REPORT OF
MARKET CONDUCT EXAMINATION
OF

UNITED AMERICAN INSURANCE COMPANY
Wilmington, Delaware

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: September 10, 2004

UNITED AMERICAN INSURANCE COMPANY

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United American Insurance Company
Market Conduct Examination as of the
close of business on July 13, 2003

Docket No.
MC04-08-032

ORDER

AND NOW, this 18TH day of May, 2007, my Order of September 10, 2004 in this matter is hereby AMENDED as follows:

1. Paragraph 1 of the September 10, 2004 Order is amended to strike the "modified Examination Report" attached to that Order and adopt a revised final Report of Examination of United American Insurance Company ("United American"), including a revised response from United American, as attached hereto, which shall be filed as an official record of this Department.

2. Paragraph 3 of the September 10, 2004 Order is amended to require United American to comply with all recommendations contained in the revised final Report of Examination, as attached hereto, from the date of this Order.

3. Paragraph 5 of the September 10, 2004 Order is stricken.

4. Within thirty (30) days of the date of this Order, United American 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 revised final Report of Examination and related Orders.

The remainder of the September 10, 2004 Order shall remain in effect.

_____ (May 18th, 2007)
Randolph L. Rohrbaugh
For and on behalf of the Pennsylvania Insurance Department

United American Insurance Company
Market Conduct Examination as of the
close of business on July 13, 2003

Docket No.
MC04-08-032

ORDER

A market conduct examination of United American Insurance Company (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, et seq., for the period July 1, 2001 through June 30, 2002. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices.

It is hereby ordered as follows:

1. The attached modified Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.

2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with all recommendations contained in the attached Report.

4. 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.

5. This matter is being referred for the filing of an Order to Show Cause requesting consideration and imposition of appropriate penalties and other relief as the Commissioner finds appropriate.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

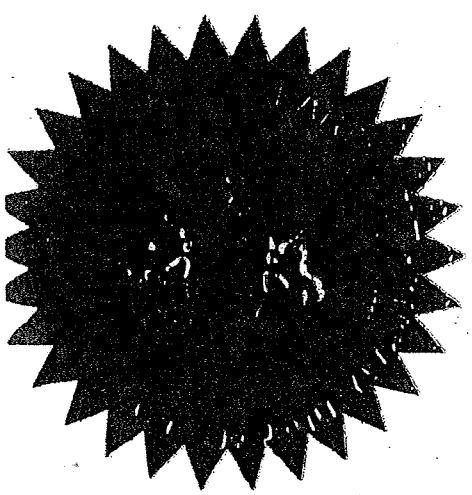
BY: The Pennsylvania Insurance Department

_____ (September 10, 2004)
Randolph L. Rohrbaugh
Deputy Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, 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 Randolph L. Rohrbaugh, 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.



M. Diane Koken
Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on United American Insurance Company, hereafter referred to as "Company," at the Company's offices located in McKinney, Texas, February 10, 2003, through April 11, 2003. 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 undersigned participated in the Examination and in the preparation of this Report.

Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Gerald P. O'Hara Jr.
Market Conduct Examiner

Michael Jones
Market Conduct Examiner

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 July 1, 2001, through June 30, 2002, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Advertising, Consumer Complaints, Forms, Agent/Broker Licensing, Underwriting Practices and Procedures, 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

United American Insurance Company (Texas) was organized as a limited capital, stock life, health and accident insurance company on June 13, 1947, and commenced business on August 13, 1947.

Torchmark Corporation (Torchmark), a Delaware corporation, formed NU Life Insurance Company of Delaware with an incorporation date of August 14, 1981, as a wholly-owned subsidiary of another Torchmark subsidiary, Globe Life and Accident Insurance Company (Delaware), Oklahoma City, Oklahoma. Subsequently, Torchmark formed NU Life Insurance Company (Delaware) to facilitate the acquisition and re-domestication of United American Insurance Company (Texas) from Texas to Delaware.

Globe Life and Accident Insurance Company (Delaware) purchased all of the outstanding common stock of United American Insurance Company (Texas) on December 31, 1981. Torchmark Corporation acquired United American Insurance Company (Texas) on December 31, 1981. Torchmark Corporation acquired United American Insurance Company (Delaware) as a direct subsidiary on August 31, 1993.

The Company is licensed to transact life, annuity and accident and health business in all states except New York. The Company is also licensed in the District of Columbia and Canada.

United American Life Insurance Company specializes in providing senior life and health insurance products including Medicare Supplement coverage and Long-

Term Care. Products are marketed nationwide through approximately 41,000 independent agents and approximately 2,000 exclusive agents.

As of their December, 2003, annual statement for Pennsylvania, the Company reported direct premium for ordinary life insurance and annuities in the amount of $5,748,487; and direct premium for accident and health in the amount of $37,752,407.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that "Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of this Regulation may be reviewed at any time at the discretion of the Department." The Department, in exercising its discretionary authority for reviewing advertising, requested the Company to provide copies of all advertising materials used for solicitation and sales during the experience period.

The Company provided 67 pieces of advertising utilized during the experience period. The advertising and marketing materials included: Slide Presentations, Television and Radio Scripts, Agent and Agency Support Documentation and Support Material including Agent and Agency Proofs. All advertising including the Company's website was reviewed to ascertain compliance with Act 205, Section 5 (40 P.S. §1171.5), Unfair Methods of Competition and Unfair or Deceptive Acts or Practices and Title 31, Pennsylvania Code, Chapter 51 and Chapter 89.

During the course of the on-site examination, the Department forwarded 2 advertising materials, which were currently running in 2 different newspapers in the Commonwealth. The advertisements were directed at Bethlehem Steel retirees. Upon responding to the phone numbers listed in the advertisements, the ads were solicitations for Medicare Supplement insurance by agents of United American Insurance Company. The following violations were noted:

2 Violations – Title 31, Pennsylvania Code, Section 51.3 Company's Responsibility and Control

(a) Every Company shall at all times maintain complete control over the content, form, and method of dissemination of all advertisements of its contracts. All such advertisements, regardless of by whom written, created, or designed, shall be the responsibility of the company whose contracts are being advertised.

(b) Advertisements prepared by persons other than the company for which the advertisement is intended to be used shall, prior to its use, be approved in writing by an officer of the company or such other person as the company may designate.

The Company failed to maintain control of the dissemination of the 2 newspaper ads directed at Bethlehem Steel retirees.

2 Violations – Title 31, Pennsylvania Code, Section 51.35

(a) The name of the actual insuring company shall be clearly identified in all of its advertisements. The contracts advertised shall be identified by form number or other appropriate identification, so as to clearly identify the contract or contracts advertised.

The 2 newspaper ads did not clearly identify the insurance company.

2 Violations – Title 31, Pennsylvania Code, Section 89.785 Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this Commonwealth whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner to the extent it may be required under State law.

The 2 newspaper ads were not submitted for file and use with the Department.

2 Violations – Title 31, Pennsylvania Code, Section 89.786 Standards for Marketing

(b) In addition to the practices prohibited by the Unfair Insurance Practices Act (40 P.S. §§1171.1-1171.15), the following acts and practices are prohibited:

(3) Cold Lead Advertising. Making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

The 2 advertisements are examples of prohibited, "Cold Lead Advertising".

V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy contracts, riders, endorsements and applications used in order to determine compliance with requirements of Insurance Company Law, Chapter 2, Section 354 (40 P.S. §477b), as well as provisions for various mandated benefits. Applications and claim forms were also reviewed to determine compliance with Title 18, Pa. C.S., Section 4117(k). The following violations were noted:

100 Violations – Insurance Company Law, Section 354 (40 P.S. §477b)

It shall be unlawful for any insurance company, association, or exchange, including domestic mutual fire insurance companies, doing business in this Commonwealth, to issue, sell, or dispose of any policy, contract, or certificate, covering life, health, accident, personal liability, fire, marine, title, and all forms of casualty insurance or contracts pertaining to pure endowments or annuities, or any other contracts of insurance, or use applications, riders, or endorsements, in connection therewith, until the forms of the same have been submitted to and formally approved by the Insurance Commissioner.

