

The following table is a synopsis of the 100 policies terminated.

Number	Termination Reason	Percent
32	Death	32%
26	Insured Request	26%
23	Exchange to Group Plan	23%
11	Free Look Provision Exercised	11%
3	Lapse	3%
3	Coverage Expiration	3%
2	Not-Taken	2%

R. Annuities Not-Taken

The Company was requested to provide a list of annuities not-taken during the experience period. The Company identified a universe of 43 annuities not-taken. All 43 annuity files were requested, received and reviewed. A not-taken annuity by definition is a contract that is issued and the annuitant requests cancellation. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

S. Life Policies Not-Taken

The Company was requested to provide a list of life policies not-taken during the experience period. The Company identified a universe of 273 life policies not-taken. A random sample of 50 not-taken policy files was requested, received and reviewed. A not-taken policy by definition is a policy that is issued and the insured requests cancellation. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

T. Accident and Health Policies Not-Taken

The Company was requested to provide a list of all health insurance contracts not-taken during the experience period. The Company identified a universe of 373 contracts not-taken. A random sample of 50 not-taken files was requested, received and reviewed. A not-taken contract by definition is a contract that is issued and the insured requests cancellation. The 50 not-taken health insurance contracts consisted of 25 Long Term Care contracts, 14 Medicare Supplement contracts, 10 Convalescent Care contracts and 1 Disability Income contract. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

U. Annuities Issued as Replacements

The Company identified a universe of 215 annuity policies issued as replacements during the experience period. A sample of 50 files was requested, received and reviewed. The policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

2 Violations - Insurance Company Law, Section 404-A (40 P.S. §625-4)

When the individual policy or annuity is delivered to the policyholder by the producer by hand, a delivery receipt shall be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be

provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered by a means other than by hand delivery by the producer, the insurer shall establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence. Policy delivery could not be verified in the 2 noted files.

1 Violation - Title 31, Pennsylvania Code, Section 81.6(c)

The replacing insurer shall maintain evidence of the Notice Regarding Replacement of Life Insurance and Annuities. The noted file did not contain a copy of the required notice of replacement.

V. Life Policies Issued as Replacements

The Company identified a total universe of 110 life policies issued as replacements during the experience period. A sample of 50 files was requested, received, and reviewed. The policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 81.5 (b)

The insurer shall require as part of a completed application for life insurance or annuity a statement signed by the applicant as to whether the proposed insurance or annuity will replace existing life insurance or annuity. The applicant's replacement question was not answered in the noted application.

1 Violation - Title 31, Pennsylvania Code, Section 81.6 (a)(1)

An insurer that uses an agent or broker in a life insurance or annuity sale shall:
Require with or as part of a completed application for life insurance or annuity a statement signed by the agent or broker as to whether the broker knows replacement is or may be involved in the transaction. The agents question on replacement was not completed in the noted application.

1 Violation - Title 31, Pennsylvania Code, Section 81.6 (a)(2)(ii)

An insurer that uses an agent or broker in a life insurance or annuity sale shall, if replacement is involved: Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained under subparagraph (I) and in the case of life insurance, the disclosure statement as required by § 83.3 (relating to disclosure statement) or ledger statement containing comparable policy data on the proposed life insurance. This written communication shall be made within 3 working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner. The replacement letter to the replaced company was not documented in the noted file.

1 Violation - Title 31, Pennsylvania Code, Section 81.6(c)

The replacing insurer shall maintain evidence of the Notice Regarding Replacement of Life Insurance and Annuities. The noted file did not contain a copy of the required notice of replacement.

1 Violation - Insurance Company Law, Section 404-A (40 P.S. §625-4)

When the individual policy or annuity is delivered to the policyholder by the producer by hand, a delivery receipt shall be used. This receipt must be in at least

a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered by a means other than by hand delivery by the producer, the insurer shall establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence. Policy delivery could not be verified in the noted file.

