

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

**THE PRUDENTIAL INSURANCE COMPANY OF
AMERICA**

Newark, New Jersey

**AS OF
November 10, 2009**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT**

Issued: January 19, 2010

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

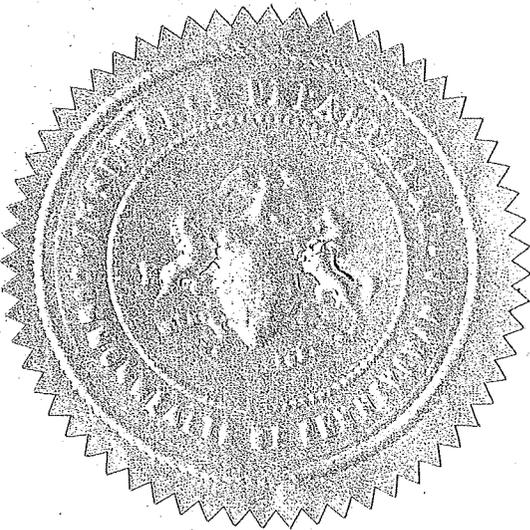
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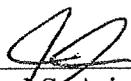
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22ND day of July, 2008, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
THE PRUDENTIAL INSURANCE	:	Sections 354, 404-A and 410E(a)(2)
COMPANY OF AMERICA	:	of the Insurance Company Law, Act
751 Broad Street	:	of May 17, 1921, P.L. 682, No. 284
Newark, NJ 07102	:	(40 P.S. §§ 477b, 625-4, and 510d)
	:	625-6 and 625-8)
	:	
	:	Title 31, Pennsylvania Code,
	:	Sections 146.6 and 146.7
	:	
	:	Title 18, Pennsylvania Consolidated
	:	Statutes, Section 4117(k)
	:	
	:	
Respondent.	:	Docket No. MC09-12-025

CONSENT ORDER

AND NOW, this *19th* day of *JANUARY*, 2010, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

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

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

3. Respondent neither admits nor denies the Findings of Fact or Conclusions of Law contained herein; further Respondent expressly denies that it violated any Pennsylvania Insurance laws or regulations.

FINDINGS OF FACT

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

- (a) Respondent is The Prudential Insurance Company of America, and maintains its address at 751 Broad Street, Newark, New Jersey 07102.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2008 to December 31, 2008.
- (c) On November 10, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on

December 10, 2009.

- (c) After consideration of the December 10, 2009 response, the Insurance Department has modified the Examination Report as attached.

- (f) The Examination Report notes violations of the following:
 - (i) Section 354 of the Insurance Company Law (40 P.S. § 477b), which prohibits issuing, selling, or disposing of any policy, contract or certificate until the forms have been submitted to, and formally approved by, the Insurance Commissioner;

 - (ii) Section 404-A of the Insurance Company Law, No. 284 (40 P.S. §625-4), which requires when the individual policy or annuity is delivered to the policyholder by the producer by hand, a delivery receipt shall be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered by a means other than by hand-delivery by the producer, the insurer shall establish appropriate means of

verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence;

- (iii) Section 410E(a)(2) of the Insurance Company Law, No. 284 (40 P.S. § 510d), which states individual fixed dollar annuity contracts which are offered as replacements for an existing annuity contract or life insurance policy with the same insurer or insurer group shall not be entered into in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such contract or attached thereto a notice stating in substance that the contract holder shall be permitted to return the contract within at least forty-five (45) days of its delivery;
- (iv) Title 31, Pennsylvania Code, Section 146.6 states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;
- (v) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer; and

- (vi) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms shall contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

CONCLUSIONS OF LAW

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

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent’s violation of Section 354 of The Insurance Company Law is punishable by the following, under Section 354 of The Insurance Company Law (40 P.S. § 477b):
 - (i) suspension or revocation of the license(s) of Respondent;
 - (ii) refusal, for a period not to exceed one year thereafter, to issue a

new license to Respondent;

(iii) imposition of a fine of not more than one thousand dollars

(\$1,000.00) for each act in violation of the Act.

(c) Respondent's violations of Sections 404-A and 410E(a)(2) of the Insurance Company Law, No. 284 (40 P.S. §§625-4, 625-6 and 625-8) are punishable by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation.

