

MARYLAND INSURANCE ADMINISTRATION

ALFRED W. REDMER, Jr., COMMISSIONER



MARKET CONDUCT DESK AUDIT REPORT

OF

Colorado Bankers Life Insurance Company

5990 Greenwood Plaza Boulevard
Suite 325
Greenwood Village, CO 80111

NAIC COMPANY CODE 84786

Report #: 1862-03

January 29, 2004

Examination Dates: May 12, 2003 – July 7, 2003

Examination Survey Period: January 1, 2002 – December 31, 2002

The Honorable Alfred W. Redmer, Jr.
State Insurance Commissioner of Maryland
525 Saint Paul Place
Baltimore, Maryland 21202

Dear Commissioner:

Pursuant to your instructions and authorizations, a target desk examination has been made of the market conduct affairs of Colorado Bankers Life Insurance Company whose offices are located at 5990 Greenwood Plaza Boulevard, Suite 325, Greenwood Village, Colorado 80111.

The report of the examination is respectfully submitted herein.

Table of Contents

<u>Section</u>	<u>Page</u>
I. Scope of Examination.....	4
II. Company History	5
III. Policy Form/Contract Review.....	6
A. Policy Form Review	6
B. Policy Issue	6
1. Policies Issued During the Survey Period	6
2. Policies Renewed During the Survey Period	7
C. Administrative Service Contracts	8
IV. Review of Claim Administration	9
A. Claims Register.....	9
B. Sampling Process	9
C. Claims Review	9
1. Life Claims.....	9
2. Resisted Claims.....	9
3. Accident Only Claims.....	10
4. Disability Income.....	10
5. Waiver of Premium Claims	11
6. Dental Claims.....	11
D. Appeals Process	14
1. Appeals and Grievance Procedure	14
2. Grievances.....	14
E. Litigated Claims	14
V. Rates and Rate Increases.....	15
A. Rates.....	15
B. Rate Increases	15
VI. Summary of Violations and Recommendations	16
Acknowledgement	17

I. Scope of Examination

The Maryland Insurance Administration (“MIA”) conducted a desk examination of Colorado Bankers Life Insurance Company, (hereinafter referred to as the “Company” or “CBL”) which was conducted at the offices of the MIA, located at 525 St. Paul Place, Baltimore, Maryland 21201, pursuant, but not limited to Sections 2-205, 2-206, 2-207, 2-208, 2-209 and of the Insurance Article of the Annotated Code of Maryland (“Insurance Article”). The examination covers the survey period from January 1, 2002 through December 31, 2002 (“survey period”).

The purpose of the examination was to determine compliance by the Company with the Insurance Article of the Annotated Code of Maryland, as well as, applicable provisions of the Code of Maryland Regulations (“COMAR”). Additionally, the examination was to determine if operations were consistent with the public interest.

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 does not constitute acceptance of such practices. Examination report recommendations that do not reference specific insurance laws, regulations or bulletins are presented to improve the Company’s practices and ensure consumer protection.

The examination and testing methodologies follow standards established by the National Association of Insurance Administrators (“NAIC”) and procedures developed by the Maryland Insurance Administration. Testing performed during the review provides a credible basis for the findings and recommendations contained in the report.

Schedule T of the Company’s 2002 annual report indicates that the Company is licensed in all states and the District of Columbia except New York and Vermont. The chart that follows identifies those states in which the Company wrote 3% or more in premium:

State	Premium	Percent
California	\$5,442,765	15.3%
Florida	\$2,638,632	7.4%
Illinois	\$3,740,112	10.5%
Maryland	\$5,516,911	15.5%
New Jersey	\$1,740,607	4.9%
Ohio	\$2,281,077	6.4%
Texas	\$1,964,560	5.5%
Virginia	\$1,428,191	4%

II. Company History

CBL was incorporated under the laws of Colorado on May 28, 1974.

CBL's authorized capital stock consists of common and preferred stock. All of the outstanding common stock of the Company is owned by Preferred Financial Corporation ("PFC"), also domiciled in the State of Colorado. The Company is a wholly owned subsidiary of PFC, which is a holding company principally engaged, through its subsidiaries, in the marketing and servicing of insurance, retirement annuities, credit union and mutual fund products. PFC specializes in the marketing of payroll deduction insurance and other employee benefit products through small and medium size employers. PFC is a wholly owned subsidiary of Health Care Service Corporation ("HCSC"). HCSC is the largest health insurer in the State of Illinois, where it operates as Blue Cross Blue Shield of Illinois/Texas.