The following forms utilized in the Medicare Supplement Issued Section of the exam were not filed for approval.

Form	Form Number	Description	Number of Files
Application	MA12(37)-MSA MA12(37)R	Individual Medicare Supplement Application	98
Application	MA12(37)-MSA MA13(37)R	Individual Medicare Supplement Application	2

VI. AGENT LICENSING

The Company was requested to provide a list of all agents active and terminated during the experience period. Section 606 (40 P.S. §236) of the Insurance Department Act requires all entities to report all appointments and terminations to the Insurance Department. Section 605 (40 P.S. §235) of the Insurance Department Act prohibits agents from doing business on behalf of any entity without a written appointment from that entity. Section 623 (40 P.S. §253) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. A random sampling of the Company's list of agents and those agents identified in the underwriting files during the examination were compared to Insurance Department licensing records to verify compliance with Section 605, Section 606 and Section 623 of the Insurance Department Act.

The Company provided a list of 1,074 active agents, and 726 terminated agents. Random samples of 200 active agents and 200 terminated agents were compared to departmental records of agents and brokers to verify appointments, terminations and licensing. In addition, a comparison was made on the agents identified as producers on applications reviewed in the policy issued sections of the exam. The following violations were noted:

1 Violation – Insurance Department Act, Section 606 (40 P.S. §236)

All entities shall report to the Insurance Department all appointments and terminations of appointments in the format and time frame required by the Insurance Department's regulations.

The Company misreported an agent appointment to the Insurance Department.

10 Violations – Insurance Department Act, Section 605(c)(d) (40 P.S. §235)

(a) No agent shall do business on behalf of any entity without a written appointment from that entity.

(b) All appointments shall be obtained by procedures established by the Insurance Department's regulations.

(c) Insurance entities authorized to do business in this Commonwealth shall, from time to time as determined by the Insurance Department, certify to the Insurance Department the names of all agents appointed by them.

(d) Each appointment fee, both new and renewal, shall be paid in full by the entity appointing the agent.

The Company failed to certify and submit appointment fees to the Insurance Department for the following 4 agents listed as active by the Company.

Agent Name
Courtney L. Cole
Thomas A. Derrickson
Steven J. Destephano
Lawrence L Ranallo Sr.

The Company failed to certify and submit appointment fees to the Insurance Department for the following 6 agents listed on applications reviewed in the underwriting sections of the exam.

Agent Name
John Gilliams
John Berarducci
B.D. Keisler
Paul Gauthier
Peter Rader
Mark Petruso

3 Violations – Insurance Department Act, Section 623 (40 P.S. §253)

Any entity or the appointed agent of any entity accepting applications or orders for insurance or securing any insurance business through anyone acting without a license commits a misdemeanor of the third degree.

The following 3 individuals were listed as agents for the Company, however Department records do not identify them as holding a Pennsylvania insurance license.

Agent Name
Courtney L. Cole
Lawrence L Ranallo Sr.
Arthur Albert

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for 1998, 1999, 2000, and 2001. The Company identified 25 written consumer complaints and provided complaints logs for 1999, 2000, 2001 and 2002. All 25 consumer complaint files were requested, received and reviewed. 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. The following is a synopsis of the 25 complaints reviewed.

Number - 25	Complaint Reason	Percentage – 100%
9	Premium Increases	36%
7	Service/Administrative Problems	28%
4	Agent Handling	16%
3	Agent Misrepresentation	12%
2	Claim Denial/Processing	8%

The following violation was noted:

1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(11) [40 P.S. §1171.5(a)(11)]

Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

The 4 years of complaint logs (1998, 1999, 2000 and 2001) indicated 61 complaints forwarded through the Department and only 1 complaint received direct from an insured. The Company failed to list a written complaint in its complaint log. The written complaint was identified in the review of the life claim files.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 18 general segments.

A. Underwriting Guidelines
B. Life Policies Issued
C. Long-Term Care Policies Issued
D. Health Policies Issued
E. Medicare Supplement Policies Issued
F. Life Policies Declined
G. Long-Term Care Declined
H. Health Policies Declined
I. Medicare Supplement Declined
J. Life Policies Not-Taken
K. Long Term Care Not-Taken
L. Health Policies Not-Taken
M. Medicare Supplement Not-Taken
N. Life Policies Terminated
O. Long-Term Care Terminated
P. Health Policies Terminated
Q. Medicare Supplement Terminated
R. Medicare Supplement Issued as Replacements

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

A. Underwriting Guidelines

The Company was requested to provide copies of all established written underwriting guidelines in use during the experience period. Underwriting guidelines were reviewed to ensure guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following manuals and guides were provided and reviewed:

General Underwriting Instructions for United American Products
United American CS Guide to Field Underwriting – Common Sense Plan
Web Site Underwriting Guidelines- www.uageneralagency.com. Print Copy
Underwriting Guidelines for Long-Term Care

B. Life Policies Issued

The Company identified a universe of 1053 life policies issued during the experience period. A random sample of 150 life issued files was requested, received and reviewed. Life issued policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 81.5(b)

The insurer shall require as part of a completed application for life insurance or annuity a statement signed by the applicant as to whether the proposed insurance or annuity will replace existing life insurance or annuity.

The applicant's replacement question was not answered in the 2 files noted.

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

An insurer that uses an agent or broker in a life insurance or annuity sale shall: Require with or as part of a completed application for life insurance or annuity a statement signed by the agent or broker as to whether the broker knows replacement is or may be involved in the transaction.

The 29 files noted did not include an agent replacement statement as part of or with the application.

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

An insurer that uses an agent or broker in a life insurance or annuity sale shall, if replacement is involved: Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained under subparagraph (I) and in the case of life insurance, the disclosure statement as required by §83.3 (relating to disclosure statement) or ledger statement containing comparable policy data on the proposed life insurance. This written communication shall be made within 3 working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner.

The replacement letter to the replaced company was not documented in the file noted.

5 Violations – Title 31, Pennsylvania Code, Section 83.3 Disclosure Statement

(a) Required written disclosure. A life insurance agent, broker or insurer soliciting the type of business to which this subchapter applies shall provide a prospective purchaser with a written disclosure statement clearly labeled as such. An acceptable disclosure statement is attached as Appendix A.

The Disclosure Statement was not included in the 5 files noted.

29 Violations – Title 31, Pennsylvania Code, Section 83.55

(a) The Surrender Comparison Index Disclosure shall be given as a separate document upon delivery of the policy or earlier if requested by the life insurance applicant. If requested earlier, the index disclosure shall be provided as soon as reasonably possible.

(b) A disclosure that is minimally satisfactory to the Insurance Department is set forth in Appendix B. If the Appendix B disclosure will be used, a letter to that effect, prior to use, is adequate notification to the Department for review prior to use.

The 29 files noted did not include the Surrender Comparison Index Disclosure.

4 Violations–Title 31, Pennsylvania Code, Sections 83.55a and 83.55b

a) *The agent shall submit to the insurer a statement, signed by him, certifying that the surrender comparison index disclosure was given upon delivery of the policy or earlier at the request of the life insurance applicant.*

b) *The insurer shall maintain the agent's certification of surrender comparison index disclosure delivery in its appropriate files for at least 3 years or until the conclusion of the next succeeding regular examination by the insurance department of its domicile, whichever is later. The absence of the agent's certification from the appropriate files of the insurer shall constitute prima facie*

evidence that no surrender comparison index disclosure was provided to the prospective purchaser of life insurance.

The agent's certification of the surrender comparison index disclosure delivery was not evident in the 4 files noted.

37 Violations – Title 31, Pennsylvania Code, Section 83.55c

If it is the practice of the insurer to mail the policy directly to the applicant, the appropriate officer of the insurer shall certify, in conjunction with the annual statement of the insurer, that in accordance with this subchapter surrender comparison index disclosures have been included with policies at delivery or provided earlier upon request. Failure to so certify shall constitute prima facie evidence that surrender comparison index disclosures have not been provided to prospective purchasers of life insurance.

The 37 files noted were mailed to the insured and an appropriate officer's certification of the surrender comparison index disclosure was not provided.