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

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

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

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

(i) for each method of competition, act or practice which the company knew

or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);

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

ORDER

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

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall pay Fifty Thousand Dollars (\$50,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.
- (d) Payment of this matter shall be made by check payable to the Commonwealth

of Pennsylvania. Payment should be directed to Sharon Fraser, Bureau of Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

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

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

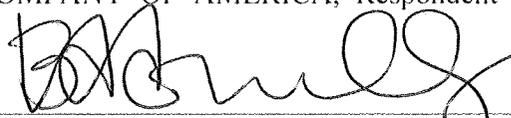
9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

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

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

12. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

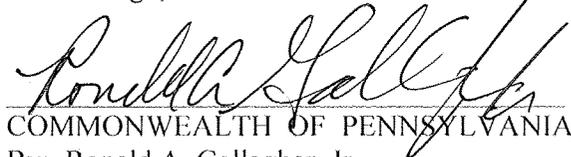
BY: THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA, Respondent



Beth A. Connelly, Senior Vice President and
COO



Lori L. High, Senior Vice President



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

I. INTRODUCTION

The Market Conduct Examination was conducted on The Prudential Life Insurance Company of America; hereafter referred to as “Company,” at the Company’s office located in Newark, New Jersey, April 20, 2009, through June 26, 2009. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

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

Daniel Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief

Frank W. Kyazze, AIE, FLMI, ALHC, MCM
Market Conduct Examiner

Lonnie L. Suggs
Market Conduct Examiner

Verification

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

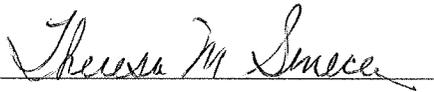


Frank W. Kyazze, MCM, AIE, ALHC, FLMI

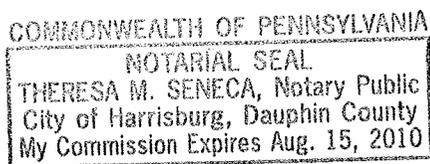
[Examiner in Charge]

Sworn to and Subscribed Before me

This *21* Day of *October*, 2009



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2008, through December 31, 2008, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

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

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

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

III. COMPANY HISTORY AND LICENSING

The Prudential Insurance Company of America has its statutory home office at 751 Broad Street, Newark, NJ 07102, and its main administrative office at 213 Washington Street, Newark, NJ 07102. The Company is licensed in all 50 states, including the District of Columbia, Puerto Rico, Virgin Islands and Guam.

Prudential was incorporated in 1873 by a special act of the New Jersey Legislature as a stock life insurance company under the name of the Widows and Orphans Friendly Society. Business commenced in 1875 and in the same year, by a supplemental act of the Legislature, the Company's name was changed to the Prudential Friendly Society. In 1877, the company name was changed to the Prudential Insurance Company of America. The changeover to a mutual company began in 1913 and did not end until 1943, when the Company repurchased the last capital stock. In 1975, the Pruco Life Insurance Company was created as a subsidiary of the Prudential Insurance Company of America with the purpose of conducting individual life insurance and single pay deferred annuity business in all states except New York.

On December 18, 2001, Prudential Insurance converted from a mutual life insurance company owned by its policyholders to a stock life insurance company and became an indirect, wholly owned subsidiary of Prudential Financial.

Until September 2002, Prudential was organized into three primary business segments: insurance, asset management and securities. The insurance segment included domestic and international life insurance, group life and disability insurance and property and casualty insurance. The asset management segment included mutual funds, fixed and

variable annuities, retirement services products and the management of all affiliated and not-affiliated assets.

The insurance segment manufactured and distributed protection products to retail and institutional customers both domestically and internationally as well as distribute investment products (annuities and mutual funds) primarily to retail customers in the United States. This segment's operations were conducted through the Company's U.S. Consumer Group, Institutional and International Insurance business groups.

In September 2002, Prudential reorganized its businesses into three operating divisions: Insurance, Investments, and International Insurance and Investments. The Insurance Division includes Individual Life Insurance, Annuities, Group Insurance, Retail Distribution, and Real Estate and Relocation Services. On June 1, 2006, Prudential acquired Allstate's variable annuity business through a reinsurance transaction.

