



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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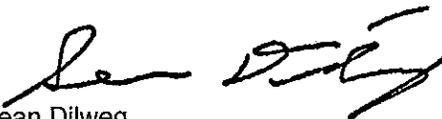
Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

BANKERS LIFE & CASUALTY COMPANY
222 MERCHANDISE MART PLAZA
CHICAGO IL 60654

dated August 7 - 18, 2006 and served upon the company on June 20, 2007, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 6th day of November, 2007.


Sean Dilweg
Commissioner of Insurance

**STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE**

MARKET CONDUCT EXAMINATION

OF

BANKERS LIFE AND CASUALTY INSURANCE COMPANY

AUGUST 7 – 18, 2006

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Wisconsin.gov

September 12, 2006

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Honorable Sean Dilweg
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted of:

BANKERS LIFE AND CASUALTY COMPANY

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Bankers Life and Casualty Company (the company) is organized as a stock company domiciled in Illinois and is a subsidiary of Conseco, Inc., a financial services organization headquartered in Indianapolis, Indiana. Established in 1879, the company was licensed in Wisconsin in 1960. Except for New York, the company is licensed to write business in all states and the District of Columbia.

The company focuses on products for seniors. The company writes Medicare supplement and Medicare Select insurance in Wisconsin. Medicare Select policies differ from Medicare supplement policies in that they provide benefits through a contracted network of providers and require that the policyholder use specific hospitals and doctors to receive full insurance benefits, except in an emergency. Medicare

supplement policies issued in Wisconsin differ from those issued in most other states in that Wisconsin received a waiver from the federal standardization regulations that created Medicare supplement plans A-L. Wisconsin's Medicare supplement policies consist of basic benefits that supplement Medicare, and optional benefit riders that provide Medicare Part A deductible, Medicare Part B deductible, excess charge and foreign travel coverage.

During the period of review, the company offered tax-qualified and non-tax-qualified policies long-term care insurance, including nursing home and home health care insurance policies. Tax-qualified long-term care policies allow for certain federal income tax advantages that allow policyholders to include part or all of the premium paid as part of the deduction for other annual uncompensated medical expenses in excess of 7.5% of adjusted gross income.

The company also writes universal, whole life and term life insurance and deferred, immediate and equity indexed annuities.

In 2004 and 2005 the company reported written premium in all states where it is licensed. The following table summarizes the total direct national premium written in 2004 and 2005 as compared it to the total direct premium written in Wisconsin.

National Direct Business to Wisconsin Direct Business Summary

2005					
	Life Insurance Premiums	Annuity Considerations	A&H Insurance Premiums	Deposit Type Funds	Other Considerations
Wisconsin	\$ 6,512,440	\$ 50,043,178	\$ 52,111,067	\$ -	\$ -
National	\$210,294,505	\$951,288,328	\$1,198,782,670	\$ -	\$ -
<i>Wisconsin As a % of National</i>	<i>3%</i>	<i>5.26%</i>	<i>4.35%</i>		

2004					
	Life Insurance Premiums	Annuity Considerations	A&H Insurance Premiums	Deposit Type Funds	Other Considerations
Wisconsin	\$ 4,157,778	\$ 40,531,630	\$ 53,034,483	\$ -	\$ -
National	\$168,683,178	\$950,691,447	\$1,166,278,453	\$ -	\$ -
<i>Wisconsin As a % of National</i>	<i>2.46%</i>	<i>4.26%</i>	<i>4.45%</i>		

The majority of the premium written by the company in both 2004 and 2005 was for individual accident & health insurance.

The following tables summarize the company's Wisconsin premium written and benefits paid in 2004 and 2005, broken down by line of business.

Wisconsin Life Insurance Business

2005	Ordinary	Credit Life	Group	Industrial
Direct Premiums & Annuity Considerations				
Life Insurance	\$ 6,512,440	-	-	-
Annuity Considerations	\$ 50,043,178	-	-	-
Deposit Type Funds	-	-	-	-
Other Considerations	-	-	-	-
Direct Claims & Benefits Paid				
Death Benefits	\$ 2,296,886	-	-	-
Annuity Benefits	\$ 8,708,078	-	22,029	-
All Others	-	-	-	-

2004	Ordinary	Credit Life	Group	Industrial
Direct Premiums & Annuity Considerations				
Life Insurance	\$ 4,156,722	-	\$ 1,056	-
Annuity Considerations	\$ 40,531,630	-	-	-
Deposit Type Funds	-	-	-	-
Other Considerations	-	-	-	-
Direct Claims & Benefits Paid				
Death Benefits	\$ 2,553,336	-	-	-
Annuity Benefits	\$ 5,584,088	-	22,566	-
All Others	-	-	-	-

In 2004, the company ranked as the 83rd largest writer of life insurance and the 28th largest writer of annuities in Wisconsin. In 2005, the company ranked as the 63rd largest writer of individual life and the 26th largest writer of annuities.