CBL markets an individual whole life policy with a flexible annuity rider, an individual term life policy with a flexible annuity rider, an individual term life policy with a critical condition term rider, an individual accident only policy, a group dental policy and a deposit fund contract. CBL previously assumed a block of individual endowment policies and accident-only policies from Monumental Life in December of 1990. Net premiums during 2002 were \$35,035,730; 61% for individual life, 30% for individual annuities, 5% for the individual accident only policy and 4% for group dental.

III. Policy Form/Contract Review

A. Policy Form Review

The examiners requested a list of all forms in use by CBL during the survey period. The Company provided a list of 73 policy forms. The examiners compared the Company list to the list of approved forms on file with the MIA.

The examiners found no exceptions during the review of this area.

B. Policy Issue

1. Policies Issued During the Survey Period

The examiners requested a list of all policies issued by the Company during the survey. The Company provided the examiners with a list of 4,423 policies from which 75 were randomly selected for review. The policies reviewed included all the products issued by the Company. The examiners reviewed the new issues to ensure that the policies were properly completed and that the writing agent was licensed to do business in the State of Maryland.

The examiners found the following inappropriate alterations to policy applications:

MIA#	Policy #	Alteration
NI#6	776378	Premium amount-written-over Insured Child-cross out Replacement question-answered yes and no
NI#7	782566	Medical question 1B-answered yes and no-cross out
NI#42	606086	Beneficiary-cross out
NI#55	529753	Spouse and Insured child-cross-outs

The Company is in violation of §12-206 of the Insurance Article which, states in pertinent part:

- (c) **Alteration of application.** – (1) Except as provided in paragraph (2) of this subsection, an alteration of a written application for a life insurance or health insurance policy or annuity contract may not be made by a person other than the applicant without the applicant's written consent.

The following policies were written during the survey period by agents who were not appointed by the Company:

MIA#	Policy #	Agent Name
NI#39	603206	Kathleen Romonouskas
NI#41	605605	Kathleen Romonouskas
NI#42	606086	Kathleen Romonouskas
NI#71	603238	Robert W. Lochte, Jr.
NI#73	614323	Robert W. Lochte, Jr.

The Company is in violation of §10-118 of the Insurance Article, which states in pertinent part:

- (a) **In general. – (1) When an insurer doing business in the State makes or terminates an appointment, the insurer immediately shall:**
 - (i) file with the Commissioner written notice of the appointment or termination and the reasons for the termination.
- (b) **Application from agent without appointment. – Within 30 days after an insurer receives an application for life insurance, health insurance, or an annuity from, an agent that does not have an appointment from the insurer, the insurer shall:**
 - (1) reject the application in accordance with §27-501 of this article; or
 - (2) file with the Commissioner written notice of appointment under subsection (a) of this section.

Company Response

Regarding policies written during the examination period by Robert Lochte, the Company sponsored him for his temporary license, but did failed to reappoint him when he obtained a permanent license. For policies written by Kathleen Romonouskas during the examination period, the Company did not properly appoint her.

2. Policies In Force During the Survey Period

The examiners requested a list of all policies that were in force during the survey period. The Company provided the examiners a list of 16,100 policies from which the examiners randomly selected 100 for review.

The examiners found that the majority of the policies were relatively small life insurance plans (\$10,000 to \$15,000) paid for on a payroll deduction plan.

The examiners noted that none of the life insurance policies involved replacement of another plan.

The examiners found no exceptions during the review of this area.

C. Review of Administrative Service Contracts

The examiners requested copies of all administrative service contracts in force during the survey period. The Company provided the examiners 3 administrative service contracts issued to:

- Dental Network of America (“DNOA”)
- Select Benefits Communications Group (“SBCG”)
- S F & C Insurance Associates (“SF&C”)

The examiners reviewed the contracts and found no exceptions. The examiners also confirmed that the above named entities are registered with the MIA as Third Party Administrators (“TPAs”).

IV. Claims Administration

A. Claims Register

The examiners requested and received copies of the Company's claim registers for the survey period. The claim registers were provided in electronic format according to the type of business. The examiners reviewed the claim registers and determined that the Company does not assign a claim number to its claims. **The Company is in violation of COMAR 31.15.08.05 D which states in pertinent part:**

D. Each claim shall be assigned a unique claim number

B. Sampling Procedure

Since the Company has multiple lines of business, the examiners requested and were provided separate claims register for each line of business. The examiners then randomly selected a sample of each type of policy in accordance with the standards set by the NAIC and the MIA.

