REPORT OF
MARKET CONDUCT EXAMINATION
OF

WASHINGTON NATIONAL INSURANCE COMPANY

CHICAGO, ILLINOIS

AS OF
September 9, 2005

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: November 7, 2005

WASHINGTON NATIONAL INSURANCE COMPANY

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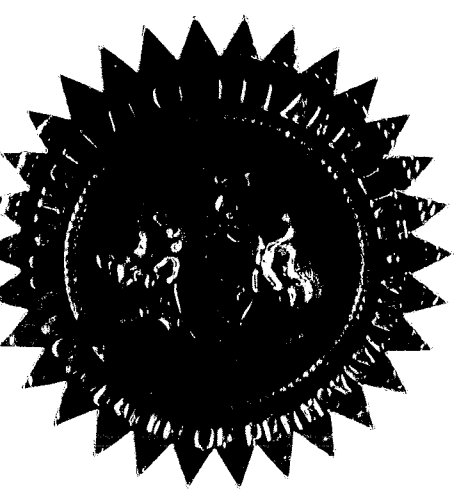
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Randolph L. Rohrbaugh, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
WASHINGTON NATIONAL INSURANCE COMPANY 11825 North Pennsylvania Street Carmel, IN 46032	:	Section 903(a) of the Insurance Department Act, Act of May 17, 1921, P.L. 789, No. 285 (40 P.S. § 323.3)
	:	
	:	Sections 2166(A) and (B) of the Insurance Company Law, Act of May 17, 1921, P.L. 682, No. 284 (40 P.S. § 991.2166)
	:	
	:	Sections 4, 5(a)(10)(ii)(vi), 5(a)(10)(x), and 5(a)(11) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§ 1171.5)
	:	
	:	Title 31, Pennsylvania Code, Sections 146.3, 146.5(a) and (d), and 146.6
	:	
	:	Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	
Respondent.	:	Docket No. MC05-10-015

CONSENT ORDER

AND NOW, this 7th day of November, 2005, this Order is hereby issued by the Deputy Insurance Commissioner 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. Without admitting the allegations of fact and conclusions of law contained herein, Respondent neither admits nor denies that it violated any laws or regulations of the Commonwealth.

FINDINGS OF FACT

3. The Deputy Insurance Commissioner 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, Indiana 46032.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2003 to December 31, 2003.

(c) On September 9, 2005, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on October 6, 2005.

(e) After consideration of the October 6, 2005 response, the Insurance Department has modified the Examination Report as attached.

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

(i) Section 903(a) of the Insurance Department Act, No. 285 (40 P.S. § 323.3), which requires every company or person subject to examination must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require, in order that its representatives may ascertain whether the company has complied with the laws of the Commonwealth;

(ii) Section 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and

ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;

(iii) Section 4 of Act 205 (40 P.S. § 1171.4), which states no person shall engage in any trade practice which is defined or determined to be an unfair method of competition or unfair or deceptive act or practice in the business of insurance pursuant to this Act;

(iv) Section 5(a)(10)(ii)(vi) of Act 205 (40 P.S. § 1171.5), which states any of the following acts, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies; and (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear;

(v) Section 5(a)(10)(x) of Act 205 (40 P.S. § 1171.5), which states any of the following acts, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (x) Making claims payments to insured or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(vi) Section 5(a)(11) of Act 205 (40 P.S. § 1171.5), which requires a complete record of all the complaints which it received during the preceding four years; the record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. "Complaint" means any written communication primarily expressing a grievance;

(vii) 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;

(viii) Title 31, Pennsylvania Code, Section 146.5(a), which requires every insurer, upon receiving notification of a claim, shall within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated;

(ix) Title 31, Pennsylvania Code, Section 146.5(d), which requires every insurer, upon receiving notification of a 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);

(x) 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

(xi) 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

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

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

(b) Respondent's violations of Sections 2166(A) and (B) of the Insurance Company Law (40 P.S. § 991.2166) are punishable under Section 2182 of the Insurance Company Law, which states the Department may impose a penalty of up to five thousand dollars ($5,000.00) for a violation of this article.

(c) Respondent's violations Sections 4, 5(a)(10)(ii)(vi), 5(a)(10)(x) and 5(a)(11) of the Unfair Insurance Practices Act (40 P.S. § 1171.5) 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.

(d) 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).