WISCONSIN MEDICARE SUPPLEMENT BUSINESS

The following table summarizes the company's Medicare supplement business for 2004 and 2005.

Wisconsin Medicare Supplement Summary

2005	Premiums Earned	Amount Incurred Claims	% of Premiums Earned - Incurred Claims	No. of Covered Lives
Classification				
<i>Individual Policies</i>				
Most Current 3 Years	\$ 4,808,186	\$ 3,801,587	79.065%	2,9072
All Years Prior to Most Current 3 Years	\$ 31,164,138	\$ 21,724,627	69.710%	11,560
<i>Group Policies</i>				
Most Current 3 Years	\$ 380,065	\$ 310,787	81.772%	257
All Years Prior to Most Current 3 Years	\$ 4,540,558	\$ 3,872,253	85.281	2,385
2004				
Classification				
<i>Individual Policies</i>				
Most Current 3 Years	\$ 5,233,322	\$ 3,821,696	67.252%	3,403
All Years Prior to Most Current 3 Years	\$ 32,887,064	\$ 22,116,820	70.026%	12,718
<i>Group Policies</i>				
Most Current 3 Years	\$ 2,127,301	\$ 1,773,649	83.376%	1,454
All Years Prior to Most Current 3 Years	\$ 2,511,048	\$ 2,006,005	79.887%	1,484

In 2004, the company ranked as 5th largest writer of Medicare supplement insurance in Wisconsin. In 2005, the company ranked as 5th largest writer of these policies in Wisconsin.

WISCONSIN LONG TERM CARE BUSINESS

The following table summarizes the company's long-term care insurance business for 2004 and 2005.

2004						
Line Of Business	Earned Premium	Incurred Claims	Loss Ratio	No. of Policies in force at end of year	No. of Policies Issued	Market Share
Individual LTC	\$ 13,536,559	\$ 15,461,600	114.2%	7,697	711	5 th
Total	\$ 13,536,559	\$ 15,461,600	114.2%	7,697		

2005						
Line Of Business	Earned Premium	Incurred Claims	Loss Ratio	No. of Policies in force at end of year	No. of Policies Issued	Market Share
Individual LTC	\$13,859,880	\$ 12,433,254	90%	7,767	680	5 th
Total	\$13,859,880	\$ 12,433,234	90%	7,767		

In 2004, the company ranked as 5th largest writer of long-term care insurance in Wisconsin. In 2005, the company also ranked as 5th largest writer of these policies in Wisconsin.

Complaints

The Office of the Commissioner of Insurance received 117 complaints involving the company between January 1, 2004 through June 1, 2006. A complaint is defined as 'a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent.' The company's complaints primarily involved marketing and sales followed by policyholder service.

The company ranked 8th on the 2004 complaint summary for life and annuity insurance with 16 complaints and a complaint ratio of .04 compared to a Wisconsin average of .01 complaints per \$100,000 of written premium. The company ranked 13th on the 2005 complaint summary for life and annuity insurance with 14 complaints and a complaint ratio of .03 compared to a Wisconsin average of .01 complaints per \$100,000

of premium written. The company did not rank on the 2004 or 2005 complaint summary for individual health insurance complaints, which includes all categories of individual health insurance products.

