REPORT OF
MARKET CONDUCT EXAMINATION
OF

WASHINGTON NATIONAL
INSURANCE COMPANY
Carmel, IN

AS OF
December 23, 2010

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: January 27, 2011

WASHINGTON NATIONAL INSURANCE COMPANY

TABLE OF CONTENTS

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

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

Michael F. Consedine
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
WASHINGTON NATIONAL INSURANCE COMPANY 11825 North Pennsylvania Street Carmel, IN 46032	:	Title 31, Pennsylvania Code, Sections 146.3, 146.5, 146.6 and 146.7
Respondent.	:	Docket No. MC11-01-004

CONSENT ORDER

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

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

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

FINDINGS OF FACT

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

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

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

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

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

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

(i) Title 31, Pennsylvania Code, Section 146.3, which requires the claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers

pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed;

(ii) Title 31, Pennsylvania Code, Section 146.5, which states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;

(iii) Title 31, Pennsylvania Code, Section 146.6 states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected; and

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

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

ORDER

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

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

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

(c) Respondent shall pay Forty Thousand Dollars ($40,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

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

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

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action

pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

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

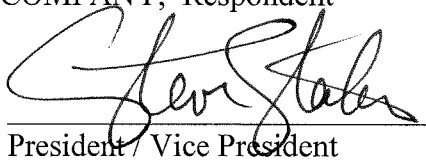
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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

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

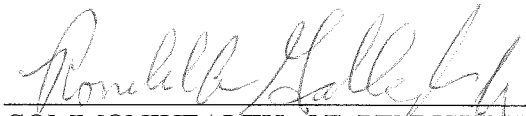
contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: WASHINGTON NATIONAL INSURANCE COMPANY, Respondent



President / Vice President

Secretary / Treasurer



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

I. INTRODUCTION

The Market Conduct Examination was conducted on Washington National Insurance Company; hereafter referred to as "Company," at the Company's office located in Carmel, Indiana, May 17, 2010, through June 10, 2010. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

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

Yonise A. Roberts Paige
Market Conduct Division Chief

Michael A. Jones
Market Conduct Examiner

Gary L. Boose, MCM, LUTC
Market Conduct Examiner

Verification

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

Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 27 Day of October , 2010

Notary Public

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

II. SCOPE OF EXAMINATION

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

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

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

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

III. COMPANY HISTORY AND LICENSING

Washington National Insurance Company (hereafter referred to as "the Company" and/or "WNIC") was established and incorporated in Illinois and commenced business on September 7, 1923 following incorporation as a stock legal reserve life insurance company on May 26, 1923. The Company was formed as the Washington Fidelity National Insurance Company through the merger of the United States National Life and Casualty Company, of Chicago, Illinois (organized in 1923), the Washington Life and Accident Insurance Company of Chicago, Illinois (organized in 1923) and the Fidelity Life and Accident Insurance Company, of Louisville, Kentucky (organized in 1923). The merger was effective February, 1926. The present title was adopted on January 22, 1931.

On April 30, 1968, the Stockholders of the Company voted to approve a Plan of Exchange, which became effective as of October 2, 1968. Under the Plan, the Stockholders of the Company exchanged their shares for shares of common stock of Washington National Corporation and the Company became a wholly owned subsidiary of Washington National Corporation. The Illinois Director of Insurance approved the Plan of Exchange on August 9, 1968.

The Company became part of the Conseco insurance holding company system on December 5, 1997, when Conseco, Inc. acquired all of the issued and outstanding capital stock of Washington National Corporation, a publicly traded company that owned WNIC. The acquisition was approved by the Illinois Director of Insurance on December 3, 1997. On December 31, 1998, 100% of the issued and outstanding common stock of Washington National Corporation was contributed to Jefferson National Life Insurance Company of Texas, now named Conseco Life of Texas. On

June 30, 1999, Washington National Corporation was dissolved and the Company became a wholly-owned subsidiary of Conseco Life Insurance Company of Texas.

Effective June 30, 2001, Wabash Life Insurance Company (NAIC #92436), an Indiana company [and part of the Conseco insurance holding company system since 1961] merged with and into WNIC, after obtaining approval from the Indiana, Illinois and California Insurance Departments.

Effective July 1, 2003, Pioneer Life Insurance Company (NAIC #68330) and Conseco Medical Insurance Company (NAIC #93769), Illinois companies [and part of the Conseco insurance holding company system since 1997] merged with and into WNIC, after obtaining regulatory approvals from the Illinois and California Insurance Departments.

Effective October 1, 2004, Bankers National Life Insurance Company (NAIC #71900), a Texas company [and part of the Conseco insurance holding company system 1986] merged with and into WNIC, after obtaining regulatory approvals from the Illinois, Texas and California Insurance Departments.