W. Accident and Health Policies Issued as Replacements

The Company initially identified a total universe of 228 Accident and Health policies issued as replacements during the experience period. A random sample of 45 files was requested, received and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

1 Violation – Title 31, Pennsylvania Code, Section 88.101. Application Forms
Application forms shall contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used. The applicant's replacement question was not answered in the noted application.

3 Violations – Title 31, Pennsylvania Code, Section 88.102

Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant at the time of completing the application, the notice described in § 88.103 of this title (relating to notice form). One copy of such notice shall be furnished to the applicant and an additional copy signed by the applicant shall be retained by the insurer. The noted files did not contain a copy of the required notice of replacement.

X. Term Life Conversions

The Company identified a total universe of 9 term life policies converted during the experience period. All 9 converted policy files were requested, received and reviewed. The 9 term conversions resulted in the issuance of 5 flexible premium life policies and 4 whole life policies. The files were reviewed to determine compliance to issuance and underwriting statutes and regulations. The following violations were noted:

2 Violations - Insurance Company Law, Section 404-A (40 P.S. §625-4)

When the producer delivers the individual policy or annuity to the policyholder by hand, a delivery receipt shall be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered by a means other than by hand

delivery by the producer, the insurer shall establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence. Policy delivery could not be verified in the 2 files noted.

IX. Internal Audits and Compliance Procedures

The Company was requested to provide copies of their internal audit and compliance procedures. The audits and procedures were reviewed to ensure compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides for the establishment and maintenance of internal audit and compliance procedures, which provides for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising, and filing and approval requirements for life insurance and annuities. The procedures shall also provide for the following:

- (1) Periodic reviews of consumer complaints in order to determine patterns of improper practices.
- (2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.
- (3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

No violations were noted.

X. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided a comprehensive reference manual consisting of the plan descriptions, claim descriptions, claim content descriptions, system processing guides, correspondence formats (form letters), and summaries of standards for Life and Health insurance claims. The claim procedures and manuals were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Claim file review consisted of six areas:

- A. Annuity Claims
- B. Life Claims
- C. Individual Accident and Health Paid Claims
- D. Individual Accident and Health Denied Claims
- E. Group Medicare Supplement Paid Claims
- F. Group Medicare Supplement Denied Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The insured submitted claims were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices and the provider submitted claims were reviewed for compliance with Act 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. The life claims were additionally reviewed for compliance with Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b).

A. Annuity Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 134 annuity claims. A random sample of 25 claims was requested, received and reviewed. The claim files were reviewed for compliance with Act 205 and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

2 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The 2 claims noted were missing the claim forms.

2 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. The 2 files noted were absent any evidence this requirement was complied with.

7 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable

written explanation for the delay and state when a decision on the claim may be expected. The 7 files noted were absent any evidence this requirement was complied with.

B. Life Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 652 paid life insurance claims and 25 denied life claims. A random sample of 50 paid claims and all 25 denied claims were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest. The following violations were noted:

2 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The 2 files noted were incomplete or missing pertinent data.

5 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The 6 files noted were absent any evidence this requirement was complied with.

12 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The 12 files noted were absent any evidence this requirement was complied with.

C. Individual Accident and Health Paid Claims

The Company was requested to provide a list of all health claims received during the experience period. The Company identified 258,252 individual health claims paid and 11,636 health claims denied. Of the 258,252 claims paid, 247,403 were paid to providers, 10,527 were paid to insureds and 322 were paid to both providers and insureds. Initially, an auditing program was used to query the 247,403 paid provider claims to identify claims that were paid over 45 days from the date of receipt. The result of that query was that all paid health claims were paid within 45 days. In order to verify the claim data listed, a random sample of 120 paid claim files was requested, received and reviewed. Of the 120 claim files reviewed, 104 were paid to providers and 16 were paid to insureds. The insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and the provider-submitted claim files were reviewed for compliance with Act 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. No violations were noted.