The following table categorizes the complaints received involving the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

May 26, 2006						
Reason Type	Total	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H	3	0	0	0	3	0
Medicare Supplement	11	0	8	1	2	0
Medicare HMO	0	0	0	0	0	0
Long Term Care	8	2	1	4	1	0
Individual Life	0	0	0	0	0	0
Individual Annuity	5	0	5	0	3	0
All Others	0	0	0	0	0	0
Total	27	2	14	5	9	0

2005						
Reason Type	Total	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H	3	0	0	1	2	0
Medicare Supplement	21	3	12	8	9	1
Medicare HMO	1	0	0	0	1	0
Long Term Care	7	0	6	6	1	0
Individual Life	7	0	2	0	6	0
Individual Annuity	7	0	11	0	4	0
All Others	1	0	2	0	0	0
Total	47	3	33	15	23	1

2004						
Reason Type	Total	Under writing	Marketing & Sales	Claims	Picyhlder Service	Othe r
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H	5	0	0	4	1	0
Medicare Supplement	12	2	17	4	7	0
Medicare HMO	0	0	0	0	1	0
Long Term Care	12	1	4	14	5	0
Individual Life	7	0	4	4	8	0
Individual Annuity	9	1	5	0	6	0
All Others	0	0	0	0	0	0
Total	45	29	30	26	28	0

Grievances and Independent Review Requests Reported

The company filed grievance reports for 2004 and 2005 indicating it received one grievance in 2005 and none in 2004. The company reported to the OCI that it did not receive any independent review (IRO) requests in 2004 or 2005.

II. PURPOSE AND SCOPE

A targeted examination of the company was conducted to determine whether the company's practices and procedures complied with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2004 through June 18, 2006. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of the company's operations and practices in the areas of company operations and management, claims, electronic-commerce, grievances and independent review requests, policy forms & rates, policyholder services & complaints, privacy, producer licensing, and new business & underwriting.

The targeted examination was also conducted to determine the company's compliance with the provisions of the Medicare Prescription Drugs, Improvement and Modernization Act of 2003 (MMA), the amendments to s. Ins 3.39, Wis. Adm. Code, adopted to comply with the MMA, and s. 632.347, Wis. Stat., regarding suitability of annuity sales to senior consumers, which became effective November 1, 2004.

Prior to the November 1, 2004 effective date of s. 632.347, Wis. Stat., the OCI sent a survey to insurers writing annuities in Wisconsin to obtain information concerning the number and type of annuities issued by each company. Based in part on the information the company provided to the OCI in response to the survey, the OCI requested detailed policy data and further information regarding the company's in-force annuity business and contracts issued during the 3-year period, 2000-2002. The policy

data indicated that the company wrote individual annuities primarily to the senior market, with 76.25% of its new business during 2000-2002 issued to individuals age 65 and above, and 37.18% issued to individuals age 76 and above. During this period, eight of the company's top writing agents of annuities sold more than 50% of their policies to individuals age 65 and above, including two agents who sold 90% or more of their policies to individuals age 65 and above. Since many of the top writers of annuities for the company, including the top writers to seniors, are relatively new agents with no previous insurance experience, it is important that the company monitor and provide oversight of annuity sales, maintain a compliance program, and prohibit unsuitable sales. The OCI's analysis of the company's policy data and information, and the company's complaints involving annuity sales by agents, many of which alleged misrepresentation and unsuitability, concluded that an on-site examination of the company's sales and new business processing of annuities was warranted. The annuity portion of the examination was in major part focused on determining whether the company had sufficient oversight and supervisory control over the company's appointed agents, as required by s. 628.347, Wis. Stat., to ensure that annuity sales to consumers age 65 and above were appropriate and suitable for their needs.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. CURRENT EXAMINATION FINDINGS

Grievances & Independent Review Organization (IRO)

The examiners reviewed the company's response to the OCI's grievance and IRO interrogatory, its written grievance procedures and practices, and its written procedures for handling independent review requests from Wisconsin insureds. Section 632.83, Wis. Stat., provides that every insurer that issues a health benefit plan shall establish and use an internal grievance procedure for the resolution of insureds' grievances with the health benefit plan. The company markets Medicare supplement and Medicare Select insurance policies that meet the definition of health benefit plans.

The company provided the examiners with a copy of the company's plan dictionary referencing form rider 16290-WI, which described the company's grievance and IRO procedures for Wisconsin insureds. The examiners found that the company's procedures required the policyholder or his representative to file a grievance within 60 days after the policyholder received written notice of the company's decision with regard to services or claim practices. Wisconsin grievance regulations do not provide for a time frame for the filing of a grievance. The examiners also found that the company's procedures were not clear with respect to the Wisconsin insurance regulation that allows an insurer to extend by 30 days its review of a grievance in certain situations. Section Ins 18.03 (2) (a), Wis. Adm. Code, provides that each time an insurer offering a health benefit plan denies a claim or benefit or initiates disenrollment proceedings, the health benefit plan shall notify the affected insured of the right to file a grievance. Section Ins 18.03 (6) (b), Wis. Adm. Code, provides that if the insurer offering a health benefit plan is unable to resolve the grievance within 30 calendar days, the time period

may be extended an additional 30 calendar days, if the insurer provides a written notification to the insured and the insured's authorized representative, if applicable, that the insurer has not resolved the grievance, when resolution of the grievance may be expected, and the reason additional time is needed.