C. Claims Review

1. Life Claims

The examiners requested a list of all life claims processed during the survey period. The Company provided the examiners with a list of 33 life claims from which a random sample of 15 was selected for review. The examiners verified that the correct benefits amounts were paid to the correct beneficiaries and that interest was correctly paid, when due.

The examiners found no exceptions during the review of this area.

2. Resisted Claims

The examiners requested a list of all claims that were resisted by the Company during the survey period. Resisted claims are those claims that are not paid by the Company during the contestable period because of material misrepresentation on the application or death of the insured by suicide. Material misrepresentation can include failure to include or properly provide pertinent medical information on the application and or incorrectly answering the smoking question. Benefits are not available under the policy terms for deaths that occur as the result of suicide within the first two years of the policy. The policy states that all premiums are to be returned in the event of suicide.

The Company provided the examiners with a list of 7 resisted claims that occurred during the survey period. The examiners selected all 7 for review. The review consisted of determining whether the Company acted within its rights in denying the claims based on the application completed by the insured and the information obtained by the Company at the time the claim was filed.

The examiners determined that all the resisted claims were appropriately denied. The examiners found no exceptions during the review of this area.

3. Accident Only Claims

The examiners requested a list of all accident-only claims that were submitted to the Company during the survey period. The Company provided the examiners with a list of 206 claims from which the examiners selected a random sample of 25 for review.

The examiners verified that the correct benefit amount was paid and determined that the claims processing time ranged from 2 days to 22 days with an average of 11.3 days.

Elapsed Time	# of claims
1-15 days	20 (80%)
16-30 days	5 (20%)
Over 30 days	0 (0%)
Total	25

During the review of the 25 processed claims, the examiners determined that all the claims were processed within 30 days of receipt.

The examiners found no exceptions during the review of this area.

4. Disability Income

The examiners requested a list of all disability income claims processed by the Company during the survey period. The Company provided the examiners with a list of 22 claims from which a random sample of 10 claims was selected for review.

The examiners verified that the correct benefits payments were made and determined that the claims processing time ranged from 2 days to 15 days with an average of 5.9 days.

The examiners found no exceptions during the review of this area.

5. Waiver of Premium Claims

The examiners requested a list of all claims submitted by insureds claiming benefits under the waiver of premium clause of their policy. The Company provided the examiners with an electronic list containing 23 files. The examiners randomly selected 10 files for review.

The examiners reviewed the files to determine if the waiver of premium was correctly applied, i.e.: did it go into effect at the proper time and was the insured credited for the proper amount of premiums. The examiners determined that the Company properly processed the waiver of premium claims. In the event that the waiver of premium was claimed retroactively, the examiners noted that the Company made the appropriate refunds to the insured.

The examiners found no exceptions during the review of this area.

6. Dental Claims

The examiners requested a list of all dental claims processed by the Company during the survey period. The Company informed the examiners that the dental products were administered by Dental Network of America (“DNOA”) a third party administrator. The Company, working in conjunction with DNOA provided the examiners with a list of 1,447 paid and denied claims processed during the survey period. The examiners randomly selected 200 claims for review. The sample selected by the examiners contained 134 paid and 66 denied claims.

The examiners also reviewed the claim register for DNOA. The claims register does not assign a unique claim number to each claim. The following is an example of the claim numbering system currently in use:

Example: 2000001193

Digits 1,2,3, & 4 – 2000 represent the year the claim was received.

Digits 5, 6, & 7 – 001 represents the number of claims filed by the particular insured in that year; in this instance the first claim

Digits 8, 9, &10 – represent the adjuster id number.

Therefore, all initial claims submitted by all insureds and processed by adjuster 193 would have the same claim number. DNOA can only identify an individual claim by identifying the insured by policy number or social security number.

Because the claim number is not unique the Company is in violation of COMAR 31.15.08.05 D which states in pertinent part:

D. Each claim shall be assigned a unique claim number

The examiners determined that the claims processing time for the sample ranged from 6 days to 174 days with an average of 20.6 days.

Elapsed Time	# of claims
1-15 days	76 (38%)
16-30 days	108 (54%)
Over 30 days	16 (8%)
Total	200

The examiners found that 16 of the 200 claims were not processed within 30 days of receipt:

The following chart identifies the 16 claims that were not processed within 30 days of receipt.

