offer that was unreasonably low; failure to investigate and failure to effectuate prompt, fair, equitable settlement of a claim.

**RESULTS OF REVIEWS OF
CONSUMER COMPLAINTS AND INQUIRIES,
AND PREVIOUS EXAMINATIONS**

The Companies were the subject of 20 California consumer complaints and inquiries closed between July 16, 2005 and July 16, 2006 in regard to the line of business reviewed in this examination. The review showed alleged non-compliance with respect to the following: failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied, failure to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, failure to begin investigation and provide necessary forms, instructions, and reasonable assistance within 15 calendar days upon receiving notice of claim, failure to accept or deny the claim within 40 calendar days upon receipt of proof of claim and failure to respond to Department of Insurance claim inquiries within 21 calendar days of receipt of such inquiry. The Examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from April 1, 2001 through March 31, 2002. The most significant noncompliance issues identified in the previous examination report were: failure to provide an explanation of benefit, failure to provide written basis for the denial of a claim, failure to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance and failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied. These issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

GLAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	1,107	27	3
Accident and Disability/Individual Cancer	7	7	8
Accident and Disability/Individual Hospital	17	1	1
Accident and Disability /Individual Medicare Supplement	409	7	1
Accident and Disability / Group Medicare Supplement	1,222	9	2
General Business Practices	-	-	1
TOTALS	2,762	51	16

LNLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	173	4	0
TOTALS	173	4	0

UAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life / Individual Life	276	7	0
Accident and Disability/ Individual Cancer	14	14	6
Accident and Disability/Individual Medical	1,074	64	14
Accident and Disability/ Individual Hospital	2,258	65	85
Accident and Disability/ Individual Surgical	66	34	3
Accident and Disability/ Individual Indemnity	7	6	13
Accident and Disability/ Individual Disability	2	2	0
Accident and Disability/ Individual Long-Term Care	487	60	146
Accident and Disability/ Individual Medicare Supplement	444,568	23	4
Accident and Disability/ Group Medicare Supplement	28,687	22	0
TOTALS	477,439	297	271

UILIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	96	2	0
Annuities/ Individual Annuities	39	20	2
TOTALS	135	22	2

AILIC SAMPLE FILES REVIEW

LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	810	39	2
Annuities/ Individual Annuities	3	3	1
Accident and Disability/ Individual Income Disability	12	11	13
Accident and Disability/ Individual Accident and Sickness	1,596	65	12
Accident and Disability/ Individual Cancer	266	54	62
Accident and Disability/ Individual Surgical	42	26	89
Accident and Disability/ Individual Indemnity	63	33	32
Accident and Disability/ Individual Medicare Supplement	3,245	6	1
Life/ Group Life	38	20	0
Life/ Group Accident Death & Dismemberment	120	43	0
TOTALS	6,195	300	212

TABLE OF TOTAL CITATIONS

Citation	Description	GLAIC	LNLIC	UAIC	UILIC	AILIC
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	1	0	76	1	52
CCR §2695.7(b)(3)	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	4	0	53	0	30
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	2	0	41	0	57
CCR §2695.7(b)(1)	The Company failed to provide the written basis for the denial of the claim.	2	0	60	0	23
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	1	0	4	0	27
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	0	23	0	2
CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file.	1	0	11	0	3
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	0	0	1	1	4
CCR §2695.7(d)	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.	0	0	0	0	5
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	1	0	2	0	1
CCR §2695.5(e)(2)	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	0	0	0	0	3

TABLE OF TOTAL CITATIONS						
Citation	Description	GLAIC	LNLIC	UAIC	UILIC	AILIC
CCR §2695.7(h)	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	0	0	0	0	2
CCR §2695.7(c)(1)	The Company failed to provide written notice of the need for additional time every 30 calendar days.	1	0	0	0	1
CCR §2695.3(b)(1)	The Company failed to maintain claim data that are accessible, legible and retrievable for examination.	0	0	0	0	1
CCR §2695.7(b)	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	0	0	0	0
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days.	0	0	0	0	1
Total Citations		15	0	271	2	212

TABLE OF TOTAL CITATIONS General Business Practices		
Citation	Description	COMPANIES
CCR §2695.6(b)	The Company failed to provide thorough and adequate training regarding these regulations to all its claims agents.	1
Total Citations		1

TABLE OF CITATIONS BY LINE OF BUSINESS

<p>LIFE</p> <p>2006 AILIC Written Premium: \$ 40,665,299 2006 GLAIC Written Premium: \$32,128,536 2006 UAIC Written Premium: \$11,723,608 2006 LNLIC Written Premium: \$10,263,914 2006 UILIC Written Premium: \$2,251,509</p>	<p>NUMBER OF CITATIONS</p>
<p>AMOUNT OF RECOVERIES \$0</p>	
CCR §2695.7(c)(1)	2
CCR §2695.7(b)	1
CCR §2695.3(a)	1
CIC §790.03(h)(3)	1
<p>SUBTOTAL</p>	<p>5</p>

<p>ANNUITIES</p> <p>2006 AILIC Written Premium: \$ 657 2006 GLAIC Written Premium: \$1,089 2006 UAIC Written Premium: \$101,945 2006 LNLIC Written Premium: \$1,788 2006 UILIC Written Premium: \$30,213</p>	<p>NUMBER OF CITATIONS</p>
<p>AMOUNT OF RECOVERIES \$0</p>	
CCR §2695.5(e)(2)	1
CCR §2695.11(b)	1
CIC §790.03(h)(3)	1
<p>SUBTOTAL</p>	<p>3</p>

ACCIDENT AND DISABILITY		NUMBER OF CITATIONS
2006 AILIC Written Premium: \$ 4,926,653 2006 GLAIC Written Premium: \$2,986,358 2006 UAIC Written Premium: \$51,527,101 2006 LNLIC Written Premium: \$84,312 2006 UILIC Written Premium: \$0		
AMOUNT OF RECOVERIES	\$ 20,234.00	
CCR §2695.11(b)		129
CCR §2695.4(a)		100
CCR §2695.7(b)(3)		87
CCR §2695.7(b)(1)		85
CCR §2695.7(g)		32
CIC §790.03(h)(5)		26
CCR §2695.3(a)		14
CIC §790.03(h)(3)		4
CCR §2695.7(d)		5
CIC §790.03(h)(1)		4
CCR §2695.5(e)(2)		2
CCR §2695.7(h)		2
CCR §2695.3(b)(1)		1
CCR §2695.5(b)		1
SUBTOTAL		492

GENERAL BUSINESS PRACTICES	NUMBER OF CITATIONS
CCR §2695.6(b)	1
SUBTOTAL	1

TOTAL	501
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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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each criticism, the Companies are required to identify remedial or corrective action that has been, or will be taken to correct the deficiency. The Companies are obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Companies were asked, and did not indicate, if they intend to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was \$20,234.00 as described in sections number 9, 10 and 16 below.