1. **Recommendation:** It is recommended that the company revise its form 16290-WI and remove the 60 day time limit imposed on policyholders to file a grievance in compliance with s. Ins 18.03, Wis. Adm. Code.
2. **Recommendation:** It is recommended that the company revise its form 16290-WI to state that for any grievance the plan is unable to resolve within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides written notification to the insured that the insurer has not resolved the grievance; when resolution of the grievance may be expected and the reason additional time is needed to consider the grievance in order to demonstrate compliance with s. Ins 18.03 (6), Wis. Adm. Code.

The examiners reviewed the company's definition of grievance and complaint and its procedures for handling grievances. The company defined a complaint as a written or oral communication primarily expressing a grievance. It defined a grievance as a more formal method for the insured to use in expressing dissatisfaction with a company decision. The company provided copies of amendments attached to Medicare supplement and Medicare Select policies as evidence that it had written procedures for handling Wisconsin grievances. The examiners found that the company was not able to provide specific internal written procedures that accurately defined and made a distinction between complaints and grievances and that clearly explained how it handled grievances. Section Ins 18.01 (2), Wis. Adm. Code, defines a "Complaint" as any expression of dissatisfaction expressed to the insurer by the insured, or an insured's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract. Section Ins 18.01 (4), Wis. Adm. Code, defines a "Grievance"

as any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured. Section 632.83, Wis. Stat., provides that every insurer that issues a health benefit plan shall establish and use an internal grievance procedure for the resolution of insureds' grievances with the health benefit plan.

- 3. Recommendation:** It is recommended that the company revise its written procedures for the handling of grievances to include definitions of complaints and grievances consistent with the definitions in s. Ins 18.01 (2) and (4), Wis. Adm. Code and s. 632.83, Wis. Stat.

The examiners reviewed a copy of the company administrative services agreement with Olympic Health Management Services (OHMS) and other information provided by the company as regards to handling grievances and complaints for its Medicare Select policy. The company delegated to OHMS the handling of complaints and grievances for its Medicare Select policy. Although OHMS had a process for recording and handling complaints, the examiners found that the process was not adequate to ensure that complaints were properly recorded and handled because the company did not review how OHMS was handling complaints. An internal audit of OHMS by the company in January, 2006, identified this deficiency and the company reported that it is in the process of developing an oversight plan to review the manner in which OHMS handles complaints. The examiners also found that OHMS's grievance procedures, like the company's own procedures were not compliant with Wisconsin insurance law because grievances and complaints were not accurately distinguished and defined, and the procedures did not clearly explain how grievances are handled. OHMS reported that it did not receive any grievances during the period of review. The

examiners found that the company had not audited OHMS's grievance process or its identification of and reporting of grievances to ensure compliance with Wisconsin insurance law. Section Ins 18.01 (2), Wis. Adm. Code, defines a "Complaint" as any expression of dissatisfaction expressed to the insurer by the insured, or an insured's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract. Section Ins 18.01 (4), Wis. Adm. Code, defines a "Grievance" as any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of an insured. Section Ins 18.03 (2) (c) 2., Wis. Adm. Code, provides that an insurer offering a health benefit plan that is a preferred provider plan shall do all of the following:

- a. Include in each contract between it and its providers, provider networks and within each agreement governing the administration of provider services, a provision that requires the contracting entity to promptly provide the insurer the information necessary to permit the insurer to respond to complaints or grievances
- b. Require contracted entities that subcontract for the provision of services, to incorporate within their contracts, including subcontracts with health care providers, a requirement that the subcontractor promptly provide the insurer with the information necessary to respond to complaints or grievances
- c. Include in its description of the grievance process a clear statement that an insured may submit to the insurer offering a health benefit plan a complaint or grievance relating to covered services provided by a participating health care provider.
- d. Process and respond to a complaint or grievance
- e. Maintain records and reports reasonably necessary to monitor compliance with the contractual provisions required under this paragraph.

