REPORT OF
MARKET CONDUCT EXAMINATION
OF

CONSECO LIFE INSURANCE COMPANY
Carmel, IN

AS OF
December 23, 2010

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: January 27, 2011

CONSECO LIFE INSURANCE COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 24 day of January, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.

Michael F. Consedine
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
CONSECO LIFE INSURANCE COMPANY 11825 North Pennsylvania Street Carmel, IN 46032	:	Section 671-A of Act 147 of 2002 (40 P.S. § 310.71)
	:	Sections 404-A and 411B of the Insurance Company Law, Act of May 17, 1921, P.L. 682, No. 284 (40 P.S. §§ 625-4 and 511b)
	:	Title 31, Pennsylvania Code, Sections 146.3, 146.5, 146.6 and 146.7
Respondent.	:	Docket No. MC11-01-003

CONSENT ORDER

AND NOW, this 27th day of January, 2011, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is Conseco Life Insurance Company, and maintains its address at 11825 North Pennsylvania Street, Carmel, IN 46032.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2009 to December 31, 2009.

(c) On December 3 and 23, 2010, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on December 23, 2010.

(e) The Examination Report notes violations of the following:

(i) Section 671-A of Act 147 of 2002 (40 P.S. § 310.71), which prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act;

(ii) Section 404-A of the Insurance Company Law, No. 284 (40 P.S. §625-4), which requires 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;

(iii) Section 411B of the Insurance Company Law, No. 284 (40 P.S. §511b), which states life insurance death benefits not paid within 30 days after satisfactory proof of death shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest

shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than 180 days after the death of the insured and the death benefits are not paid within 30 days after satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid;

(iv) Title 31, Pennsylvania Code, Section 146.3, which requires 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;

(v) Title 31, Pennsylvania Code, Section 146.5, which states 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. 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;

(vi) Title 31, Pennsylvania Code, Section 146.6 states that if an 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; and

(vii) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Respondent's violations of Section 671-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):

(i) suspension, revocation or refusal to issue the certificate of qualification or license;

(ii) imposition of a civil penalty not to exceed five thousand dollars

($5,000.00) for every violation of the Act;

(iii) an order to cease and desist; and

(iv) any other conditions as the Commissioner deems appropriate.

(c) Respondent's violations of Sections 404-A and 411B of the Insurance Company Law, No. 284 (40 P.S. §§625-4 and 511b) 510) are punishable by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than $5,000 per violation.

(d) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.3, 146.5, 146.6 and 146.7 are punishable under Section 9 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(e) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

(c) Respondent shall pay Thirty Thousand Dollars ($30,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(d) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law

contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: CONSECO LIFE INSURANCE COMPANY, Respondent

President / Vice President

Secretary / Treasurer

COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Conseco Life Insurance Company; hereafter referred to as "Company," at the Company's office located in Carmel, Indiana, June 14, 2010, through August 6, 2010. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige
Market Conduct Division Chief

Michael A. Jones
Market Conduct Examiner

Gary L. Boose, MCM, LUTC
Market Conduct Examiner

June Coleman
Market Conduct Examiner

James Myers
Market Conduct Examiner

Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 27 Day of October , 2010

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
LINDY McMILLEN, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires March 23, 2014

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2009, through December 31, 2009, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Advertising, Producer Licensing, Consumer Complaints, Forms, Underwriting Practices and Procedures, Rating and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

The Company was incorporated under the laws of Massachusetts on January 30, 1962 as Massachusetts General Life Insurance Company and was licensed and commenced business on May 3, 1962. Since the Company's incorporation, there have been several mergers with the Company as the surviving entity. The following chart depicts the insurance companies that have merged with and into the Company since its incorporation:

Insurance Company	Year of Merger
Gateway Life Insurance Company (NC)	1972
Loyal Protective Life Insurance Co. (MA)	1978
Security Guaranty Life Ins. Co. (AL)	1985
Bankers Union Life Ins. Co. (CO)	1988
Chase National Life Ins. Co. (KY)	1991
Philadelphia Life Insurance Co. (PA)	1998
Lamar Life Insurance Co. (MS)	1998
United Presidential Life Insurance Company (IN)	2001

On March 30, 1990, Life Partners Group, Inc., A Delaware holding company, purchased the Company and seven affiliated insurers from ICH Corporation. As a result of this transaction, the Company became a wholly owned subsidiary of Wabash Life Insurance Company, a Kentucky domestic insurer.