MIA#	DNOA Claim #	Received Date	Processed Date	Elapsed Time
Den #001	202000101	08/21/2001	02/11/2002	174
Den#002	202000101	12/14/2001	01/28/2002	45
Den#005	202000201	12/27/2001	01/28/2002	32
Den#016	202000102	1/14/2002	2/18/2002	35
Den#039	202000202	03/18/2002	04/20/2002	33
Den#066	202000201	08/06/2001	01/21/2002	168
Den#067	202000102	11/09/2001	03/18/2002	129
Den#068	202000401	12/10/2001	02/18/2002	70
Den#071	202001001	01/08/2002	02/18/2002	41
Den#072	202000201	01/15/2002	02/25/2002	41
Den#083	202000501	02/21/2002	03/25/2002	32
Den#134	202002802	6/21/2002	7/29/2002	38
Den#149	202000302	07/19/2002	08/20/2002	32

MIA#	DNOA Claim #	Received Date	Processed Date	Elapsed Time
Den#171	202001102	10/04/2002	11/18/2002	45
Den#185	202001302	11/08/2002	12/16/2002	38
Den#187	202000602	11/15/2002	12/16/2002	31

The Company is in violation of §15-1005(c) of the Insurance Article which, states in pertinent part:

Within 30 days after receipt for a claim for reimbursement from a person entitled to reimbursement under 15-701(a) of this title or from a hospital or related institution, as those terms are defined in 19-301 of the Health-General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

- (1) pay the claim in accordance with this section; or
- (2) send a notice of receipt and status of the claim that states:
 - (i) that the insurer, nonprofit health plan, health maintenance organization refuses to reimburse all or a part of the claim and the reasons for refusal.

The examiners also determined that of the 16 claims paid over 30 days CBL did not pay the appropriate interest at the time of payment on 11 (68.8%) of those claims as follows:

MIA#	DNOA Claim #	Amount of claim	Elapsed time	Interest Due
Den#002	202000101	\$77.00	45	\$0.38
Den#005	202000201	\$7.00	32	\$0.01
Den#039	202000202	\$49.00	33	\$0.07
Den#071	202001001	\$61.00	41	\$0.33
Den#072	202000201	\$63.00	41	\$0.34
Den#083	202000501	\$91.00	32	\$0.09
Den#134	202002802	\$68.00	38	\$0.27
Den#149	202000302	\$49.00	32	\$0.05
Den#171	202001102	\$49.00	45	\$0.36
Den#185	202001302	\$63.00	38	\$0.25
Den#187	202000602	\$44.00	31	\$0.02

The Company is in violation of Section 15-1005(f) of the Insurance Article which states:

- (2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

D. Appeal Process

1. Appeal and Grievance Procedure

The examiners requested a listing of all adverse decisions made during the survey period and were informed that the Company made no adverse decisions.

The examiners requested a copy of the Company's appeal and grievance process. The Company provided the examiners with a copy of its grievance and appeal procedure that was filed and received by the MIA on August 3, 2000. The Company also provided the examiners with sample copies of the letters that are used in the event of an adverse decision.

2. Grievances

The examiners were provided with copies of the quarterly reports filed by the Company concerning the number of adverse decisions made by the Company during the reporting period. All of the quarterly report indicated that the Company has not made any adverse decisions during the survey period.

The examiners found no exceptions during the review of this area.

E. Litigated Claims

The examiners requested a list of all claims litigated and resisted during the survey period. The Company responded and indicated that had no claims in litigation.

V. Rate and Rate Increases

A. Rates

During their review of items discussed in other sections of this report, the examiners confirmed that the rates being charged to the policyholders are those that are on file and approved by the administration.

The examiners found no exceptions during the review of the rates being charged to Maryland policyholders.

B. Rate Increases

The examiners requested a list of all rate filings by the Company during the survey period. The Company responded with the following statement:

Company Response

There were no rate increases implemented in 2002 [survey period]. The first rate increase was for the Accident Only policy which was approved in late 2002, but with the 60 days prior written notice required, the first rate increase did not occur until May 2003.

The examiners verified that no other rate increases were filed during the survey period. The examiners also confirmed that the above referenced rate filing was approved by the MIA December 2002.

VI. Summary of Violations and Recommendations

Below is an outline of important points from the report sections in which they appear:

III. Policy Form/Contract Review

B. Policy Issue

1. The examiners found 4 applications that contained 6 alterations in violation of §12-206 of the Insurance Article for making an alteration to an application without the approval of the applicant.
2. 5 violations of §10-118 of the Insurance Article for accepting 5 applications from 2 agents who have not been appointed by the Company.

IV. Claims Administration

A. Claim Register

1. The examiners determined that the Company is in violation of COMAR 31.15.08.05 D for not assigning a unique claim number to each claim.

