pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

OXFORD LIFE INSURANCE COMPANY
PHOENIX, AZ

As of: December 1, 2011
Issued: January 20, 2012

MARKET ACTIONS BUREAU
LIFE AND HEALTH DIVISION

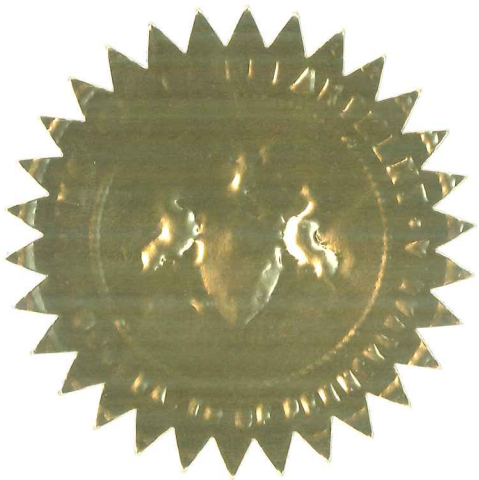
OXFORD LIFE INSURANCE COMPANY

TABLE OF CONTENTS

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 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
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
OXFORD LIFE INSURANCE COMPANY	:	40 P.S. §1171.5(a)(10)(v)
2721 North Central Avenue	:	Title 31, Pa. Code, §146.7(c)(1)
Phoenix, AZ 85004-1172	:	
	:	
Respondent.	:	Docket No. MC12-01-004

CONSENT ORDER

AND NOW, this 20th day of January, 2012, 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 Oxford Life Insurance Company and maintains its address at 2721 North Central Avenue, Phoenix, AZ 85004-1172.

(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 1, 2011, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on December 29, 2011.

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

(i) 40 P.S. §1171.1(a)(10)(v), which defines any of the following acts, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claims settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after

proof of loss statements have been completed and communicated to the company or its representative; and

(ii) Title 31, Pa. Code, §146.7(c)(1), which states the following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

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 40 P.S. §1171.5(a)(10)(v) are punishable by the following, under 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.

(c) 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).

(d) Respondent's violations of Title 31, Pa Code, §146.7(c)(1) are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10 and 1171.11), as described above.

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 Twenty-Five Thousand Dollars ($25,000.00) 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: OXFORD 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 Oxford Life Insurance Company; hereafter referred to as "Company," at the Company's office located in Phoenix, AZ August 8, 2011, through October 28, 2011. 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

Lonnie L. Suggs
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).

Lonnie L. Suggs

[Examiner in Charge]

Sworn to and Subscribed Before me

This 17 Day of November, 2011

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: Forms, Claim Handling Practices and Procedures, Internal Audit & Compliance and Consumer Complaints.

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

Oxford Life was founded in 1965 in Arizona and is a subsidiary of AMERCO, a publicly traded financial holding network. AMERCO's other significant holdings include U-Haul International, Inc. and Republic Western Insurance Company. Oxford Life's marketing strategy focused upon providing life, annuities and Medicare supplement insurance for the senior market.

In 1997, Oxford Life expanded its services with the acquisition of Encore Financial, Inc., a Wisconsin-based insurance holding company, which owned the stock of North American Insurance Company, a third-party administrator of Medicare supplement insurance programs.

In 2000, Oxford Life expanded its growth and distribution in the Medicare supplement market with the acquisition of Christian Fidelity Life Insurance Company ("Christian Fidelity"). Christian Fidelity is a Medicare supplement and final expense life insurance company.

In 2006, the Company continued their growth in the Texas Medicare supplement market with the acquisition of Dallas General Life Insurance Company ("Dallas General").

As of the Annual Statement for the year 2009 for Pennsylvania, the on Oxford Life Insurance Company reported direct premium for ordinary life insurance in the amount of $4,704,870.00; and direct premium earned for accident and health in the amount of $81,345.00

IV. 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.

V. CLAIMS

The claims review consisted of a review of the Company's claims 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 claims manual material:

- **Procedures Elite Sales Processing Inc. (ESP)**
- **Underwriting Guidelines**
- **Annuity Claims Procedures**
- **Final Expense & Life Policies & Procedures**
- **Life Death Claim Procedures – Madison Office**
- **Group Disability Claims Audit Manual**
- **Group LTD Claims Procedures and Training Manual**
- **Short Term Disability (STD) Training Manuals**
- **Group Life Claims Audit Manual**
- **Group Life Claims Training Manual**
- **Claims Procedural Bulletins**
- **Claimfacts Coding and Processing Manual**
- **VSP Provider Reference Manual (Vision)**
- **VSP Plan Information Manual (Vision)**

