

**MARKET CONDUCT EXAMINATION REPORT
OF THE
LIFE & HEALTH BUSINESS OF
AMERICAN BANKERS LIFE ASSURANCE
COMPANY OF FLORIDA**

**11222 Quail Roost Drive
Miami, Florida 33157**

NAIC Company Code 60275

REPORT NUMBER 7871-05

AS OF DECEMBER 31, 2004



**STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION**

RALPH S. TYLER, COMMISSIONER

AUGUST 29, 2008

ROBERT L. EHRLICH, JR.
Governor

MICHAEL S. STEELE
Lt. Governor



RALPH S. TYLER
Commissioner

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August 29, 2008

The Honorable Ralph S. Tyler
State Insurance Commissioner of Maryland
Maryland Insurance Administration
525 Saint Paul Place
Baltimore, Maryland 21202

Dear Commissioner:

Pursuant to your instructions and authorizations, a comprehensive market conduct examination of the life and health insurance business of the:

AMERICAN BANKERS LIFE ASSURANCE COMPANY OF FLORIDA,

a foreign insurer, whose home office is located at 11222 Quail Roost Drive, Miami, FL 33157, has been completed.

The report of the examination is respectfully submitted herein.

Sincerely,

Signature on file with original

P. Todd Cioni, Associate Commissioner
Compliance and Enforcement

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1. EXECUTIVE SUMMARY

The Maryland Insurance Administration (hereinafter referred to as “MIA”) conducted a target market conduct examination of the American Bankers Life Assurance Company of Florida (hereinafter referred to as the “Company” or “ABLAC”) regarding its life, health, credit life, credit disability, and accident insurance business in Maryland for the period January 1, 2002 through December 31, 2004 (“survey period”). The examiners were on site at the Company from March 7, 2005 through May 27, 2005.

The examination identified various non-compliant practices, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in Maryland according to its laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

Section VIII of this report contains a summary of the examiners’ findings relative to a Compliance Plan implemented by ABLAC in 2000 as a result of the multi-state Consent Order expedited November 23, 1998.

Section IX of this report contains a Summary of Violations, the frequency by which they occurred, and the location within the report that details the violation(s). In general, the following Maryland laws (referenced as the “Insurance Article of the Annotated Code of Maryland” or, in short, “Insurance Article”) and regulations (referenced as the “Code of Maryland Regulations” or “COMAR”) were found to have been violated by the Company during the survey period:

Insurance Article § 10-130	Commission only to licensed insurance producer
Insurance Article § 27-214	The in Sales
Insurance Article § 27-901	Credit life or disability insurance premiums
COMAR 31.03.13	Producer Registers and Documentation of Appointments
COMAR 31.10.30	Disability Benefit Claim Procedures
COMAR 31.13.01	Standards for Credit Life and Credit Health Insurance
COMAR 31.15.02	Telemarketer’s promised effective date of coverage different from policy/certificate language

Though the numbers of violations for delays in claim handling and payment of commissions may appear substantive, the frequency of both are not considered to be a “General Business Practice” as defined in the regulation.

2. SCOPE OF EXAMINATION

The primary purpose of the examination was to assess the Company's compliance with the requirements of Titles 10, 12, 13, 15, 16, 17, 18, and 27 of the Insurance Article ("Insurance Article") and Code of Maryland Regulations ("COMAR") Title 31, Subtitle 04 "Insurers"; Subtitle 09 Life Insurance And Annuities; Subtitle 13, Standards for Credit Life, Credit Health Insurance, and Credit Involuntary Unemployment Benefit Insurance"; Subtitle 15 "Unfair Trade Practice".

In 2000, the Company entered into a Consent Agreement with multiple states to pursue a Compliance Plan. Representatives of the MIA participated in a multiple state examination conducted in 2001 that monitored the progress of that Plan.

This examination was to determine the progress of the implementation of the Compliance Plan and if operations were consistent with the public interest. The examination survey period was January 1, 2002 through December 31, 2004.

The examination planning and testing methodologies follow the standards established by the National Association of Insurance Commissioners ("NAIC") and procedures developed by the MIA.

All unacceptable or non-compliant practices may not have been discovered or noted in the Report. Failure to identify or criticize improper or non-compliant business practices in Maryland or in other jurisdictions does not constitute acceptance of such practices. Examination report findings and recommendations that do not reference specific insurance laws, regulations or bulletins are presented to improve the Company's practices and ensure consumer protection.

3. COMPANY PROFILE

American Bankers Insurance Company of Florida, NAIC 10111, (ABIC) commenced business in October 1947. ABLAC commenced business in April 1952. Both companies are incorporated under the laws of the State of Florida and have throughout their dual histories retained their separate identities and processes.

The shares of both companies were traded on the NASDAQ in the 1970s. In 1980 a new holding company was formed, the American Bankers Insurance Group, Inc (ABIG). Each shareholder exchanged the shares of the individual companies for holding company shares. In 1997, the shares of ABIG began trading on the New York Stock Exchange. In 1999, shareholders of ABIG approved the acquisition of the Group by Fortis, Inc., one of the largest European financial institutions based in the Netherlands. The Assurant Group was created initially to be the holding company for the members of ABIG and the American Security Insurance Group.

During 2003, the Assurant Group expanded to include all of the US holdings of Fortis, Inc., and the Assurant Group separated from the Fortis/AMEV, NV holdings. Fortis NV and Fortis SA/NV retain approximately 35% of the ownership interest in Assurant Group. The shares of the Assurant Group are now traded on the New York Stock Exchange (symbol AIZ).

During 2004, Voyager Life Insurance Company and Voyager Life & Health Insurance Company, two affiliated Assurant Group companies, were merged into the Company. For this examination, the examiners were provided sampling data derived as if the business of both of these merged companies were direct business of the Company.

ABLAC provides a wide array of credit related and non credit related insurance products including life, disability, accidental death and dismemberment insurance plans. The products are primarily issued through producers related to financial institutions and retailers that provide consumer financing.

Below is a chart of the premium income derived from Schedule T of the Company's 2004 annual report. The states represented below produced 3.00% or more of the Company's premium volume exclusive of Canadian volume which comprised 49.19% or \$220,300,577.00.

<u>Rank</u>	<u>Jurisdiction</u>	<u>Total Premium</u>	<u>Market Share</u>
1)	Florida	35,527,134	15.62%
2)	Texas	34,611,001	15.21%
3)	California	15,716,139	6.91%
4)	Pennsylvania	13,271,473	5.83%
5)	North Carolina	13,011,453	5.72%
6)	South Carolina	9,162,165	4.03%
7)	Louisiana	7,741,750	3.40%
8)	Illinois	7,655,800	3.37%
28)	Maryland	1,827,098	0.41%
	All Others	<u>88,987,720</u>	<u>39.11%</u>
	Total	<u>\$227,511,733</u>	<u>100.00%</u>

4. GENERAL BUSINESS PRACTICES

A. Audits

1. Internal Audits

Standard—The Company maintains an internal audit procedure that allows the Company to detect improper procedures and methods.

The examiners requested a list from the Company of all internal audits conducted during the examination survey period.

The 2000 Compliance Plan that appears as Appendix A to this report itemizes various audits to be performed both on clients and internally as a part of that multi state Consent Agreement.

The Company informed the examiners that they did not perform any internal audits during the examination survey period. During the course of the examination, in meetings with the Company's Compliance staff, the presenters referred to many reviews in process, the examiners were not provided any lists of the reports of internal audits concluded. The examiners conclude that the Company is not in compliance with this established standard and acceptable practice. The MIA direct the Company to develop an appropriate internal audit program in compliance with the Consent Agreement.

Company Response:

The normal duties of the internal auditors include assessing risk, developing audit programs, audit testing, audit workpaper documentation, preparing and issuing audit reports, and monitoring the implementation of previously issued audit recommendations. Our annual audit plan is approved by the Assurant, Inc. Audit Committee of the Board of Directors and shared with Senior Management of the various business units.

The extent of the audit performed consists of about 45% operational audits, 22% information systems related audits, 10% general control/compliance audits, 12% financial audits, and 11% special projects and other. This breakdown will vary slightly from year to year depending on the overall direction the Company is headed. For example, if there are a higher than usual number of system conversions in a particular year, our audit plan would reflect this accordingly by the assignment of more resources towards information systems development audits. Internal audit also supports PriceWaterhouse Coopers in the annual external financial audit performing controls and substantive based audit procedures.

There are currently 51 positions in the Assurant Audit Services Department. The Senior Vice President of Audit Services oversees all Assurant Audit Services activities. The Department includes five different sites in Atlanta, GA, Kansas City, MO, Miami, FL, Milwaukee, WI, and Woodbury, MN. Most sites have people that occupy the following positions: Director of Audit Services, Financial/Operational Managers, Information Systems Managers, and Financial/Operational Seniors as well as support staff if necessary.