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

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

and of establishing the date from which any applicable policy or examination period shall commence. Furthermore, a certificate of mailing is adequate proof of delivery. The date stamp, used to establish a means of verifying delivery, was either missing or not legible in the 22 noted files.

1 Violation–Insurance Company Law, Section 406-A (40 P.S. §625-6)

No alteration of any written application for a life insurance policy or annuity shall be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

The file noted contained an alteration without the applicant's appropriate written consent.

1 Violation – Insurance Company Law, Section 408-A (40 P.S. §625-8)

(a)(1) Each insurer marketing policies to which this act is applicable shall notify the commissioner whether a life insurance policy is to be marketed with or without an illustration.

The Company did not notify the department that the following life insurance policy form would be marketed without an illustration. The chart below contains the plan type and coverage as well as the number of files reviewed with that plan.

Plan	Coverage	Number of Files
E61	Modified Whole Life (URL-CBP)	3

C. Long-Term Care Policies Issued

The Company was requested to provide a list of all Long-Term Care Policies issued during the experience period. The Company provided a list of 26 policies issued. All 26 policies were requested, received and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

5 Violations - Title 31, Pennsylvania Code, Section 89a.121 Suitability

(a) Every insurer, nonprofit hospital plan and professional health services plan corporation or other entity marketing long-term care insurance (the issuer) shall meet the following conditions:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its producers in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(b) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the items in paragraph (1) into consideration.

(1) The producer and issuer shall take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(iii) The values, benefits and costs of the applicant's existing insurance when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and when a producer is involved, the producer shall make reasonable efforts to obtain the information in paragraph (1). The efforts shall include presentation to the applicant, at or prior to application of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B (relating to long-term care insurance personal worksheet), in at least 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.

(c) The issuer shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(d) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in

Appendix C (relating to things you should know before you buy long-term care insurance), in at least 12-point type.

(f) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the one presented in Appendix D (relating to long-term care insurance suitability letter). If the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(g) The issuer shall report annually to the Commissioner the total number of applications received from residents of this Commonwealth, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

The Company failed to include the Suitability Form in the 5 files noted.

D. Health Policies Issued

The Company was requested to provide a list of all health policies issued during the experience period. The Company provided a list of 338 health policies issued. A random sample of 75 health policies was selected, received and reviewed. The files were reviewed to determine compliance to issuance, replacement and underwriting statutes and regulations. The following table is a synopsis of the 75 health policies reviewed.

Policy Description	Contract Form	Plan Codes	Reviewed
Limited Hospital/Surgical Expense	GSP1	H39	26
Surgical/Hospital Expense	SHXC	913,914	17
Surgical/Medical Expense	SMXC	566	13
Cancer Expense and Indemnity	CAXC	629,630,631	7
Accident Only	UA250	I01, I02	6
Hospital Indemnity	HIXC	593, 594	5
Medical/Surgical Benefit	MSXC	412	1

The following violations were noted:

7 Violations – Title 31, Pennsylvania Code, Section 88.102

Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant at the time of completing the application, the notice described in § 88.103 of this title (relating to notice form). One copy of such notice shall be furnished to the applicant and the insurer shall retain an additional copy signed by the applicant.

The 7 files noted did not contain the required replacement notice.

E. Medicare Supplement Policies Issued

The Company was requested to provide a list of all Medicare Supplement policies issued during the experience period. The Company provided a list of 3,858 policies issued. A random sample of 100 policies was requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

F. Life Policies Declined

The Company was requested to provide a listing of all policies declined during the experience period. The company identified 71 life policies declined. All 71 declined policy files were requested, received, and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and any remittance of unearned premium was properly refunded. No violations were noted.

The following is a synopsis of the reasons for declination.

Number	Reason for Declination	Percent
22	Medical History	31%
17	Applicant Requested Application Withdrawal	24%
15	Required Forms Not Received	21%
14	Insufficient Underwriting Information	20%
2	Underwriting – Policy Lapse History Within 1 Year	3%
1	Underwriting- Maximum Coverage Reached	1%

G. Long-Term Care Policies Declined

The Company was requested to provide a list of all Long-Term Care policies declined during the experience period. The Company identified 27 declined Long-Term Care policies. All 27 declined policy files were requested, received and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and any remittance of unearned premium was properly refunded. No violations were noted.

The following is a synopsis of the reasons for declination.

Number	Reason for Declination	Percent
18	Medical History	67%
8	Insufficient Underwriting Information	29%
1	Required Forms Not Received	4%

H. Health Policies Declined

The Company was requested to provide a list of all health insurance policies declined during the experience period. The Company identified 27 declined health policies. All 27 declined policy files were requested, received and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and any remittance of unearned premium was properly refunded. The following violation was noted:

1 Violation – Insurance Department Act, Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth.

The file noted was missing verification of the premium return and reason for declination letter.

The following is a synopsis of the reasons for declination.

Number	Reason for Declination	Percent
17	Medical History	63%
4	Insufficient Underwriting Information	15%
3	Underwriting- Need More Recent Application Form	11%
2	Required Forms Not Received	7%
1	Underwriting – Same Coverage Issued	4%

I. Medicare Supplement Policies Declined

The Company was requested to provide a list of all Medicare Supplement policies declined during the experience period. The Company identified 18 declined Medicare Supplement policies. All 18 declined policy files were requested, received and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and any remittance of unearned premium was properly refunded. No violations were noted.

The following is a synopsis of the reasons for declination.

Number	Reason for Declination	Percent
7	Medical History	39%
4	Insufficient Underwriting Information	22%
3	Applicant Requested Application Withdrawal	17%
2	Required Forms Not Received	11%
2	Underwriting – Same Coverage In Force	11%

J. Life Policies Not-Taken

The Company was requested to provide a list of all policies not-taken during the experience period. The Company identified a universe of 256 life policies not-taken. A random sample of 25 not-taken policy files was requested, received and reviewed. The files were reviewed to ensure compliance with the free look provisions of the contract. A not-taken policy by definition is a policy that is issued and the insured requests cancellation. The 256 policies identified by the Company as not-taken policies, included policies that were issued but later declined coverage due to no receipt of required forms and/or return of initial premium checks. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

The following is a synopsis of the Not-Taken Policies reviewed:

Number	Company Reason for Not-Taken Status	Percent
13	Insured Requested Cancellation	52%
8	Initial Premium Check Returned by Bank	32%
4	Required Form not Received Underwriting Withdrew Coverage	16%

K. Long-Term Care Policies Not-Taken

The Company was requested to provide a list of all policies not-taken during the experience period. The Company identified a universe of 2 Long-Term Care policies not-taken. Both not-taken policy files were requested, received and reviewed. A not-taken policy by definition is a policy that is issued and the insured requests cancellation. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

L. Health Policies Not-Taken

The Company was requested to provide a list of all policies not-taken during the experience period. The Company identified a universe of 85 Health policies not-taken. A random sample of 25 not-taken policy files was requested, received and reviewed. A not-taken policy by definition is a policy that is issued and the insured requests cancellation. The 85 policies identified by the Company as not-taken policies, included policies that were issued but later declined coverage due to no receipt of required forms and/or return of initial premium checks. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

The following is a synopsis of the Not-Taken Policies reviewed:

Number	Company Reason for Not-Taken Status	Percent
23	Insured Requested Cancellation	92%
2	Initial Premium Check Returned by Bank	8%

M. Medicare Supplement Policies Not-Taken

The Company was requested to provide a list of all policies not-taken during the experience period. The Company identified 610 Medicare Supplement policies not-taken. A random sample of 25 files was requested, received and reviewed. A not-taken policy by definition is a policy that is issued and the insured requests cancellation. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

N. Long-Term Care Policies Terminated

The Company identified a universe of 9 long-term care policies terminated during the experience period. All 9 terminated policy files were requested, received, and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper disbursement of cash values. No violations were noted.

The following table is a synopsis of the 9 files terminated.