As of the Company's December 31, 2008, annual statement for Pennsylvania, The Prudential Insurance Company of America reported direct life insurance premiums and annuity considerations in the amount of \$739,177,604, and direct premiums for accident and health insurance in the amount of \$66,133,575.

IV. ADVERTISING

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

V. FORMS

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

VI. PRODUCER LICENSING

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

The Company provided a list of 3,925 active and terminated producers. A random sample of 150 producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam.

No violations were noted.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2004, 2005, 2006 and 2007. The Company identified 2,026 consumer complaints received during the experience period. A random sample of 50 complaint files was requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

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

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 4 general segments.

- A. Underwriting Guidelines
- B. Group Conversions
- C. Annuity Contracts Issued
- D. Annuity Contracts Issued as Replacements

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

A. Underwriting Guidelines

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The documentation provided was reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following guidelines were reviewed:

1. Life Manual
2. Disability Manual
3. General Underwriting – The Group Underwriting Roles and Responsibilities
4. General Underwriting – Authority and Referral Limits
5. General Underwriting – Quality Assurance

6. Underwriting Memoranda
7. Medical Underwriting Guidelines
8. Group Insurance Performance Guarantees and Procedures
9. Group Insurance Performance Guarantee Standard Operating Policy and Procedure
10. Underwriting and Product Guidelines
11. Field Underwriting Guidelines
12. Group Insurance Conversion Manual

The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

B. Group Conversions

The Company was requested to provide a list of all applications for conversion of group coverage to individual coverage during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 171 certificate holders converting their group life coverage upon termination to an optional individual life insurance plan. A random sample of 50 conversion files was requested, received and reviewed. The files were reviewed to ensure compliance with applicable issuance, conversion and underwriting statutes and regulations. The following violations were noted:

50 Violations - Insurance Company Law, Chapter 2, Section 354 (40 P.S. §477b)

It shall be unlawful for any insurance company, doing business in the Commonwealth of Pennsylvania, to issue, sell, or dispose of any policy, contract, or certificate, covering life insurance, or use application, riders, or endorsements, in connection therewith, until the forms have been submitted to, and formally approved by, the Insurance Commissioner.

Department form approval could not be established for the conversion application forms noted.

Form No.	Frequency of Use
GL.2001.155 Ed 8/2007	45
GL.2001.155 Ed. 1/2008	1
GL.2001.155 Ed. 1/2003	1
GL.2004.403 Ed. 8/2007	3

50 Violations - Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)

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

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

The following conversion applications for insurance did not contain or have attached the required fraud statement.

Form No.	Frequency of Use
GL.2001.155 Ed 8/2007	45
GL.2001.155 Ed. 1/2008	1
GL.2001.155 Ed. 1/2003	1
GL.2004.403 Ed. 8/2007	3

C. Annuity Contracts Issued

The Company identified a universe of 369 annuity contracts issued during the experience period of January 1, 2008 through December 31, 2008. A random sample of 75 contract files was requested, received and reviewed. The files were reviewed to determine compliance with issuance, and replacement statutes and regulations. The following violations were noted:

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

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

Verification of the date of annuity contract delivery could not be established in 6 files and the producer did not sign the contract delivery receipt in 18 files.

D. Annuity Contracts Issued as Replacements

The Company identified a universe of 10 annuity contracts issued as replacements during the experience period of January 1, 2008 through December 31, 2008. All 10 contract files were requested, received, and reviewed. Of the 10 contracts, 3 were determined to be duplicates. The remaining 7 files were reviewed to determine compliance with issuance, and replacement statutes and regulations. The following violations were noted:

2 Violations - Insurance Company Law, Section 410E(a)(2) (40 P.S. §510d)

Individual fixed dollar annuity contracts which are offered as replacements for an existing annuity contract or life insurance policy with the same insurer or insurer group shall not be entered into in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such contract or attached thereto a notice stating in substance that the contract holder shall be permitted to return the contract within at least forty-five (45) days of its delivery.

The 2 contract files noted did not contain the required 45-day "free look" statement.

IX. INTERNAL AUDIT & 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.
- (4) The laws requires that each insurer shall make available for the Department's inspection upon request its internal audit and compliance procedures which are instituted as required by this section.