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 7 areas:

1. **Whole Life Insurance Claims Denied**
2. **Whole Life Insurance Claims Paid**
3. **Whole Life Insurance Claims Pended**
4. **Medicare Supplement Insurance Plan C Claims Paid (MSCPAIA)**
5. **Medicare Supplement Insurance Plan F Claims Paid (MSFPAIA)**
6. **Medicare Supplement Insurance Plan I Claims Paid (MSIPANR)**
7. **Individual Fixed Annuity Insurance Claims**

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. Whole Life Insurance Claims Denied

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 19 whole life insurance claims denied. All 19 whole life insurance claim files were requested, received and reviewed. Of the 19 files reviewed 3 files were duplicates and the 16 remaining files were determined to be paid rather than denied. This is in contrast to their NAIC annual market conduct statement reporting. The 16 claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b) and to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.7

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The letter in the 2 noted files to the claimant failed to

communicate the reason additional time is needed for the investigation and state when a decision on the claim may be expected.

2 Violations – Act 205, Section 5 (40 P.S. §1171.5)(a)(10)(v)

(a) **"**Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny claims within a reasonable time period after receiving the insured proof of loss in the 2 noted files.

B. Whole Life Insurance Claims Paid

The Company was requested to provide a list of all claims received during the experience period. The Company identified 42 whole life insurance claims paid during the period. All 42 whole life insurance claims paid 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 (40 P.S. §511b). The following violations were noted:

4 Violations - Title 31, Pennsylvania Code, Section 146.7

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The letter in the 4 noted files to the claimant failed to communicate the reason additional time is needed for the investigation and state when a decision on the claim may be expected.

4 Violations – Act 205, Section 5 (40 P.S. §1171.5)(a)(10)(v)

(a) **"**Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny claims within a reasonable time period after receiving the insured proof of loss in the 4 noted files.

C. Whole Life Insurance Claims Pended

The Company was requested to provide a list of all claims received during the experience period. The Company identified 24 whole life insurance claims pended during the period. All 24 whole life insurance claims pended were requested, received and reviewed. Of the 24 files reviewed 13 were duplicates, 9 policies were rescinded due to misrepresentation of medical history and 2 files were paid. The 11 claim files

were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

4 Violations- Title 31, Pennsylvania Code, Section 146.7

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The letter in the 4 noted files to the claimant failed to communicate the reason additional time is needed for the investigation and state when a decision on the claim may be expected.

4 Violations – Act 205, Section 5 (40 P.S. §1171.5)(a)(10)(v)

(a) **"**Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny claims within a reasonable time period after receiving the insured proof of loss in the 4 noted files.

D. Medicare Supplemental Insurance Plan C Claim Paid (MSCPAIA)

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 85 Medicare Supplemental Insurance Plan C Claims Paid (MSCPAIA). A random of 30 paid claims were requested, received and reviewed. All 30 Medicare Supplemental Insurance Claims Plan C files were electronically received direct from Medicare. The 30 claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

E. Medicare Supplemental Insurance Plan F Claims Paid (MSFPAIA)

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 69 Medicare Supplemental Insurance Plan F Claims Paid (MSFPAIA). A random sample of 25 paid claims were requested, received and reviewed. All 25 Medicare Supplemental Insurance Claims Plan F files were electronically received direct from Medicare. The 25 claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

F. Medicare Supplemental Insurance Plan I Claims Paid (MSIPANR)

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 42 Medicare Supplemental Insurance Plan I Claims Paid (MSIPANR). A random sample of 20 paid claims were requested, received and reviewed. All 20 Medicare Supplemental Insurance Claims Plan I files were electronically received direct from Medicare. The 20 claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

G. Individual Fixed Annuity Insurance Claims Paid

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 3 individual fixed annuity insurance claims. The 3 individual fixed annuity insurance claim files were requested, received and reviewed. Two files were identified as duplicate claim files. The 1 claim file was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

VI. 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, 2008 and 2009. The Company identified 3 consumer complaints received during the experience period January 1, 2009 to December 31, 2009. All 3 complaint files were requested, received, and reviewed. The company also 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, PA Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. No violations were noted.

VII. INTERNAL AUDIT & COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures utilized during the experience period. 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.
(4) The laws requires that each insurer shall make available for the Department's inspection upon request its internal audit and compliance procedures which are instituted as required by this section. No violations were noted.