Number	Termination Reason	Percent
2	Death	22%
7	Lapse of Premium	78%

O. Health Policies Terminated

The Company identified a universe of 98 health policies terminated during the experience period. A random sample of 50 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper disbursement of cash values. The following violations were noted:

4 Violations- Insurance Department Act, Section 903 (40 P.S. §323.3)

(a) Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth.

The 4 files noted were incomplete.

The following table is a synopsis of the 46 files reviewed.

Number	Termination Reason	Percent
30	Lapse	65%
6	Insured Request	13%
5	Conversion to Another Plan	11%
5	Death	11%

P. Medicare Supplement Policies Terminated

The Company identified a universe of 4683 Medicare Supplement policies terminated during the experience period. A random sample of 100 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper disbursement of cash values. No violations were noted.

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

Number	Termination Reason	Percent
67	Lapse	67%
13	Insured Request	13%
12	Death	12%
8	Conversion to Another Plan	8%

Q. Medicare Supplement Issued as Replacements

The Company was requested to provide a list of all Medicare Supplement policies issued as replacements during the experience period. The Company provided a list of 24 replacement policies issued. All 24 policies were requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

IX. INTERNAL AUDIT AND COMPLIANCE PROCEDURES

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

(1) Periodic reviews of consumer complaints in order to determine patterns of improper practices.

(2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.

(3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

The following violation was noted.

1 Violation – Insurance Company Law, Section 405-A (40 P.S. §625-5)

Establishment of Internal Audit and Compliance Procedures.

(a) Every insurer shall institute and maintain internal audit and compliance procedures which provide 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. These procedures shall also provide for the following:

(1) Periodic reviews of consumer complaints in order to identify 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 line of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirements 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 and sales.

(b) Each insurer shall make available for department inspection upon request its internal audit and compliance procedures that are instituted as required by this section.

The Company did not provide evidence of compliance with regards to the following:

1. Specific compliance requirements and internal audits specific to Pennsylvania statutes and regulations dealing with sales methods and filing and approval requirements.
2. Establishment of communication, control and responsibility over dissemination of illustrations and illustration explanations, with requirements that illustrations are not to be used.

X. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided a 3 page explanation of the "Medicare Supplement Claims Processing Procedures", and a brief outline of its use of the Medicare Handbook and various other reference books and manuals. There is no claims manual for handling specified disease or other health policy claims. The policy contract is the guide used to paying or denying claims. The claim procedures and manuals were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Claim file review consisted of 5 areas:

A. Life Claims
B. Health Claims
C. Long-Term Care Claims
D. Medicare Supplement Provider Submitted Paid Claims
E. Medicare Supplement Insured Submitted Claims

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

A. Life Claims

The Company was requested to provide a list of all life claims received during the experience period. The Company identified a universe of 132 life claims. All 132 life claim files were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest. The following violations were noted:

5 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge 5 claims within 10 working days.

13 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

The Company failed to provide status letters within 30 days in the 13 claim files noted.

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.

The Company failed to provide notice of acceptance or denial in the 4 claim files noted.

B. Health Claims

The Company was requested to provide a list of all health claims received during the experience period. The Company identified 735 individual health claims received. Of the 735 health claims received, providers submitted 459 and 276 were submitted by the insured. As a result of a query performed on the claims submitted by providers, 393 were identified as paid and 66 were denied. Of the 393 claim files identified as provider submitted paid claims, 157 were randomly selected, received and reviewed. The 276 claims submitted by the insureds was queried, through an auditing program, to identify claims paid over 14 days. The result of that query was 98 claims. All 98 insured submitted claim files were requested for review. Of the 98 insured submitted claim files requested, 96 were received and reviewed. The provider submitted claim files were reviewed for compliance with Act 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

2 Violations – Title 31, Pennsylvania Code, Section 146.3

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

The Company failed to provide 2 claim files.

44 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge 44 claims within 10 working days.

5 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

The Company failed to provide status letters within 30 days in the 5 claim files noted.

24 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.

The Company failed to provide notice of acceptance or denial within 15 working days in the 24 claims files noted.

C. Long-Term Care Claims

The Company was requested to provide a list of Long-Term Care claims received during the experience period. The Company identified a universe of 172 Long-Term Care claims. A random sample of 50 files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, and Chapter 146. The following violations were noted:

22 Violations – Title 31, Pennsylvania Code, Section 146.3

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

The 22 files noted were missing pertinent data to verify date of claim receipt.

1 Violation - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge a claim file within 10 working days.

D. Medicare Supplement Provider Submitted Paid Claims

The Company was requested to provide a list of Medicare Supplement claims received during the experience period. The Company identified two distinct lists of 369,556 and 191,602 Medicare Supplement claims received. Of the 369,556 and 191,602 claims received, 362,996 and 188,031 claims, respectively, were submitted by providers. A query, through an auditing program, was performed on the total number of provider submitted claims of 551,027 to identify those claims that were paid over 45 days from the date of receipt. The result of that query was 141 claims. All 141 claims were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Section 146.3 and Act 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. The following violations were noted:

2 Violations – Title 31, Pennsylvania Code, Section 146.3

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

The 2 files noted were missing pertinent data to verify date of claim receipt.

74 Violations – Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166) Prompt Payment of Provider Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

The 74 clean claims noted were not paid within the required 45 days.

5 Violations – Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166) Prompt Payment of Provider Claims.

(B) If a licensed insurer or a Managed Care Plan Fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

The 5 clean claims noted were paid over 45 days from receipt and interest was not paid as required.

E. Medicare Supplement Insured Submitted Claims

The Company was requested to provide a list of Medicare Supplement claims received during the experience period. The Company identified 369,556 and 191,602 Medicare Supplement claims received. Of the 369,556 and 191,602 claims received, 6,560 and 3,571 claims, respectively, were submitted by insureds. A query, through an auditing program, was performed on the 6,560 and 3,571 claims to identify those claims that were paid, denied or suspended over 14 days from the date of receipt. The result of that query was 141 and 98 claims, respectively. All 239 claims were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. 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 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 claim files noted were missing pertinent data.

83 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge 83 claims within 10 working days.

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.

The Company failed to provide status letters within 30 days in the 2 claims noted.

16 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.

The Company failed to provide notice of acceptance or denial within 15 working days in the 16 claims noted.

XI. 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 implement procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

2. The Company must revise control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). The Company must provide to the Insurance Department within 30 days of the Report issue date proof of interest payment on the claims noted in the examination.

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

4. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5(a)(10) and complaint maintenance requirements of Section 5(a)(11) of the Unfair Insurance Practices Act [40 P.S. §1171.5(a)(10)] and to provide for the full claim investigation and adjudication of the death claims noted in Section N, Life Policies Terminated and Section A, Life Claims of the Report.

5. The Company must review and revise Licensing procedures to ensure compliance with Section 605, Section 606 and Section 623 of the Insurance Department Act of 1921 (40 P.S. §§235, 236 and 253).

6. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a) of the Insurance Department Act of 1921 [40 P.S. §323.3(a)].

7. 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).

8. The Company must review and revise their internal audit and compliance procedures to ensure compliance with Section 405-A of the Insurance Company Law of 1921 (40 P.S. §625-5).

9. The Company must review and revise internal control procedures to ensure compliance with the advertising requirements of Title 31, Pennsylvania Code, Chapter 51 and Chapter 89.

10. The Company must review and revise internal control procedures to ensure compliance with the replacement requirements of Title 31, Pennsylvania Code, Chapter 81 and Chapter 88.

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

12. The Company must review internal control procedures to ensure compliance with Long-Term Care suitability requirements of Title 31, Pennsylvania Code, Section 89a.121.

13. The Company must review internal control procedures to ensure compliance with Section 408-A of the Insurance Company Law of 1921 (40 P.S. §625-8), relating to the notification requirements to the Department of the use of Illustrations.

14. The Company must review internal control procedures to ensure compliance with forms filing and approval requirements of Section 354 of the Insurance Company Law of 1921 (40 P.S. §477b).