The Company became part of Conseco, Inc. ("Conseco"), a publicly-held specialized financial services holding company, on August 2, 1996, when Conseco acquired all of the issued and outstanding capital stock of Life Partners Group, Inc. As a result of this

acquisition, the Company and its affiliates were consolidated into Conseco's operations in Carmel, Indiana.

Effective June 17, 1997, the Company re-domesticated from Massachusetts to Indiana after obtaining regulatory approvals from both states. Effective November 25, 1997, Massachusetts General Life Insurance Company changed its name to Conseco Life Insurance Company.

On December 17, 2002, CIHC, Inc. (the Company's former indirect parent), Conseco, and certain non-insurance subsidiaries filed voluntary petitions for reorganization under Chapter 11 of the United States Bankruptcy Code. The Company is a separate legal entity and was not included in the petitions filed by Conseco of CIHC, Inc. On September 10, 2003, upon consummation if the sixth amended plan of reorganization, Conseco and CIHC, Inc. emerged from bankruptcy.

On September 12, 2003, CIHC, Inc. was merged into CIHC Incorporated of Texas, a wholly-owned subsidiary of CDOC, Inc., a wholly owned subsidiary of Conseco, which then converted to a Texas insurance company named CIHC Life Insurance Company of Texas and was granted a certificate of authority as a Texas domiciled insurance company. Thereafter on the same date, Conseco Life Insurance Company of Texas, the Company's former indirect parent, was merged into CIHC Life. The current name, Conseco Life Insurance Company of Texas, was then adopted.

The Company is a direct subsidiary of Washington National Insurance Company, an indirect subsidiary of CNO Financial Group, Inc. The Company is domiciled in the State of Indiana and licensed in every state except for New York. The Company is also licensed in the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.

The Company has in-force equity indexed annuity, fixed rate annuity, Medicare supplement, universal life, traditional life and supplemental health insurance products in force which were sold through professional independent producers.

As of the Company's December 31, 2009, annual statement for Pennsylvania, Conseco Life Insurance Company reported direct premiums for life insurance considerations in the amount of $12,879,233 and direct premiums for accident and health insurance in the amount of $2,216,682.

IV. ADVERTISING

The Department, in exercising its discretionary authority requested, received and reviewed the Company's Advertising Certificate of Compliance. The certification was reviewed to ensure compliance with Title 31, Pennsylvania Code, Section 51.5. Section 51.5 provides that "A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth." No violations were noted.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law Section 354 and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Notice. No violations were noted.

VI. PRODUCER LICENSING

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of or as a representative of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all producer terminations to the Department.

The Company provided a list of 615 producers and 10 terminated producers. A random sample of 50 producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam. The following violations were noted:

2 Violations - Insurance Department Act, No. 147, Section 671-A
(40 P.S. §310.71)

(a) Representative of the insurer. – An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.

(b) Representative of the consumer. – An insurance producer acting on behalf of or representing an insurance consumer shall execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:

(1) Delineates the services to be provided; and

(2) Provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.

(c) Notification to department. – An insurer that appoints an insurance producer shall file with the department a notice of appointment. The notice shall state for which companies within the insurer's holding company system or group the appointment is made.

(d) Termination of appointment. – Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer terminates the appointment in writing to the insurance producer or until the insurance producer's license is suspended, revoked or otherwise terminated.

(e) Appointment fee. – An appointment fee of $12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation.

(f) Reporting. – An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.

The Company failed to file a notice of appointment and submit appointment fees to the Insurance Department for the following producers. The Company listed the producers as active; however, Department records did not indicate their appointment.

Producer
Thomas H. Drucis
Mark Perilman

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2005, 2006, 2007 and 2008. The Company identified 45 consumer complaints received during the experience period. All 45 complaint files were requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. No violations were noted.

VIII. UNDERWRITING

The Underwriting review consisted of 2 general segments.

A. Policy Rescissions
B. Conversion

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Policy Rescissions

The Company was requested to provide a list of all rescinded policies during the experience period. The Company's list included 1 rescinded policy. The file was requested, received and reviewed. The file was reviewed to ensure compliance with Title 18, Pennsylvania Consolidated Statutes, Section 4117(k). No violations were noted.