The Company provided the following:

1. A Narrative Statement of the Individual Life Insurance Internal Control Methods
2. A copy of the Group Insurance Quality Assurance Memoranda
3. A copy of the Company's Insurance Market Standards Association (IMSA) Recertification
4. Internal Control Structure – Corporate Governance and Ethics, Key Corporate Functions including Corporate Compliance and Internal Audit
5. Advertising, Sales and Marketing Policy and Procedures - Section 2.0 of the Compliance Manual
6. Marketing Review Corporate Oversight Standard Operating Procedures
7. Standard Operating Procedures For Marketing Review Process
8. Quality Review of Marketing Material Procedures - to help ensure that marketing material is being reviewed for compliance with applicable Laws and Regulations, the Marketing Review Guide and the Company's Policies and Procedures
9. Review of Supervisory Procedures to determine whether they are adequate, up-to-date, and in compliance with the Laws and Regulations
10. Prudential Financial's Compliance Department – Marketing Review Corporate Oversight, Marketing Review Guide – Advertising Policies, Procedures and Disclosures
11. Audit Committee of the Board of Directors – Audit Committee Charter
12. Complaints Handling: Procedures and Guidelines

No violations were noted.

X. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following claim manuals and procedural guidelines:

1. Group Insurance Short Term Disability Claims Calculation and Adjustment Handling Reference Guide
2. Short Term Disability Contract Reference Guide
3. Short Term Disability (STD) Technical Claim Handling Reference Guide
4. Claims Manuals Letters and Forms Guidelines
5. Quality Review Process Procedures – Short Term Disability, Long Term Disability, and Waiver of Premium Claims
6. Group Insurance Long Term Disability Claims Manuals
7. Individual Health Claims Procedures
8. Group Claims Memoranda
9. Life Claim Rules and Procedures
10. Life Claims Reference Library
11. Response Due Date Guidelines
12. State Requirements For Complaint Resolutions
13. Pennsylvania Insurance Fraud
14. Pennsylvania Statutory Interest
15. Attachment A: Unfair Claim Settlement Practices State Charts
16. Pennsylvania Specific Claims Guidelines For Individual Health

The claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The claim file review consisted of 10 areas:

- A. Group Waiver of Premium Claims
- B. Group Life Insurance Claims
- C. Group Long Term Disability Claims
- D. Group Short Term Disability Claims
- E. Individual Life Claims
- F. Individual Intermediate & Weekly Premium Claims
- G. Individual Disability Claims Not Paid
- H. Individual Disability Claims Paid
- I. Individual Premium Waiver Claims Approved
- J. Individual Life Premium Waiver Claims Denied

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

A. Group Waiver of Premium Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 609 group waiver of premium claims received. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices. The following violations were noted and amended subsequent to the receipt of the Company's response to the Report:

8 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 timely status letters in the 8 claim files noted.

B. Group Life Insurance Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified 8,562 group life insurance claims received. A random sample of 50 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices, and Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b). The following violations were noted:

3 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 timely status letters in the 3 claim files noted.

1 Violation - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days for the claim noted.

C. Group Long Term Disability Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 1,228 group long term disability claims. A random sample of 25 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices. The following violation was noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim.

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

D. Group Short Term Disability Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 2,990 group short-term disability claims. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices. No violations were noted.

E. Individual Life Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 26,512 individual life claims received. A random sample of 100 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices, and Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b). The following violations were noted:

16 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 timely status letters in the 16 files noted.

F. Individual Intermediate and Weekly Premium Claims

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 11,661 individual intermediate & weekly premium claims received. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices, and Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b). The following violations were noted:

12 Violations - Title 31, Pennsylvania Code, Section 146.6

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

The Company failed to provide timely status letters for the 12 claim files noted.

G. Individual Disability Claims Not Paid

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 2 individual disability claims not paid. The 2 claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. No violations were noted.

H. Individual Disability Claims Paid

The Company was requested to provide a list of claims received and paid during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 73 individual disability claims paid. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices. The following violations were noted:

1 Violation - 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 a timely status letter in the claim file noted.

1 Violation - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim.

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

I. Individual Premium Waiver Claims Approved

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 831 individual premium waiver claims approved. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

7 Violations - Title 31, Pennsylvania Code, Section 146.6

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

The Company failed to provide timely status letters for the 7 claims noted.