LIFE

1. **In two instances, the Companies failed to provide written notice of the need for additional time or information every 30 calendar days.** In the first instance, the Company sent status update notices that failed to specify any additional information the Company requires in order to make a determination, to state any continuing reasons for the Company's inability to make a determination, and to provide an estimate as to when the determination can be made. In the second instance, the Company failed to send a status letter to a beneficiary advising of the reason for a 48 day delay in determination of coverage. The Department alleges these acts are in violation of CCR §2695.7(c)(1).

Summary of Companies' Response: The Companies acknowledge this finding and indicate that this error is not in line with company standard policies and procedures. The Company will address this issue with the individual claims staff for reinforcement and compliance training.

2. **In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** A settlement check was issued to an incorrect payee. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges this finding and indicates that this error is not in line with company standard policies and procedures. The Company will address this issue with the individual claims staff for reinforcement and compliance training.

3. **In one instance each, the Companies failed to comply with the Fair Claims Settlement Practices Regulations.** The Company failed to comply with CCR §2695.3(a) -

failure to maintain all documents, notes and work papers in the claim file. In this instance, the Company has a denial letter dated July 12, 2005 in the claim file which allegedly was not sent to the claimant. However, a copy was maintained in the claim file for an unknown reason. In the second instance, the Company failed to comply with CCR §2695.7(b) – failure upon receiving proof of claim, to accept or deny the claim within 40 calendar days. Proof of claim was received on May 10, 2006. The claim was rescinded June 27, 2007, or 48 days later. The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

Summary of Companies' Response: The Companies acknowledge these findings and indicate that claims handling was not in line with company standard policies and procedures. The Companies have reviewed claim documentation processes with their personnel to reinforce the importance of maintaining complete and accurate files. The failure to rescind the claim within regulatory timelines was also due to an inadvertent oversight and the pertinent claims personnel were counseled regarding this finding.

ANNUITIES

4. **In one instance each, the Companies failed to comply with the Fair Claims Settlement Practices Regulations and the California Insurance Code.** The Company failed to comply with CCR §2695.11(b) – failure to provide an explanation of benefits; CCR §2695.5(e)(2) - failure to provide necessary forms, instructions, and reasonable assistance within 15 calendar days; and CIC §790.03(h)(3) - failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. In the first instance, the Company failed to clarify the appropriate distribution of benefits among beneficiaries. In the second instance, the Company did not provide necessary forms and instructions to the claimant until 21 days after notice of claim. In the last instance, the Company generated an incorrect 1099 form and report to the Internal Revenue Services (IRS) pertaining to settlement proceeds. The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations and the California Insurance Code.

Summary of Companies' Response: The Companies acknowledge these findings and indicate that claims handling was not in line with company standard policies and procedures. The Companies found that these were results of unintentional handling errors, and have provided further guidance to their claims staff with respect to these issues. The Companies do not believe however that these mistakes amount to a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

ACCIDENT AND DISABILITY

5. **In 129 instances, the Companies failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** The Companies transmitted an Explanation of Benefits (EOB) letter to the policyholder upon claim settlement which is not a clear computation or explanation of benefits. The following EOB deficiencies were noted: no provider information; missing dates of service, number of days of qualified benefits and other pertinent references; daily benefit or periodic rates not disclosed; no explanation for the methodology of calculating unscheduled benefits which should be commensurate with the operation or surgery; no explanation on Medicare offsets applied for 20 days; system limitations on the length of

characters allowed for inadequate description of benefits or plan of care; allocation and allowable percentage of benefits payable on actual services were not disclosed; clerical processing errors in inputting information such as pertinent dates of service; application of rider benefits, bonus benefits and maximum payouts (limits) are not explained; re-pricing of billed charges according to non-existent policy contract rate agreement and references to non-insurance discount programs; for one or more surgeries, surgery benefits are not distinctively described or clarified; line items or incurred amounts were missing, or invoice items were not properly matched on the EOB; rejected, denied and 'bundling' of charges were not explained or listed; specific charges were batched with a general description of benefits; and other unpaid invoice charges were not acknowledged as to their disposition in the EOB. The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Companies' Response: The Companies disagree with the Department's findings. It is the Companies' position that the regulation does not elaborate upon, or define the terminology of 'a clear explanation of the computation of benefits'. The Companies assert that there is no format prescribed by the law to assure compliance with this section of the regulation. The Companies believe it is in compliance with California law.

The Companies further stated that they, "have not received indications from its insureds that its explanation of benefits (EOB) forms are insufficient or unclear, nor have their insureds expressed confusion as to whether previously-handled claims have been completely resolved. Therefore, the details set forth in the Companies' explanation of benefits (EOBs) supplies ample information for insureds regarding the handling of their respective claims".

While the Companies believe that their EOBs are sufficient, they have offered to make some changes in their EOB formats. In the category of Long-Term Care, United American Insurance Company through its McKinney, Texas claims administration, indicates that it will create a new "remark code" which will be added to all EOBs for Long Term Care policies when invoices submitted reflect additional charges that are not covered expenses under the policy. The additional remark will state, "This payment represents the total daily benefit available for each day confined during this period. Your policy does not provide separate benefits for other services that might be itemized on the nursing home bill, such as charges for telephone, radio or television, extra beds or cots, wheelchair, (to be specified)...". Another remark code option added by the McKinney claims administration is "This long term care policy pays for expenses actually incurred, up to the daily benefit limits as stated in the policy. If the expense actually incurred is less than the daily benefit limit, then the amount paid under the policy will be no greater than the expense incurred".