2. Client Audits

Standard—The Company conducts periodic audits of clients in accordance with regulation and maintains copies of all reports of such audits as required.

COMAR 31.13.01.26 requires that every insurer selling credit life and or disability insurance shall conduct a periodic review of each of its creditor accounts. The regulation describes the minimum standards for the review and the duration for maintaining copies of reports of those reviews. The regulation requires that each creditor be reviewed every 36 months and that the Company retain copies of the report for a period of five years. The minimum review covers five specific areas, proper premium computation, proper premium refunds, prompt claim filing, proper computations of amounts due the creditor and second beneficiaries, and prompt processing of complaints regarding credit insurance operations. The Company is required to keep copies of reports for at least 5 years. COMAR 31.13.01, though amended in 2000 and 2001, was in effect during the entire examination survey period.

The examiners requested a list of all client audits conducted by the Company during the examination survey period. The Company provided the examiners with a list of 30 reports of compliance review conducted during the examination survey period. The examiners requested to see all 30 reports. The Company was able to produce copies of only 24 of the reports. Of the 24 reports reviewed, the Company consistently did not validate computation of funds due the second beneficiary in the event of the death claim.

The Company is in violation of COMAR 31.13.01.26B(4) and 31.13.01.26C. The Company is directed to assure future retention of copies of all client audits and to amend procedures to certify compliance with the regulation to include all required processes.

The dates of review of the 30 reports listed indicate that reexaminations were not made within the required 36 months. **The Company is in violation of COMAR 31.13.01.26A for not conducting follow up reviews as required by the regulation. The Company is directed to conduct reviews in compliance with the regulation.**

Company Response:

We review life, disability and IUI insurance coverages as part of standard Maryland creditor audit scope. As requested, creditor reviews for 5 creditors were provided to the Maryland Examiners.

It's important to acknowledge the Company's commitment to validate all reported premium production. Detail premium transactions are validated 100% for correct premiums, refunds and underwriting limits. The creditor audits of detail business utilize these edited results for its sample selections.

In 2002 we changed our creditor auditing approach to focus on the required audit areas. Annual premium production information is used to identify which clients wrote in that years required states. To accommodate the number of clients, our sampling techniques and sizes were changed. We changed the number of audits from counting multiple products by state to a client basis. Under the prior approach, a client writing life, disability and IUI in a state would have three audits versus one audit under the new approach.

As requested, the additional creditor reviews during the period 1999 through 2002 were provided.

Our creditor reviews only report on the results of sample items-no projection of sample results is made to the entire population. We select a random sample of items per state for each product depending on the number of systems/processes and degree of variability (automated vs manual). If appropriate, we report the findings as applying to the entire process. For example, an incorrect state premium rate in the client's system would impact the entire population. Determination to review a number of branches or an entire account is based on the client's extent of automation and reporting method. An automated client with only one processing system would only require a minimal sample of one or two items per state.

All creditor audit work papers and reports are retained for a minimum of five years from the completion date.

Effective January 1, 2007, Maryland was increased from a triennial to a biannual review state.

B. Previous Market Conduct Examinations

Standard: The Company has responded to the findings and directives of previous examinations.

ABLAC was a subject of a multi-jurisdiction examination completed in 2000. That examination and findings are discussed in Section VIII of this report.

The examiners requested and received copies of all other reports of market conduct examinations finalized during the examination survey period. The Company provided copies of examination reports from Arizona and California.

The Report by the Arizona Department of Insurance Market Oversight Division was concluded on September 16, 2002. The report identified instances of compensation paid to creditor related agencies that did not possess proper licensing, payment of claims to creditors in excess of the net balance due that should have been paid to second beneficiaries, and instances of creditors settling or adjusting credit insurance claims (a prohibited practice).

The Rating & Underwriting Bureau, Market Conduct Division of the California Department of Insurance issued a report dated November 15, 2003 that included other affiliated companies of the parent Assurant Group. The Company was cited for several instances regarding programs not subject of this examination. However, the Company was unable to produce either applications or certificates for 157 selections of the sample chosen by the examiners. Two master policies covering California citizens contained an improper method to compute unearned premium refunds at early termination of individual coverage.

The Company maintains that they have corrected their advertising materials to reflect the proper rates and to describe the coverage afforded more accurately. The Company has taken steps to eliminate use of unapproved policy and certificate forms, avoid paying commissions to unlicensed agents and to revise claim handling practices. Among the revisions to claim handling practices has been to eliminate adjudication of claims by creditor related affiliates.

The examiners paid particular attention to the areas of concern expressed in each of the examination reports reviewed to confirm ABLAC took appropriate corrective action.

C. Antifraud Plan

Standard: The Company has antifraud initiatives in place that are easily implemented to detect, prosecute and prevent fraudulent insurance acts.

The examiners requested a copy of the Company's current Anti-Fraud Plan. The Company provided a copy of their current plan. The Company had previously filed a copy of that edition with the MIA Fraud Division.

The Company is in compliance.

D. Disaster Recovery Plan

Standard: The Company has a valid disaster recovery plan in place and has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

The examiners requested information regarding the Company's Disaster Recovery Plan. The Company provided a copy of information relating to the Assurant Business Continuity and Disaster Recovery Programs. ABLAC along with multiple carriers and business offices in which the Assurant Solutions Group transacts business has been included in this disaster recovery plan. The plan is extensive and contemplates multiple disaster scenarios. Because of the devastation experienced by both the September 11, 2001 disaster in New York City and that caused by Hurricane Andrew years earlier, the Assurant Solutions Group appears acutely aware of the need for such preparation.

In April 2004 a four day exercise was held coordinating 177 employees at 15 locations utilizing all of the major computer systems. By its own measure, the Company achieved a 92% successful recovery within 80 hours, well within its objective of 96 hours.

The Company's home office location was threatened by weather forecasts of hurricane damage on at least three occasions in the Summer and Fall of 2004. While no direct damage was incurred, the Company was placed on elevated alert status on all three occasions and the plan was implemented.

ABLAC appears to maintain an updated and satisfactory disaster recovery plan.

5. MARKETING AND ADVERTISING

A. Advertising

Standard: The Company maintains a complete advertising file.

COMAR 31.15.02, COMAR 31.15.03 and COMAR 31.15.04 require that the Company maintain a complete advertising file.

The examiners requested a copy of the Company's advertising log (or list of each item contained in its advertising file). The Company provided the examiners with a list of 335 items considered as advertising in use by the Company and its producers during the examination survey period. The list included brochures, mailing materials, solicitation materials, producer scripts, producer training materials and print advertising produced by the Company and its producers. The examiners selected a random sample of 70 of the listed items for review.

The Company's list appears comprehensive and in compliance with the regulation.

Standard: The Company's advertising is in compliance with regulations and does not contain deceptive information.

The examiners reviewed the 70 advertising items requested. No items were found to be deceptive.

The Company's advertisements, mail solicitations, producer scripts and producer training aids are in compliance with the advertising regulations.

B. Producer Register

Standard: The Company maintains a complete register of its producer appointments and terminations.

During the examination survey period, Title 10 of Insurance Article of the Annotated Code of Maryland was amended in two ways. In 2003, the definitions of "agent" and "broker" were eliminated and replaced by "producer"; simultaneously, all previously licensed persons (including business entities) were issued producer licenses. The second change required that each company maintain its own register of producer appointments and terminations. COMAR 31.03.13 became effective January 1, 2004 and described the detailed maintenance requirements and documentation of the Producer Register. Additionally each company was to monitor various internet sources such as the MIA and NAIC web sites to update its register to reflect those producers whose licenses have lapsed, have been revoked or were surrendered. The Company is required to produce a copy of its producer register within 10 working days of a request from the

Commissioner. Each producer is required to maintain certain individual records of appointment and termination by carriers.

The examiners requested and received from the Company a list of all producer firms active, appointed and or terminated during the examination survey period. The examiners compared a sample of 100 of the MIA records to the Company list. Because of the composition of the two lists, the number of entries on each list will not be identical. Below is an analysis of that comparison showing discrepancies between Company and MIA information:

<u>Category</u>	<u>Company List</u>	<u>MIA List</u>
Agree	72	55
Date Disagreement	14	9
Not On Other List	<u>36</u>	<u>36</u>
Total Each List	<u>122</u>	<u>100</u>

Because the Company produced the list 20 days after the examiners' request, the Company is in violation of COMAR 31.03.13.02B(4) for not producing the list within the required time period (10 working days). The Company also violated COMAR 31.03.13.03C for the various inaccuracies of the Producer Register. The examiners direct the Company to correct its producer register and to update register maintenance standards and practices.