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

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Deputy Insurance Commissioner 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 comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Ten Thousand Dollars ($10,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Harbert, Administrative Assistant, Bureau of Enforcement, 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 Deputy Insurance Commissioner 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 Deputy Insurance Commissioner 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 Deputy Insurance Commissioner 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 Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner 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 Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner 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 Deputy Insurance Commissioner.

BY: WASHINGTON NATIONAL INSURANCE COMPANY, Respondent

Stephen W Robertson SVP

President / Vice President

Karl W Kindig

Secretary / Treasurer

RANDOLPH L. ROHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted on Washington National Insurance Company, hereafter referred to as "Company," at the Company's offices located in Carmel, Indiana, December 13, 2004, through February 18, 2005. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

The undersigned participated in the Examination and in the preparation of this Report.

Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Yonise Roberts Paige
Market Conduct Examiner

Michael A. Jones
Market Conduct Examiner

Tawana L. Dean
Market Conduct Examiner

Frank W. Kyazze, FLMI, ALHC
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 Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 9 Day of September, 2005

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
THERESA M. SENECA, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Aug. 15, 2006

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, 2003, through December 31, 2003, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Consumer Complaints, Forms, Producer Licensing 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 was incorporated on May 26, 1923 under the laws of Illinois and commenced business on September 7, 1923. Originally incorporated as Washington Fidelity National Insurance Company, the present title was adopted in 1931. The Company is licensed in all states except New York.

Washington National Insurance Company is a stock life insurance company and a member of Conseco, Ins. Group. Beginning in 2001, the Company discontinued the writing of new major medical policies and non-renewed substantially all existing major medical policies in order to improve its operation force. In 2002, the Company focused its health business on supplemental health products, which resulted in the Company non-renewing substantially all existing group disability policies in 2003. The sale of Washington National Insurance Company life products ceased in or prior to 1994. The Company ceased marketing annuity products when its operations moved to Carmel, several years ago. Washington National Insurance Company is a closed block of business with only in-force business. The Company is not marketing any new products. Part of the inforce is run-off business.

As of their December, 2003, annual statement for Pennsylvania, Washington National Insurance Company reported direct premium for ordinary life insurance and annuities in the amount of $2,582,963; and direct premium for accident and health in the amount of $23,753,267.

IV. FORMS

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

11 Violations – Title 18 PA. C.S., 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 11 files noted did not contain or have attached the required fraud statement.

Type	Form Description	Number
Annuity	Form# AA114 (6/01)	1
Whole Life	Form#LLC-002(09-02)118997	8
Whole Life	Form#LLC-002(07-00)09504	1
?	No number provided	1

V. PRODUCER LICENSING

The Company was requested to provide a list of all agents/producers active and terminated during the experience period. Section 605 (40 P.S. §235) of the Insurance Department Act prohibits agents from doing business on behalf of any entity without a written appointment from that entity. Section 623 (40 P.S. §253) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Title 31, Pennsylvania Code, Section 37.61 requires the Company to report all agent terminations to the Department.

Effective June 4, 2003, Insurance Department Act, No. 147, Licensing of Insurance Producers, replaced Section 601 through Section 663 of the Insurance Department Act and any sections of Title 31, Pennsylvania Code, Chapter 37 which are inconsistent with the new statute.

The Company provided a list of 18 active producers and 9 terminated producers. All 18 active producers and all 9 terminated producers were 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.

VI. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for 2000, 2001, 2002 and 2003. The Company identified 54 written consumer complaints and provided complaints logs for 2000, 2001, 2002 and 2003. Of the 54 consumer complaints identified, 46 were forwarded from the Department. All 54 consumer complaint files were requested, received and reviewed.

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

3 Violations – Unfair Insurance Practices Act, No. 205, Section 4
(40 P.S. §1171.4)

No person shall engage in this State in any trade practice, which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act. The premium mode for

the 3 files noted was unfairly changed from monthly to annual, an action that prompted the policyholders to complain to the Department of Insurance.

18 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(11) (40 P.S. §1171.5)

Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years; This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance. Of the 18 files noted, one file was missing the disposition and one complaint was identified in the terminated section, but not recorded in the complaint log. The remaining 16 files were not produced by the Company and appeared on the Insurance Department's list of complaints.

2 Violations – Title 31, Pennsylvania Code, Section 146.5

(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 acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 communication from a claimant who reasonably suggests that a response is expected. The Company did not provide timely responses to the complainants for the 2 files noted.