B. Conversions

The Company was requested to provide a list of all term life conversions policies issued during the experience period. The Company identified a list of 2 term life conversions policies and issued. Both policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

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. Verification of the date of policy delivery could not be established in the noted file.

IX. 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 the following claim manuals:

A. A. Claims Bulletin
B. Annuity State Tax
C. CIC Claims Bulletin Creditors 1.5.06
D. CIG L & A Claims Interest Change Memo
E. CIG Rejection Codes
F. CLIC Claims Interest Calculation Change
G. Community Property by State
H. Creditors Attachment
I. General Overview
J. Interest Memo 8.1.08 CIG
K. Life and Annuity Prompt Pay Chart
L. Life Waiver Document
M. Life Waiver Proc Note
N. Medicare Supplement Booklet
O. Non- Resident Alien Tax
P. Notices and Consent
Q. Small Estate Admin 50 States
R. Swiss Re
S. Uniform Transfer to Minors Act (UTMA)

The claim manuals and procedures 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 6 areas:

A. Annuity Claims Paid
B. Disability Claims Paid
C. Major Medical Claims Paid
D. Life Claims Paid

E. Life Claims Pending
F. Life Claims Denied

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Annuity Claims Paid

The Company was requested to provide a list of annuity claims paid that were received during the experience period. The Company identified a universe of 45 annuity claims paid. All 45 annuity claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

13 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 13 noted files were missing pertinent information.

Pertinent Information
Actual Contract
Application

2 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(a) 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. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant who reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the 2 noted files.

4 Violations - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a timely status letter could not be established in the 4 noted files.

4 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 4 noted files.

B. Disability Claims Paid

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 3 disability claims paid. The 3 claims which included 1 ongoing disability was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a timely status letter could not be established in the noted file.

C. Major Medical Claims Paid

The Company was requested to provide a list of disability claims paid during the experience period. The Company identified a universe 14 major medical disability income claims received during the period indicated. All 14 claim files were requested, received and reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

7 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 7 noted files.

D. Life Claims Paid

The Company was requested to provide a list of endowment insurance claims received during the experience period. The Company identified a universe of 436 life claims received. A random sample of 100 claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

13 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(a) 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. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant who reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the 13 noted files.

11 Violations - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a timely status letter could not be established in the 11 noted files.

15 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 15 noted files.

7 Violations - Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b)

(a) Life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured, and the death benefits are not paid within thirty days after the satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

(b) Notwithstanding section 6 of the act of May 11, 1949 (P.L. 1210, No. 367), referred to as the Group Life Insurance Policy Law, this section shall apply to all life insurance policies except variable insurance policies.

(c) The term “left on deposit” shall mean a specific settlement option provided within the life insurance policy under which the death benefit proceeds are retained by the insurer for the beneficiary and are credited with a specific rate of interest.

Required interest was not paid in the 7 noted files.

E. Life Claims Pending

The Company was requested to provide a list of life claims pended that were received during the experience period. The Company identified a universe of 2 claims received. Both claims were requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

2 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. Verification of a timely status letter could not be established in the 2 noted files.

F. Life Claims Denied

The Company was requested to provide a list of life claims denied during the experience period. The Company identified 12 claims received. All 12 claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

1 Violation - 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 noted claim file was missing pertinent information.

Pertinent Information
Death Certificate and Claimant Statement

4 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(a) 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. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant who reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the 4 noted files.

2 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. Verification of a timely status letter could not be established in the 2 noted files.

1 Violation - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the noted file.

X. RECOMMENDATIONS

The 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 Sections 641.1-A and Section 671-A of the Insurance Department Act of 1921 (40 P.S. §§310.41a and 310.71).

2. The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of Section 404-A of the Insurance Company Law of 1921 (40 P.S. §625-4).

3. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

4. The Company must review and revise internal control procedures to ensure compliance with requirements of Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b)

XI. COMPANY RESPONSE

CNO FINANCIAL GROUP

December 27, 2010

Yonise Roberts Paige, Chief
Life, Accident and Health Division
Bureau of Market Actions
Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

RE: Market Conduct Exam Report
Conseco Life Insurance Company, NAIC #65900

Dear Ms. Paige:

The Company is in receipt of your December 3, 2010 communication. I respectfully submit to you the formal response to the Conseco Life Insurance Company ("CLIC") Market Conduct Examination Report. Thank you for the opportunity to respond. The Company requests the following responses to the Recommendations be made part of the Report.

X. Recommendations:
The following represents the actions taken by the Company to ensure compliance with the following Recommendations:

1. The Company must review and revise Licensing procedures to ensure compliance with Sections 641.1-A and Section 671-A of the Insurance Department Act of 1921 (40 P.S. §§ 310.41(a) and 310.71).

Please find attached (Exhibit 1) licensing procedures which are compliant with Sections 641.1-A and Section 671-A of the Insurance Department Act of 1921 (40 P.S. §§ 310.41(a) and 310.71).

2. The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of Section 404-A of the Insurance Company Law of 1921 (40 P.S. § 625-4).

The Company currently has a process for obtaining the delivery receipts in New Business for the state of Pennsylvania but we are not selling new policies under Conseco Life Insurance Company at this time. Please find attached (Exhibit 2) pages from the 228 page CIG LifePRO CIK Life Term Conversion Processing Manual relevant to delivery requirements as documented on page numbers 10, 115, 171, 172 and 182.

3. The Company must review and revise internal control procedures to ensure compliance with the requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Daily and weekly prompt pay monitoring reports which reflect the aging level of each claim by line of business and state as reported in the BICPS claims administrative system are generated. These reports are reviewed by management on a daily and weekly basis to prioritize workflow and allocate human resources effectively to help ensure compliance with prompt pay requirements. The daily report was implemented in mid 2006 and the weekly report was implemented during the first quarter of 2006.

Processing updates are continually communicated to claims adjusters via the Knowledge Center, a reference tool for adjusters which includes desktop tools, state prompt pay charts, state specific mandates and life and health claims procedures. The Knowledge Center was implemented in early 2006 and we continually add updates as procedures or state regulations change to ensure accurate understanding of prompt pay requirements.

Restructuring of our claim departments, hiring new management, and improvements in technology has gained efficiencies for reducing the claim processing time. Training of adjusters is an ongoing process. Auditing will occur on 100% of all claims exceeding an adjuster's authority level and 5%-8% random auditing of all claims to ensure processing and financial accuracy.

4. The Company must review and revise internal control procedures to ensure compliance with requirements of Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b).

Processing updates are continually communicated to claims adjusters via the Knowledge Center, a reference tool for adjusters which includes desktop tools, state prompt pay charts, state specific mandates and life and health claims procedures. The Knowledge Center was implemented in early 2006 and we continually add updates as procedures or state regulations change to ensure accurate understanding of prompt pay requirements.

We would like to express our gratitude for the professional and courteous approach of the Department. If you have any questions or concerns, please do not hesitate to contact Renee Wake by telephone at 317 817-2070, or by email at renee.wake@cnoinc.com.

Sincerely,

Nancy Hjort

Nancy Hjort, Manager,
Market Conduct, on behalf of
Renée Wake, AIRC, ACS
Manager, Market Conduct
Government Relations

EXHIBIT 1

APPOINTMENT PROCESS

New Contract (new agent)

- Receive request
- Input agent information into contract database, which requests agent background from Applicant Insight
- Check Vector One
- Verify agent does not currently hold an active contract and appointment with Conseco
- Verify agent holds an active license in the state being set up
- If background and Vector One passes Conseco's criteria, input additional agent information into the contract database (level, recruiter, advancing, EFT, license(s)
- Contract database builds the agent information in the various admin systems
- Manually appoint agent via nomoreforms
- Send an executed copy of the agent contract, compensation schedule(s) and welcome letter to the agent and copy IMO stating effective date of contract and appointment
- Validate appointment via nomoreforms or PDB (producer database/NIPR)

Additional Appointment (existing agent)

- Receive request
- Verify agent does not currently have an active appointment with Conseco in the state being set up in
- Verify agent holds an active license in the state being set up in
- Manually appoint agent via nomoreforms
- Manually build appropriate license screen in the various admin systems
- Send letter to the agent and copy IMO stating effective date of appointment
- Validate appointment via nomoreforms or PDB (producer database/NIPR)

EXHIBIT 2

Term Conversion Request Procedures

When a Term conversion quote for a **CIG** policy or rider is mailed to a policyowner or active agent and the policyowner makes the decision to convert their Term product to a permanent plan of insurance, they policyowner will complete a **Reinstatement/Policy Change Application Form CLIC-8006**. The form is then returned to the Home Office for processing along with a check for the initial premium or with a note requesting to draft the initial premium from their bank account.