Company Response:

The Company agrees with the finding(s) and has already made corrections:

Previous to 2006 our audit of our system records against the state listing was only completed once annually. In addition, our system was updated as we were informed by our clients of their employee's leaving or canceling their licenses.

In 2006 we implemented a new method of audits. For the state of MD the licenses are renewed based on the issue month. We are now conducting quarterly audits for the state of MD for any licenses with issue dates during that quarter. For the first and second quarters of 2006 this included reviewing 496 licenses.

To complete our audit we request a listing from NIPR of all agents and confirm all available information (name, address, license title, license numbers, effective date, etc.). In addition, we registered with NIPR for their ALERT process.

C. Commission Payment**Standard: The Company pays commissions only to licensed producers.**

Section 10-130 of the Insurance Article requires that commissions be paid only to licensed producers. COMAR 31.04.12 defines the frequency of conditions of insurer transactions with unappointed persons to become a general business practice.

The examiners requested a list of commissions paid and the associated licensee. The Company provided the examiners with one list of ordinary life commissions and two lists of credit related commissions paid during the survey period. The examiners compared the lists provided to MIA records.

All of the ordinary life commissions paid during the examination survey period were for policies written prior to the examination survey period, renewal commissions not subject to § 10-130.

Of 242 entries that totaled \$518,264.00 on the two lists of credit related commissions, examiners found payments to 11 persons in the amount of \$8,743.67 were to persons (listed below) who did not have a proper Maryland license and or appointment. The frequency of occurrence of these payments to unauthorized producers did not constitute a general business practice.

<u>Creditor Name</u>	<u>Amount</u>
Cato Corporation	\$ 100.09
David T. Robinson	317.72
Goldome Credit	2,024.59
Harlem Furniture Co	12.50
Reliable Stores, Inc.	280.22
TA Standard American Ins. Agency	<u>6,008.55</u>
Total	<u>\$ 8,743.67</u>

The Company is in violation of § 10-130 of the Insurance Article for payment of \$8,743.67 in commissions to 6 persons without proper license or appointment. The examiners direct the Company to make sure future commissions are paid only to properly licensed producers.

Company Response:

The Company agrees with the finding(s) and has already made corrections:

Our current process for new client implementation is to ensure they have proper licenses and appointments in place before writing any business.

For existing clients a quarterly audit is completed to ensure that all licenses and appointments are still active with the state.

If an issue is identified, notification is immediately sent to the client and internal areas with a timeline for the issue to be resolved. The timeline is broken into two phases. If at the end of Phase 1 the license is not reinstated the client's commissions are reduced to zero.

If at the end of Phase 2 the client's license is not reinstated the client must discontinue writing new business.

D. Third Party Administrators

Standard: The Company uses properly registered Third Party Administrators.

Section 8-301 of the Insurance Article defines the types of coverage for which third party administrators (TPAs) are required special qualifications and registration with the MIA.

The examiners requested a list of all of the TPAs used by the Company and a description of the plans administered. None of the plans covered by the Company are subject to Title 8 Subtitle 3 registration. The Company is in compliance with the statute.

E. Telemarketing

Standard: The Company adequately monitors the activities of any entity that contractually assumes a business function or acts on behalf of the Company or its group policyholder to solicit insurance products.

Section 27-214 of the Insurance Article describes tie-in sales as an illegal, unfair trade practice. COMAR 31.15.02.05 requires that advertisements of health insurance products clearly and completely describe the plan benefits, provisions, and exclusions with language that is not deceptive.

The Company recognized that certain of its products were being sold by unregulated third parties on behalf of client creditors. Those third-party sellers were independent telemarketing companies, receiving income based either on the prospect list length or an hourly rate rather than a premium based commission schedule. The Company implemented contractual restrictions on telemarketers to require compliance to licensing and solicitation requirements. Additionally, the Company implemented the requirement to use only compliant scripts.

To assure regulatory compliance by its telemarketers, the Company implemented an audit program to periodically review performance. The examiners requested, received and reviewed three audits of telemarketers performed by the Company during the examination survey period.

The examiners found that the reports of the Company's onsite reviews of each of the telemarketing firms were thorough and complete. The Company auditor found in each review

that the telemarketing firms adhered to required scripts, provided adequate security of client data, followed proper licensing procedures where required, provided adequate employee training, and maintained proper electronic monitoring of its employees. The Company auditors awarded performance scores that averaged 3.7 on a scale of 1 (unacceptable) to 5 (exceeds requirements) for the telemarketer reports reviewed by the examiners.

While reviewing the audio tapes that represented the presentations of the telemarketers to the insured debtors and the answers of the applicants to the telemarketers, the examiners discovered that the tapes relative to enrollments from one credit card bank suggested that eligibility to buy the insurance was either tied to the sale of magazines (which provided extra income to the credit card bank) or appeared to provide free magazines to the credit cardholder only if the insurance was purchased. **Because the eligibility to purchase the insurance appeared tied to the purchase of the magazines, the Company is in violation of §27-214 of the Insurance Article.**

Company Response:

The client made a separate offer that was not tied to the purchase of insurance. This was a separate offer from a separate company. We are no longer selling insurance for this client.

Additionally, the examiners found that the telemarketer and the approved telemarketing scripts tell the prospect that his coverage is immediate but that premium is not billed until 30, 60 or 90 days later. However, during the new business processing review, the examiners noted that instead of a specific effective date being inserted in the certificate, the certificate reads, "SEE SUMMARY PAGE". The Summary Page for the telemarketed MOB coverages bears the verbiage, "Effective Date: 30 days prior to the billing date for which a premium is first charged." When queried about such language in a claim situation, the company responded that a "Direct Mail Master File" screen is used by the claims examiner to verify the effective date of the coverage. Such script language is deceptive. **The Company is in violation of COMAR 31.15.02.05 because the sales material is deceptive for sales description of the effective date not matching the documentation provided the purchaser. The examiners direct the Company to modify the scripts to provide only a description of starting dates of coverage to match the plans of insurance and to amend certificate preparation to include a specific date as effected by the specific account billing system.**

Company Response:

At this time we no longer telemarket this type of coverage. The Certificate Schedule indicates that the effective date is contained in the Summary Page, which lists the premium components and total premium, all of which are important information relating to the insurance. The Summary Page directs the insured to a specific effective date, being "30 days prior to the billing date for which a premium is charged." There is only one such date which can result from this and it is specific to each insured. The insured

will receive a billing statement from the group master policyholder, which is clearly dated, and the insured can easily determine the exact date which is 30 days earlier. This would comply with COMAR 31.15.02.05 in that the information is not ambiguous or intermingled with an advertisement; and further, is in close proximity with other significant insurance information.

6. ADMINISTRATION

A. New Business Processing

Standard: The Company may not unfairly discriminate in underwriting life, health or annuity contracts.

Section 27-501 of the Insurance Article prohibits unfair discrimination in underwriting insurance. Section 27-901 requires written consent by an individual for the purchase of credit insurance. Title 12 of the Insurance Article provides requirements, content and procedures regarding policy forms. Title 13 of the Insurance Article requires the use of filed and approved forms, the use of premiums rates that have been filed and approved (subject to case rate review and minimum loss ratio requirements), issuance of credit insurance policies and certificates of insurance, and the terms of the insurance. COMAR 31.09.09 provides the rules, disclosures and procedures for replacement contracts of life insurance and annuities. COMAR 31.13.01 provides the standards for credit life and credit health insurance; among those standards is the requirement that other than qualifying age, for risks below \$15,000 insurance no other underwriting questions may be asked.

Non Credit Related Life & Health Insurance

The examiners selected a random sample of 100 certificates from 7,748 policies and certificates of non credit related life and health insurance policies and certificates. Each of these certificates was issued during the examination survey period.

No certificates or policies were issued during the examination survey period subject to the replacement regulation. Also, no policies of life insurance were issued subject to the illustrations regulation.

The examiners found no evidence of underwriting discrimination.

Credit Life and Disability Insurance

The examiners selected a random sample of 100 certificates from 1,580 single premium credit life and credit disability certificates. Each of these certificates was issued during the examination survey period.

The examiners received and reviewed 100 of the sample single premium credit life and credit disability certificates requested. The examiners verified that the premiums charged were correct, that the ages of the applicants were within the group limit and that the producer was properly licensed.