Effective June 25, 2008, Washington National Insurance Company changed its statutory home office address. On July 23, 2008, Conseco Life Insurance Company of Texas paid an extraordinary dividend in the form of 100% of the common stock of WNIC to CDOC, Inc. As a result, all outstanding shares of WNIC are owned by CDOC, Inc., which is a wholly-owned subsidiary of Conseco. WNIC is a direct subsidiary of CDOC, Inc., and indirect wholly owned subsidiary of CNO Financial Group, Inc.

The Company is domiciled in the state of Illinois and licensed in the District of Columbia and every state except New York. WNIC has life, annuity and supplemental health insurance policies in force. The Company began marketing the RewardMark and Educators Choice annuity products in 2006 through professional independent producers and ceased marketing other lines of business. WNIC is currently only selling the Educators' Choice annuity products.

As of the Company's December 31, 2009, annual statement for Pennsylvania, Washington National Insurance Company reported direct premiums for life insurance considerations in the amount of $2,278,710 and direct premiums for accident and health insurance in the amount of $6,402,964.

IV. ADVERTISING

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

V. FORMS

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

VI. PRODUCER LICENSING

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

The Company provided a list of 615 producers and 10 terminated producers. A random sample of 50 producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam. 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 2005, 2006, 2007 and 2008. The Company identified 67 consumer complaints received during the experience period. Of the 67 complaints identified, 39 were forwarded from the Department. All 67 complaint files were requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

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

VIII. CLAIMS

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

A. Random audits on auditor-released claims
B. Annuity State tax tables 2006
C. CIC Claims Bulletin/Exemptions
D. CLIC and WNIC Interest Calc
E. Community Property by State
F. Conseco Insurance Group Rejections
G. Exemptions from Attachments by Creditors
H. General Overview
I. Interest Memo
J. Life and Annuity Claims Payment Interest Requirement
K. Life Examiner Check List for Waiver Claims
L. Life Waiver Document
M. Life-end Waiver Procedures
N. Medicare Supplement Booklet
O. Non-resident Tax
P. Notice and Consent
Q. Response Memo
R. Small Estate Administration
S. Swiss Re Guidelines/ PA
T. Taxation NE Administration
U. Uniform Transfer to Minors Act

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 11 areas:

A. Annuity Claims Paid
B. Disability Claims Paid
C. Waiver of Premium Claims Pend.
D. Spec. Disease Claims Denied
E. Spec. Disease Claims Paid
F. Med. Supp. Claims Paid
G. Med. Supp. Claims Pending
H. Med. Supp. Claims Denied
I. Claims Manuals
J. Life Claims Denied
K. Life Claims Paid

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

A. Annuity Claims Paid

The Company was requested to provide a list of annuity claims paid that were received during the experience period. The Company identified a universe of 34 claims received. A random sample of 10 claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

4 Violations - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time. If the investigation cannot be completed within 30 days, and every 45 days

thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. Verification of a timely status letter could not be established in the 4 noted files.

B. Disability Claims Paid

The Company was requested to provide a list of disability claims paid that were received during the experience period. The Company identified 18 claims received. A random sample of 10 claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

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

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

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that

first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the noted file.

1 Violation - Title 31, Pennsylvania Code, Section 146.7

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

C. Waiver of Premium Claims Pending

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

1 Violation - Title 31, Pennsylvania Code, Section 146.6

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

for the delay and state when a decision on the claim may be expected. Verification of a timely status letter could not be established in the noted file.

D. Specified Disease Insurance Claims Denied

The Company was requested to provide a list of specified disease insurance claims that denied during the experience period. The Company identified a universe of 4 claims received. All 4 claim files was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process adhered to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.7

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

E. Specified Disease Insurance Claims Paid

The Company was requested to provide a list of specified disease insurance claims received during the experience period. The Company identified a universe of 8 claims received. All 8 claim files was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process adhered to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

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

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

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

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

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

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. Verification of a timely status letter could not be established in the 8 noted files.

5 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 5 noted files.

F. Medicare Supplement Claims Paid

The Company was requested to provide a list of all Medicare Supplement claims paid during the experience period. The Company identified a universe of 40,456 claims received. A random sample of 100 files was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

G. Medicare Supplement Claims Pended

The Company was requested to provide a list of all Medicare Supplement claims pended during the experience period. The Company identified a universe of 497 claims received. A random sample of 25 files was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted

H. Medicare Supplement Claims Denied

The Company was requested to provide a list of all Medicare Supplement claims denied during the experience period. The Company identified a universe of 3,693 claims received. A random sample of 50 files was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.3

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

Missing Information
Policy
Claims Payment information

I. Life Claims Denied

The Company was requested to provide a list of life claims denied received during the experience period. The Company identified a universe of 4 life claims received. The claim files were reviewed to ensure that the Company's claim adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

J. Life Claims Paid

The Company was requested to provide a list of life claims Paid received during the experience period. The Company identified a universe of 124 life claims received. A random sample of 50 requested, received and reviewed. The claim files were reviewed to ensure that the Company's claim adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

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

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

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The

Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the noted file.