J. Individual Life Premium Waiver Claims Denied

The Company was requested to provide a list of claims received during the experience period of January 1, 2008 through December 31, 2008. The Company identified a universe of 61 individual life premium waiver claims denied. A random sample of 20 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Insurance Practices. The following violations were noted:

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.

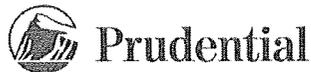
The Company failed to provide timely status letters for the 5 claims noted.

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 review internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
2. 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).
3. The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes, Section 4117(k).
4. 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).
5. The Company must review internal control procedures to ensure compliance with Section 410E of the Insurance Company Law of 1921 (40 P.S. §510d) pertaining to the “Free Look” provision requirements for annuity and pure endowment contracts.

XII. COMPANY RESPONSE



Stephen Willis
Compliance Analyst
The Prudential Insurance Company of America
213 Washington St., 12th Flr., Newark NJ 07102
Tel 973 802-2094 Fax 973 367-8571

December 10, 2009

Via Fax and UPS Express

Office of Market Regulation
Bureau of Market Conduct
1227 Strawberry Square
Harrisburg, PA 17120
Attn: Daniel A. Stemcosky
Market Conduct Division Chief

Re: Examination Warrant Number: 09-M27-003

Dear Mr. Stemcosky:

The Prudential Insurance Company of America (the "Company" or "Prudential") is in receipt of you letter dated November 10, 2009 enclosing the Pennsylvania Insurance Department's (the "Department") report on the market conduct examination (the "report") of Prudential. Please consider this letter and the attached document as the Company's written submission, rebuttal and request for modifications to the report.

Prudential requests that the Department continue to hold the contents of the report as private and confidential until such time as we have had an opportunity to meet with you and discuss the issues raised in our response. We will be contacting you shortly to request a mutually convenient time for such a meeting. In the meantime, please feel free to contact me at (973) 802-2094 or Michael Kmiecik at (973) 802-5685 if you have any questions or require anything further.

Please note that this written submission, rebuttal and request for modifications to the report is without prejudice to or waiver of any other rights or defenses that may be available to Prudential.

Sincerely,

A handwritten signature in cursive script that reads "Stephen Willis".

Stephen Willis

Response of The Prudential Insurance Company of America to the Pennsylvania Insurance Department Report on Examination

Group Conversions

Report Finding (Report page 14-15): Group conversion application forms were not filed with and approved by the Department. 40 P.S. Sec. 477b

Company Response: The Company respectfully disagrees with this finding.

The conversion forms at issue are not “applications” within the meaning of the cited statute and are not required to be filed for approval with the Department. These forms are used when an individual converts the existing life insurance coverage provided under a group insurance contract issued to his/her employer to an individual life insurance contract. The conversion privilege is guaranteed and there is no underwriting in the process. Thus, the forms are administrative in nature and contain no questions as to health, occupation or avocation, and do not become part of the individual insurance contract. In addition, the Prudential individual life insurance products currently available for group conversions are deregulated forms that are not required to be filed for approval. (Department Bulletin 2001-07) The group conversion forms in question are used only with these products and, as a result, we believe that these forms are also exempt from prior approval requirements.

The Company, however, acknowledges that the use of the word “application” on these conversion forms could be confusing and suggest that the forms need to be filed for approval. Thus, we propose to change the title of the form to “Conversion of Group Life Insurance” and remove the references to the word “application” within the form to accurately reflect the form’s purpose.

The Company respectfully requests that this finding be removed from the report.

Report Finding (Report page 14-15): Group conversion forms did not contain the required fraud statement. 40 P.S. Section 4117 (b)

Company Response: The Company respectfully disagrees with this finding.

For the reasons stated above, we do not believe that the group conversion forms in question are “applications” within the meaning of the cited statute and do not require an anti-fraud statement.

The anti-fraud statement refers to an individual who “files an application containing materially false information” or who “conceals...information concerning any fact material thereto.” The conversion privilege is guaranteed so there is no motivation for an individual to provide false information or conceal material facts in this context. In addition, the conversion forms ask the individual to provide only the basic information needed to set up the policy so that there is limited opportunity or reason to provide false information to the Company.

The Company respectfully requests that this finding be removed from the report.