Monthly Outstanding Balance Credit Life

The examiners selected a random sample of 100 certificates from 135,592 certificates issued for monthly outstanding balance credit life certificates. Each of these certificates was issued during the examination survey period. The examiners received and reviewed 99 certificates of the 100 certificates from the requested sample of monthly outstanding balance credit life insurance issued on credit cards. Of the 99 certificates issued and reviewed, the Company was only able to provide 29 written applications and one recorded voice request for monthly outstanding balance credit life insurance issued on credit cards. The examiners requested copies of billing statements to verify proper premium billing for each card holder. The Company was only able to provide 44 billing statements. The Company explained that a number of applicants for the insurance never generated insured balances if the credit cards carried no balance over from month to month. The premiums charged each debtor were consistently computed according to the package rates of that creditor.

The examiners found 26 of the 99 certificates issued on application forms not approved by the MIA. These violations are detailed in appendix A and discussed in the forms review section of this report.

Because the Company could not produce 70 of the requested written applications for credit life insurance on credit cards, the Company is in violation of §27-901 of the Insurance Article to evidence that borrowers had provided written consent to purchase the credit life and credit disability insurance.

Company Response:

Thirty (30) signed authorizations were provided. Sixty-two (62) of the 69 signed authorizations not provided were actually from conversions. The original underwriting insurance Company could not provide the authorizations. We were unable to locate 7 signed authorizations.

B. Policy Values

Standard: The Company promptly makes payment of policy values upon request and accurately computes all values with appropriate contractual or statutory interest.
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Subtitle 3 and 5 of Title 16 of the Insurance Article provides the formulae to compute the minimum required reserve values for ordinary life and annuity contracts. Section 13-112 of the Insurance Article and COMAR 31.13.01 provide the requirement and formulae for refund of unearned premiums at premature termination of credit insurance policies and certificates.

The examiners requested to review 18 of 18 credit insurance certificates terminated as “flat cancellations”, a random sample of 100 of 1,365 credit insurance certificates routinely terminated and 14 of 14 non-credit insurance policies terminated during the examination survey period.

The examiners reviewed all 118 of the credit insurance refund sample requested and delivered. All 118 refunds were made through the creditors to the accounts of the insured debtors as required by the policies. Each refund value was properly computed on the basis of the requests, either for refund of the entire unearned premium (terminations within first 14 days of the contract) or by appropriate formulation if requested after.

The examiners reviewed all 14 of the non-credit insurance policy terminations requested. All 14 refunds of unearned premiums were made according to contract and there were no complaints about those refunds.

There were no ordinary life insurance policies or annuity contracts terminated during the examination survey period. The Company is in compliance

C. Complaints

Standard: The Company has adequate procedures to resolve complaints and inquiries from its policyholders and regulators in a timely fashion.

The examiners requested a copy of the Company's procedures for processing complaints and inquiries. The Company provided the examiners with a manual of their procedures. When a complaint is received, it is:

- Date stamped
- Entered to a data base
- An acknowledgement is sent to the initiator
- A copy of the complaint is sent to the responsible department for response
- Additional information is requested when required
- Status tracking (follow up)
- Data base is updated
- Resolution is determined
- Resolution is communicated to the initiator
- A record of the resolution is posted to the data base
- Successful resolution case closed.

The Company routinely evaluates the time and quality of response. The Company tracks each complaint for reason, product, source, relationship to policyholder, and resolution.

The examiners requested a copy of each complaint and inquiry received during the examination survey period. The Company provided the examiners with a list of 22 inquiries. The examiners reviewed all 22 files.

In each of the 22 cases, the company resolved the complaint or inquiry within 30 days. Twenty of the 22 cases were closed within 20 days of receipt.

Of the 22 complaints, two involved credit disability claim denials. Upon review of the information in original claim file and the additional information provided with the complaint, the Company was able to reverse their initial denial and pay the claims.

The reasons recorded by the examiner for the complaints were:

Denial of Claim	10
Delays in policy holder service	4
Coverage Cancelled	1
Claim Delay	5
Coverage Not Requested	1
Failure to respond to policy holder	<u>1</u>
Total	22

The Company's procedures are in compliance.

D. Policy Form Review

Standard: The Company uses only policy, certificate and application forms that have been filed and approved prior to use.

The examiners compared lists of forms in use by the Company with MIA records. The examiners discovered 5 forms used prior to approval. During the course of the review, the Company provided approval documentation for all 5 forms.

Also during that review, one single premium credit life certificate form AC2266CL-0202 was found to have been used incorrectly. The form was filed and approved as a joint life certificate to be used only with a joint credit life rate. The form was observed in a case in which only one life was covered and the premium charged was single credit life insurance, not the joint rate.

The Company is in compliance with the standard

E. Statistical Reports and Commissioner Requests

Standard: The Company files all statistical reports accurately and in a timely manner.

The Insurance Article requires that certain statistical reports are routinely filed and that special requests from the Commissioner be responded within a specific time limit. COMAR requires certain additional reports be filed.

The examiners requested to review copies of all statistical reports filed with the MIA during the examination survey period. All statistical, case and experience reports were filed in a timely and satisfactory manner.

7. CLAIM REVIEW

A. Claim Register

Standard: The Company maintains a complete Claim Register as required by law and regulation.

COMAR 31.15.08 describes the requirements for the Claim Register to be maintained by a carrier writing life, accident and health coverage. COMAR 31.15.08 specifies that each health claim be assigned a unique claim number and that the same number be used for ongoing periods of disability be considered a single claim.

The examiners requested lists of claims from the Company's claim register for random selection of files for review. The examiners reviewed each of the lists provided. The Company's claim register is in compliance.

B. Claim Processing

Standard: The Company processes all claims within the requirements of policy provisions, applicable statutes, and regulations.

Subtitle 3 of Title 27 of the Insurance Article prohibits Unfair Claim Settlement Practices and provides administrative remedies. COMAR 31.15.08 defines Unfair Claims Practices for life and health insurance policies. COMAR 31.10.30 became effective in 2004 to include appeal rights and notification procedures for disability claimants. COMAR 31.13.01 provides requirements for credit life and health insurance.

The examiners requested to review the Company's manual of claim processing procedures. **The examiners discovered the Company's procedure manuals nor any of the disability claims processed in the last quarter of 2004 contained the proper notifications to the claimant regarding their rights of appeal. The Company is in violation of COMAR 31.10.30.03. The examiners direct the Company to establish procedures for appeal of adverse decisions regarding disability benefits and to create proper notices to the insured parties.**

Company Response:

The Company agrees with the finding(s) and has taken corrective action. The Company has added notification language to all denial letters for the State of MD.

Claim Processing Standards

Standard: The Company has appropriate written standards for processing and reviewing claims.

The examiners requested, received and reviewed a copy of the Company's claim processing manuals.

The Claim Decision Process

The claims process is managed by the guidelines set forth by the International Claim Association (ICA) statement of principles.

The Claims decision process is governed by:

- 1) Was the policy in force?
- 2) Was the insured actually covered by the policy?
- 3) Is the policy contestable?
- 4) What is the nature of the loss?
- 5) Is the loss covered by the policy?
- 6) What benefits are payable? and
- 7) Who is to receive the benefits?

The ICA Unfair Settlement Practices (totaling 13) are described with explanations for each act that would occur with such frequency as to indicate general business practice(s).

Financial Claims Credit Claim Checklist

Check lists are used to determine the type of documentation required prior to the payment for all contracts. Documentation for the payment of Credit Life is to include:

- 1) The Creditors statement,
- 2) Death Certificate,
- 3) Schedule of Insurance,
- 4) Documents verifying payoff amount, and
- 5) Loan Agreement.

Credit Disability payments (single premium) require:

- 1) The insured's statement,
- 2) Employers statement
- 3) Creditor's statement,
- 4) Attending Physicians Statement, and
- 5) The schedule of insurance.

Payments for Outstanding Balance (such as credit card or open end credit) payments are similar but require:

- 1) balance on the date of loss,
- 2) monthly benefit on the date of loss,
- 3) premium charge, and
- 4) annual percentage rate.

The examiners determined that the written procedures were in compliance with the standard.

Death Claims

The examiners selected a random sample of 100 of 1,222 death claims paid and denied during the examination survey period. Of the 100 files requested only 65 of the paid claim files and 14 of the denied claims files (79 of 100 total sample) contained enough information to evaluate the complete processing of the claims. 63 of the 65 paid claim files and 12 of 14 denied claim files were processed within 30 days or less.

The Company paid 11 of the death claims paid for lives of insured debtors ranging from ages 71 through 94. The policy provisions were such that the terminal age for coverage read either age 65 or age 70. However, because the credit card company continued to bill premiums past the terminal age, the Company chose to pay the claims. **The Company is not administering the termination age provision in its contracts.**

The remaining 52 paid claims appeared to have been adjudicated promptly and accurately.