XII. COMPANY RESPONSE

united american insurance company

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Monday, August 9, 2004 (Revised)

VIA HAND DELIVERY

Daniel A. Stemcosky, AIE, FLMI
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Bureau of Enforcement
1321 Strawberry Square
Harrisburg, Pennsylvania 17120

RE: Report on Market Conduct Examination of
United American Insurance Company, NAIC # 92916

Examination Warrant Number: 02-M12-024

Dear Mr. Stemcosky:

United American Insurance Company ("United American", "the Company") is in receipt of the above-referenced Report of Market Conduct Examination (the "Report"). We respectfully offer the following in response to the Examiners' findings.

For the sake of efficiency, the order of the items in this Response corresponds to that of the violations contained in the Report. All statements, references and representations contained in this Response are being submitted without prejudice to United American's ability to fully defend against any and all claims that the Insurance Department may institute. No such item(s) may be used in any fashion as an admission or otherwise, and all such items are being provided in an effort to amicably resolve and settle this matter. United American, by responding to the Report, is not waiving any defense, set-offs, claims, etc., that it may have with regard to the Insurance Department's Examination.

Advertising (pages 6 – 8 of the Report)

The Company was cited for the following violations related to 2 newspaper advertisements generated by a United American agent: 2 violations of Title 31, Pennsylvania Code, Section 51.3 (failure to maintain control over the dissemination of advertising); 2 violations of Title 31, Pennsylvania Code, Section 51.35 (failure to identify insurance company name in advertising); 2 violations of Title 31, Pennsylvania Code, Section 89.785 (failure to submit advertising to the Insurance Department for file and use); and 2 violations of Title 31, Pennsylvania Code, Section 89.786 (advertising constituted "cold lead advertising").

The Company acknowledges these violations as contained in the Report, but offers the following comments. The agent who circulated these advertisements failed to submit them to the Company for approval prior to their use, a requirement that is stated in the agent's contract. Additional reminders of this requirement are provided from time-to-time by way of the Company's agent magazines, *UA News* (for branch agents) and *Vision* (for brokers), as well as during agent seminars, and in response to agent inquiries regarding the Company's advertising guidelines. When the advertisement was discovered during the course of the Examination, the Company immediately ordered the agent who had circulated the advertisements to cease doing so, and counseled the agent regarding his actions. The Company's practice is to review advertising submitted to it by its agents, noting changes to the advertising required by law or by Company policy. Because these advertisements were not submitted to the Company, the Company did not have the opportunity to correct the advertisements by, for example, including the full name of the Company in the advertisement.

Forms (page 9 of the Report)

The Company was cited for 100 violations of Insurance Company Law, Section 354 (40 P.S. § 477b). The allegation associated with these violations is that the Company utilized two application forms that had not been filed for approval with the Insurance Department.

The Company disagrees with these violations. The referenced application forms were filed with and approved by the Insurance Department. These applications were incorporated into brochures that, although not filed with the Department and approved for use as forms, were filed with the Insurance Department as advertising filings. The Examiners contend that the applications that the Company used contained additional text such that they were not the same applications filed with and approved by the Insurance Department. However, the "additional text" referenced by the Examiners is simply part of the advertising. The approved application form appears within the brochure form, itself composing roughly the middle section of the advertising. Wording that appears before that middle section and after that middle section is purely part of the advertising, not the application form. The application form, as it appears in the advertising, was clearly delineated from the remainder of the brochure by a separation line and form number. The Company discontinued the use of this particular advertising since the examination period.

Agent Licensing (pages 10 – 12 of the Report)

The Company was cited for the following violations concerning agent licensing matters: 1 violation of Insurance Department Act, Section 606 (40 P.S. § 236) (failure to report agent appointment to the Insurance Department); 10 violations of Insurance Department Act, Section 605(c)(d) (40 P.S. § 235) (failure to certify and submit appointment fees to the Insurance Department); and 3 violations of Insurance Department Act, Section 623 (40 P.S. § 253) (Insurance Department records do not identify agents as holding Pennsylvania appointments).

The Company acknowledges these violations as contained in the Report, but offers the following comments. With respect to the 1 violation of Insurance Department Act, Section 606 (40 P.S. § 236), the misreported appointment was as a result of an error in the data provided to the Examiners. The Company discovered during the Examination, incorrect data was inadvertently provided to the Examiners.

The Company acknowledges the 10 violations of Insurance Department Act, Section 605(c)(d) (40 P.S. § 235) and 3 violations of Insurance Department Act, Section 623 (40 P.S. § 253). The Company appeals to the Insurance Department to consider that the Examination resulted in relatively few violations in this area, and that the Company was found in the main to have been compliant with laws and regulations regarding agent licensing.

Consumer Complaints (pages 13 – 14 of the Report)

The Company was cited for the following violations concerning issues related to complaint handling: 1 violation of Unfair Insurance Practices Act, No. 205, Section 5(a)(11) [40 P.S. § 1171.5(a)(11)] (failure to maintain complete complaint log).

The Company acknowledges the **1** violation of the **Unfair Insurance Practices Act, No. 205, Section 5(a)(11) [40 P.S. § 1171.5(a)(11)]** concerning a consumer complaint not included in the Company's complaint log. However, while the Company agrees that the referenced complaint was not included in the Company's complaint log, it asks the Department to consider that this isolated, absent complaint was clearly an exception to the manner in which the Company maintains its complaint log. Accordingly, the Company contends that the Unfair Insurance Practices Act does not correctly or appropriately characterize this violation. The Unfair Insurance Practices Act sets forth a list of 6 generalized practices following an introduction that states that if any of the listed practices are "performed with such frequency as to indicate a business practice [it] shall constitute [an] unfair claim settlement or compromise practices." The Company is aware of no other instances in Report in which the Examiners allege violations identical to this one. The Company respectfully requests that the Examiners reconsider including the violation in the Report, or, alternatively, cite this criticism as a violation of a statute or regulation other than one reserved for activities rising to the level of a practice.

Underwriting (pages 15 – 32 of the Report)

Life Insurance Policies Issued (pages 16 – 20):
The Company was cited for the following violations related to issuance of life insurance policies: 2 violations of Title 31, Pennsylvania Code, Section 81.5(b) (replacement question not answered); 29 violations of Title 31, Pennsylvania Code, Section 81.6(a)(1) (agent replacement statement not included with or as part of the application for insurance); 1 violation of Title 31, Pennsylvania Code, Section 81.6(a)(2)(ii) (no file documentation of replacement letter sent to replaced company); 5 violations of Title 31, Pennsylvania Code, Section 83.3 (Disclosure Statement not included in file); 29 violations of Title 31, Pennsylvania Code, Section 83.55 (Surrender Comparison Index Disclosure not included in file); 4 violations of Title 31, Pennsylvania Code, Section 83.55a and 83.55b (agent's certification of the Surrender Comparison Index Disclosure Delivery was not evident); 37 violations of Title 31, Pennsylvania Code, Section 83.55c (appropriate officer's certification of the Surrender Comparison Index Disclosure was not provided on policies mailed to insureds); 22 violations of Insurance Company Law, Section 404-A (40 P.S. § 625-4) (date stamp used to establish means of verifying delivery was either missing or not legible); 1 violation of Insurance Company Law, Section 406-A (40 P.S. § 625-6) (file contained alteration without applicant's appropriate written consent); and 1 violation of Insurance Company Law, Section 408-A (40 P.S. § 625-8) (failure to notify Insurance Department as to whether illustrations would be used with life insurance policies).

The Company was cited for **2** violations of **Title 31, Pennsylvania Code, Section 81.5(b)** because the Examiners determined that the replacement question was not answered on the referenced applications. The Company acknowledges this violation and acknowledges that the applicant's replacement question was unanswered in the two applications referenced. However, the Company would like to point out that it is the Company's practice, as part of its underwriting process, to require a signed statement by the applicant regarding whether or not the policy will replace another prior to issuing a life insurance or annuity policy. Going forward, the Company will continue to emphasize to its underwriting managers and staff the importance of ensuring that the applicant's replacement question is answered prior to policy issuance.

The Company was also cited for **29** violations of **Title 31, Pennsylvania Code, Section 81.6(a)(1)** because the Examiners concluded that the agent replacement statement was not included with or as part of the application for insurance in 29 of the examined files. We disagree with this violation. The Company maintains that the current application form is compliant with the applicable regulation, notwithstanding the fact that there is no overt agent replacement statement as part of or with the application.