D. Individual Accident and Health Denied Claims

The Company was requested to provide a list of all health claims received during the experience period. The Company identified 258,252 individual health claims paid and 11,636 health claims denied. A random sample of 100 health denied claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

E. Group Medicare Supplement Paid Claims

The Company was requested to provide a list of all health claims received during the experience period. The Company identified 75,028 Group Medicare Supplement claims paid and 3,394 Group Medicare Supplement claims denied. Of the 75,028 claims paid, 72,593 were paid to providers, 2,384 were paid to insureds and 51 were paid to both providers and insureds. Initially, an auditing program was used to query the 72,593 paid provider claims to identify claims that were paid over 45 days from the date of receipt. The result of that query was that 72,587 provider-paid health claims were paid within 45 days and 6 provider-paid claims were paid over 45 days from the date of receipt. In order to verify the claim data listed, a random sample of 100 paid-provider claim files and the 6 provider claims paid over 45 days were requested. In addition, an auditing program was used to query the 2,384 insured-paid claims to identify claims paid over 15 days from the date of receipt. The result of that query was that 17 insured-paid claims were identified as paid over 15 days. These 17 claim files were also requested for review. All 123 claim files requested, were received and reviewed. The insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania

Code, Chapter 146 and the provider-submitted claim files were reviewed for compliance with Act 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. The following violations were noted:

4 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The 4 claim files noted were incomplete or missing pertinent data.

7 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The 7 files noted were absent any evidence this requirement was complied with.

3 Violations-Act 68, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The 3 noted clean claims were not paid within 45 days of receipt.

F. Group Medicare Supplement Denied Claims

The Company was requested to provide a list of all health claims received during the experience period. The Company identified 75,028 Group Medicare Supplement paid claims and 3,394 Group Medicare Supplement denied claims. A random sample of 100 Group Medicare Supplement denied claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

4 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The claim files noted were incomplete or missing pertinent data.

The following table summarizes the reasons for claim denial.

Number	Claim Denial Reason	Percent
49	Medicare Part B Deductible Not Met	49%
27	Duplicate Claim	27%
9	Insurance Lapsed or Ended	9%
6	Charges Not a Covered Benefit	6%
4	100% Medicare Paid Benefit	4%
3	Loss Occurred Prior to Issue	3%
2	Insurance Voided	2%

XI. RECOMMENDATIONS

The following recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253).
2. The Company must review internal control procedures to ensure compliance with prompt payment of claim requirements of Act 68, Section 2166 (40 P.S. §991.2166).
3. The Company must review internal control procedures to ensure compliance with claims settlement practice requirements of Title 31, Pennsylvania Code, Chapter 146.
4. The Company must review internal control procedures to ensure compliance with disclosure requirements of Title 31, Pennsylvania Code, Chapter 83.
5. The Company must review internal control procedures to ensure compliance with replacement requirements of Title 31, Pennsylvania Code, Chapter 81 and Chapter 89.
6. The Company must review internal control procedures to ensure compliance with application and outline of coverage requirements of Title 31, Pennsylvania Code, Chapter 88.
7. The Company must review internal control procedures to ensure compliance with forms filing and approval requirements of Insurance Company Law, Section 354 (40 P.S. §477b).

8. The Company must implement internal control procedures to ensure compliance with policy delivery receipt requirements of Insurance Company Law, Section 404-A (40 P.S. §625-4).
9. The Company must review internal control procedures to ensure compliance with illustration certification and delivery requirements of Insurance Company Law, Section 408-A (40 P.S. §625-8).
10. The Company must review internal control procedures to ensure compliance with the "Free Look" provisions of Insurance Company Law, Section 410 (40 P.S. §510).
11. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.
12. The Company must ensure all applications contain the fraud notice required by Title 18, Pa. C.S., Section 4117(k).