American Income Life through its Waco, Texas claims administration also indicates that the EOBs on its disability/health claims which are provided to each claimant will be expanded. They will include the daily, weekly, or monthly rate at which benefits are paid for hospital confinement or disability/recuperation, and will include reference when the maximum benefit is reached.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

6. **In 100 instances, the Companies failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.** The Companies were inconsistent in disclosure of all benefits, coverage and policy provisions that may apply when a claim is presented by the claimant. This includes applicable coverage such as daily or periodic benefit rates for various levels of care, elimination period, waiver of premium benefits, maximum benefit periods, prescription drug benefits, 10% bonus and inflation benefit riders and other provisions affecting the determination of benefits. The Department alleges these acts are in violation of CCR §2695.4(a).

Summary of Companies' Response: The Companies disagree that they have any obligation to disclose benefits, coverage, and provisions of the policy to its policyholders when a claim has been presented. It is the Companies' position that the insureds should refer instead to their own policy copies which was provided to them at the time the policy was issued.

However, in October 2007, American Income Life Insurance Company through its Waco, Texas claims unit began providing all claimants with a Disclosure of Benefits letter that details the benefits available under the policy contract and includes the benefit amounts and the maximum limits payable for each coverage item.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

7. **In 87 instances, the Companies failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.** The Department alleges these acts are in violation of CCR §2695.7(b)(3).

Summary of Companies' Response: The Companies acknowledge these findings and indicate that it is their Companies' policy to include the California Department of Insurance contact reference with each denied claim. American Income Life Insurance Company through its Waco, Texas claims administration indicates that it has corrected its systems programming in January 2006 so that all notices of denial now include the required language. In October 2007, AILIC also began providing all claimants with a Disclosure of Benefits letter which contains the CDI denial language.

UAIC and GLAIC state that an EOB that does not address each and every item of a billing does not constitute a claim denial and therefore does not require the CDI denial language.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

8. **In 85 instances, the Companies failed to provide the written basis for the denial of the claims.** The Companies failed to provide the written basis for a full or partial denial of the claims. The Companies did not provide a legal basis for the denial, failed to address the specific charges that were being denied and/or failed to send a denial notice to the insured. The examiners identified 24 instances of a variety of submitted charges such as prosthetic devices, and ambulance charges that were not paid. However, there was no written basis for the denial of these charges. In 16 instances paid charges/limits did not match actual submitted charges. In the

other 45 instances, denial notices were not sent when diagnostic procedures and services such as office visits, therapy and room charges were not paid. The Department alleges these acts are in violation of CCR §2695.7(b)(1).

Summary of Companies' Response: The Companies' response in 16 of the instances is that "the additional charges on the bills submitted were not denied; rather the eligible benefits were paid per policy terms". The Companies' response in 26 of the instances is that the EOB includes the following statement, "Only those charges that are eligible for benefits have been considered. All other charges are not covered under the terms of the policy". In the 43 other instances, the Companies disagree that they failed to provide a legal basis for the denial, or failed to send a denial letter on pertinent charges presented. The Companies state the policies in question are limited benefit policies, not comprehensive or major medical policies. Therefore, they explained it is not necessary to address in a written denial each billed charge they deem ineligible for payment.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

9. **In 32 instances, the Companies attempted to settle a claim by making a settlement offer that was unreasonably low.** The Companies underpaid and/or failed to pay benefits under Surgical, Cancer, Long-Term Care, and Income Disability policies. The following summarizes the examiners' findings:

- a) In seven instances, the Companies failed to pay qualified cancer benefits and defined benefits such as EKG, hypodermics, drugs, surgical dressings and supplies, and anesthesia.
- b) In five instances, the Companies did not pay for all pertinent surgical supplies under their policy. It is AILIC's procedure to pay only for surgical dressings and supplies limited to the date of the surgery only. This restrictive policy is self-imposed by AILIC and is not in conformity with the policy provisions. There were no limitations or restrictions on the policy to support AILIC's interpretation and settlement of these specific benefits.
- c) In four instances, there was either a miscalculation or non-payment of surgical benefits and procedures.
- d) In three instances, there was an underpayment of disability benefits.
- e) In two instances, the Companies failed to pay other eligible benefits such as surgical benefits, anesthesia, laboratory, x-rays, medicines and 10% bonus.
- f) In two instances, invoice items were not paid pursuant to Use of Lung Benefits.
- g) In two instances, room charges were not paid under Long-Term Care benefits.
- h) In two instances, the Companies did not pay the maximum limits on EKG and antibiotics.

i) In one instance each, the Companies did not pay for physician call charges, miscalculated unscheduled surgery benefits, failed to issue Good Risk Benefits discount on a cancer policy, used incremental payment of \$5 or \$10 in non-scheduled benefits instead of actual charges, and incorrectly bundled benefits for a lower settlement amount.

The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Companies' Response: The Companies acknowledge that these claims were improperly paid. As a result of these findings, a total amount of \$ 18,911.28 was paid to policyholders/claimants identified within the examination samples.

However, on item #b above, the Companies disagree with the Department's findings and believe they have correctly applied benefits limited to the date of surgery only. The Companies indicate that the exception to this limitation would be "dressings" on wounds which may need to be replaced after the date of surgery.

Under the Companies' HGF policy Part I Hospital Expense Benefits, if an insured is necessarily confined within a hospital as a resident patient on account of such injury or such sickness, the Company will pay the hospital expense actually incurred, but not to exceed the regular and customary charges stated under Surgical Dressings and Supplies.