When a request for a Term conversion is submitted, it is important that the following tasks are completed while processing a Term conversion request:

- Review the Term Conversion Guidelines and Term Conversion Product Information
- Access the request in **AWD**
- Review the **Reinstatement/Policy Change Application Form CLIC-8006** application for submission requirements
- Review the status of the Term product in the administrative system
- Assign a new policy number for the new policy
- Issue a new conversion policy in the **LifePRO CIK** system
- When applicable, set the policy up on monthly PAC or List Bill
- Apply the initial premium payment to the new policy
- Add Notes to the Policy Notepad
- Send an email to CICCommissions for Term Conversions submitted by an active agent
- Print the new policy pages
- Construct a new policy and mail it to the policyowner or active agent
- Terminate the Term policy or Term rider being converted
- Clear suspense created by the conversion process
- Upload the conversion paperwork to **Filenet** using **AWD Revisable Objects**

Delivery Requirement – The Term Delivery Requirement will be referenced throughout this document. This Term is typically used when issuing insurance policies. A Delivery Requirement is the demand by the Home Office that an item of materiel must be submitted or returned by the policyowner or active agent to the Home Office by the date specified, once the new policy has been delivered.

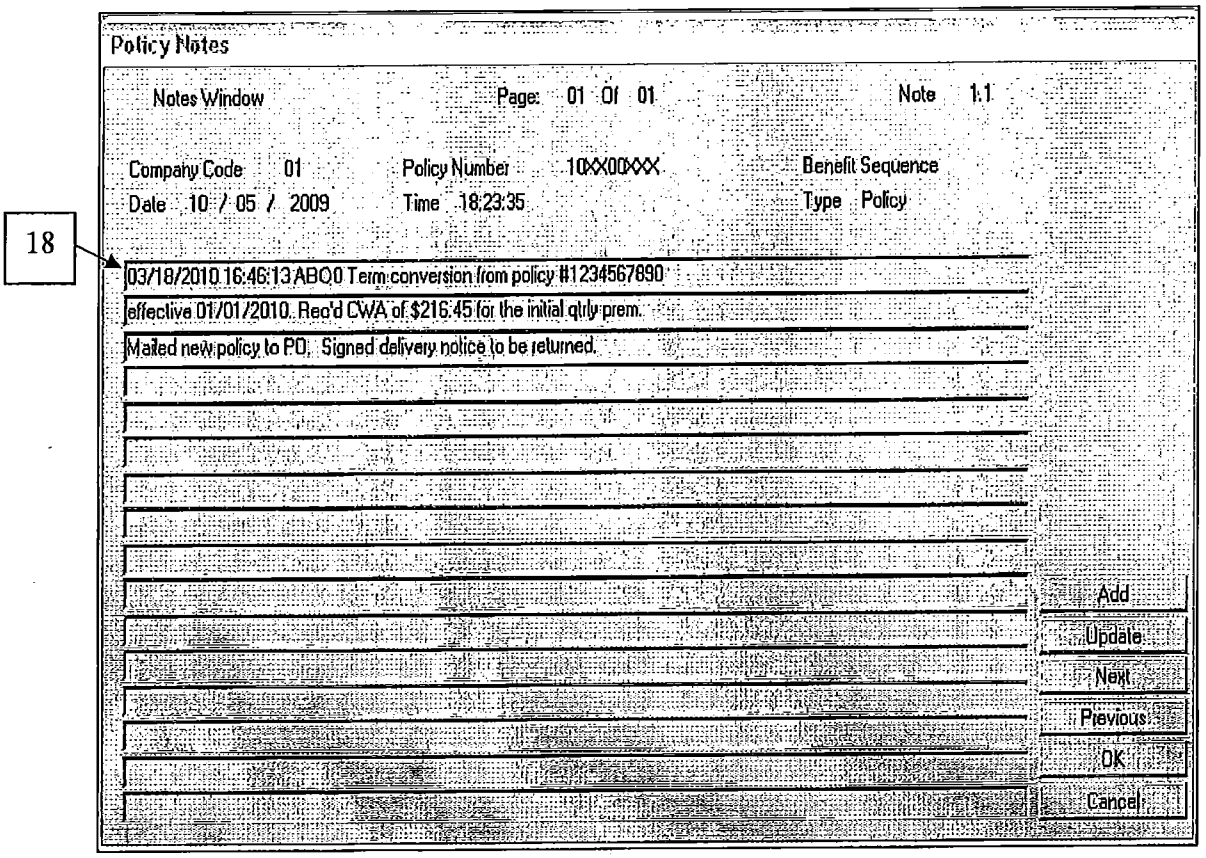
Step 18: Press **F8** to create a **Notepad**. All policy notes should include the policy number of the original policy being converted, the effective date of new policy, cash with application amount received, if the policy was set up on PAC, where the policy was mailed, what the delivery requirements are and any other special instructions.