Nonetheless, we recognize the Department’s strong interest in deterring insurance fraud. For this reason, we have added the prescribed anti-fraud statement to our group conversion forms.

Annuity Contracts Issued

Report Finding (Report page 16): The annuity contract delivery date could not be verified in 6 cases and the producer did not sign the contract delivery receipt in 18 cases. 40 P.S. 625-4

Company Response: The Company acknowledges that these findings are accurate.

In accordance with the Department's recommendation, we have reviewed our procedures for obtaining annuity contract delivery receipts or other appropriate proof of delivery. We can report that in cases where the Company mails an annuity contract directly to a client, the Company uses UPS. A delivery receipt is included with the contract and the client is asked to sign, date and return the delivery receipt to the Company. The completed delivery receipt is maintained in the contract file. We recognize that the client will not always return the delivery receipt and thus, our procedures also require that we retain a copy of the UPS mailing slip in the contract file as proof of mailing.

These requirements have been reiterated to the individuals in the Company's Annuity Operations area who are responsible for this process.

In other cases, the Company mails the annuity contract and contract delivery receipt to the producer who either hand-delivers or mails the annuity contract to the client. In order to emphasize the requirement for the producer to sign the contract delivery receipt and return proof of mailing to the Company, we have revised the contract delivery receipt form used in these cases to state the following:

- The producer *must* sign the contract delivery receipt if the contract was hand-delivered, indicate on the form that the contract was hand-delivered, and send the form back to the Home Office.
- If the contract was not hand-delivered, the producer *must* send the proof of mailing to the Home Office, which will be filed together with the contract delivery receipt signed, dated and sent back to the Home Office by the client.

If the Company receives neither of these items, we will mail the annuity contract directly to the client, as described above.

We believe that these actions will address the findings in the report related to annuity contract delivery receipts.

Annuity Contracts Issued as Replacements

Report Finding (Report page 17): 2 annuity replacement contracts did not include the required 45-day free look statement. 40 P.S. 510 (d)

Company Response: The Company acknowledges that this finding is accurate.

In accordance with the Department's recommendation, we have reviewed our procedures for handling annuity replacement cases. We can report that the Company's procedures include the requirement for a 45-day free look statement in replacement cases such as those at issue. In

these two cases, the 45-day free look statement was omitted due to processor error. As a result, we have reiterated the applicable requirements to the individuals in our Annuity Operations area who are responsible for this process.

We believe that this action will address the findings in the report related to the 45-day free look statement.

Claims

Introduction: The Department found that the Company did not provide timely status letters to claimants in a number of the claim populations reviewed (31 PA Code Section 146.6). We understand that the Department considers the Company's first receipt of information informing it of the insured's death to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons that follow.

Please note that 31 PA Code Section 146.7(a)(1) provides that the Company must provide notice of the acceptance or denial of a claim within 15 working days of receipt by the insurer of a properly executed proof of loss. So, the notice for the purpose of the prompt review and payment of a claim is triggered by the receipt of the proof of loss. In addition, Section 146.7(c)(1) provides: "If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of initial notification and every 45 days thereafter, send to such claimant a letter setting forth the reason additional time is needed for investigation and state when a decision on the claim may be expected."

This language makes it clear that the notice regarding the continuing investigation of the claim is triggered by the Company's receipt of proof of loss and continues until the investigation is complete, and the claim can either be paid or denied. We believe this interpretation is reasonable given the fact that the Company cannot begin a claim investigation until it has received the completed claim form which provides the necessary information and authorizations that will allow it to investigate the claim.

In addition, we interpret the inclusion in Section 146.7(c)(1) of the same investigation notice language that appears in section 146.6 to clarify the fact that notice requirements for a continuing claim investigation are triggered by receipt of proof of loss as set forth in Section 146.7(c)(1). If this were not the case, then the insurer would be sending notice about the continuing status of the claim at multiple intervals that could only prove to confuse the claimant. Specifically, notice would be sent 30 days after notice of the death and every 45 days thereafter until a claim decision is made, as well as 15 days after receipt of proof of loss and 30 days after that date and every 45 days thereafter.

Clearly, for the two sections to work together properly, notice for purposes of the investigation of the claim would need to begin after receipt of the proof of loss by the Company.