The Companies interpret this to mean "surgical dressings used throughout the hospital confinement to dress the wound, and supplies used for surgery only" therefore any supplies used on any date of confinement other than the date of surgery would not qualify as a surgical supply. The Companies do not agree that all surgical supplies and dressing used throughout the hospital confinement qualify for benefits under this category. It is the Companies' position that their interpretation of surgical supplies mean only those supplies used during the actual performance of the surgery and will qualify only supplies used on the date of the surgery, not those used during the entire confinement due to surgery.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

10. In 26 instances, the Companies failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The examiners found the following exceptions in their review of claims:

a) In 16 instances, actual charges including room and board charges were "re-priced" and/or discounted ten to twenty percent without substantiation. UAIL contracts with two vendor companies administer a non-insurance discount program on health services for policyholders who purchase non-Medicare supplement health insurance policies. However, all the Companies utilize one of these vendors for "re-pricing" of services instead of paying the usual and customary charges pursuant to the policy contract provisions. If the re-pricing information is not available with the two contracted vendors, the Companies use a non-contracted vendor's discount information in claims processing.

b) In five instances, valid charges submitted by claimants were deemed ineligible as "covered benefits" by the Companies.

c) In one instance each, the Companies utilized an internet search to estimate the value of an implant device in lieu of paying the usual and customary charges; delayed the application of the waiver of premium (WOP) on a long-term care policy; omitted two weeks of eligible services by imposing an incorrect maximum limit; did not pay or issue Good Risk provision benefit in an Individual Health Cancer policy; and did not verify a Medicare Remittance Summary Notice to validate Medicare offsets to reduce benefits on Long-Term Care claims by at least 20 days.

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

Summary of Companies' Response: The Companies agree that two of the 31 violations were inadvertent processing mistakes on the part of its adjusters. The Companies issued additional monies to claimants in the amount of \$834.53 and will counsel the individual payment processors.

The Companies dispute the remaining findings and maintain that they are in compliance with regulations. The Companies disagree that the informal discounts provided by these non-insurance programs should include an explanation that an out-of-pocket expense as a result of the discount is not the responsibility of the insured.

With regard to the Medicare offsets, UAIC applies its knowledge of Medicare payment patterns when reviewing bills received from a skilled nursing facility and does not believe it is necessary to validate offsets by securing copies or verifying Medicare remittances. In the instances cited, UAIC contends the pattern of Medicare is to pay the first 20 days at one-hundred percent, therefore Long-Term Care benefits were reduced.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

11. In 14 instances, the Companies failed to maintain all documents, notes and work papers in the claim file. The claim files were missing copies of denial letters, Medicare Remittance Summary/Advice, supporting Medicare offsets, copy of application and the declaration page of policies for verification of benefits. The Department alleges these acts are in violation of CCR §2695.3(a).

Summary of Companies' Response: The Companies acknowledge that communication letters, invoices, worksheets, and other claim documents were missing from claim files. Furthermore, the Companies acknowledge they were unable to reproduce copies of their application records as they had been "purged". The Companies state that they began transitioning their paper "hard copy" filing systems to electronic "scanned image" filing systems and may have accidentally lost some records during the examination window period. The Companies have now fully transitioned to electronic scanned image filing systems and do not expect to have further issues related to lost or missing documents. Nonetheless, the Companies have reminded their respective document imaging departments to capture all documents at the time of scanning.

12. **In four instances, the Companies failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** The Companies: (a) did not have a procedure in place to investigate and validate medical charges; (b) and (c) placed two claims on its pending list for 16 months and 8 months respectively without monitoring, follow-up, or appropriate closure procedures; and (d) failed to investigate and expedite payment of claim – a 58 day gap in file activity occurred. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Companies' Response: The Companies acknowledge delay issues as noted above and have discussed the claims with the pertinent examiners who handled them. However, the Companies maintain that their procedure to secure general pricing information using a general internet search is appropriate and acceptable as this may be considered as “usual and customary” charges. The Companies indicate they could not retrieve cost information related to the particular implant components and therefore used the internet referencing “typical” rather than specific implant component costs.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

13. **In five instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim.** These acts include: three instances wherein the Company required the insured (1) to secure claim information such as the surgical procedure code, (2) to produce a written verification of the hospital facilities requirement, and (3) to secure manufacturer and model information on prosthetic devices. Although the actual model number and manufacturer information were later provided to the Company in this third instance, it did not use usual and customary charges to settle the claim but used general information from the internet for pricing. As a result, the Companies withheld payment for hospital confinement benefits and failed to use accurate information to settle the usual and customary charges. In another instance, the Company utilized a general “internet” search without matching the appropriate information on prosthetic devices such as the model number, manufacturer, geographic or territorial information, and other pertinent search parameters. This general “internet” search resulted in differences in actual payments from actual billed charges. In the last instance, the Company failed to contact the provider or secure a medical authorization. As a result, medical charges in excess of \$30,000 were not considered for payment. The Department alleges these acts are in violation of CCR §2695.7(d).

Summary of Company Response: AILIC acknowledges these findings and has counseled its claims examiner regarding its claims-handling processes including the verification of provider licensee information. The Company disagrees that it has the responsibility to assist the insured in obtaining additional provider invoices in two of the instances. The Company maintains that its procedure to secure general pricing information using a general internet search in two instances is appropriate and acceptable as an internet source may be considered as “usual and customary” charges.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

14. **In four instances, the Companies failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.** In two instances, EOBs on Long-Term Care included an inaccurate statement that policy benefits are to be reduced by Medicaid payments. This information contradicts the actual policy language which excludes Medicaid payments from any offsets. In one instance, a statement in a denial letter indicated that none of the special services were rendered for the treatment of cancer therefore no benefits were payable under the policy. However, the treatment of the bladder tumor qualified as a scheduled benefit under the policy. In the last instance, the policyholder was advised that the maximum period had been reached and maximum limits exhausted on a policy as of December 19, 2005. Actual benefits were not set to expire until February 25, 2006. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Companies' Response: The Companies acknowledge these findings and attribute them to examiner error which has been addressed on a case by case basis with the claims associates. With regard to the programmed remark codes on Medicaid, the Companies agree this was incorrect language and will change its EOB codes to reflect "including Medicare, but excluding Medicaid". The incorrect remark code was an oversight. The Companies further explained that there was no harm done as nothing was owed to the claimant.

15. **In two instances, the Companies failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.** In one instance, the Company failed to send a medical authorization to the insured in order to secure the necessary information from the provider and pay the claim. In the second instance, the Company received an initial invoice of over \$99,000 on October 26, 2005 but did not request additional information or provide claims instructions to the insured until November 15, 2005. The Department alleges these acts are in violation of CCR §2695.5(e)(2).