1 Violation – Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigations of a claim within 30 days after notification of 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 claimant was not provided a status letter within 30 days of claim notification in the complaint file noted.

VII. UNDERWRITING

The Underwriting review was sorted and conducted in 3 general segments.

A. Annuity Contracts Terminated
B. Life Policies Terminated
C. Individual Accident and Health Policies Terminated

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

A. Annuity Contracts Terminated

The Company identified a universe of 265 annuity contracts terminated. A random sample of 50 annuity contracts terminated was requested, received and reviewed. Of the 50 contracts received, 36 were annuity contracts, 12 were whole life policies and 2 were term insurance policies. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations and proper return of any unearned premium. The following violation was noted.

1 Violation – Insurance Department Act, Section 903 (40 P.S. § 323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order

that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth. The file noted was missing the surrender form.

B. Life Policies Terminated

The Company was requested to provide a list of all policies terminated during the experience period. The Company identified a universe of 100 life insurance policies terminated. A random sample of 50 files was requested. Of the 50 files requested, 49 were received and reviewed. The policies were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted.

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

(a) Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth.
The 8 files noted were missing pertinent information.

1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)(x) (40 P.S. §1171.5)

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

practices: (x) Making claims payments to insured or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company effectuated two payments to the claimant without a statement setting forth the coverage under which payments were made.

C. Individual Accident and Health Policies Terminated

The Company was requested to identify all policies terminated during the experience period. The Company identified 53 individual accident and health policies terminated. All 53 terminated policies were requested, received and reviewed. The files were reviewed to ensure that terminations were not the result of any discriminatory underwriting practice. The following violations were noted.

2 Violations – Insurance Department Act, Section 903 (40 P.S. §323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to it's property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may ascertain whether the Company or person has complied with the laws of this Commonwealth. The 2 files noted were missing pertinent information.

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:

1. Claims Settlement Practice Requirements
2. Abandoned Property Claims Guidelines
3. Interest on Death Claims Guidelines (PA)
4. Cancer Claims Manual Procedures
5. Hospital Indemnity Claims Procedures
6. Life Claims Procedures

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

The Claim file review consisted of 7 areas:

A. Annuity Claims
B. Long Term Care Claims
C. Medicare Supplement Claims Denied
D. Medicare Supplement Claims Pended
E. Paid Medicare Supplement Claims
F. Health Claims Paid/Denied
G. Individual Life Claims

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

A. Annuity Claims

The Company was requested to provide a list of all annuity claims received during the experience period. The Company identified a universe of 52 annuity claims. All 52 annuity claim files were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted.

2 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge receipt of notice for the 2 claims within 10 working days.

1 Violation - Title 31, Pennsylvania Code, Section 146.5(a) and (d)

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

(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 the claim within 10 working days and did not provide reasonable assistance to the claimant.

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.

1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)(ii)(vi) (40 P.S. §1171.5)

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

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

The Company requested additional documentation that was not required and delayed settlement of the claim.

B. Long Term Care Claims

The Company was requested to provide a list of long term care claims received during the experience period. The Company identified a universe of 56 long term care claims. All 56 claim files were requested, received and reviewed. Of the 56 claim files reviewed, 6 claim files were found to be duplicated, 1 claim file contained only a letter of correspondence on behalf of the insured and the remaining 49 claim files were reviewed to determine compliance to Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A), and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted.

3 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The 3 clean claim files noted were not paid within 45 days of receipt.

C. Medicare Supplement Claims Denied

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 230,683 Medicare Supplement claims of which 23,310 were identified as denied claims. A random sample of 50 claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and the Quality Health Care Accountability and Protection Act. No violations were noted.

D. Medicare Supplement Claims Pended

The Company was requested to provide a list of Medicare Supplement claims received and pended during the experience period. The Company identified a universe of 230,683 Medicare Supplement claims of which 1,703 were identified as pended claims. A random sample of 50 claims was requested, received and reviewed. The 50 claim files were reviewed for compliance with Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

E. Paid Medicare Supplement Claims

The Company was requested to provide a list of paid Medicare Supplement claims received during the experience period. The Company identified a universe of 230,683 of which 205,512 were identified as paid Medicare supplement claims. A random sample of 100 claims was requested and received. The 100 claims files were submitted by providers and reviewed for compliance with Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511B). The following violations were noted.

4 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The 4 claim files noted were missing payment notification information.