XII. COMPANY RESPONSE


BANKERS
LIFE AND CASUALTY COMPANY
We specialize in seniors

Commonwealth of Pennsylvania
Insurance Department
Bureau of Enforcement
Market Conduct Division
1321 Strawberry Square
Harrisburg, PA 17120

May 5, 2004

Attn: Chester A. Derk Jr., AIE, HIA
Market Conduct Division Chief

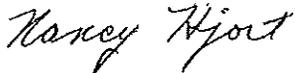
Re: Examination Warrant Number: 02-M12-024

Dear Mr. Derk:

The Company appreciates the courteous, timely and professional manner in which the examination was conducted by Mr. Daniel Stemcosky, Mr. Michael Jones, Ms. Deborah Lee and the Pennsylvania Department of Insurance.

The Company respectfully submits the attached response to the Examination Report.

Very truly yours,



Nancy Hjort
Manager, Consumer Relations
312-396-6619

CC: Karren Leonard
Assistant Vice President
Consumer Relations

CC: James Valdez
Vice President
Legal

CC: Ron Kotowski
Vice President
Compliance

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SECTION IV. ADVERTISING and SECTION V. FORMS

The Company was alleged to be in violation of Title 18 PA.C.S., Section 4117(k) for failing to include fraud warning language on the following 6 application forms:

REPORT SECTION	APPLICATION #	DESCRIPTION
Advertising	L-12570-PA	Whole Life
Advertising	3833-PL	Accident Only
Advertising	7353	Hospital Confinement Indemnity
Forms	11602A-PA	Whole Life
Forms	L-12570-PA	Whole Life
Forms	12046A-PA	Disability Income
Forms	2260A(86)	Juvenile Life

It does not appear to the Company that this statute pertains to life or disability income insurance applications.

Title 18 PA. C.S., Section 4117(k) appears to be clearly directed to health insurance only. Both the definitions of "Insurance Policy" and "Insurer" found in this section refer to health insurance:

"Insurance Policy." A document setting forth the terms and conditions of a contract of insurance or agreement for the coverage of **health or hospital services**. (emphasis added) Subparagraph (3)(k)(1) requires certain fraud language in "All applications for insurance and claim forms". The statute is completely silent concerning any form of insurance other than health. Yet, the Section defines an insurance policy as health insurance. There is no mention of life insurance or any other types of insurance.

The language is specific and not broad in both the definitions of a "policy" and "Insurer". It appears to the Company that it is very clear that Subparagraph (3)(k)(1) applies to only health insurance policies.

Although it does not appear to the Company that 4 of the 6 applications are in violation of the statute, the Company has revised all 6 of the applications to include fraud warning language. The life and disability income applications have been filed and approved by the Department. All 6 applications are currently in use. Please refer to the Advertising/Forms Exhibit.

All future life and disability income applications will contain the fraud warning language.

The Company was alleged to be in violation of Insurance Company Law, Section 354(40 P.S. s477b) for utilizing 2 forms with Medicare Supplement applications that were not filed with the Department for approval. The 2 forms are 12513-AU and 14119-PA(4/99).

The Company respectfully disagrees that these forms fall under the scope of this law. Form 14119-PA(4/99) is an acknowledgement form that the Company utilizes in order to comply with Pennsylvania delivery requirements. It is not part of the application. Section 40-39-607(g)(1) states, "Insurers issuing medicare supplement policies subject to this act shall deliver an outline of coverage to the applicant at the time application is made and, except for the direct response policy, acknowledgment of receipt or certification of delivery of such outline of coverage shall be provided to the insurer." Pennsylvania insurance code is very definitive regarding forms needing prior Department approval. The Company is unaware of a regulation mandating filing of forms needed to satisfy Section 40-39-607(g)(1). While literally every other state has this same delivery requirement, no other state has ever required that such forms be submitted for approval prior to use.

The Section states that it is unlawful to issue, sell or dispose of any policy, contract or certificate or use applications, riders, or endorsements, in connection therewith, until the forms of the same have been submitted to and formally approved by the Insurance Commissioner.

The Company's interpretation of the Section is:

It is unlawful to issue, sell or dispose of any policy, contract or certificate or use applications, riders, or endorsements, in connection therewith (issuing, selling or disposing of any policy), until the forms of the same (applications, riders, or endorsements) have been submitted to and formally approved by the Insurance Commissioner.