The purpose of Title 31, Pennsylvania Code, Section 81.6(a)(1) is to ensure proper disclosure. On the application form, the applicant is required to answer "Yes" or "No" in response to a question as to whether the proposed insurance or annuity will replace existing life insurance or

annuity. The agent then signs the application form, and in doing so demonstrates his or her knowledge regarding whether the policy is intended to be a replacement policy. Additionally, it is the Company's practice to attach a replacement form to the application in each instance in which a policy is designated as a replacement policy, further evidencing the agent's knowledge as to whether a policy is intended to replace an existing life insurance policy or annuity.

The public policy supporting the requirement of Title 31, Pennsylvania Code, Section 81.6(a)(1) (*i.e.*, that the agent must state whether he or she knows that replacement is or may be involved in the transaction) is not to create an independent body of knowledge apart from the application; rather, the purpose of this law is to ascertain whether, in fact, the agent obtained information from the applicant as to whether replacement of life insurance coverage would result from the sale of the policy, and whether the agent otherwise complied with replacement notice requirements. During the application process, the agent has no separate or distinct knowledge of whether a replacement is involved in the sale of a life insurance policy. That is, the agent relies on the applicant's statement that the policy is or is not intended to replace current coverage. The agent's signature on the application confirms the agent's knowledge of the applicant's intentions with respect to replacement.

It is the Company's position that the signature of the agent on the application meets the requirement of a statement by the agent as to whether he knows replacement is or may be involved in the sale of a given policy because the agent's signature confirms the agents knowledge of the applicant's intentions regarding replacement, as evidenced by the applicant's response to the application's replacement question. In cases where the applicant does intend to replace current coverage, the agent's signature on the replacement form – a document "with the application" – is a second confirmation of the agent's knowledge of the applicant's intentions regarding replacement. It should also be noted that the application form has previously been filed with and approved by the Department.

The Company was cited for **1** violation of **Title 31, Pennsylvania Code, Section 81.6(a)(2)(ii)** because the Examiners determined that it failed document in an examined file whether a replacement letter had been sent to the replaced insurer. The Company acknowledges this violation and recognizes that the referenced file did not document the requisite replacement letter to the replaced Company.

However, the Company adds that it makes every effort to ensure compliance with Title 31, Pennsylvania Code, Section 81.6(a)(2)(ii) by documenting the delivery of such written communication.

The Company was cited for **5** violations of **Title 31, Pennsylvania Code, Section 83.3** because the Examiners determined that the Disclosure Statement was not included in 5 examined files. The Company acknowledges these violations and recognizes that the referenced files did not include the Disclosure Statement required pursuant to Title 31, Pennsylvania Code, Section 83.3.

However, the Company would like to point out that it is its general practice to include such a written disclosure in its files.

The Company was cited for **29** violations of **Title 31, Pennsylvania Code, Section 83.55** because the Examiners determined that the Surrender Comparison Index Disclosure was not included in 29 examined files. The Company acknowledges these violations and offers the following comments. A review of the approval file for policy form WL-2 (plan 08) indicates that a Surrender Cost Index was requested by the Department of Insurance, and prepared and submitted by the Company. Further review of the policy production system found that the Surrender Cost Index form was indeed missing. Changes to the policy production system are currently being tested for implementing the Surrender Cost Index as referenced during the policy approval process.

The Company was cited for **4** violations of **Title 31, Pennsylvania Code, Section 83.55a and 83.55b** based upon the Examiners' determination that the agent's certification of the Surrender Comparison Index Disclosure Delivery was not evident in 4 examined files. The Company acknowledges these violations. As previously explained in reference to violations noted under Title 31, Pennsylvania Code, Section 83.55, above, while the Company prepared and submitted a Surrender Cost Index to the Department for approval, a review of the policy production system reveals that the form was apparently never utilized in relation to policy form WL-2 (Plan 08). As a result, no agent certification of the Surrender Comparison Index Disclosure delivery was included in the referenced files. The Company will modify its policy production system to incorporate use of the Surrender Comparison Index Disclosure form and will similarly amend its processes to ensure that the appropriate agent certification is included in the applicable files.

The Company was cited for **37** violations of **Title 31, Pennsylvania Code, Section 83.55c** because the Examiners determined that 37 examined files lacked verification that an appropriate officer's certification of the Surrender Comparison Index Disclosure was provided when policies were mailed to the respective insureds. The Company acknowledges these violations and recognizes that it did not certify, in conjunction with its annual statement, that Surrender Comparison Index Disclosures were included with policies at delivery or provided earlier upon request. However, given that the primary intent of Title 31, Pennsylvania Code, Section 83.55c is to ensure that an annual *certification* of disclosure is made by the insurer, the Company submits that its failure to make such certification represented a single omission and, accordingly, should result in a solitary violation. It is the Company's belief that any violations regarding its failure to *deliver* the document to applicants would more properly fall under Title 31, Pennsylvania Code, Section 83.55c (which is entitled "Delivery"). In any event, please note that going forward the Company will include the required certification in conjunction with its annual statement filing, as required.

The Company was cited for **22** violations of **Insurance Company Law, Section 404-A (40 P.S. § 625-4)** because the Examiners determined that the date stamp used to establish a means of

verifying delivery was either missing or not legible on 22 examined files. The Company acknowledges these violations and offers the following comments. The Company has developed and implemented procedures that serve as a means of verifying the delivery of policies or annuities. The date stamp that is generally utilized by the Company, while helpful, should not be viewed as the Company's sole means of verifying delivery. As part of the underwriting process, an issue date, referred to as "date of issue" on the issue worksheet, indicates the date upon which the underwriting process has been completed and a particular policy is ready to be issued. It is the Company's practice to mail the applicable policy to the policyholder the next business day following the date of issue, otherwise known as the "disposition date". In order to allow for the associated mailing time, the Company gives customers 45 days from the disposition date to examine and determine their satisfaction with the policy (*i.e.*, the 30-day "free look" period).

It is the Company's position that its policy delivery date verification practices comport with the purpose and spirit of 40 P.S. §625-4, which is to verify the date of policy delivery in order to ensure that insureds may take full advantage of the 30-day policy examination period. While the Company generally utilizes the date stamp as a means of policy delivery verification, date stamping is not foolproof: the stamp's ink may print in an illegible fashion at times, and, occasionally, inadvertent error may result in a failure to date stamp a given policy. In the event that a date stamp is missing or illegible, the Company's practice of mailing the applicable policy to the policyholder the next business day following the date of issue provides an alternative policy delivery verification practice; this mailing practice is no more or less a "written procedure" than the Company's practice of date stamping. Note that the Company allows an insured to examine his or her policy for a period of 45 days from the date of issue, which period affords 15 days for policy mailing. In many cases, an insured will receive his or her policy in fewer than 15 days, meaning that such an insured will have more than 30 days to examine his or her policy.

The Company was cited for **1** violation of **Insurance Company Law, Section 406-A (40 P.S. § 625-6)** based upon the Examiners' determination that 1 examined file contained an alteration without applicant's appropriate written consent. The Company acknowledges this violation. However, the Company continues to maintain that no alteration existed which materially affected the application or issuance of the policy. Administrative alterations are permitted under 40 P.S. § 625-6. Consequently, the applicant's written consent was not required here. A review of the application revealed that the only alterations made were in regards to the application date and were not material in nature. The bank draft authorization and two separate disclosure statements included in the file all referenced the same date, March 1, 2002, evidencing the clear intent of the parties.

The Company was cited for **1** violation of **Insurance Company Law, Section 408-A (40 P.S. § 625-8)** because the Examiners determined that it failed to notify the Insurance Department as to whether illustrations would be used with life insurance policies. The Company disagrees with this violation. When researching this matter during the Examination, it came to the Company's

attention that, via correspondence of June 3, 1999, it did notify the Commissioner that it does not market policies with illustrations. This correspondence was previously provided to the Examiners.