Note: The note typed on the notepad can not be edited or changed once you press **Enter** or click **OK** to accept the note.

Note: Delivery Requirements include anything that the policyowner must submit or return upon receiving their new policy. (Example: Every new policy prints out a Delivery Notice, which is a form that the policyowner must sign and return as proof that they have received their new policy. Another example is if the application has been changed for some reason, such as the date of birth was incorrect, a policy amendment must be created and mailed to the policyowner with the correction to the application. The policyowner must sign and return a copy of the Amendment acknowledging the change or correction).

Step 19: Press **Enter** or click **OK** when complete.

Note: The date and time the note was added will automatically be stamped onto the notepad with the note.



Step 20: Press the **Esc** key to return to the **View Contract (1 of 2)** screen.

Step 18: Press **F8** to create a **Notepad**. All policy notes should include the policy number of the original policy being converted, the effective date of new policy, cash with application amount received, if the policy was set up on PAC, where the policy was mailed, what the delivery requirements are and any other special instructions.

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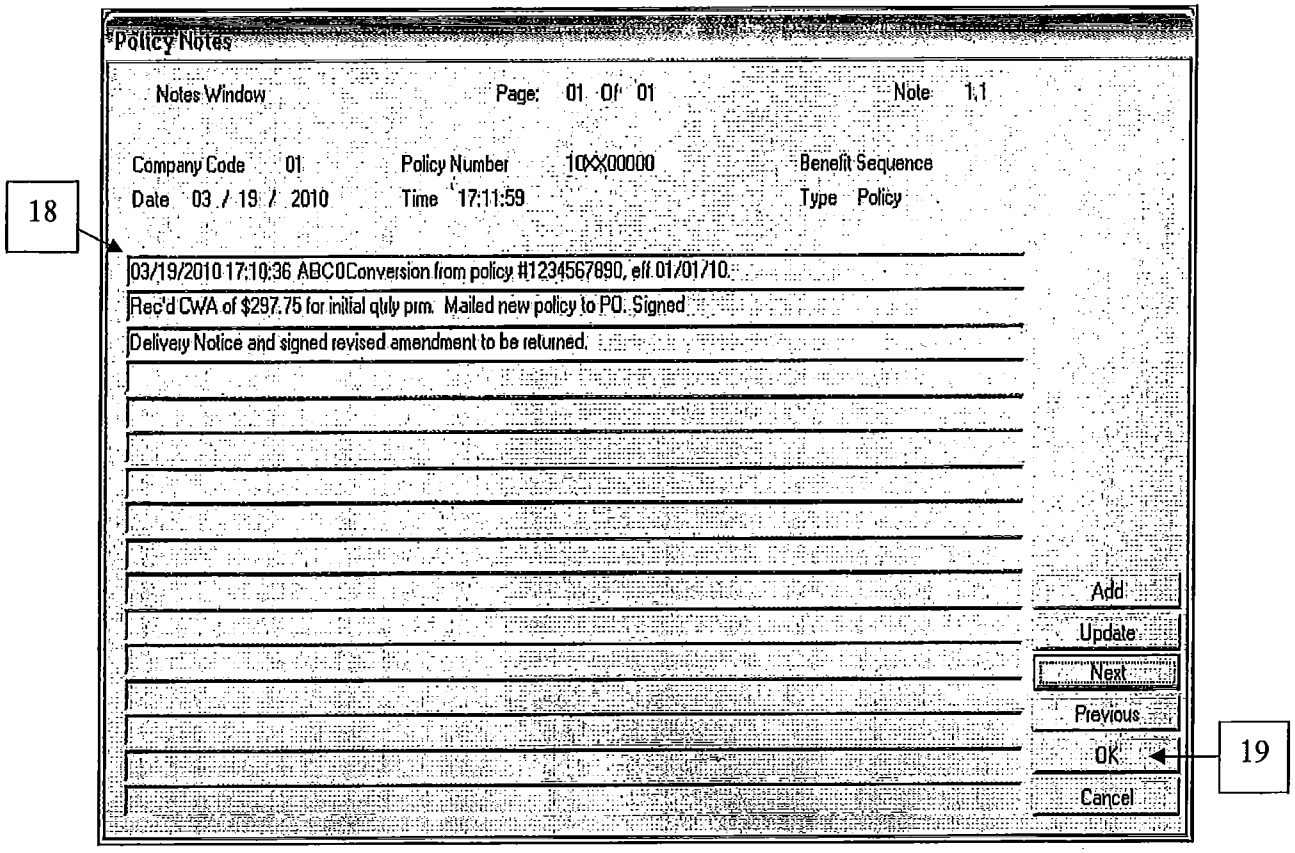
Step19: Press **Enter** or click **OK** when complete.