Group Waiver Of Premium Claims

Report Finding (Report page 21-22): The Company did not provide timely status letters in 22 claims and did not provide notice of acceptance or denial in 1 claim. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with the finding that timely status letters were not provided in 20 of the 22 claims and that notice of acceptance or denial was not provided in 1 claim.

There are two categories of claims at issue in this section of the Report. In the first category are 14 waiver of premium claims that were “auto-created” from previously approved long-term disability (LTD) claims. This arrangement applies to group LTD clients who also have group life coverage with a waiver of premium provision. For those clients with an approved LTD claim, a waiver of premium claim will be “auto-created” in the system one month before the end of the group policy elimination period and the Company will review the LTD information to determine if the claimant qualifies for waiver of premium benefits. Thus, the client experiences a seamless transition between LTD benefits and the waiver of premium claim.

The 14 “auto-created” claims were handled as follows:

- 6 claims were approved before the end of the elimination period for the waiver of premium claim;
- Of the remaining 8 claims, 6 claims were processed within 14 calendar days of the end of the elimination period;
- Of the remaining 2 claims, a status letter was sent to the claimant within 14 calendar days of the end of the elimination period.

The date a waiver of premium claim is “auto-created” appears as the “proof received date” in the Company system. We understand that the Department used this date to determine the timeliness of status letters. As discussed, the “auto-created” date is established by the Company as part of the service we provide to our clients; it is not the date that the Company receives either notice or proof of claim from a claimant. Using the analysis provided above, we believe that these claims were properly handled.

Therefore, the Company respectfully disagrees with this finding and requests that it be removed from the report.

In the second category are 8 waiver of premium claims submitted directly by the claimant to the Company. The Company paid 6 of the 8 claims within 15 working days of receipt of proof of loss. There was no investigation and thus, no requirement to provide a status letter to the claimant in these cases.

We understand that the Department considers the initial notification of claim to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above.

The Company acknowledges that a timely status letter was not provided in 2 claims out of a sample of 25 claims reviewed for a ratio of 8%. This result falls slightly outside the (7%) error tolerance threshold referenced in the NAIC Market Regulation Handbook (2008) for claim procedures and, we believe, is indicative of an isolated error and not a general business practice.

With respect to the 1 claim where the Company allegedly did not provide notice of acceptance or denial within 15 working days, note that this claim was “auto-created” and the decision was made 5 days after the end of the elimination period. Therefore the Company respectfully disagrees with this finding and requests that it be removed from the report.

Group Life Insurance Claims

Report Finding (Report page 22-23): The Company did not provide timely status letters in 2 claims and did not provide notice of acceptance or denial in 1 claim. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with the finding that timely status letters were not provided in 2 claims.

The Company’s procedures provide that the requirement to provide status letters to the claimant is triggered when we commence a claim investigation after receipt of proof of loss. In this case, the Company paid the 2 claims in question within 15 working days of receipt of proof of loss. There was no investigation and thus, no requirement to provide a status letter to the claimant.

We understand that the Department considers the Company’s first receipt of information informing it of the insured’s death to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above.

Therefore the Company respectfully disagrees with this finding and requests that it be removed from the report.

The Company acknowledges that neither a notice of acceptance or denial nor a timely status letter was provided in 1 claim out of a sample population of 25 claims reviewed for a ratio of 4%. This result falls within the (7%) error tolerance threshold referenced in the NAIC Market Regulation Handbook (2008) for claims procedures and, we believe, is indicative of an isolated error not a general business practice.

Group Long Term Disability Claims

Report Finding (Report page 23): The Company did not provide notice of acceptance or denial in 1 claim. 31 PA Code Section 146.6

Company Response: The Company acknowledges that notice of acceptance or denial was not provided in 1 claim out of a sample of 25 claims reviewed for a ratio of 4%. This result falls within the (7%) error tolerance threshold referenced in the NAIC Market Regulation Handbook (2008) for claim procedures and, we believe, is indicative of an isolated error not a general business practice.

Therefore, we respectfully request that this finding be removed from the report.

Individual Life Claims

Report Finding (Report page 24): The Company did not provide timely status letters in 16 claims. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with the finding that timely status letters were not provided in 15 of the 16 claims.