Long-Term Care Policies Issued (pages 21 – 23):
With respect to long-term care insurance policy issuance, the Company was cited for 5 violations of Title 31, Pennsylvania Code, Section 89a.121 based upon the Examiners' determination that it failed to include the Suitability Form in the examined files. The Company acknowledges these violations. It should be noted, however, that the Company has an established process in place to ensure that the required Suitability Form is included in the files. The Company has established Suitability Standards for the review of all long-term care insurance policies. Since at least 1996, the Company has required that its agents submit a Suitability Checklist [Form LTSC (37)] with all long-term care insurance applications. The inadvertent omission of the form in the referenced files is not indicative of the Company's processes and represents a deviation from its current and accepted practices. The Company will continue to stress to its Underwriting staff the importance of ensuring inclusion of the required Suitability form in the files.

Health Insurance Policies Issued (page 24):
Regarding health insurance policy issuance, the Company was cited for 7 violations of Title 31, Pennsylvania Code, Section 88.102 because the Examiners determined that the replacement notice was not contained in 7 examined files. The Company acknowledges these violations and recognizes that the referenced files did not contain the required replacement notice. It is the Company's practice to retain such notices in the applicable files. The Company will make every effort going forward to comply with Title 31, Pennsylvania Code, Section 88.102 by ensuring that a copy of the replacement notice is maintained in each file requiring same.

Health Policies Declined (pages 26 – 27):
The Company was cited for 1 violation of Insurance Department Act, Section 903 (40 P.S. § 323.3) because the Examiners determined that the examined file was missing verification of the premium return and the letter regarding the reason for declination. The Company acknowledges this violation and recognizes that the referenced file did not contain the required verification of the premium return and reason for declination letter. However, it is generally the Company's practice to keep such verification and rationale for declination in the applicable file. Of the files examined, it should be noted that this was the only file without the required documentation.

Health Policies Terminated (page 31):
The Company was cited for 4 violations of Insurance Department Act, Section 903 (40 P.S. § 323.3) because the Examiners determined that they had been provided incomplete files during the Examination. The Company acknowledges these violations, but continues to contend that for each of the files criticized by the Examiners, the reason for termination was apparent both from the file as well as from the chronology prepared for and accompanying each file.

Internal Audit and Compliance Procedures (pages 33 – 34 of the Report)

The Company was cited for 1 violation of Insurance Company Law, Section 405-A (40 P.S. § 625-5) based upon the Examiners' conclusion that it does not have in place specific internal audit and compliance procedures that include its life insurance and annuity operations in the State of Pennsylvania.

The Company adamantly disagrees with this violation and asserts that it has established internal audit and compliance procedures that comport with the requirements of the 40 P.S. § 625-5; the following are examples of those procedures:

(1) Periodic reviews of consumer complaints in order to identify patterns of improper practices.

Quarterly meetings with senior officers of the Company are held to discuss consumer complaints on both a national and a State basis, including complaints specific to the Company's operations in Pennsylvania. Additionally, the following complaint reports, which are extrapolated from the complaint log that the Company maintains, analyze complaint information in great detail: Quarterly Complaint Review; Annual Complaint Review; Multiple Agent Complaints; Agent Department of Insurance Violations; and Medicare Supplement Replacement Complaints. These reports include information about the Company's operations in Pennsylvania. Other reviews of consumer complaints are often conducted; the preceding is merely an example of such reviews.

(2) Regular reporting to senior officers and the Board of Directors or an appropriate committee thereof with respect to any significant findings.

The Company's compliance, legal, and internal audit departments regularly communicate with senior officers and/or members of the Board of Directors regarding significant findings that these departments may discover. Such findings include information relevant to the Company's operations in the Commonwealth. By way of example, Internal Audit conducts quarterly audits of Medicare supplement replacement business to insure that the correct documentation (*e.g.*, replacement forms, etc.) are collected at the time of application. These audits are shared with senior officers and/or Board members. In addition, for the past two years, members of Compliance and Legal have held a weekly meeting with at least one senior officer and one Board member to discuss significant legal and compliance issues, including issues concerning the Company's operations in Pennsylvania. These are merely examples of the types of communication referenced by the statute, and are not inclusive of all communications of this type.

(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.

With respect to advertising processes, the Company provides to its agents access to advertising that it has created, including advertising for use in the Commonwealth. Any agent – whether selling the Company's policies in the Commonwealth or elsewhere – who wishes to create alternative advertising is required to submit such advertising to the home office for approval. Home office employees reviewing such advertising are not remunerated by compensation directly linked to marketing or sales. The requirement that agents submit to the home office advertising that they have created prior to use is set forth in the agent contract. Additionally, reminders of this requirement are provided from time-to-time by way of the Company's agent magazines, *UA News* (for branch agents) and *Vision* (for brokers), as well as during agent seminars, and in response to agent inquiries regarding the Company's advertising guidelines. Pennsylvania agents receive these reminders. On a weekly basis, members of Legal and Compliance meet to review submitted advertisements and discuss issues related thereto. During these meetings, advertisements submitted by Pennsylvania agents are reviewed, and issues related to Pennsylvania advertising and marketing are discussed. Legal and Compliance employees are not recompensed in a manner directly linked to marketing or sales.

Frankly, the Company is at a loss to understand the Examiners' continued assertion that the Company has no established internal audit and compliance procedures comporting with the requirements of the 40 P.S. § 625-5. On numerous occasions during the Examination, the Company provided materials and documents to the Examiners that corroborated its compliance with the statute; these materials and documents included items referenced in the discussion, above.

Claims (pages 35 – 43 of the Report)

Life Insurance Claims (pages 36 – 37):
The Company was cited for the following violations concerning issues related to life insurance claims handling: 5 violations of Title 31, Pennsylvania Code, Section 146.5 (failure to acknowledge a claim within 10 working days); 13 violations of Title 31, Pennsylvania Code, Section 146.6 (failure to provide status letters within 30 days); and 4 violations of Title 31, Pennsylvania Code, Section 146.7 (failure to provide notice of acceptance or denial of a claim).

The Company was criticized for failing to acknowledge **5** claims within 10 working days of receipt. In support thereof, the Examiners cite **Title 31, Pennsylvania Code, Section 146.5**, of which the pertinent part reads as follows: "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." The Company acknowledges these violations and notes its practice is to notice receipt of claim within 10 working days of actual receipt, if payment of a proofed claim cannot be processed within such period.

The Company was also criticized for failing on 13 claims to provide status letters within 30 days after receiving notification of a claim. The Company acknowledges these violations and notes it has implemented procedures to ensure that status letters are issued within 30 days from the receipt of a claim in the event the claims investigation is not completed within the initial 30 day period.

The Company was cited for allegedly failing to advise claimants of the acceptance or denial of **4** claims within 15 working days after the submission of properly executed proofs of loss. In support thereof, the Examiners cite **Title 31, Pennsylvania Code, Section 146.7**, which provides that "within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer". The Company has implemented procedures to ensure claimants are timely advised of the acceptance or denial of their claim after their submission of "properly executed proofs of loss" as required by the applicable regulation.

In each of the cases cited by the Examiners, the date used to begin the time period was either that of the insured's actual death or the date the Company was given notice of the death by a phone call. The regulation clearly states that the time period begins after receipt of proofs of loss. In each of these cases, the Company had not received any "properly executed" documents by the date referenced by the Examiners, much less documents sufficient to establish proof of loss. It also does not appear that the Examiners have taken into account that status letters in compliance with Title 31, Pennsylvania Code, Section 146.7(c)(1) were sent in a number of the cited files.

Most, if not all, of the files presented in this criticism involved material misrepresentations of health history of an insured. Therefore, it was necessary for several departments within the Company, as well as our medical director, to closely review the facts of each file. These reviews, of course, were completed on a timely basis and the beneficiary was at all times kept apprised of the status.

Health Insurance Claims (pages 37 – 39):
The Company was cited for the following violations concerning issues related to health insurance claims handling: 2 violations of Title 31, Pennsylvania Code, Section 146.3 (failure to provide claims files); 44 violations of Title 31, Pennsylvania Code, Section 146.5 (failure to acknowledge claims within 10 working days); 5 violations of Title 31, Pennsylvania Code, Section 146.6 (failure to provide status letters within 30 days); and 24 violations of Title 31, Pennsylvania Code, Section 146.7 (failure to provide notice of acceptance or denial within 15 working days).