It appears to us, that the phrase "in connection therewith," refers to applications, riders or endorsements used "in connection" with a policy, contract or certificate. It does not appear the phrase "in connection therewith," should be tied to documents used "in connection" with an application, rider or endorsement.

Form 12513-AU is an authorization for release of medical information. It is not a part of the application. The Company is unaware of a regulation mandating filing of authorizations for release of medical information.

Section 354 states, in part, "...use applications, riders or endorsements, in connection therewith, until the forms of the same have been submitted to and formally approved by the Insurance Commissioner." Forms 12513-AU and 14119-PA(4/99) are not applications, riders or endorsements which would appear to fall under the scope of this law.

Although it does not appear to the Company that these forms are required to be filed, the Company has filed both of the forms with and received approval from the Department. Please see the Advertising/Forms Exhibit. In the future, the Company will also file any similar forms with the Department.

SECTION X. A. ANNUITY CLAIMS AND SECTION X. B. LIFE CLAIMS

The Company was alleged to be in violation of Title 31, Pennsylvania Code, Section 146.6 for failing to provide timely claim investigation status letters for 7 annuity and 12 life claims. It does not appear to the Company that it violated the statute.

Section 146.2 defines notification of a claim as:

"Notification of claim - a notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim."

Section 146.6 indicates that an investigation of a claim must be completed within 30 days of the notification of claim. It does not appear to us that a call or letter simply advising us of an insured's death "reasonably apprises the Company of the facts pertinent to a claim" and could be considered "notification of claim." Without such pertinent facts, it would not appear the "notification of claim" requirement of Section 146.2 was met to trigger the "investigation" requirements of Section 146.6. The Company obtains facts pertinent to a claim upon receipt of proof of loss, such as a claim form or death certificate.

With respect to these specific claims, they were not of such a nature that they needed to be investigated. Once complete proof of loss was received, the claims were paid without investigation.

Although it does not appear to the Company that the claims cited are in violation of Section 146.6, we have already implemented procedures to assure status letters will be sent within 30 days of notification of loss and every 45 days thereafter. The field has been notified to inform the Home Office immediately upon notification of a death claim. This will allow the claim adjuster to contact the claimant within 30 days and allow for follow up letters to be sent at 45 day intervals. Please see the Annuity/Life Claims Exhibit.

SECTION XI. RECOMMENDATIONS

Report Recommendation 1.

The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Section 605, Section 606 and Section 623 (40P.S. ss235, 236 and 253).

Company Response:

The Company was not found to be in violation of Section 605 and Section 623 (40P.S. ss235 and 253). No applications were found to be accepted by the Company after an agent was terminated by the Company. No applications were found to be accepted by the Company by an agent without a license. The Company was found to be in violation of Section 606 (40P.S. s236) for failure to report one agent termination to the Department.

The Company uses AppointPak to notify the Department electronically of agent appointments and terminations. The examiners reviewed 188 active agent records and 50 terminated agent records. Of these 238 records, only one (1) violation was found for an agent terminated by the Company July 27, 2002. The termination was inadvertently not reported to the Insurance Department at that time. The termination was reported to the Insurance Department during the examination period. For documentation, please see the Exhibit for Recommendation 1.

This one isolated instance was due to human error. The Company has adequate procedures in place to ensure compliance with Pennsylvania licensing procedures.

Report Recommendation 2.

The Company must review internal control procedures to ensure compliance with prompt payment of claim requirements of Act 68, Section 2166 (40P.S. s991.2166).

Company Response:

The Company has implemented an improved report that enhances current open claim reporting. This report is automatically disbursed to Claim supervisors on a weekly basis, allowing tracking of all open claims.

Report Recommendation 3.

The Company must review internal control procedures to ensure compliance with claims settlement practice requirements of Title 31, Pennsylvania Code, Chapter 146.