Note: The date and time the note was added will automatically be stamped onto the notepad with the note.

Step 20: Press the **Esc** key to return to the **View Contract (1 of 2)** screen.

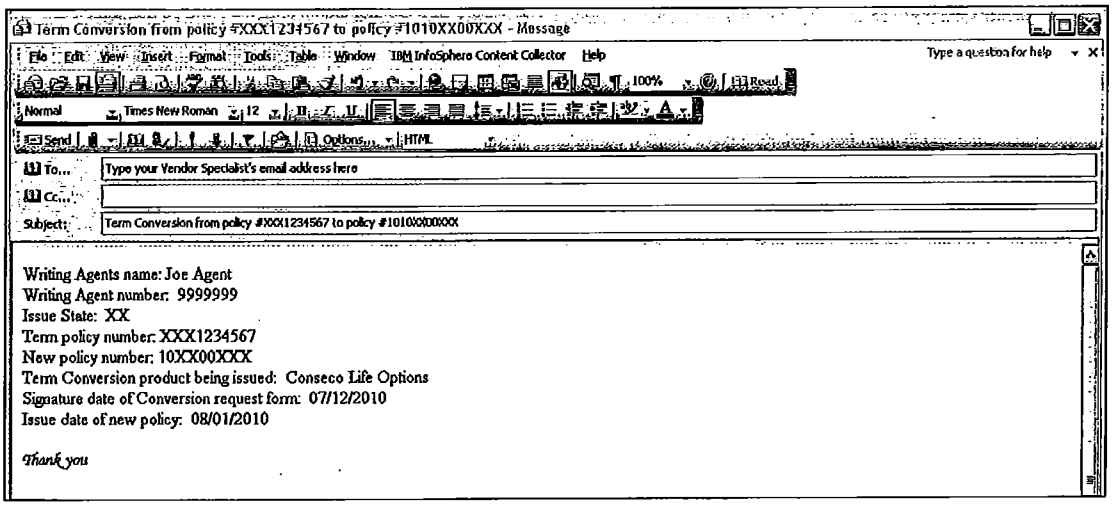
Step 21: If the conversion request was submitted by an active agent, the agent is only entitled to renewal commissions. Send an email to **CICCommission@conseco.com** for each Term conversion processed with an active agent involved.