Summary of Companies' Response: The Companies acknowledge there were inadvertent mistakes made that have been addressed on a case by case basis with its claims associates.

16. **In two instances, the Companies failed, upon acceptance of the claim, to tender payment within 30 calendar days.** In two separate instances, the Companies failed to pay hospital confinement benefits and emergency accident benefits within regulatory timelines. The Department alleges these acts are in violation of CCR §2695.7(h).

Summary of Companies' Response: The Companies acknowledge these were inadvertent errors and issued additional monies owed to claimants in the amount of \$488.19. These criticisms were addressed with AILIC claims-handling personnel in order to improve future claim processing efficiencies.

17. **In one instance, the Company failed to respond to communications within 15 calendar days.** The communications to the Company included a policyholder's inquiry regarding benefits. However, the Company did not respond to this inquiry within the prescribed time limit. The Department alleges this act is in violation of CCR §2695.5(b).

Summary of Company Response: The Company disagrees with the examiner as it believes the policyholder's communication did not require a response. However, AILIC will remind its claims examiners to address all aspects of an insured's correspondence.

18. **In one instance, the Company failed to maintain claim data that are accessible, legible and retrievable for examination.** One claim file was missing and was not presented to the Department for examination. The Department alleges this act is in violation of CCR §2695.3(b)(1).

Summary of Company Response: The Company acknowledges it was unable to locate a claim file. This is an isolated case and is not reflective of the Company procedure on maintenance of electronic records.

GENERAL BUSINESS PRACTICES

19. **The Company failed to provide thorough and adequate training regarding these regulations to all its claims agents.** The claims personnel from the Alabama and McKinney, Texas claims units for Globe Life and Accident Insurance Company did not have California claims training for the years 2004 and 2005. The Department alleges these acts are in violation of CCR §2695.6(b).

Summary of Company Response: The Company acknowledges it did not have formal California claims training, however it believes that regular training from their team leads, supervisors and managers was sufficient. The Company emphasized "hands-on" training does occur on a day-to-day basis as examiners have frequent interaction with their supervisors and their department manager creating an ongoing discourse and discussion regarding claims processes and procedures. All personnel will be trained on California regulations annually on a moving-forward basis.

[THIS VERSION OF THE REPORT MAY BE MADE PUBLIC IN ACCORDANCE
WITH THE PROVISIONS OF CIC SECTIONS 735.5(a) and (c)]

REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

NAIC # 91472 CDI # 2439-8

AMERICAN INCOME LIFE INSURANCE COMPANY

NAIC # 60577 CDI # 1908-3

LIBERTY NATIONAL LIFE INSURANCE COMPANY

NAIC# 65331 CDI# 1679-0

UNITED AMERICAN INSURANCE COMPANY

NAIC #92916 CDI# 2505-6

UNITED INVESTORS LIFE INSURANCE COMPANY

NAIC# 94099 CDI# 2493-5

AS OF JULY 15, 2006

ADOPTED ON November 12, 2008

STATE OF CALIFORNIA



DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

TABLE OF CONTENTS

SALUTATION.....	1
FOREWORD.....	2
SCOPE OF THE EXAMINATION.....	3
EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED.....	4
RESULTS OF REVIEWS OF CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS.....	5
DETAILS OF THE CURRENT EXAMINATION.....	6
TABLE OF TOTAL CITATIONS.....	9
TABLE OF CITATIONS BY LINE OF BUSINESS.....	10
SUMMARY OF EXAMINATION RESULTS.....	12

DEPARTMENT OF INSURANCE

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



November 12, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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 practices and procedures in California of:

Globe Life and Accident Insurance Company

NAIC # 91472

American Income Life Insurance Company

NAIC # 60577

Liberty National Life Insurance Company

NAIC# 65331

United American Insurance Company

NAIC #92916

United Investors Life Insurance Company

NAIC# 94099

Group NAIC # 0290

Hereinafter, the Companies listed above also will be referred to as GLAIC, AILIC, LNLIC, UAIC, UILIC, or the Company or, collectively, as the Companies.

FOREWORD

The examination covered the claims handling practices of the aforementioned Companies during the period July 16, 2005, through July 15, 2006. The examination was made to discover, in general, if these and other operating procedures of the Companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

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 resulted in 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. 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 Companies' 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 Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of 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) consumer complaints and inquiries about these Companies handled by the CDI during the same time period and a review of previous CDI market conduct examination reports on these Companies.

The review of the sample of individual claims files was conducted at the offices of the Companies in Oklahoma City, Oklahoma, McKinney, Texas, and Waco, Texas.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were closed from July 16, 2005 and July 15, 2006, referred to as the "review period". The examiners randomly selected 51 GLAIC claims files, 4 LNLIC claims files, 297 UAIC claims files, 22 UILIC claims files, and 300 AILIC claims files for examination. The examiners cited 46 alleged claims handling violations of the California Insurance Code and other specified codes from this file review.

Findings within the scope of this report included: failure to pay interest on a claim that remained opened longer than 30 days from the date of death, failure to notify the beneficiary that interest will be paid and failure to include the California fraud warning on insurance forms.

**RESULTS OF REVIEWS OF
CONSUMER COMPLAINTS AND INQUIRIES,
AND PREVIOUS EXAMINATIONS**

The Companies were the subject of 20 California consumer complaints and inquiries closed between July 16, 2005 and July 16, 2006 in regard to the line of business reviewed in this examination. The review showed alleged non-compliance with respect to the following: failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied, failure to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, failure to begin investigation and provide necessary forms, instructions, and reasonable assistance within 15 calendar days upon receiving notice of claim, failure to accept or deny the claim within 40 calendar days upon receipt of proof of claim and failure to respond to Department of Insurance claim inquiries within 21 calendar days of receipt of such inquiry. The Examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from April 1, 2001 through March 31, 2002. The most significant noncompliance issues identified in the previous examination report were: failure to provide an explanation of benefit, failure to provide written basis for the denial of a claim, failure to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance and failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied. These issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

GLAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	1,107	27	0
Accident and Disability/Individual Cancer	7	7	0
Accident and Disability/Individual Hospital	17	1	0
Accident and Disability /Individual Medicare Supplement	409	7	0
Accident and Disability / Group Medicare Supplement	1,222	9	0
TOTALS	2,762	51	0

LNLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	173	4	0
TOTALS	173	4	0

UAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life / Individual Life	276	7	0
Accident and Disability/ Individual Cancer	14	14	0
Accident and Disability/Individual Medical	1,074	64	1
Accident and Disability/ Individual Hospital	2,258	65	0
Accident and Disability/ Individual Surgical	66	34	0
Accident and Disability/ Individual Indemnity	7	6	0
Accident and Disability/ Individual Disability	2	2	0
Accident and Disability/ Individual Long-Term Care	487	60	0
Accident and Disability/ Individual Medicare Supplement	444,568	23	0
Accident and Disability/ Group Medicare Supplement	28,687	22	0
TOTALS	477,439	297	1

UILIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	96	2	0
Annuities/ Individual Annuities	39	20	24
TOTALS	135	22	24

AILIC SAMPLE FILES REVIEW

LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Life/ Individual Life	810	39	14
Annuities/ Individual Annuities	3	3	1
Accident and Disability/ Individual Income Disability	12	11	1
Accident and Disability/ Individual Accident and Sickness	1,596	65	0
Accident and Disability/ Individual Cancer	266	54	0
Accident and Disability/ Individual Surgical	42	26	0
Accident and Disability/ Individual Indemnity	63	33	0
Accident and Disability/ Individual Medicare Supplement	3,245	1	0
Life/ Group Life	38	20	3
Life/ Group Accident Death & Dismemberment	120	43	1
TOTALS	6,195	300	20

TABLE OF TOTAL CITATIONS						
Citation	Description	GLAIC	LNLIC	UAIC	UILIC	AILIC
CIC §10172.5(a)	The Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death.	0	0	0	8	18
CIC §10172.5(c)	The Company failed to notify the beneficiary that interest will be paid.	0	0	0	16	1
CIC §10111.2(c)	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.	0	0	0	0	1
CIC §10198.7(b)	The Company excluded coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage.	0	0	1	0	0
Total Citations		0	0	1	24	20

TABLE OF TOTAL CITATIONS General Business Practices		
Citation	Description	COMPANIES
CIC §1879.2(a)	The Company failed to include the California fraud warning on insurance forms.	1
Total Citations		1

TABLE OF CITATIONS BY LINE OF BUSINESS

<p>LIFE</p> <p>2006 AILIC Written Premium: \$ 40,665,299 2006 GLAIC Written Premium: \$32,128,536 2006 UAIC Written Premium: \$11,723,608 2006 LNLIC Written Premium: \$10,263,914 2006 UILIC Written Premium: \$2,251,509</p>	<p>NUMBER OF CITATIONS</p>
<p>AMOUNT OF RECOVERIES \$213.12</p>	
CIC §10172.5(a)	14
SUBTOTAL	14

<p>ANNUITIES</p> <p>2006 AILIC Written Premium: \$ 657 2006 GLAIC Written Premium: \$1,089 2006 UAIC Written Premium: \$101,945 2006 LNLIC Written Premium: \$1,788 2006 UILIC Written Premium: \$30,213</p>	<p>NUMBER OF CITATIONS</p>
<p>AMOUNT OF RECOVERIES \$ 134.74</p>	
CIC §10172.5(a)	8
CIC §10172.5(c)	17
SUBTOTAL	25

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. This report contains alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each criticism, the Companies are required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Companies are obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Companies were asked, and did not indicate, if they intend to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was \$349.51 as described in the sections numbered 1, 2 and 4.

LIFE

1. **In 18 instances, the Companies failed to include interest on a claim that were paid beyond 30 days from date of death.** The Companies miscalculated the amount of interest due from the date of death until the date of processing of the request for issuance of payment. These miscalculations resulted from delays in the issuance of payments as a result of Supervisory reviews, settlement amounts above approval level of adjuster and other administrative processes that prevented immediate issuance of proceeds or payments under a policy of life insurance. The Department alleges these acts are in violation of CIC §10172.5(a).

Summary of Companies' Response: While the Companies do not agree with the Department's interpretation of the statute, the Companies implemented a systems program that adds an additional three days of interest if the benefit amount is under the approval of the adjuster. Moving forward, the Companies will use processing functions designed to limit administrative controls such that claims are processed without delay, thus eliminating the need for the additional interest. As a result of this examination, the Companies issued additional monies to the beneficiaries in the amount of \$213.12.

ANNUITIES

2. **In eight instances, the Companies failed to include interest on a claim that was paid beyond 30 days from date of death.** These instances pertain to the underpayment of interest by the Companies as a result of delays in processing the immediate issuance of payments. The Department alleges these acts are in violation of CIC §10172.5(a).

Summary of Companies' Response: While the Companies do not agree with the Department's interpretation of the statute, the Companies implemented a systems

program that adds an additional one to three days of interest to adjust for any additional processing delays. As a result of this examination, the Companies issued additional monies to the beneficiaries in the amount of \$134.74, after conducting a review of the cited annuity contracts.

3. In 17 instances, the Companies failed to notify the beneficiary that interest will be paid. The Companies did not include any notice to the beneficiaries as to the pertinent rate of interest applied on the settlement proceeds. The Department alleges these acts are in violation of CIC §10172.5(c).

Summary of Companies' Response: The Companies acknowledge these findings and indicate that they will be addressed with the individual claims staff for reinforcement and compliance.

ACCIDENT AND DISABILITY

4. 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. Interest was omitted on two weeks' benefits not paid within regulatory timelines. The Department alleges this act is in violation of CIC §10111.2(c).

Summary of Company Response: The Company acknowledges this finding and indicates that this was an inadvertent error which has been addressed with its policy benefits department. As a result of this examination, the Company issued additional monies to the beneficiary in the amount of \$1.65.

5. In one instance, the Company excluded coverage on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. The Company denial letter references the Insuring Clause that states a "loss due to a pre-existing condition is not covered unless the loss is incurred more than 2 years after the effective date". California law mandates that pre-existing condition provisions cannot exceed six months following the insured's effective date of coverage. The Department alleges this act is in violation of CIC §10198.7(a).