Company Response:

The Company has reviewed its internal control procedures to ensure compliance with Title 31, Pennsylvania Code, Chapter 146. The Company has:

- Issued a reminder to the field to use Company Form 2196 to record claim information, including the date of first notification.
- Issued a directive to the field to notify the Home Office immediately upon notification of a death.
- Changed follow up handling to send status letters within 30 days and 45 days thereafter for all pending life and annuity claims.
- Implemented a system to scan and image all incoming documents. This allows the Company to record the date of receipt for all items.

For documentation, please see the Exhibit for Report Recommendation 3.

Report Recommendation 4.

The Company must review internal control procedures to ensure compliance with disclosure requirements of Title 31, Pennsylvania Code, Chapter 83.

Company Response:

The Company has reviewed its internal control procedures and has issued a directive to its agents in Pennsylvania to leave one completed copy of the Surrender Comparison Index Disclosure Form with the policyholder and return a copy to the Home Office. For documentation, please see the Exhibit for Recommendation 4.

Report Recommendation 5.

The Company must review internal control procedures to ensure compliance with replacement requirements of Title 31, Pennsylvania Code, Chapter 81 and Chapter 89.

Company Response:

The Company's underwriting management conducted a review session on May 5 with underwriters, with special attention to the replacement aspect of applications. Department of insurance regulations were reinforced. Management will perform audits of applications to assure compliance.

Report Recommendation 6.

The Company must review internal control procedures to ensure compliance with application and outline of coverage requirements of Title 31, Pennsylvania Code, Chapter 88.

Company Response:

The Company reviewed its internal control procedures. Issue System edits are in place to alert the underwriter of the need for outline of coverage forms, replacement forms and complete answers to questions appearing on the application. Company procedures have been reinforced with the underwriters.

Report Recommendation 7.

The Company must review internal control procedures to ensure compliance with forms filing and approval requirements of Insurance Company Law, Section 354 (40 P.S. s477b).

Company Response:

The Company was alleged to be in violation of this Section for utilizing two (2) forms, 12513-AU and 14119-PA(4/99), with Medicare Supplement applications that were not filed with the Department for approval. Although it does not appear to the Company that these forms fall under the scope of this law, the forms were filed on January 9, 2004. Please see the Exhibit for Recommendation 7. for documentation of the Department's approval dated February 9, 2004. In the future, the Company will also file any similar forms with the Department.

Report Recommendation 8.

The Company must implement internal control procedures to ensure compliance with policy delivery receipt requirements of Insurance Company Law, Section 404-A (40P.S. s625-4).

Company Response:

The Company issued a reminder dated June 30, 2003 to all agents, managers and administrators instructing them to forward one copy of the completed policy delivery receipt to the Home Office. All correspondence is now scanned upon receipt at the Home Office. Policy delivery receipts will be scanned and available for review. Please see the Exhibit for Recommendation 8. for the reminder memorandum to the field.

Report Recommendation 9.

The Company must review internal control procedures to ensure compliance with illustration certification and delivery requirements of Insurance Company Law, Section 408-A (40P.S. s625-8).

Company Response:

The Company reviewed its internal control procedures to ensure compliance with illustration certification and delivery and determined one underwriter was responsible for the mistakes. The underwriter has been counseled. Underwriting management conducted a review session with underwriters on May 5. Information in the Company booklet "Understanding the NAIC Life Illustration Model Regulation" was reinforced. Please see the Exhibit for Recommendation 9.

Report Recommendation 10.

The Company must review internal control procedures to ensure compliance with the "Free Look" provisions of Insurance Company Law, Section 410 (40P.S. s510).

Company Response:

One out of fifty annuity policies reviewed by the examiners was found to have been in violation. It had a 20 day rather than a 45 day free look provision. The Company issues annuities with a 45 day free look provision for annuity policies issued as replacements for a policy with the same company (Bankers). The Company has changed its procedures to provide for a 45 day free look provision in all replacement sales for annuity policies issued as replacements for any Consecoco company policy.

Report Recommendation 11.

The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40P.S. s323.3) of the Insurance Department Act.

Company Response:

The examiners requested 1,496 files for review. The Company regrets 2 health rejected files (0.13%) were not available for review. The Company now scans all incoming documents.