The Company's procedures provide that the requirement to provide status letters to the claimant is triggered if we commence a claim investigation after receipt of proof of loss. In this case, the Company paid the 15 claims in question within 15 working days of receipt of proof of loss. Since these claims were paid within the 15 working days and there was no investigation, there was no requirement to provide a status letter to the claimant.

We understand that the Department considers the Company's first receipt of information informing it of the insured's death to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above.

It is important to note that the Individual Life claims handling area sends a series of follow up letters to a claimant who has provided initial notification of claim but has not submitted the requirements needed to process the claim. The first follow up letter is sent 70 days after initial notification and then 2 subsequent follow up letters are sent at 30 day intervals. These are service-oriented letters stating that we need information in order to process the claim. We enclose a reply envelope and provide a toll-free telephone number should the claimant require assistance. By contrast, our status letter confirms that the claim package has been received and advises the claimant that additional time will be needed to process the information.

Therefore we respectfully request that this finding be removed from the report.

The Company acknowledges that a timely status letter was not provided in 1 claim out of a sample of 100 claims reviewed for a ratio of 1%. This result falls within the (7%) error tolerance threshold referenced in the NAIC Market Regulation Handbook (2008) for claim procedures and, we believe, is indicative of an isolated error not a general business practice.

Intermediate and Weekly Premium Claims

Report Finding (Report page 24): The Company did not provide timely status letters in 12 claims. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with this finding.

The Company's procedures provide that the requirement to provide status letters to the claimant is triggered if we commence a claim investigation after receipt of proof of loss. In this case, the Company paid the 12 claims in question within 15 working days of receipt of proof of loss. There was no investigation and thus, no requirement to provide a status letter to the claimant.

We understand that the Department considers the Company's first receipt of information informing it of the insured's death to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above.

It is important to note that the Individual Life claims handling area sends a series of follow up letters to a claimant who has provided initial notification of claim but has not submitted the requirements needed to process the claim. The first follow up letter is sent 70 days after initial notification and then 2 subsequent follow up letters are sent at 30 day intervals. These are service-oriented letters stating that we need information in order to process the claim. The letter includes a reply envelope and provides a toll-free telephone number should the claimant require

assistance. By contrast, our status letter confirms that the claim package has been received and advises the claimant that additional time will be needed to process the information.

Therefore we respectfully request that this finding be removed from the report.

Individual Disability Claims

Report Finding (Report page 26): The Company did not provide a timely status letter in 1 claim and notice of acceptance or denial in 1 claim. 31 PA Code Section 146.6

Company Response: The Company acknowledges that a timely status letter was not provided in 1 claim (which was paid 32 days after receipt of proof of loss), and notice of acceptance or denial was not provided in 1 claim (which was paid 22 days after receipt of proof of loss), out of a sample of 25 claims reviewed for a ratio of 8%. This result falls just outside the (7%) error tolerance threshold referenced in the NAIC Market Regulation Handbook (2008) for claim procedures and, we believe, is indicative of an isolated error not a general business practice. Nonetheless, we have reiterated to our TPA the requirement to adhere to all regulatory time standards for claims handling.

Individual Waiver of Premiums Approved

Report Finding (Report page 27): The Company did not provide a timely status letter in 7 claims. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with this finding.

The Company's procedures provide that the requirement to provide status letters to the claimant is triggered if we commence a claim investigation after receipt of proof of loss. In these cases, the Company either approved the claim in question within 15 working days of receipt of proof of loss and a status letter was not required; or the Company provided a timely status letter to the claimant after receipt of proof of loss.

We understand that the Department considers the initial notification of a claim to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above in the "Group Life Claims" section.

Therefore, we respectfully request that this finding be removed from the report.

Individual Waiver of Premiums Denied

Report Finding (Report page 27-28): The Company did not provide a timely status letter in 5 claims. 31 PA Code Section 146.6

Company Response: The Company respectfully disagrees with this finding.

The Company's procedures provide that the requirement to provide status letters to the claimant is triggered if we commence a claim investigation after receipt of proof of loss. In these cases, the Company denied the claims in question within 15 working days of receipt of proof of loss. Thus, a status letter was not required.

We understand that the Department considers the initial notification of claim to be the starting point for determining when status letters are required. The Company respectfully disagrees with the Department for the reasons stated above.

Therefore, we respectfully request that this finding be removed from the report.