Section Ins 18.06 (2), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall submit a grievance experience report required by s. 632.83 (2) (c) , Stats., to

the commissioner by March 1 of each year. The report shall provide information on all grievances received during the previous calendar year. Section Ins 9.42 (4) (a), Wis. Adm. Code, provides that an insurer that materially relies upon another party to carry out functions under ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07 shall do include in the insurer's compliance program provisions to monitor, supervise and audit the performance of the other party in carrying out the functions.

4. **Recommendation:** It is recommended that the company develop and implement grievance and complaint procedures for vendors that administer its Medicare Select policies to ensure compliance with s. Ins 18.03 (2) (c) 2., Wis. Adm. Code.
5. **Recommendation:** It is recommended that the company revise its current audit of OHMS's grievance process and procedures and its process and procedures for recording and filing annual grievance reports with the OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.
6. **Recommendation:** It is recommended that the company require OHMS to use the definition of complaint and grievance in Wisconsin insurance law in order to accurately record and report grievances and to document compliance with s. Ins 18.01, Wis. Adm. Code.
7. **Recommendation:** It is recommended that the company develop and implement written procedures for a compliance program for its Medicare Select vendor, including provisions to monitor, supervise and audit the performance of the vendor in carrying out the functions to ensure compliance with s. 632.83, Wis. Stat., and s. Ins 18.03 (1) (c) and 9.42, Wis. Adm. Code.

The examiners reviewed the company's internal grievance and independent review (IRO) procedures. The examiners found that although the company's procedures included paragraph "CORR CODE 3WI" to provide notification of the right to independent review, the company utilized "CORR Code 2WI", which did not include notification language. The company confirmed that it did not consistently provide to Wisconsin policyholders the notice of the right to request an independent review

whenever the insurer made an adverse determination or an experimental treatment determination as required by s. Ins 18.11 (2), Wis. Adm. Code and s. 632.835 (2), Wis. Stat. Section Ins 18.11 (2), Wis. Adm. Code, provides that each time an insurer offering a health benefit plan makes an adverse determination or an experimental treatment determination the insurer shall provide a notice to an insured of the right to request an independent review. The notice shall comply with s. 632.835 (2) (b), Stats., and be accompanied by the informational brochure developed by the office, or in a form substantially similar, describing the independent review process. The notice shall be sent when the insurer offering a health benefit plan makes an adverse determination or experimental treatment determination.

- 8. Recommendation:** It is recommended that the company implement paragraph 3WI within 90 days of adoption of the examination report to ensure compliance with s. Ins 18.11 (2), Wis. Adm. Code.

The examiners reviewed the company's training materials used in responding to inquiries from policyholders regarding the independent review process. The company indicated that it used Internal Appeals rider 16163-WI for long-term care policies in Wisconsin. The rider required that a written appeal be filed within 60 days of receipt of the company decision that the policyholder wished to appeal. The rider also provided that if the policyholder did not provide the information requested within 60 days of the requesting date, the company would reconsider the decision based on the information in the file. Section 632.84 (2) (b), Wis. Stat., regarding benefit appeals under certain policies, provides that an insurer offering a Medicare supplement policy, Medicare replacement policy, nursing home insurance policy or long-term care insurance policy shall establish an internal procedure by which the policyholder or the certificate holder or a representative of the policyholder or the certificate holder may

appeal the denial of any benefits under the Medicare supplement policy, Medicare replacement policy, nursing home insurance policy or long-term care insurance policy. An insurer shall describe the procedure in every policy, group certificate and outline of coverage issued in connection with a Medicare supplement policy, Medicare replacement policy, nursing home insurance policy or long-term care insurance policy.

9. **Recommendation:** : It is recommended that the company revise its form 16163-WI and remove the 60 day time limit imposed on policyholders to file a benefit appeal and to provide information in order to comply with s. 632.84, Wis. Stat.

The examiners found that the company filed a summary of benefit appeals for its long-term care and Medicare supplement policies for the calendar years 2004 and 2005 as required by s. Ins 3.55 (5), Wis. Adm. Code.