Concern: The Pennsylvania Insurance Department learned during the review of Section C, Whole Life Insurance Claims Pended that the Company processes policy

rescission in which the Company's "system automatically totals all premiums received when a claim is rescinded, thus the Company does not have worksheets that calculate the amount of refund to be paid." The Pennsylvania Insurance Department made inquiry of when the system was audited and how frequently to insure accuracy of refund calculations. The Company advised the Department that the system had not been audited. The Pennsylvania Insurance Department expressed a concern in reference to no auditing procedure in place for premium refund calculations.

VIII. 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 internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

2. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance – Act 205, Section 5 (40 P.S. §1171.5)

IX. COMPANY RESPONSE

OXFORD®
LIFE INSURANCE COMPANY

2721 NORTH CENTRAL AVENUE • PHOENIX, ARIZONA 85004 • PHONE (602) 263-6666 • FAX (602) 277-5901 • www.oxfordlife.com

December 29, 2011

Via Email and FedEx Standard Overnight Delivery

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

Re: Oxford Life Insurance Company (NAIC No. 76112)
Market Conduct Examination Report
Examination Warrant Number: 10-M27-065
Experience Period: January 1, 2009 to December 31, 2009
Pennsylvania Business Only

Dear Ms. Paige:

Oxford Life Insurance Company ("Oxford Life") is in receipt of your correspondence dated December 1, 2011. The Market Conduct Examination Report ("Report") cites violations of Title 31, Pennsylvania Code, Section 146.7 for failure to communicate the reason additional time is needed for the investigation and state when a decision may be expected. The Report also cites violations of Act 204, Section 5 (Title 40, Pennsylvania Statutes Section 1171.5 (a)(10)(v)) for failing to affirm or deny claims within a reasonable time period after receiving the insured proof of loss. The Report includes a concern related to the auditing of automated premium refund calculations.

Oxford Life respectfully submits that it is in compliance with Title 31, Pennsylvania Code, Section 146.7, and provided notification letters within the prescribed timeframe (within 15 days after receipt of the proofs of loss and if more time is needed, within 30 days from the date of initial notice; and every 45 days thereafter as prescribed by Title 31, Pennsylvania Code, Section 146.7) for the claims listed below. All of the claims cited in the Department's exit summaries required additional medical records/review and thus required additional time to complete as is permissible pursuant to Title 31, Pennsylvania Code, Section 146.7.

Oxford Life respectfully maintains that pursuant to Section 146.7 (c) (1), the follow-up notice letters to the claimant set forth the reason additional time was needed for investigation, which was generally because the Company was awaiting receipt of and/or review of medical records.

In addition, Oxford Life respectfully maintains that each of the Company's follow-up letters met the requirements of Section 146.7 (c) (1), as the letters communicated to the claimant that "once a decision on the claim has been made, the Company will contact the claimant in writing."

Upon further discussion with Mr. Suggs, Oxford Life respectfully concedes that while the follow-up notices did indicate that the Company will contact the claimant in writing once a decision on the claim has been made, the notices may not have provided a specific timeframe for a decision and/or additional follow-up pursuant to the Department's interpretation of Section 146.7 (c) (1), "...and state when a decision on the claim may be expected."

As such, Oxford Life will include the following language in its follow-up notices: "If a claim determination has not been made within 30 days, we will contact you in writing within 30 days concerning the status of the claim." Attached for your reference is a copy of the revised follow-up notice to the claimant when we are awaiting medical records on a policy that remains within the contestability period.

In regard to the concern related to the auditing of automated premium refund calculations, as discussed, Oxford Life tests all calculations in the LSP system against Actuarial modeling to ensure accuracy prior to the release of any product. As such, Oxford Life tested the output of the LSP system prior to its release of the automated premium refund calculations. Enclosed please find an Actuarial Certification to the accuracy of the program.

Thank you to you and your staff for the courtesy and cooperation extended to us during the examination.

Please let me know if you have any questions. I can be reached at (602) 263-6666, Extension 670129, or via email at janriedell@oxfordlife.com.

Sincerely,

Jan Riedell
Secretary

Enclosures

cc: Lonnie Suggs
Market Conduct Examiner
Pennsylvania Insurance Department

OXFORD
LIFE INSURANCE COMPANY

Oxford Life Insurance Company

Actuarial certification

I, Robert Simmons, ASA, MAAA, am an employee of Oxford Life Insurance Company and act as the Appointed Actuary. I have reviewed our system and procedures for premium refund calculations regarding rescinded whole life policies and certify to the best of my knowledge and belief that the automated payments and calculations are correct.

The premium refund calculation and process was audited on December 28th, 2011 and resulted in no errors being found.

ASA, MAAA

Robert Simmons, ASA, MAAA

12/29/11

Date