4 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. Verification of a timely status letter could not be established in the 4 noted files.

2 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 2 noted files.

XI. RECOMMENDATIONS

The recommendation made below identify a corrective measure the Department found necessary as a result of the number of some violations noted in the Report.

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

X. COMPANY RESPONSE

CNO FINANCIAL GROUP

December 30, 2010

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

RE: Market Conduct Exam Report
Washington National Insurance Company, NAIC # 70319

Dear Ms. Paige:

The Company is in receipt of your December 3, 2010 communication. I respectfully submit to you the formal response to the Washington National Insurance Company ("WNIC") Market Conduct Examination Report. Thank you for the opportunity to respond.

The Company respectfully requests the following modifications to the Exam Report. The sections given in this response refer directly to those sections in the Exam Report, and are in the same order as found in the Report. The Company requests that the Exam Report be appropriately modified to reflect all of its comments.

Cover Letter
The Company respectfully requests that the cover page reflect the correct legal name of the Company, specifically Washington National Insurance Company.

III. Company History and Licensing, Page 8
The Company respectfully requests that the last paragraph on page 8 of the Company History reflect the correct legal name of the Company, specifically Washington National Insurance Company.

A. Annuity Claims Paid, Pages 14 & 15
4 Violations-Title 31, Pennsylvania Code, Section 146.6

The Company respectfully requests that the cited violation be stricken from the Exam Report for the reasons set forth below:

The Company believes it complied with section 146.6 of Title 31 of the Pennsylvania administrative code. Specifically, Title 31, Pennsylvania Code, Section 146.2 defines a notice of claim as "a demand for payment by a claimant and not an inquiry concerning coverage." Moreover, section 146.2 (b) defines notice of a claim as "a notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim." The examiners based their recommendation on the interpretation that a request for a claim form is within the definition of notice of claim. However, the Company respectfully disagrees and believes that a request for a claim form is not a notification which reasonably apprises it of facts pertinent to a demand for payment and therefore is not notification of a claim. Therefore the appropriate trigger for the 30 day timeframe which would invoke the Company's duty to provide its claimants with a status update is the date of the actual receipt of the claim information and not the request for a claim form.

J. Life Claims Paid, Page 22
4 Violations-Title 31, Pennsylvania Code, Section 146.6

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The Company believes it complied with section 146.6 of Title 31 of the Pennsylvania administrative code. Specifically, Title 31, Pennsylvania Code, Section 146.2 defines a notice of claim as "a demand for payment by a claimant and not an inquiry concerning coverage." Moreover, section 146.2 (b) defines notice of a claim as "a notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim." The examiners based their recommendation on the interpretation that a request for a claim form is within the definition of notice of claim. However, the Company respectfully disagrees and believes that a request for a claim form is not a notification which reasonably apprises it of facts pertinent to a demand for payment and therefore is not notification of a claim. Therefore the appropriate trigger for the 30 day timeframe which would invoke the Company's duty to provide its claimants with a status update is the date of the actual receipt of the claim information and not the request for a claim form.

XI. Recommendations:
The following represents the actions taken by the Company since the exam period (January 1, 2009 through December 31, 2009) to ensure compliance with Title 31, Pennsylvania Codes, Sections 146.3, 146.5, 146.6 and 146.7 as noted in the Examination Report.

Recommendation 1: The Company must review and revise internal control procedures to ensure compliance with the requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Company Response: The Company generates daily and weekly prompt pay monitoring reports which reflect the aging level of each claim by line of business and state as reported in its claims administrative system. These reports are reviewed by management on a daily and weekly basis to prioritize workflow and allocate human resources effectively to assist in compliance with prompt pay requirements. The daily report was implemented in mid 2006, and the weekly report was implemented during the first quarter of 2006, following the 2005 Examination.

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

Restructuring of our claim departments, hiring new management, and improvements in technology have gained efficiencies for reducing the claim processing time. Training of adjusters is an ongoing process. Auditing will occur on100% of all claims exceeding an adjuster's authority level and 5%-8% random auditing of all claims to ensure processing and financial accuracy.

Conclusion
The Company is committed to resolving the issues addressed in the Report. We will continue to improve our claim adjudication process, including the quality of our claims review, the speed with which the review is conducted and the manner in which we keep claimants informed of the status of their claim throughout the review process.

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

Sincerely,

Renee Wake

Renée Wake, AIRC, ACS
Manager, Market Conduct
Government Relations