Policyholder Services & Complaints

The examiners reviewed the company's response to the OCI's policyholder service & complaint interrogatory, the company's complaint handling procedures, and its complaint log. The company's Customer Service Department was responsible for handling questions and requests from policyholders, their representatives and agents about life, health, and annuity policies. The department provided information on policy benefits, premium, claim payments and explanation of all policy features. The department was responsible for making policy changes, including deleting members, ending policies and processing loans.

Prior to the examination, the examiners completed a complaint analysis of 54 health complaints and 17 life and annuity complaints involving the company that were received by the OCI during 2005 and 2006. The top complaint reasons were marketing and sales (37%), claims handling (29%) and policyholder service (29%).

The examiners requested from the company a copy of its life & annuity complaint log and its health complaint log. The company did not have in its complaint handling procedures, a working definition of a "complaint" as regards life and annuity products. The company indicated and its complaint log showed that during the period of review it received a total of 16 complaints; 6 involving life and annuity products and 10 involving accident and health products. The examiners questioned the accuracy of the complaint logs given the low number of complaints recorded compared to the company's volume of business and based on the examiners' experience with other companies writing business in Wisconsin. The company reported that the complaint logs were "complete."

- 10. Recommendation:** It is recommended that the company review its complaint log tracking system and make any changes necessary to ensure that all health insurance complaints are correctly identified and recorded in order to document compliance with s. Ins 18.01 (2) and s. Ins 18.06 (1) Wis. Adm. Code.
- 11. Recommendation:** It is recommended that the company revise and maintain written complaint log tracking procedures to ensure that it has a system to accurately identify, collect, and record complaints involving annuity sales and contracts, as well as develop and maintain written procedures to conduct periodic reviews of the complaint log that are reasonably designed to assist in detecting and preventing violations relating to the suitability of annuity sales to senior consumers as required by s. 628.347 (3), Wis. Stat.
- 12. Recommendation:** It is recommended that the company conduct an audit of its process for identifying, collecting, storing, and reporting complaints and file with the OCI a copy of its audit report in order to document compliance with s. 601.42, Wis. Stat.

Privacy & Confidentiality

Section 610.70, Wis. Stat., regarding medical records privacy, became effective June 1, 1999, and created restrictions on insurers regarding their collection and release of personal medical information that correspond with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements. Chapter Ins 25, Wis. Adm. Code, became effective July 1, 2001, to address the provisions of Gramm Leach Bliley, and is based on the National Association of Insurance Commissioners (NAIC) privacy of consumer financial and health information model regulation.

The examiners reviewed the company's response to the OCI's privacy of consumer financial and health information interrogatory, training manuals and procedures for employees regarding treatment of personally identifiable information, privacy notices, enrollment and disclosure information forms, and employee privacy agreements. The examiners also interviewed the company's privacy officer.

The company's privacy program was developed by the Chief Privacy Office of its parent company Conseco and implemented by the company in 2001. Until a Company downsizing occurred in 2005, the Company had its own privacy office that was assigned responsibility for ensuring day to day compliance with the Company's privacy manual.

The Company privacy office reported to the Conseco Chief Privacy Officer. After the downsizing was completed, the Company's written procedures provided that its legal counsel coordinate duties with Conseco's Chief Privacy Officer at corporate headquarters in Carmel, Indiana to ensure that responsibility was adequately assigned at the Company relative to day to day compliance."

The examiners found that they could not document that the company had a process that followed its procedures for ensuring day to day compliance with the company's privacy manual. The examiners also found that the company did not consistently monitor accountability for staff assigned responsibility for compliance with the company's privacy manual.

The company reported that its legal department monitored and was ultimately responsible for privacy compliance. The company indicated that the Board of Director's Audit Committee received a quarterly report from senior executive management on the state of privacy compliance. When the examiners asked to review these reports the company responded that the reports were "verbal." The company reported that its former chief privacy officer periodically conducted privacy compliance "walk throughs" of work areas, but the company was not able to produce any records to document that this was done or any findings related to this activity were. Subsequent to the completion of fieldwork for the examination, the company provided the examiners documentation that verified the compliance "walk throughs" had been performed. The examiners reviewed an internal privacy audit the company performed in 2004. The audit identified multiple problems including but not limited to; lack of adequate procedural documentation within each business unit, inadequate employee training, inadequate education of management regarding privacy issues and the company privacy program and inadequate safeguards for the handling of protected health information (PHI), i.e. shredding practices, unlocked computers, and unattended PHI.