F. Health Claims Paid/Denied

The company was requested to provide a list of all health claims received during the experience period. The Company provided a list of 1,614 health claims. A random sample of 75 health claims was requested and in addition, 2 files were found and transferred from the health terminated section. Of this total, 9 files were determined as missing and the remaining 68 files were reviewed to determine compliance to Insurance Company Law, Section 2166 (40 P.S. §991.2166),

Prompt Payment of Provider Claims (A), and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted.

9 Violations – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail so that pertinent events and the dates of such events can be reconstructed. The 9 claim files noted were missing pertinent information.

22 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the 22 claims noted within 10 working days.

6 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The 6 clean claims noted were not paid within the required 45 days.

G. Individual Life Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 172 individual life claims. A random sample of 50 claims was requested. Of the 50 files requested, 49 were received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511B). The following violations were noted.

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 for the claim noted.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

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

2. The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes Section 4117(k).

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

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

5. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

6. The Company must implement procedures to ensure compliance with the complaint maintenance requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

XII. COMPANY RESPONSE

CONSECO®

CONSECO SERVICES, L.L.C.
11825 N. Pennsylvania Street
P.O. Box 1911
Carmel, Indiana 46082-1911

EXPRESS MAIL

October 6, 2005

Mr. Daniel A. Stemcosky, AIE, FLMI
Market Conduct Division Chief
Bureau of Enforcement
Commonwealth of Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 717-787-0163
Fax: 717-705-0428

Re: Washington National Insurance Company
Market Conduct Examination
Examination Warrant Number: 04-M21-013

Dear Mr. Stemcosky:

We are responding to the draft examination report that we received on September 12, 2005. We recognize the issues raised in the report that need correction, and appreciate your bringing them to our attention. Please know that we are taking, or have already completed, steps to resolve them. Our goal is to be in full compliance with all requirements, and we are working hard in order to accomplish that. We want to make additional comments to some of the issues raised in the report. The sections given in our response below refer directly to those sections and review segments in the report, and they are in the same order as found in the report. In those review segments described below, we respectfully request that the report be appropriately modified.

IV. FORMS

11 Violations – The company has amended its forms to include the correct fraud warning language. We are attaching a sample as Exhibit I.

VI. CONSUMER COMPLAINTS

18 Violations – Sixteen of the eighteen violations are attributable to policyholder complaint files that could not be produced to the insurance department. Despite the company's best efforts to produce these files, it appears they were not provided to Conseco during the acquisition of Pioneer Life and its transfer of records from Rockford, Illinois to Carmel, Indiana. The company now has a complaint database and procedures in place to track and retain all complaint files.

CONSECO SERVICES, L.L.C.
11825 N. Pennsylvania Street
P.O. Box 1911
Carmel, Indiana 46082-1911

We wish to reserve all of our rights with respect to a hearing on the merits of this examination report. Thank you for your consideration.

Sincerely,

Ann Smith

Ann Smith, FLMI
2nd Vice President
Market Conduct

Enclosures

EXHIBIT I

___ Conseco Insurance Company
___ Conseco Life Insurance Company
___ Bankers National Life Insurance Company
___ Washington National Insurance Company
___ Conseco Life Insurance Company of Texas

CONSECO®

Administrative Office: P.O. Box 1982, Carmel, IN 46082-1982

ANNUITY CLAIMANT STATEMENT FOR SUPPLEMENTAL CONTRACTS

Contract Number _____

1. Full name of deceased annuitant: _____
2. Full name of deceased owner (if other than above) _____
3. In what capacity are you claiming the proceeds? _____
4. What percentage of the death benefit are you claiming?: _____%

   A. NAME OF CLAIMANT/BENEFICIARY: _____

   B. ADDRESS: _____

   _____

   C. CLAIMANT'S SOCIAL SECURITY NUMBER: _____ - ____ - _____ (complete certification below)

   D. DATE OF BIRTH: _____ PHONE NUMBER: ( ) _____

   E. RELATIONSHIP TO DECEASED _____

5. CHOICE OF SETTLEMENT OPTION

   _____ Payment continuation - *Please complete Annuity Service Request, form AA109, to elect your beneficiary designation.*

   _____ Lump sum payment - ***Only** available for the SPIA 3 product. <u>All others must continue with the same mode and manner</u>*

Withholding Election and Taxpayer Certification (Substitute IRS form W-9)