Summary of Company Response: The Company acknowledges that the language in the policy is not in conformity with the statute of no more than six months for pre-existing condition provisions. However, the Company indicates that for this specific one instance, the inaccurate information had no effect or relevance on the actual denial as the policyholder's pre-existing condition was within the 6-month regulatory timeline.

With regard to the policy language, the Company indicates that it is in the process of re-filing the policy form in question with language limiting the pre-existing condition exclusion to six months. In the interim, the denial letter format referenced in this one instance was modified in February 2006 to reflect a six-month pre-existing condition exclusionary period rather than the two-year period.

GENERAL BUSINESS PRACTICES

6. **The Companies failed to include the California fraud warning on insurance forms.** The Companies' claim forms did not contain the statutory California fraud language. In the previous examination report as of March 31, 2002, there were 209 citations for this violation and the Companies indicated they would revise all pertinent claim forms to be in compliance. The Department alleges these acts are in violation of CIC §1879.2(a).

Summary of Companies' Response: The Companies acknowledge that in the previous examination, the Department raised this issue with regard to American Income Life and Globe Life and Accident Insurance Company. As a result of the previous examination, the Companies modified their respective claim forms to include the word-specific California language. Liberty National Life Insurance Company is one of the Companies that use claim forms which contained substantially "similar language" under the heading "Certificate of Information". In the spirit of cooperation, the Companies have modified this language pursuant to the requirement under CIC § 1879.2(a). The Companies provided the Department with a draft claim form for Liberty National Life Insurance Company containing the required language on August 4, 2008.

EXHIBIT 3

PUBLIC REPORT OF EXAMINATION OF THE CLAIMS

PRACTICES OF THE

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

NAIC # 91472 CDI # 2439-8

AMERICAN INCOME LIFE INSURANCE COMPANY

NAIC # 60577 CDI # 1908-3

LIBERTY NATIONAL LIFE INSURANCE COMPANY

NAIC # 65331 CDI # 1679-0

UNITED AMERICAN INSURANCE COMPANY

NAIC # 92916 CDI # 2505-6

UNITED INVESTORS LIFE INSURANCE COMPANY

NAIC # 94099 CDI # 2493-5

AS OF MARCH 31, 2002

STATE OF CALIFORNIA



DEPARTMENT OF INSURANCE

FIELD CLAIMS BUREAU

TABLE OF CONTENTS

SALUTATION.....1

SCOPE OF THE EXAMINATION.....2

CLAIMS SAMPLE REVIEWED AND OVERVIEW OF FINDINGS.....3

TABLE OF TOTAL CITATIONS.....4

SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS
AND TOTAL RECOVERIES..... 5

CALIFORNIA DEPARTMENT OF INSURANCE

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



January 2, 2003

The Honorable Harry W. Low
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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 practices and procedures in California of:

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**NAIC # 91472****AMERICAN INCOME LIFE INSURANCE COMPANY****NAIC # 60577 CDI # 1908-3****LIBERTY NATIONAL LIFE INSURANCE COMPANY****NAIC # 65331 CDI # 1679-0****UNITED AMERICA INSURANCE COMPANY****NAIC # 92916 CDI # 2505-6****UNITED INVESTORS LIFE INSURANCE COMPANY****NAIC # 94099 CDI # 2493-5**

Hereinafter referred to as GL, AI, LN, UA, UI or the Companies

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Companies during the period April 1, 2001 through March 31, 2002. The examination was made to discover, in general, if these and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.
2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted at the headquarters of Globe Life and Accident Insurance Company in Oklahoma City, Oklahoma and American Income Life Insurance Company in Waco, Texas.

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period April 1, 2001 through March 31, 2002, commonly referred to as the "review period". The examiners reviewed 100 GL claims files, 154 AI claim files, 82 LN claim files, 119 UA claim files and 30 UI claim files. The examiners cited 111 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Globe Life and Accident Insurance Company (GL)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	1,006	63	0
Individual Health	170	37	30
TOTALS	1,176	100	30

American Income Life Insurance Company (AI)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Group and Individual Life	722	63	2
Group Accidental Death and Dismemberment	96	24	2
Individual Disability	2,453	67	44
TOTALS	3,271	154	48

Liberty National Life Insurance Company (LN)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	367	69	0
Individual Health	13	13	5
TOTALS	380	82	5

United American Life Insurance Company (UA)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	488	55	0
Individual Health	997	64	28
TOTALS	1,485	119	28

United Investors Life Insurance Company (UI) Individual Life			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	55	30	0
TOTALS	55	30	0

TABLE OF TOTAL CITATIONS

Citation	Description	GL	AI	LN	UA	UI
CCR § 2695.11(b)	The Company failed to provide a clear explanation of the computation benefits.	29	43	0	27	0
CCR 2695.7(b)(1)	The Company failed to provide written basis for the denial of the claim	1	1	5	0	0
CCR § 2695.7(b)(3)	The Company failed to include the claimant's right to a CDI review in the denial notice.	0	3	0	0	0
CCR § 2695.3(b)(3)	The Company failed to maintain hard claim files that are accessible, legible, and capable of duplication to hard copy for five years.	0	1	0	0	0
CCR § 2695.7(c)(1)	The Company failed to provide written notice of the need for additional time every thirty calendar days,	0	0	0	1	0
Total Citations		30	48	5	28	0

SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES

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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. 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. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. There were no recoveries discovered within the scope of this report.

1. **The Companies failed to provide an explanation of benefits.** In 99 instances, the Companies failed to provide to the insured an explanation of benefits including a clear explanation of the computation of benefits. The Companies' Explanation Of Benefits (EOB) form did not contain information as regards the charges incurred and the applicable co-insurance factors. The Department alleges these acts are in violation of CCR § 2695.11(b).

Summary of Companies' Response: These errors were brought to the attention of the Companies and they are in the process of updating their systems in order to produce EOB's that fully address the requirements of CCR § 2695.11(b). In the interim, the Companies have developed an EOB form that includes a clear explanation of the computation of benefits as required by CCR § 2695.11(b). A copy of this form has been provided to the examiners. Lastly, claims personnel have been apprised of the errors noted during the on-site examination and management directives have been issued accordingly.