Include the following information:

Subject: Term Conversion with active agent – please pay renewal commission only

Body:
Writing Agents name: Joe Agent
Writing Agent number: 9999999
Issue State: XX
Term policy number: XXX1234567
New policy number: 10XX00XXX
Term Conversion product being issued: Conseco Life Options
Signature date of Conversion request form: 07/12/2010
Issue date of new policy: MM/DD/YYYY

Example email:



Step 22: Set a Reminder on your **Outlook** calendar to follow up in 30 days for the delivery requirements. When the reminder comes up, review **AWD** and **Filenet** to see if the delivery requirements have been received. If the delivery requirements have not been received within 30 days, send a reminder letter using **Respond ID LPC0153**. Include a copy of the outstanding requirement(s) with the reminder letter, (e.g., a copy of the Delivery Notice, bank draft authorization form, signed signature page of illustration). A Delivery Notice is required for the following issue states: California, Colorado, Louisiana, Pennsylvania, South Dakota and West Virginia. If a Delivery Notice is not received within 45 days for one of these issue states, contact your supervisor to get approval to cancel the policy as Not Taken.

Follow Ups for Delivery Requirements

The delivery requirements requested when the new conversion policy was mailed to the policyowner or agent should be returned within 30 days. To verify that the delivery requirements have been received, it will be necessary to follow up 30 days after the policy has been mailed. If the delivery requirements have not been received within 30 days, it will be necessary to mail a follow up letter to the policyowner.

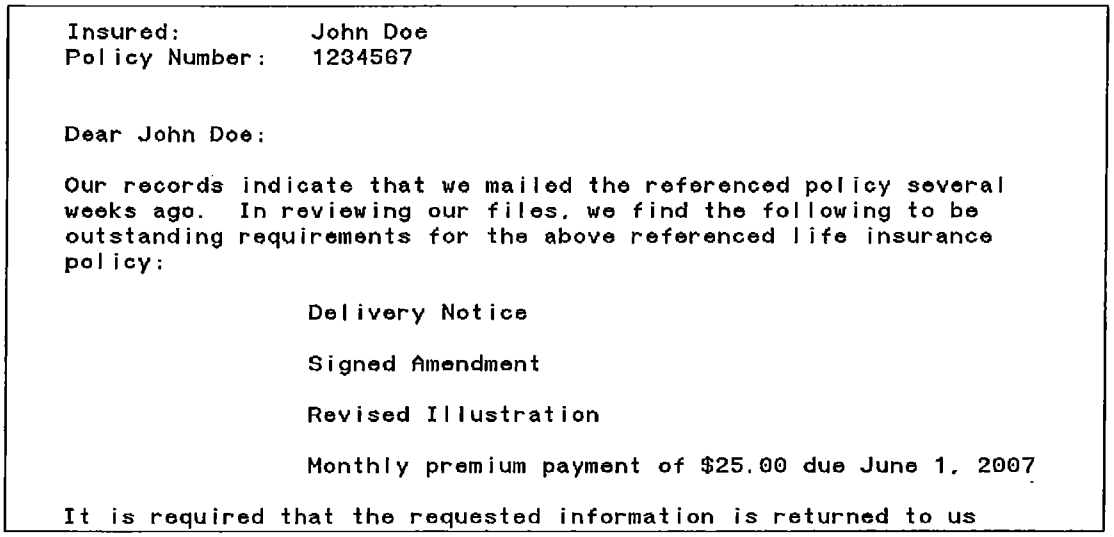
Take the following steps to follow up on a Term conversion:

Step 1: When the follow up reminder displays in **Outlook**, review the comments advising the policy number to be reviewed and the delivery requirements that are expected.

Step 2: Review **AWD** and **Filenet** to verify if the outstanding delivery requirements have been received.

- If the outstanding delivery requirements have been received, there is nothing more to be done.
- If the outstanding delivery requirements have not been received, follow up **Respond** letter ID **LPC0153** must be mailed to the policyowner as a reminder that the items must be returned.

See example below:



Insured: John Doe
Policy Number: 1234567

Dear John Doe:

Our records indicate that we mailed the referenced policy several weeks ago. In reviewing our files, we find the following to be outstanding requirements for the above referenced life insurance policy:

Delivery Notice

Signed Amendment

Revised Illustration

Monthly premium payment of $25.00 due June 1, 2007

It is required that the requested information is returned to us

Step 3: Create a work item in **AWD** under the **CORR** work type and update comments that a follow up letter for the outstanding delivery requirements has been mailed to the policyowner and close the work item with the appropriate status.

Step 4: Reset the date on the **Outlook** follow up reminder for 10 business days from today.