Of the 1,222 death claims processed during the survey period, 125 were closed by denying benefit payment. The reasons for the denials were as follows:

<u>Reason for denial</u>	<u>#</u>
No Insurance on date of loss	85
Zero balance on date of loss	11
No Life Coverage on Deceased	25
Other Reasons	<u>4</u>
Total	<u>125</u>

Each claimant received a notice from the Company that clearly stated the Company's reason for denial of benefits.

Regarding the 21 claim files with inadequate documentation for thorough review, the examiners direct the Company to keep better records.

8. COMPLIANCE PLAN REVIEW

In 1998, ABLAC and ABIC, collectively referred to as American Bankers Insurance Group (“ABIG”), were subject of a “multi-state” Consent Order. The Order required that ABIG implement a broad compliance program and submit to a multi-state market conduct examination. Additionally, ABIG agreed to conduct an internal audit of all credit life and credit health premium transactions to assure against premium overcharges.

ABIG sought to comply with the terms of the Consent Order, including the Compliance Program (Appendix A of this report). Maryland and Illinois were the two lead states for the multi-state market conduct examination. That examination determined that ABIG had not attained full compliance. The MIA and the Illinois Department of Insurance agreed that if either state conducted a routine market conduct examination of an ABIG company that a review would be made of the Company’s achievement with respect to its Compliance Program. Though the review would pertain to the business of the reviewing state only, the results could serve as a general guideline to ABIG’s degree of compliance for the other states that participated in that agreement.

Compliance Review:

In assessing ABIG’s degree of compliance, the examiners were cognizant of the significant changes in the marketing of credit insurance products since the conclusion of the multi-state market conduct compliance examination in 2000. Of primary importance is the change in the credit insurance market due to federal legislation and the introduction of debt cancellation and debt suspension programs by federally chartered banks. The debt cancellation and debt suspension products are not subject to state statute, review or regulation. Introduction of these plans has resulted in a reduction in the sale of regulated credit life, credit health and credit involuntary unemployment insurance products to banks. To offset the lost income, ABIG increased the sale of credit involuntary unemployment insurance to banks and other lending institutions.

ABIG informed the examiners that it no longer markets ordinary life insurance products. ABIG’s withdrawal from the ordinary market and the reduction in the sale of credit insurance have altered to some degree ABIG’s initial plans regarding the implementation of the compliance program.

The examiners met with ABIG’s management team to discuss the progress of the Compliance Program. ABIG has made a significant effort to implement the Compliance Program, but there are still deficiencies in the Company’s performance under the Program. The deficiencies reported by the examiners do not mean that ABIG has failed to implement the compliance program in certain areas but that ABIG must do more to be fully compliant in these specific areas.

Client Auditing (Compliance items 1B, 2E2)

ABIG has increased its overall number of audits of its clients. However, based upon the examiners' review, the audit reports do not appear to be comprehensive or frequent enough to comply with the requirements of Maryland regulations (COMAR 31.13.01.26 and COMAR 31.13.03.21). In particular, none of the Company's reports addressed the issue of payments of benefits excess of the creditor's need.

Form Filing/Approval (Compliance items 2C, 2D, 2E, 2F)

ABIG has improved its ability to monitor its form filing practices and procedures in order to ensure that its forms are filed timely and to ensure that its forms are compliant with the various state laws and regulations.

Premium Rate Filing/Approval (Compliance item 4E5)

The examiners reviewed the credit insurance new business and found that generally, ABIG charged the correct/approved rate for its credit life, credit health and credit property insurance but failed to use an approved rate for its credit involuntary unemployment insurance for Maryland business written in 2003 and a portion of 2004. To be compliant ABIG must file all of its rates for approval prior to utilization and must implement stronger compliance procedures for filing and approval of rates.

Agent/Producer Licensing (Compliance item 3)

Although ABIG has made progress in the licensing portion of the Compliance Program, the examiners found 6 creditor producers that received compensation without proper licensing. ABIG must institute additional procedures to ensure that all producers writing life, health and property insurance in Maryland are licensed for the proper lines of insurance that they are selling.

Advertising & Outbound Telemarketing (Compliance items 6, 7)

The examiners noted that ABIG's telemarketing for its accidental death and dismemberment insurance plans include information concerning a free magazine offer. This offer appears to be in the nature of a tie-in sale or of a rebate of premium. ABIG disagrees with the examiners observations and responded that the magazine offer is not part of the insurance solicitation, but is a separate offer which happens to be on the telemarketing tapes given to the examiners. The Company further stated that solicitation was from one telemarketing firm operating on behalf of the credit card bank rather than the Company.

The examiners do not agree with the Company's position, because the conversation between the cardholder and the solicitor is continuous. The insurance solicitation and the magazine solicitation must be done separately in order to avoid the conception that the free magazine offer is not a rebate or a tie-in sale, either of which is a violation of the Unfair Trade Practices Act (Title 27 of the Insurance Article). ABIG is not in compliance with this section of the Compliance Program.

Summary of Deficiencies in the Implementation of the Compliance Program

The deficiencies noted in the implementation of the Compliance program are summarized as follows:

Compliance Item	Comment
Client Auditing Items 1B, 2E2	ABIG is not in compliance with Maryland's regulations and laws concerning content and formation of credit insurance audit reports.
Agent/Producer Licensing Item 3	ABIG is not in compliance with Maryland's laws and regulations concerning the recording and licensing of producers receiving commissions.
Advertising & Outbound Telemarketing Items 6, 7	ABIG is not in compliance with Maryland's laws and regulations concerning tie-in sales.

Recommendations

The examiners recommend that ABLAC and its affiliate ABIC improve its procedures for the licensing of producers, actively monitor the forms and rate filing operations, avoid the sharing of telephone solicitations with other non-insurer telemarketers, and improve both its internal and client audits to conform with applicable rules and regulations.

9. SUMMARY OF VIOLATIONS

Client Audits

Violation COMAR 31.13.01.26B(4) and 31.13.01.26C. The Company failed to conduct audits of client creditors or failed to maintain copies of audits of 6 client creditors. (Page 9)

Violation 31.13.01.26A. The Company failed to conduct required follow up client audits within required time period. (Page 9)

Producer Register

Violation COMAR 31.03.13.02B(4) and 31.03.13.03C. The Company failed to provide Producer Register requested by the Commissioner within the required time, and for not maintaining an accurate register. (Page 14)

Commission Payment

Violation §10-130 The Company paid \$8,743.67 to 6 persons that did not possess proper license. (Page 15)

Advertising-Telemarketing

Violation §27-214 Script used by Telemarketing firm did not separate insurance sale from magazine sale. (Page 17)

Violation COMAR 31.15.02.05 Telemarketer's promised effective date of coverage different from policy/certificate language. (Page 17)

New Business Processing

Violation § 27-901 The Company could not provide written consent for 74 of 1 sample of 99 persons who applied for credit life insurance on monthly outstanding balance policies. (Page 20)

Claim Administration

Violation COMAR 31.10.30.03 The Company's claim procedure manual did not contain procedures or notifications regarding consumer rights of appeal for claim denials. (Page 24)

EXAMINATION REPORT SUBMISSION

The courteous cooperation extended to the examiners by the Company's officers and employees during the course of the examination is gratefully acknowledged.

In addition to the undersigned, Nelson Ayling, CIE, FLMI; Hannibal Mickens; and William Rogers, AIE, AIRC, FLMI participated in this examination and in the preparation of this report.

Signature on file with original

Leighton Tabron
Chief Market Conduct Examiner
Compliance and Enforcement

APPENDIX A COMPLIANCE PLAN**1. COMPLIANCE****A. STAFFING**

At the time the Company entered into the Consent Order and Compliance Plan (Plan), the Compliance Department had seven full time employees. However, since that date we have had significant additions to staff. Currently, Compliance has 14 full-time employees, 5 additional full-time positions for which we are hiring, 4 temporary, full-time paralegal professionals and a consulting attorney. The Company continues to monitor the staffing levels of Compliance to ensure that they are adequate to maintain its obligations under the Plan.

B. CLIENT AUDITING

Most of the employees of the Compliance department are compliance auditors whose primary function is client auditing, a responsibility assumed by the department in May 1999. Prior to May 1999, the client audit function was dispersed in the various Operations areas. The Company made a decision to centralize the function in Compliance to (1) ensure uniformity in the application of compliance standards, (2) leverage the technical expertise of Compliance employees, and (3) create a level of independence similarly found in audit departments.

Since the effective date of the Plan, the Company has initiated more than 1100 client audits, an audit unit representing one product written by one client in one state. Approximately 400 of those audits have been completed, and the remainder is in various stages of progression. Inasmuch as the number of full time compliance auditors has doubled in just the past month, we expect a significant increase in client-audit volume going forward.