2. **The Companies failed to provide written basis for the denial of the claim.** In seven instances, the Companies failed to provide the written basis for denial of the claim. These errors involve failure to issue partial denials of benefits when not all charges submitted were covered. This deficiency was found in two of the files cited. Also, the examiners noted five files in which the notice issued to insureds was incomplete as the basis for the denial failed to identify the applicable policy provisions and/or limitations. The Department alleges these acts are in violation of CCR § 2695.7(b)(1).

Summary of Companies' Response: The Companies have instituted changes in their written notices in order to include the specific bases for denials and a copy of the revised language was provided to the examiners. Additionally, files will be monitored to ensure issuance of partial denials, where appropriate. Claims personnel have been apprised of the errors noted during the on-site examination and management directives have been issued accordingly.

3. **The Companies failed to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance.** In three instances, the Company failed to include a statement in their claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR § 2695.7(b)(3).

Summary of Companies Response: The Companies have acknowledged the errors and claims personnel have been advised accordingly through the issuance of management directives.

4. **The Companies failed to comply with the Fair Claims Practices Regulations** In one instance each, the Companies failed to comply with the following Fair Claims Practices Regulations: CCR § 2695.3(b)(3) and CCR § 2695.7(c)(1).

Summary of Companies Response: The Companies have acknowledged the above instances of non-compliance. Claims personnel have been apprised of the errors noted during the on-site examination and management directives have been issued accordingly.

EXHIBIT 4

REPORT OF EXAMINATION OF THE CLAIMS

PRACTICES OF THE

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

NAIC # 91472 CDI # 2439-8

AMERICAN INCOME LIFE INSURANCE COMPANY

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UNITED INVESTORS LIFE INSURANCE COMPANY

NAIC # 94099 CDI # 2493-5

AS OF MARCH 31, 2002

STATE OF CALIFORNIA



DEPARTMENT OF INSURANCE

FIELD CLAIMS BUREAU

CONFIDENTIALITY STATEMENT

The Field Claims Bureau Examination Report contained herein, including any addendum hereto, is confidential unless and until the Insurance Commissioner, by the authority vested in him pursuant to Section 735.5 of the California Insurance Code, determines otherwise.

TABLE OF CONTENTS

SALUTATION.....	1
SCOPE OF THE EXAMINATION.....	2
CLAIMS SAMPLE REVIEWED AND OVERVIEW OF FINDINGS.....	3
TABLE OF TOTAL CITATIONS.....	4
SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES.....	5

CALIFORNIA DEPARTMENT OF INSURANCE

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



January 2, 2003

The Honorable Harry W. Low
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

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UNITED INVESTORS LIFE INSURANCE COMPANY

NAIC # 94099 CDI # 2493-5

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This report is to be maintained as a confidential document pursuant to California Insurance Code section 735.5.

SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Companies during the period April 1, 2001 through March 31, 2002. The examination was made to discover, in general, if these and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

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2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

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Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period April 1, 2001 through March 31, 2002, commonly referred to as the "review period". The examiners reviewed 100 GL claims files, 154 AI claim files, 82 LN claim files, 119 UA claim files and 30 UI claim files. The examiners cited 356 claims handling violations of the California Insurance Code within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Globe Life and Accident Insurance Company (GL)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	1,006	63	52
Individual Health	170	37	0
TOTALS	1,176	100	52

American Income Life Insurance Company (AI)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Group and Individual Life	722	63	104
Group Accidental Death and Dismemberment	96	24	0
Individual Disability	2,453	67	49
TOTALS	3,271	154	153

Liberty National Life Insurance Company (LN)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	367	69	39
Individual Health	13	13	1
TOTALS	380	82	40

United American Life Insurance Company (UA)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	488	55	61
Individual Health	997	64	0
TOTALS	1,485	119	61

United Investors Life Insurance Company (UI)			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Individual Life	55	30	50
TOTALS	55	30	50

TABLE OF TOTAL CITATIONS

Citation	Description	GL	AI	LN	UA	UI
CIC § 1879.2	The Companies failed to include California fraud warning on insurance forms.	18	112	16	33	30
CIC § 10172.5(c)	The Companies failed to specify the rate of interest to the beneficiary.	34	40	17	28	20
CIC § 10172.5(a)	The Companies failed to pay interest on a claim, unpaid longer than thirty days from the date of death.	0	1	7	0	0
Total Citations		52	153	40	61	50

**SUMMARY OF CRITICISMS, INSURER
COMPLIANCE ACTIONS AND TOTAL RECOVERIES**

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 Companies are required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Companies, it is the Companies' obligation to ensure that compliance is achieved. The total money recovered was \$149.03 within the scope of this report.

1. **The Companies failed to include California fraud language on insurance forms.** In 209 instances, the Companies failed to include the California fraud warning on insurance forms. The fraud warning used by the Companies on their forms did not conform to the language required in CIC § 1879.2. The Department alleges these acts are in violation of CIC § 1879.2.

Summary of Company Response: These errors were brought to the attention of the Companies and all pertinent forms are in the process of being revised in accordance with the cited code section. Copies of the revised forms will be provided to the Department and the Companies have advised their claims personnel accordingly.

2. **The Companies failed to notify the beneficiary that interest will be paid or failed to specify the rate of interest.** In 139 instances, the Companies failed to specify the rate of interest to the beneficiary. The Department alleges these acts are in violation of CIC § 10172.5(c).

Summary of Company Response: These errors were brought to the attention of the Companies and their procedures have been changed in order to assure compliance with the CIC § 10172.5(c). Claims personnel have been apprised of the errors noted during the on-site examination and management directives have been issued accordingly.

3. **The Companies failed to pay interest on a claim, unpaid longer than thirty days from the date of death.** In eight instances, the Companies failed to pay interest on a claim, unpaid longer than thirty days from the date of death. The Department alleges these acts are in violation of CIC § 10172.5(a).

Summary of Company Response: These errors were brought to the attention of the Companies and required interest payments were issued to the pertinent beneficiaries. Claims personnel have been apprised of the errors noted during the on-site examination and management directives have been issued accordingly. In addition, the Company has agreed to conduct a self-review of all claims, paying interest on any claim that was unpaid longer than third days from the date of death. The Company will report the results of the self-review to the Department.