The Company was cited for **2** violations of **Title 31, Pennsylvania Code, Section 146.3** because it could not produce 2 files during the Examination. The Company acknowledges these

violations, but appeals to the Insurance Department to consider that its inability to produce these 2 files was anomalous to its overall facilitation of the Examination.

The Company was also cited for **44** violations of **Title 31, Pennsylvania Code, Section 146.5** because the Examiners concluded that it failed to acknowledge 44 claims within 10 working days of receipt. The Company acknowledges these violations. Please note that new procedures have been put in place to enhance the Company's ability to notice claims in a manner compliant with Title 31, Pennsylvania Code, Section 146.5.

The Company was criticized based upon the Examiners' conclusion that it failed to complete the investigation of **5** health claims within 30 days of the initial notification or to have sent the insured a letter on the 30th day and every 45 days thereafter from the date of receipt of the initial notification of the claim, in violation of **Title 31, Pennsylvania Code, Section 146.6**. The Company acknowledges these violations. Please note that new procedures have been put in place to enhance the Company's ability to acknowledge claims in a manner compliant with Title 31, Pennsylvania Code, Section 146.6.

The Company was criticized based upon the Examiners' conclusion that it failed, with respect to **24** files, to advise claimants of the acceptance or denial their respective claims within 15 working days after the submission of properly executed proofs of loss, in violation of **Title 31, Pennsylvania Code, Section 146.7**. The Company acknowledges these violations. Please note that new procedures have been put in place to enhance the Company's ability to notice claims in a manner compliant with Title 31, Pennsylvania Code, Section 146.7.

Long-Term Care Insurance Claims (pages 39 – 40):
The Company was cited for the following violations concerning issues related to long-term care insurance claims handling: 22 violations of Title 31, Pennsylvania Code, Section 146.3 (files missing pertinent data to verify date of claim receipt); and 1 violation of Title 31, Pennsylvania Code, Section 146.5 (failure to acknowledge a claim within 10 working days).

The Company was cited for **22** violations of **Title 31, Pennsylvania Code, Section 146.3** because the Examiners deemed 22 files as missing pertinent data to verify date of claim receipt. The Company acknowledges these violations, but wishes to point out that the date of claim receipt with respect to each these files can be approximated due to the manner in which nursing homes and other long-term care facilities bill for services. Generally, nursing homes and other long term care facilities bill in advance for services rendered. The Company does not pay for services in advance. The Company pays its long term care claims after services are rendered. Once the claim has been approved for payment, any ongoing payments are made at the beginning of the month following when they were incurred. For example, the Company may receive a bill for the month of May as early as May 1st, which bill is billing for the 31 days of May. The Company will not pay that claim until the beginning of June and the receipt date of that claim will be June 1st.

The Company was also cited for **1** violation of **Title 31, Pennsylvania Code, Section 146.5** based upon the Examiners' determination that it failed to acknowledge a claim within 10 working days. The Company acknowledges this violation, but requests the Insurance Department to consider that this was an isolated violation not indicative of the Company's general handling of long-tem care insurance claims.

Medicare Supplement Insurance Claims, Provider-Submitted (pages 40 – 41):
The Company was cited for the following violations concerning issues related to handling of Medicare supplement insurance claims submitted by providers: 2 violations of Title 31, Pennsylvania Code, Section 146.3 (files missing pertinent data to verify date of claim receipt); 74 violations of Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. § 991.2166) Prompt Pay of Provider Claims (clean claims not paid within the required 45 days); 5 violations of Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. § 991.2166) Prompt Pay of Provider Claims (clean claims paid over 45 days from receipt and interest not paid as required).

The Company was cited for **2** violations of **Title 31, Pennsylvania Code, Section 146.3** because the Examiners determined that 2 examined files were missing pertinent data to verify date of claim receipt. The Company acknowledges these violations, but points out that the vast majority of examined files contained data allowing the Examiners to verify claim receipt dates.

The Company was also cited for **74** violations of **Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. § 991.2166)** because the Examiners determined that 74 clean claims were not paid within the required 45 days. The Company acknowledges these violations, but continues to dispute that the majority of the identified claims were "clean" claims. Six of these claims were outpatient hospital claims that were audited for correct Medicare coinsurance. Three of these claims were received after the policy was rescinded for duplication of coverage on October 18, 2001. Upon receipt of proof of cancellation of prior coverage, the policy was put back in force on December 11, 2001 and the claims were paid December 26, 2001.

Many more of these claims were filed by the Veteran's Administration ("VA"); these claims are not clean claims. In order for the Company to pay or reject a claim for a service that is a Medicare covered service under our Medicare supplement insurance policies, we must have knowledge of Medicare's determination. By law, the VA cannot file its claims with Medicare. Therefore, when the Company receives a claim from the VA, it must determine if the service provided is a Medicare covered expense and then determine what Medicare would have approved and paid for that service. The claim is then ready for adjudication by the Company. Currently, a manual is used to process these VA claims. The Company is, or will, revise its computer software to do these determinations and calculations, which will expedite the processing of claims from the VA.

The Company was cited for **5** violations of **Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. § 991.2166)** because the Examiners determined that the Company had not paid interest on clean claims that were paid over 45 days from receipt. The Company acknowledges these violations, and points out that it has instituted programming that will enhance its abilities to gauge interest due on clean claims paid over 45 days from receipt.

Medicare Supplement Insurance Claims, Insured-Submitted (pages 42 – 43):
The Company was cited for the following violations concerning issues related to the handling of Medicare supplement insurance claims submitted by insureds: 13 violations of Title 31, Pennsylvania Code, Section 146.3 (files missing pertinent data); 83 violations of Title 31, Pennsylvania Code, Section 146.5 (failure to acknowledge claims within 10 working days); 2 violations of Title 31, Pennsylvania Code, Section 146.3 (failure to provide status letters within 30 days); and 16 violations of Title 31, Pennsylvania Code, Section 146.7 (failure to provide notice of acceptance or denial within 15 working days).

The Company was cited for **13** violations of **Title 31, Pennsylvania Code, Section 146.3** because the Examiners determined that 13 examined files lacked pertinent payment data. The Company acknowledges these violations, but points out that when the insured is paid pursuant to a Medicare supplement insurance claim, no information appears in the "Payee" field. The Medicare claims system extracts the name and address of the insured when the claim is coded to pay to the insured, thereby eliminating the need to key the insured's name and address when the claim is keypunched or data entered.

The Company was also cited for **83** violations of **Title 31, Pennsylvania Code, Section 146.5** because the Examiners determined that it failed to acknowledge claims within 10 working days. The Company acknowledges these violations. Please note that the Company is reviewing, or will review, programming changes to its claims system that will improve its ability to acknowledge Medicare supplement claims within 10 working days.

The Comapny was cited for **2** violations of **Title 31, Pennsylvania Code, Section 146.3** because the Examiners determined that it failed to provide Medicare supplement insureds status letters regarding their respective claims within 30 days of claim notification. The Company acknowledges these violations, and requests the Insurance Department to consider that these 2 occurrences are contrary to its routine claims handling practices.

The Company was cited for **16** violations of **Title 31, Pennsylvania Code, Section 146.7** because the Examiners determined that it failed to provide to Medicare supplement insureds notice of acceptance or denial of a claim within 15 working days. The Company acknowledges these violations, and requests the Insurance Department to consider that it is exploring system

improvements that will allow the Company to better track the 15-day notice deadline required by Title 31, Pennsylvania Code, Section 146.7.

We greatly appreciate the opportunity to respond to the Report. I thank you, on behalf of the Company.

Should you wish to discuss further any of the foregoing, please do not hesitate to contact me.

Very truly yours,

UNITED AMERICAN INSURANCE COMPANY

Joel Scarborough
Vice President and Associate Counsel

JPS/jps

cc: William R. Balaban, Esq.
Elliott, Greenleaf, Siedzikowski & Balaban