C. ADVERTISING COMPLIANCE

The Company has taken a number of initiatives to improve advertising compliance, particularly in the area of compliance/legal review and maintenance of advertising files. The Compliance department assumed co-responsibility with legal for advertising review as of June 1999. At the time, there were two individuals principally responsible for advertising review-an individual in Compliance, and an individual in legal. Gradually since that time, Compliance has directed more resources to the function. Initially, we added two full-time temporary paralegal professionals, then more recently we added a full-time temporary consultant and two more full-time temporary paralegal professionals, bringing to seven the total number of full-time resources currently reviewing advertising. We are in the process of hiring three full-time permanent

individuals to replace the temporary personnel. We plan to continue use of temporary personnel until all backlogs are eliminated.

Since June 1999, the Company has received 650 separate advertising pieces. With the recent and unexpected increases in advertising review staff, the Company expects continuing improvements in advertising compliance in the coming months.

To ensure compliance with the Plan with respect to advertising in general, and advertising files in particular, Compliance contracted more than 200 clients to confirm whether or not they created any advertising materials relating to American Bankers programs and, if so, to obtain samples of some of those materials. Of more than 50 percent of the clients who have responded so far, most have confirmed they do not produce materials. Those who responded that they do produce them have provided the samples requested. We are following up for responses from all other clients.

Client produced advertising is subject to review for determination of compliance with the Plan, and advertising files are being established and maintained for those pieces.

D. RESTITUTION

Pursuant to the restitution provision of the Plan, the Company reviewed recent market conduct examinations to identify any instances of premium overcharging, premium under refunding or claim underpayment. As to each instance found, the Company identified all clients writing the affected product and all states in which it was written. At that point the Company obtained for those clients and states system reports of all insured transactions occurring from May 1997 through November 1998 to determine if there were any other instances. Through this process, the Company defined the restitution scope. Having identified the scope in terms of products affected, clients affected, insureds affected, we began the process of quantifying the actual amount owing to insureds.

To date, roughly 90% of all restitution items have been quantified and checks issued. Those items remaining to be quantified are the result of client difficulty in extracting the historical records of insureds. We continue to work with these clients to obtain the necessary information. To date, the Company has issued approximately \$1.45 million in restitution to roughly 93,400 individuals for an average payment of approximately \$15.40

2. FILINGS & FORMS ADMINISTRATION

A. Staffing

1. Increased filings staff by ten employees (from 24 to 34). (We also merged the Forms Administration Group of 13 into the Filings & Forms Administration area for a total of 47 in the new department.)

B. Increased Budget

1. The budget increased as follows:

1999	2000	Increase Amount	Percentage Increase
\$1,197,419	\$2,422,665	\$1,225,246	102%

C. Existing Forms – To Ensure They Are In Compliance

1. Regulatory Review

We reviewed all state bulletins, law changes, regulations, insurance department letters, etc., received from our Government Affairs area. These are usually accompanied by a write-up from our Government Affairs area telling of the scope, impact and necessary action. We also receive ISO bulletins. The Filings area then drafts and files with the states whatever changes are needed to the forms. They also implement new printing and internal and external notification.

2. Production System Audits

Each year we are doing a state by state audit of all forms set up in our production systems for the Chargegard and Credit Life products. During these audits we check to ensure that the

- proper forms are set up for each client
- the forms and stat breakdowns match
- all forms being used are filed and approved.

The reason we do this is so that we can ensure that all new accounts or new forms are being implemented correctly. Operation's is responsible for the initial set up of our clients in the systems and Forms Administration manages the forms changes. Since both processes are extremely manual and errors could occur, this audit process serves to help identify any errors and get them corrected.

D. New Forms - To Ensure They Are Submitted Correctly

1. New Filing Submissions

We review policy conditions/provisions by using industry recognized resources such as INSOURCE and ODEN, as well as insurance department web sites prior to submitting a new program to the department.

E. Implementation of Forms

1. Forms Bulletin Audits

To ensure that all areas affected by forms changes are updated, we have developed a post implementation audit process. This process includes verifying that we have:

- Issued a new Group Master Policy
- Printed New forms
- Updated the production system
- Archived old forms
- Sent copies of new forms to claims and forms manager
- Replaced electronic files in our directories

2. Client Audits

The Chargegard, Credit Property and Credit Life product lines have clients that manage their own forms. This could mean that they are electronically generating the forms for the insureds or that they send our forms to an outside printer to have printed with their other documents.

Forms Administration has developed an audit process that facilitates the forms implementation for these circumstances. In cases where new forms are being installed, the audit process begins from the very start of the process and follows the forms through final approval. In addition to new forms, we also have clients that have been using our forms for many years.

During 2000, it is our goal to audit every account who manages their own forms. By completing these audits we will have a record of the forms being used and copies of them on site evidencing the performance of the audits. The ongoing audit process for new forms will help ensure that the accounts continue to use the forms as they are intended and as they were filed.

3. Bulletin Supply Orders

We instituted tracking procedures on all accounts impacted by forms changes to ensure they order new supplies and implement any new forms.

We expanded our supply database to track, if the requests received are in reference to a bulletin received. In addition, the information tracked is by client, state and date. We can backtrack to the original supply request to determine if they have ordered the new forms. By verifying who has not received the forms yet, we can contact the CRM for follow-up to facilitate the implementation of the new forms.

F. Tracking of Forms

1. Product System

This new system will be the corporate repository of the filed and approved forms information. It provides access to current and historical programs and forms data. The system was designed and put into test in 1999 and is now being populated by a dedicated team of seven staff members.

2. Group Master Policies Database

All GMP's issued are now stored on line for easier retrieval and better historical information.

In the third quarter of 1999 we began to store electronic copies of our issued Group Master Policies in a Lotus Notes Database. This database allows us to be able to quickly identify and generate copies of Group Master Policies whenever they are requested. The database houses the following information.

- Group Master Policy Number
- Client Name
- Creditor Name
- State of Incorporation
- States covered by GMP
- Product
- Electronic GMP files

3. Forms Archiving

Copies of all replaced forms are archived allowing for an audit trail of all forms usage and to respond to requests for copies of policies/certificates that were issued years ago. These forms have since been replaced with new forms. In the past,

copies of these forms were not always retrievable. A process has been implemented to archive copies of all forms when they are introduced. This way we are assured that even if the forms are replaced in the future, a copy will still be available if needed.

G. Increased Use of Technology

1. In the first quarter of 2000 we installed an upgraded version of Tracker. Tracker is a filing management and tracking system.

This software allows Filings to better track the status of filings and give the analyst on-line access to filings requirements for each state. This system includes features such as, activity logs, confirmation of certificate of authority by product line, research information storage, mapping to electronic copies of the forms, sorting ability, and many different reports.

H. Training & Industry Involvement

1. Employee Training and Certification

We require our filings staff to take insurance courses and pass the respective exams in order to qualify for advancement. These include courses from:

- LOMA (Life Office Management Association)
- ICA (International Claims Association)
- INS (Insurance Institute of America)
- HIAA (Health Insurance Association of America)

We also are getting various employees certified by the AICP as ASF (Associate in State Filings) and/or CSF (Certified State Filer).

In 1999, filing analysts and department associates successfully completed 14 insurance courses and exams. Twenty eight (28) courses are planned for the year 2000.

2. Merging of Filing & Forms Areas

By having the employees who print and administer the forms working closely with the employees who draft and file the forms, we are able to improve quality, consistency and efficiency. This also helps us better ensure that the forms being used are exactly as filed.

3. Increased Membership in Filings Industry Groups

We have increased our membership and participation in Filings industry groups at multiple management levels in the area. These include:

- AICP (Association of Insurance Compliance Professionals)
- SOGCA (Society of Group Contract Analysts)
- SCIC (Service Contract Industry Council)
- LHCA (Life & Health Compliance Association)

In addition we have increased our participation in industry seminars. During 1998, there was no participation, during 1999 four seminars were attended. During 2000, we expect 7 members of the management team and several contract analyst to attend various industry educational seminars.

4. Increased Insurance Department Contact

We direct our Filings staff to make contact *in person* with state insurance department personnel, whenever appropriate and possible. We have made recent visits to North Carolina, Tennessee, Pennsylvania and New York and are planning trips to Virginia and Florida, as well as others.

The intent is to work more closely with the states in order to increase the level of communication, to better understand their expectations and to make improvements in our current filing processes.

We have also increased our telephone contact with the insurance departments, using this vehicle for clarification on filing requirements, coverage questions, etc. All written correspondence in the approval files from the departments is retained.

3. LICENSING SERVICES DEPARTMENT

A. Staff Increases

1. Headcount

Headcount increased from 9 in late 1998 to 37 presently.

2. Organization

The Licensing Services Department has expanded to fit the company's needs. There are three separate areas: Customer Service (13), Renewals and Audits (8), Initial Licensing and Appointments (15) and 1 Vice President.