Report Recommendation 12.

The Company must ensure all applications contain the fraud notice required by Title 18, PA.C.S., Section 4117(k).

Company Response:

Although it does not appear to the Company that this Section applies to life or disability income applications, the Company has added fraud language to all six applications. The life and disability applications were filed with and approved by the Department. Please see the Exhibit for Recommendation 12. All future life and disability applications will contain the fraud warning language.

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Pennsylvania

Insurance Related Laws

Updated through the 186th Regular and Special Sessions (2002)

Book II Consolidated Statutes ... TITLE 18 -- CRIMES AND OFFENSES ... Part II. Definition of Specific Offenses -- Article C. Offenses Against Property ... Chapter 41 -- FORGERY AND FRAUDULENT PRACTICES

18-4117

Offenses; definitions; penalties

Parallel Citations 18 Pa.C.S.A. s 4117

(a) Offense defined. -- A person commits an offense if the person does any of the following:

(1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency's determination in approving or disapproving a motor vehicle insurance rate filing, a motor vehicle insurance transaction or other motor vehicle insurance action which is required or filed in response to an agency's request.

(2) Knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim.

(3) Knowingly and with the intent to defraud any insurer or self-insured, assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer or self-insured in connection with, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim, including information which documents or supports an amount claimed in excess of the actual loss sustained by the claimant.

(4) Engages in unlicensed agent, broker or unauthorized insurer activity as defined by the act of May 17, 1921 (P.L. 789, No. 285), known as The Insurance Department Act of one thousand nine hundred and twenty-one, {Footnote 1} knowingly and with the intent to defraud an insurer, a self-insured or the public.

(5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.

(6) Is the owner, administrator or employee of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.

(7) Borrows or uses another person's financial responsibility or other insurance identification card or permits his financial responsibility or other insurance identification card to be used by another, knowingly and with intent to present a fraudulent claim to an insurer.

(8) If, for pecuniary gain for himself or another, he directly or indirectly solicits any person to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action against any person for damages for negligence or for pecuniary gain for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, provided, however, that this paragraph shall not apply to any conduct otherwise permitted by law or by rule of the Supreme Court.

(b) Additional offenses defined. --

(1) A lawyer may not compensate or give anything of value to a nonlawyer to recommend or secure employment by a client or as a reward for having made a recommendation resulting in employment by a client; except that the lawyer may pay:

(i) the reasonable cost of advertising or written communication as permitted by the rules of professional conduct; or

(ii) the usual charges of a not-for-profit lawyer referral service or other legal service organization.

Upon a conviction of an offense provided for by this paragraph, the prosecutor shall certify such conviction to the disciplinary board of the Supreme Court for appropriate action. Such action may include a suspension or disbarment.

(2) With respect to an insurance benefit or claim covered by this section, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense provided for by this paragraph, the prosecutor shall certify such conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.

(3) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of

conduct. A person may not knowingly transmit such referral information to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this paragraph through use of any other person, including, but not limited to, employees, agents or servants, shall also be prohibited.

(4) A person may not knowingly and with intent to defraud any insurance company, self-insured or other person file an application for insurance containing any false information, or conceal for the purpose of misleading information concerning any fact material thereto.

(c) Electronic claims submission. -- If a claim is made by means of computer billing tapes or other electronic means, it shall be a rebuttable presumption that the person knowingly made the claim if the person has advised the insurer in writing that claims will be submitted by use of computer billing tapes or other electronic means.

(d) Grading. -- An offense under subsection (a)(1) through (8) is a felony of the third degree. An offense under subsection (b) is a misdemeanor of the first degree.

(e) Restitution. -- The court may, in addition to any other sentence authorized by law, sentence a person convicted of violating this section to make restitution.

(f) Immunity. -- An insurer, and any agent, servant or employee thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law, or by Insurance Department regulations.

(g) Civil action. -- An insurer damaged as a result of a violation of this section may sue therefor in any court of competent jurisdiction to recover compensatory damages, which may include reasonable investigation expenses, costs of suit and attorney fees. An insurer may recover treble damages if the court determines that the defendant has engaged in a pattern of violating this section.