Tax deferred earnings and any pretax premiums paid into an annuity contract are taxable when the contract is surrendered. You are liable for Federal/State taxes on the taxable portion of your benefits. You must indicate whether you want Federal/State income taxes withheld. If you elect not to have withholding apply or if you do not have enough Federal income tax withheld, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient. Spousal beneficiaries may be subject to mandatory 20% withholding on Tax Sheltered Annuity (403(b)) and pension contracts. NOTE: REGULAR FEDERAL WITHHOLDING IS AUTOMATICALLY 10% IF NO ELECTION IS MADE FOR LUMP SUM PAYMENTS. STATE WITHHOLDING WILL BE BASED UPON STATE SPECIFIC REQUIREMENTS.

Check one:
_____ I <u>do not</u> want Federal/State income tax withheld form my payment
_____ I <u>do</u> want ____% Federal/State income tax withheld form my payment

Taxpayer Identification Number: Social Security Number _____ - ____ - _____ OR EIN _____ - _____

CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me,) and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest of dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding
3. The payee is a U.S. Resident.

___ Conseco Insurance Company
___ Conseco Life Insurance Company
___ Bankers National Life Insurance Company
___ Washington National Insurance Company
___ Conseco Life Insurance Company of Texas

CONSECO®

Administrative Office: P.O. Box 1982, Carmel, IN 46082-1982

LOST OR DESTROYED POLICY STATEMENT

I, the below signed claimant, herby certify that the annuity contract identified on the reverse side hereof has been lost or destroyed and that said contract is not assigned, hypothecated or pledged in anyway whatsoever. I therefore warrant and agree that should the original be found in any way come in my possession, I will return or cause the same to be returned to the company, its successors or assigns. It is distinctly understood and agreed that the original policy or certificate shall become null and void.

Dated this _____ day of _____ 20_____

Claimant's Signature _____

The claimant requests that the settlement option be made to the claimant. The claimant understands and agrees that upon the Company's satisfaction of the claimant's requested settlement option, the Company's obligation for any additional payment shall thereupon immediately cease. The claimant understands and agrees that such satisfaction shall immediately terminate any and all rights that may have been available pursuant to the above-listed annuity. The claimant also understands and agrees that the Company's satisfaction of the claimant's requested settlement option shall constitute a full settlement, release, and discharge of all claims and obligations under the above-listed annuity and any and all contracts issued as a supplement to it. FOR CALIFORNIA RESIDENTS ONLY- In addition to the above, the claimant expressly waives all protection under California Civil Code §1542 which relates to unknown or unexpected claims against the Company which may exist in the claimant's favor at the time this form is signed. It is the claimant's intention to fully, finally, and forever settle and release the Company for all matters relating to the transaction (s) herein described. In furtherance of this intention, the release herein given shall be and remain in effect as full and complete notwithstanding the discovery or existence of any additional or different claims or facts.

I, the claimant, herby make claim to the Death Benefit payable under the provisions of the subject contract and agree that all papers called for by the company shall be a part of this statement.

The Certified Death Certificate and Policy must be returned with this statement if not in the possession of the company.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

THE FORM MUST BE COMPLETED AND SIGNED IN INK BY THE PERSON OR PERSONS, WHO UNDER THE TERMS OF THE CONTRACT, HAVE THE RIGHTS OF DEATH BENEFIT.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

Claimant/Beneficiary's Signature _____ Date _____

Witness Signature _____

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on its good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policyowner signing this form agrees to indemnify and hold the company harmless form the consequences of accepting this transaction.

NO AGENT IS AUTHORIZED TO ALTER THE TERMS OF THE CONTRACT OR BIND THE COMPANY.

___ Conseco Insurance Company
___ Conseco Life Insurance Company
___ Bankers National Life Insurance Company
___ Washington National Insurance Company
___ Conseco Life Insurance Company of Texas

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Administrative Office: P.O. Box 1982, Carmel, IN 46082-1982

For your protection, the laws of several states require the following statement:

Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

In order for our claim form to be compliant with the various Department of Insurance, we must furnish you with the applicable fraud statement for the states listed below:

AK, DE, RESIDENTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ RESIDENTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA RESIDENTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO RESIDENTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL RESIDENTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ID, IN, MN RESIDENTS: A person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LA, NM RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME, TN, VA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH, OR RESIDENTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA RESIDENTS: 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.

PUERTO RICO RESIDENTS: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.