B. Budget Increase**1. Budget**

Budget increased from \$365,095 in 1998 to \$1.7 million in 2000. Does not include 9 additional positions, which have been recently approved and are currently in the process of being filled.

2. Licensing Fees

In 1999, the volume of licensing fees increased by \$500,000 to a total of almost \$1.5 million.

C. New Licensing System**1. Current System**

- Installed in May 1999.
- Cost of \$1.8 million.
- Five dedicated full time IT employees.
- Ability to track information for home office and subsidiaries.
- Look up feature of state by state requirements.

2. Future planned functions:

- Automatic interface with IRIN/SIRCON to process appointments
- Automatic accounting features
- Interface with contract system
- Interface with all processing systems will enable match between licensed agents and premium production
- Interface with compensation systems
- Ability to automatically audit client branches on processing system with branches on Licensing System
- Automatic compliance reports showing incorrect licenses with products
- Automatic compliance reports that show clients who do not have active licenses (currently this process is manual)

D. Early involvement in the contracting process

- Sales Reps are to review licensing requirements before making an initial sales call to a new prospective client.
- Copy of the Letter of Agreement is sent to the Licensing Department as notice of upcoming contracting process.

- Representatives from the Legal Department and the Licensing Customer Service Department, and or the Vice President, attend customer conference calls on an ongoing basis to review requirements and discuss any licensing issues.
- Regular contact is made with the Marketing Client Relationship Managers to discuss licensing needs.
- Calls are made regularly to existing clients to discuss licensing issues/needs.

E. SILA Membership

- Effective 1999 three members of the department's management staff are members of SILA, Society of Licensing Administrators. This organization is education-based but has regional meetings where current licensing issues are discussed. This exposure to the insurance department personnel has greatly increased our knowledge, interaction with the personnel has significantly improved our communication and processing of licenses and appointments.
- All Licensing Services Department employees will be encouraged by incentives to take the Licensing education courses offered by SILA.

F. New Audit Functions

A new audit function began in 1999. Although just one quick audit was completed on average for each state, procedures were implemented and tested to find the best way to proceed in 2000. We expect to complete 2 audits in each state in 2000. The audit will include a comparison of a state list to our database with all discrepancies worked. This will result in an extensive review with clients and verifications of who should be on our Licensing database. In addition for those states that renew appointments, we will also conduct a list comparison and audit.

G. Background Investigations

We are conducting criminal background investigations on all new licensees and appointees through PRSI. In those states where it is required, we conduct credit background checks as well.

4. OPERATIONS

A. Ordinary

1. Upgrade PolicyLink system to allow in-force illustrations

The vast majority of States have passed regulations mirroring the NAIC model law for illustrations on individual Life Insurance policies. Part of that model law is the requirement to provide an in-force illustration each year along with the annual statement or upon demand by the Insured, if you notify him on the annual statement that an in-force illustration will be provided on demand. We have now modified our administrations system to give us the capability to provide this illustration.

2. Upgrade PolicyLink issue system to provide compliant cost disclosures for new policies.

It is necessary to provide a statement of cost and benefits along with the policy as a separate document not a part of the policy itself. It was necessary to modify the PolicyLink administration system to produce such a compliant document based upon the NAIC model law and that procedure is completed as required.

3. Compliance Audits performed twice a year with CAIG our partner in voluntary UL group business.

As part of the Compliance Plan we performed a compliance audit at Carolina American Insurance Group who offers a voluntary universal life insurance product on our paper. This audit is done to insure compliance with State filings, licensing, rates, underwriting and record retention. The audit is to be performed twice a year.

4. Compliance audits performed on new business policies to insure compliance with State Regulations.

Again as a result of the Compliance Plan a compliance audit is performed on policies when issued to make sure agents are licensed, policies issued are properly filed and approved, and that the cost disclosures are compliant.

5. Project underway to comply with record retention regulations.

Record retention regulations have forced us to come up with a method of producing copies of all premium due notices, grace and lapse notices, cancellation notices, and all policy correspondence. A recommendation has been made to go to storage of any correspondence produced by the system on

CD ROM through an outside vendor which will dramatically improve our capabilities of storing and retrieving this information.

B. Credit Property

1. History file

Effective 1/1/1999, we created an on-line history file that captures and maintains all the data received from automated reporting clients.

2. New processing screen

Created a new processing screen which allows us the ability to detail process our manual reporting clients.

3. Detail processing

Started the detail processing of the IUI 90's business. We are actively working with the clients that have processing concerns.

4. Front end edit system

We are in the process of designing a front end edit system for all the credit property and IUI business. This will provide us the ability to edit the premium and refund transactions.

C. Direct Responses

1. New Compliance Analyst Position.

This position was created in 1999 to insure continued compliance in the Direct Response area. The analyst updates the compliance plan monthly; conducts internal and external processing audits; reviews and updates Standard Operating Procedures (SOPs); and researches and responds to insured and Department of Insurance (DOI) inquiries.

2. Training

Several training sessions were conducted throughout the year. Employees received compliance updated and 'Back to Basics' training (a refresher course on SOPs, with an emphasis on compliance), along with monthly underwriting case clinics to insure compliance to underwriting guidelines. In addition, training on Fraud reporting regulations was presented by the Special Investigative Unit.

3. Audit Process

Created a formal audit process. The process includes an audit schedule, audit scope, findings reports, and corrective action plan. Completed audit of four accounts. Compiled and shared findings/corrective actions required with accounts and CRMS in order to insure compliance.

4. Standard Operating Procedures Established For The Following

- Underwriting Rate Edits
- Retrieval of Underwriting Files
- Department of Insurance Complaint Handling
- Underwriting Guideline audit process
- Cancellation Process (internal & external)

5. Secondary Beneficiary Field Audit

Completed secondary beneficiary field audit for top selling life product (for top three states). Reported variances and implemented corrective action.

6. Forms Review

DRO reviewed and verified forms of top 10 accounts against state approved compliant form to insure accuracy and compliance. Review process will be repeated for remaining clients as forms are refiled and approved.

In addition, we created an audit process, which includes review of all forms used by Client (enrollment and fulfillment forms). As a result of this audit process, we brought in house the processing of two clients. Audits will continue as standard procedure.

7. Forms Set Up System Enhancements

Developed and tested new system enhancements that facilitates the set up of compliant forms. Although the 'old' method worked, it was very labor intensive and prone to human error. This new process was just moved to production (April 2000).

8. Transfer of Processing

Audited and brought in-house, the processing of two clients in order to facilitate compliance to state laws and regulations.

D. Property Operations**1. Restitution**

The restitution requirements of the Compliance Plan have been completed. All issues for which Property Operations was cited for premium discrepancies have been corrected and refunds have been made to the impacted insureds.

2. Record Retention

Research for record retention requirements by state was completed and communicated to our Clients.

3. Lender Placed Coverage

Research was completed regarding state requirements with respect to type and amount of Lender Placed coverage on real property. Property inspection standard operating procedures were modified to reflect the state requirements.

4. Microfiche

A team was developed to research and correct retrieval problems that were happening with system generated microfiche. Several actions have been taken to ensure that proper data is being sent to or received from the outside vendor that produces the microfiche.

5. State Laws, Regulations, Rules & Guidelines

Information on state laws and regulations with respect to the number of days advance notice is maintained and updated in Property Operations Compliance. As changes occur, impacted departments are notified. In addition, the underwriters for all of the P&C products maintain rules and guidelines for allowable cancellation reasons and update them as required.

E. Credit Life**1. Audits**

We audit all new clients during their first 90 days of processing for the following items:

- Correct Rating
- Accurate Completion of Certificate
- Correct Form
- Adherence to Reg Z

Any out of compliance issues are investigated until resolved. At the request of Compliance, we provide detailed information on issues, cancels, edits, etc. for selected clients. Summary processed clients were audited by Credit Property to ensure compliance.

2. Edits

All single premium detailed processed clients are fully edited by the XYCOR system (this represents about 98% of our business). The system checks the following items:

- Rated Correctly (within tolerance)
- Refunded Correctly (within tolerance)
- Benefits within State and Contractual Limits
- Terms within State and Contractual Limits
- Age within State and Contractual Limits
- Compensation Taken is within State and Contractual Limits
- Producer is Active and Contracted to write program
- All required certificate level information was provided (age, apr, term, benefit, etc.)

If any certificate was issued incorrectly, appropriate action is taken. This could include; endorsing, adjusting, or returning the certificate or any overcharge or under refund amounts.

All outstanding balance business is edited for appropriate premium rating on a combined reporting basis. The system ensures that for the total reported outstanding balance covered, that the premium charged was appropriate. If an edit occurs, we go back to the client to review detail and rates programmed into their system, in order to determine cause and action needed. If an incorrect rate has resulted in an overcharge to the customer, the client is instructed to provide details of restitution.