(h) Criminal action. --

(1) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violation of this section.

(2) In addition to the authority conferred upon the Attorney General by the act of October 15, 1980 (P.L. 950, No. 164), known as the Commonwealth Attorneys Act, the Attorney General shall have the authority to investigate and to institute criminal proceedings for any violation of this section or any series of such violations involving more than one county of the Commonwealth or involving any county of the Commonwealth and another state. No person charged with a violation of this section by the Attorney General shall have standing to challenge the authority of the Attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of the Commonwealth to the person making the challenge.

(i) Regulatory and investigative powers additional to those now existing. -- Nothing contained in this section shall be construed to limit the regulatory or investigative authority of any department or agency of the Commonwealth whose functions might relate to persons, enterprises or matters falling within the scope of this section.

(j) Violations, penalties, etc. --

(1) If a person is found by court of competent jurisdiction, pursuant to a claim initiated by a prosecuting authority, to have violated any provision of this section, the person shall be subject to civil penalties of not more than \$5,000 for the first violation, \$10,000 for the second violation and \$15,000 for each subsequent violation. The penalty shall be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting insurance fraud. The court may also award court costs and reasonable attorney fees to the prosecuting authority.

(2) Nothing in this subsection shall be construed to prohibit a prosecuting authority and the person accused of violating this section from entering into a written agreement in which that person does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding, but notification thereof shall be made to the licensing authority if the person is licensed by a licensing authority of the Commonwealth so that the licensing authority may take appropriate administrative action. Penalties paid under this section shall be deposited into the Insurance Fraud Prevention Fund created under the Insurance Fraud Prevention Act.

(3) The imposition of any fine or other remedy under this section shall not preclude prosecution for a violation of the criminal laws of this Commonwealth.

(k) Insurance forms and verification of services. --

(1) All applications for insurance and all claim forms shall contain or have attached thereto the following notice:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

(2) Deleted. 1995, Sept. 4, P.L. 242, No. 28, s 2.

(l) Definitions. -- As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Insurance policy." A document setting forth the terms and conditions of a contract of insurance or agreement for the coverage of health or hospital services.

"Insurer." A company, association or exchange defined by section 101 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921; {Footnote 2} an unincorporated association of underwriting members; a hospital plan corporation; a professional health services plan corporation; a health maintenance organization; a fraternal benefit society; and a self-insured health care entity under the act of October 15, 1975 (P.L. 390, No. 111), known as the Health Care Services Malpractice Act. {Footnote 3}

"Person." An individual, corporation, partnership, association, joint-stock company, trust or unincorporated organization. The term includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, beneficial association and any other legal entity engaged or proposing to become engaged, either directly or indirectly, in the business of insurance, including agents, brokers, adjusters and health care plans as defined in 40

Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29, 1972 (P.L. 1701, No. 364), known as the Health Maintenance Organization Act. {Footnote 4} For purposes of this section, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Self-insured." Any person who is a self-insured for any risk by reason of any filing, qualification process, approval or exception granted, certified or ordered by any department or agency of the Commonwealth.

"Statement." Any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test result or computer-generated documents.

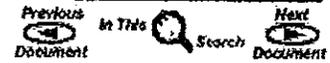
{Footnote 1} Pennsylvania Insurance Laws, s 40-1-011.

{Footnote 2} Pennsylvania Insurance Laws, s 40-3-101.

{Footnote 3} Pennsylvania Insurance Laws, s 40-85-101 et seq.

{Footnote 4} Pennsylvania Insurance Laws, s 40-83-101 et seq.

History	1990, Feb. 7, P.L. 11, No. 6, s 2; 1990, Dec. 19, P.L. 1451, No. 219, s 1; 1994, Dec. 28, No. 165, s 1; 1995, Sept. 4, P.L. 242, No. 28, s 2, eff. 9-4-95.
Cited By	Notice 2001-08
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