C. Claims Review

1. 16 instances of a claim not being processed within 30 days of receipt in violation of §15-1005(c) of the Insurance Article.
2. 11 instances of a claim not processed within 30 days of receipt not paying interest as required by §15-1005(f) of the Insurance Article.
3. The Company is in violation of COMAR 31.15.08.05 D for allowing its TPA to use a claim numbering system that is not in compliance with the regulations.

Acknowledgement

The courteous cooperation extended to the examiners by the Company's officers and employees during the course of the examination is gratefully acknowledged. Wayne C. Shockley FLMI, AIRC, ALHC, ACS, HIA, participated in this examination and in the preparation of this report.

Sincerely,

Signature on file with original

P. Todd Cioni
Associate Commissioner
Compliance and Enforcement

**INSURANCE COMMISSIONER
FOR THE STATE OF MARYLAND
525 ST. PAUL PLACE
BALTIMORE, MARYLAND 21202**

*** STATE OF MARYLAND
* MARYLAND INSURANCE
* ADMINISTRATION**

V.

**COLORADO BANKERS
LIFE INSURANCE COMPANY
5990 GREENWOOD PLAZA BLVD.
SUITE 325
GREENWOOD VILLAGE, CO. 80111
NAIC NUMBER 84786**

CASE NO.: MIA-2004-01-040

* * * * *

Consent Order

This Consent Order ("the Consent Order") is entered into by Colorado Bankers Life Insurance Company ("Respondent"), National Association of Insurance Commissioners ("NAIC") company code number 84786, and the Maryland Insurance Commissioner ("the Commissioner") ("the Parties"). The Commissioner, pursuant to §§ 2-205, 2-207, 2-209 and 4-113 of the Insurance Article, Annotated Code of Maryland (the "Insurance Article") has made the following determinations.

WHEREAS, the State of Maryland, Maryland Insurance Administration ("Administration") conducted a limited scope market conduct examination (the "Examination") of Respondent's life and health insurance operations in Maryland. Respondent, domiciled in the State of Colorado, maintains its principal offices at 5990 Greenwood Plaza Boulevard, Suite 325, Greenwood Village, Colorado 80111.

The Administration conducted the Examination at its offices located at 525 St. Paul Place, Baltimore, Maryland 21202. The Examination covered the survey period of January 1, 2002 through December 31, 2002.

1. Respondent currently holds a Certificate of Authority from the State of Maryland to operate as an Insurance Company.
2. The Examination, the details of which are contained in Report #1862-03 (the "Report"), concluded that Respondent committed various violations of the following Maryland laws and regulations:
 - Section 10-118 of the Insurance Article;
 - Section 12-206 of the Insurance Article;
 - Section 15-1005(c) of the Insurance Article;
 - Section 15-1005(f) of the Insurance Article;
 - Code of Maryland Regulations Title 31 Subtitle 15, Chapter 08, Regulation 05 D.

The Commissioner and Respondent mutually agree that the following resolution is reasonable and that the public interest is served thereby.

THEREFORE, pursuant to the Insurance Article and the powers vested in the Commissioner, the Parties agree and it is hereby, with the Consent of Respondent, **ORDERED**, by the Maryland Insurance Commissioner, that:

1. Respondent accepts the Administration Report #1862-03 as final and waives any right to a hearing on or judicial review of the Report.
2. Respondent shall take corrective actions to address the deficiencies noted in the Report.
3. Respondent shall pay an administrative penalty to the State of Maryland for the violations contained in the Report in the amount of \$6,000 within 30 days of the Consent Order being signed by the Commissioner.
4. All timeframes set forth in the Consent Order may be amended or modified only by written agreement of the Parties.
5. All administrative penalties should be made payable to the Maryland Insurance Administration and include the case number or name. Payment

should be sent to the attention of Ms. Teresa Hochrein at 525 St. Paul Place, Baltimore, MD 21202-2272. Unpaid penalties will be referred to the Central Collection Unit for collections.

6. The undersigned representative of Respondent affirms that he or she has the authority to bind the Respondent to the obligations stated herein.
7. The Consent Order shall be effective upon signature of the Commissioner.
8. Failure to comply with the terms of the Consent Order may subject Respondent to further legal and/or administrative action.

It is so **ORDERED**, this 22nd day of January, 2004.

Alfred W. Redmer, Jr.
Insurance Commissioner

Signature on file with original

by: P. Todd Cioni
Associate Commissioner
Compliance and Enforcement Unit

RESPONDENT'S CONSENT

Respondent hereby consents to the above ORDER.

MICHAEL J STONE

Name

VICE PRESIDENT/CORP SEC'Y

Title

Signature on file with original

1-15-2004

Signature

Date