3. Client Set Up

When setting up new clients, or additional branches, the Client Administrators ensure the client is set up according to state and contractual limits and guidelines. The XYCOR system also edits for compliance to certain items such as state compensation limits.

4. Bulletins

When notified, we identify all clients impacted by changes to programs within specified states, and mail bulletins to them. Internally, processors are given copies of the bulletins in order to work with their assigned clients to ensure implementation of the changes (this process was implemented 2/00).

System Support updates the rates and formulas within the XYCOR system as of the effective date stated within the bulletin. Additionally, they build the appropriate historical files. The Client Administrators then ensure that all impacted clients are updated to point to the new rate records.

5. File & Approved Rates

The XYCOR system was reviewed in 1999 to compare the rates and formulas to ensure that they matched the filed and approved rates. Any clients not pointing to a filed and approved rate were changed to the correct one.

F. Chargegard

1. Client Setup

The Client Administrators review new client set-ups, which include new agent and or branch codes. Their review includes product, state and contractual limitations for all requested setups.

2. Restitution

Chargegard Operations has completed 85% of the restitution project. This encompassed over 50,000 checks issued (approx. \$800,000 in refunds). We currently are awaiting data from five of our clients to complete this project.

3. Record Retention

A bulletin was mailed in 1999 to all Chargegard clients, advising them of the required record retention duration along with what insurance documents are to be kept.

4. Compliance Analyst Position

This position was created in 1999 to insure continued compliance in Chargegard Operations. The analyst conducts rate audits; reviews and updates Standard Operating Procedures; and researches and responds to insured and Department of Insurance inquiries.

5. Standard Operating Procedures

Created Standard Operating Procedures for 1) Rate Audits, 2) Retrieval of Enrollment Document, 3) Department of Insurance and Customer Complaint Handling, and 4) Cancellation Process.

6. Bulletins

Chargegard is notified of all state/product changes required. We will then identify all clients impacted and mail bulletins to them. The Compliance department follows up with any clients that do not sign and return the bulletin notification. Internally, the Client Administrators will update the necessary changes for implementation prior to the due date (this process was implemented in February 2000).

5. CLAIMS

A. New Hire and Refresher Training Programs

New hire training is 3 to 6 weeks (depending on the type of position) for all new claims associates, examiners or field staff adjusters.

It is a combination of lecture and hands-on activities focusing on all aspects of claims adjudication.

Refresher training occurs on a routine basis. Twenty various topics were presented to approximately 290 employees during 1999.

B. Quality Audit Program

Training and Compliance audits every examiner term semi-annually. Audit samples include the following types of claims:

- Credit Life, Disability, IUI and Property
- Chargegard Life, Disability, Unemployment, Leave of Absence and Property
- DMO Life, Disability and AD&D

C. Corrective Action Plan

Audit results are recorded in an individual's overall performance evaluation. If results are unsatisfactory, corrective action is taken in the form of Department Warning, Formal Warning, Probation and Termination. 3 employees were terminated in 1999 due to unsatisfactory audit results.

D. Training & Compliance Bulletins

Bulletins regarding regulatory, statutory or procedural requirements are distributed and maintained in a Lotus Notes environment allowing for on-line access to information for quick, easy retrieval.

E. Increased Staff

Five additional employees were hired to assist/create/develop/conduct training modules and perform audits.

F. Increased number and frequency of audits

Audit methods, sampling and reporting has been standardized. In Financial Claims, supervisors audit 15 claims files per month.

In CMS, managers audit 10 claim files per month. Training & Compliance audits 20 claim files per employee semiannually. In 1999, there were 16,913 claim file audits completed by supervisors, managers, Training and Compliance.

G. Claims Processing

Assumed the processing of claims from 10 creditors who had claims authority. Transfers were well planned to ensure that there was no interruption or delays in service for insured/claimants.

H. Virtual

Invested \$2,573,000 and 3,720 man hours in Virtual, an imaging system, to improve file retention and retrieval.

I. Developed Claims Handling Matrix by State

This job aid enables examiners to identify pertinent claim handling requirements by state. Items on the matrix include the following requirements: processing time, tax, record retention, fraud statements, etc.

J. Insurance Complaint Database

Increased awareness of using Customer Complaint Database. The company's goal is to ensure that we provide timely, complete, comprehensive and quality responses.

K. Standardized Letters

Standardized and automated the following letters: acknowledgment, explanation of benefits, denials, requests for additional information and follow-up.

6. ADVERTISING

A. Legal Review

Meetings were held with legal staff to clarify general guidelines for advertising and were disseminated to direct mail staff. Included in these meetings were the Identification of the writing agent; the difference between different types of advertising; clarification on benefits for certain products; language that should and should not be used in an advertising piece, etc.

B. Review of Masters

All masters for current direct mail products were reviewed and revised accordingly to legal/compliance reviews.

The marketing pieces for the major Direct Mail products were reviewed by legal/compliance and were revised as indicated. A special reference binder was prepared and maintained that contains samples of all revised masters.

C. Filing System

Files for legal/compliance reviews were reorganized and are now up-to-date. The files have been reorganized according to product and then if there is a separate client piece that was reviewed, it is also filed in the legal/compliance review cabinets.

D. Audit Files

Files for insurance audits were reorganized according to year, product and client. We have refiled all of the advertising samples including all monthlies, portfolio solos and inserts.

E. Sample

New procedures for securing samples of printed materials were drafted and implemented. For solos, we now obtain samples from each split (even if the creative is the same). We also have samples of every state's application. We are also filing copies of the work orders to evidence which states were mailed and which were not.

F. Compliance Checklists

A checklist indicating the major advertising guidelines as referenced in the Advertising Compliance Plan was created for solos and inserts and is now used as a last check before printing.

This checklist was created from the Principles and Policies that were contained in the Advertising Compliance Plan. It also indicates client, product, vehicle, drop date, creative form number and the person who is completing the checklist.

G. Compliance Guidelines

A poster with compliance guidelines was created and is on the wall in the direct mail campaign area as well as the creative area.

H. Testimonials

We updated all testimonials used in the direct mail pieces and created a file to store the source of each.

The source book is kept in the creative area and is updated by the Copy supervisor.

I. Statistics

A file was started to store and document the source of all statistics used in direct mail advertising.

The source book is kept in the creative area and is updated by the Copy supervisor.

7. OUTBOUND TELEMARKETING

A. Script Review

Outbound Telemarketing has produced specific checklists to be used when creating scripts for any products or programs. Once the script is created it is reviewed by management and then sent to legal for approval and review. Every time we conduct a campaign, the script is reviewed by legal and every change a client makes forces the script to be sent back for legal review.

B. Agency Licensing Status

Outbound Telemarketing works with licensing to determine the licensing status of agencies. If an agency does not have the proper licenses/appointments for a specific product, the agency will not sell in those states.

C. Implementation Period

Outbound Telemarketing has a six week implementation period to ensure proper time to evaluate licensing and script approvals.

D. Monitoring

All Outbound Telemarketing analysts monitor their programs and report their findings. All monitoring reports are kept by month to document the sessions.

E. Script Books

Script books have been created by year, by client and every version of the script is filed.

F. Agency Tapes

All agencies keep the sales tapes on-site for a period of three years and in storage after that time.

8. CONTACT CENTER OPERATIONS**A. Digitized Recording**

Digitized Recording is both an “on demand” and an automated system for recording required telephone conversations. The system works in tandem with our computer telephone integration (CTI) software. The application automatically documents the markers required to retrieve recordings, archives the recordings and performs searches for specified recordings.

With playback as needed. Searches can be made by client, customer service associate, date, state and customer fields. This will minimize the possibility of misplaced cassette tapes, incorrect indexing and simplifies the customer service associates’ recording duties.

B. Jet Forms

Jet Forms is a form-filing software application that allows our customer service associates to access the current form version via the network. These electronic forms allow “write” access to the specified fields necessary to fill-in application information with the personal computer. This is intended to eliminate the possibility of a customer service associate taking an application on an outdated application form. Application form fields are properly completed with typed text-legible information rather than by illegible customer service associate handwriting.

C. The On Line Manual

The On Line Manual is a combination of two applications, 1) Lotus Notes and 2) Adobe Acrobat. Previously, all client data and product descriptions were distributed to the customer services associates in hard copy format. The distribution was slow and with no guarantee that each customer service associate received the information

or that it was immediately filed in their individual desk reference manuals. Acrobat will allow the customer service associate to view information, perform detailed searches and if necessary, print a hard copy. We've sped up the distribution of uniform information, guaranteed manual standardization with the most current material and a consistent method for using product information.