The examiners reviewed an Internal Audit Report Response draft dated May 5, 2006, responding to the findings of the 2004 internal audit. The report indicated that

the company had taken corrective action to address some of the deficiencies noted in the 2004 audit but had not yet satisfied the audit recommendation that each business unit within the company develop formally documented procedures specific to the company's privacy manual to ensure that employees were properly handling PHI. The report also recommended that each business unit ensure that employees receive adequate training on HIPAA/privacy procedures. The company did not provide the examiners with documentation that it had formal procedures for each business unit or that it had developed a training plan for each of its business units.

13. Recommendation: It is recommended that the company implement a formal structure for reporting on privacy issues to the Board of Directors and others within the company that documents its reporting hierarchy and business unit participation in the privacy compliance process in order to document the company's compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

14. Recommendation: It is recommended that the company implement all of the unsatisfied recommendations in its 2004 internal privacy audit in order to document the company's compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

The examiners documented that the company required its appointed agents sign business associate agreements regarding the confidentiality of medical and personal information in order to meet HIPAA requirements. The company also required its outside vendors sign the business associate agreement, which was attached to the vendor contracts.

Producer Licensing

The examiners reviewed the company's response to the OCI's producer licensing interrogatories, agent agreements, the company's procedures and practices related to producer licensing, listings, terminations and training, and its recruiting processes.

The company's Agent's Licenses Department was responsible for agent appointments and terminations of listings and for maintaining agent files in an electronic format. The department tracked and recorded courses taken by agents leading to industry designation. It was also responsible for entering into the company's electronic internal record the agents that have their license suspended due to lack of continuing education or revocation. The company stated that the electronic record stops any of the suspended agent's business from being processed.

Beginning July 1, 2002, the OCI accepted only electronic agent appointments and terminations through the National Insurance Producer Registry (NIPR) and its authorized business partners. The company contracted with DF Institute, Inc., to utilize its appointpack.com software, and with nomoreforms, inc. for electronic appointments, terminations and license applications.

The company indicated that it used Applicant Insight to conduct its background investigations of agents. The company's branch offices were responsible for requesting background investigation reports through nomoreforms. These background reports were permanently attached to the candidate's file.

The company indicated that it utilized a career agent distribution system within a branch management structure. The branch managers were responsible for

recruiting agents and candidates. The company utilized field trainers, a subset of its career agent force to assist branch management in field training new agents. At the time of the examination, the company had in Wisconsin 160 career agents of which 21 were also field trainers. Both career agents and field trainers were supervised by one or more levels of management, including 6 unit supervisors, 6 unit sales managers and 6 branch sales managers. The company divided the state of Wisconsin into territories with offices in Madison, Janesville, La Crosse, Milwaukee, Green Bay, and Wausau.

The company stated that it required all producer agents to have an Agent Contract with the company prior to submitting business. The company did not use general agents. The company did not contract with brokers and did not accept brokerage business.

The examiners requested from the company a listing of all Wisconsin agents that represented the company as of the date the listing was run. The agent listing data provided by the company was compared with the agent data base maintained by the OCI. The examiners found clerical errors by the company that resulted in the following discrepancies:

- one agent who was terminated in February 2006 was included in the company's data base of active agents,
- one agent included in the company's data base of active agents was not listed with the company,
- one active agent was not included in the company's list of active agents,
- one agent was appointed but never contracted to sell insurance for the company and should have been terminated,
- one agent was terminated in 2005 but the termination was not reported to the OCI.

In addition, the company database included 88 active agents that did not appear in the OCI active agent database for the company. The company indicated that

these agents were appointed with the company but did not appear in the data call because the programmer only pulled records with "BLC" indicators. The agents were identified in the company's agent database with the following indicators: WIW-Wisconsin Insurance World organization. The agents were appointed to sell Medicare supplement policies. The company will determine who in this group should remain active and who should be terminated. GRP=Group-These are agents who were appointed but the company does not accept applications from them. No new business was written by these agents during the examination review period. The company will terminate all of these agents. CPL=Colonial Penn Life-These are non-resident agents contracted as telemarketers but the plan to use these agents to sell the company's products was never implemented with Colonial Penn Life.

Although the company had process and procedures in place providing that when it received the Wisconsin Appointment Action Notice from the OCI, that it verify information with its internal agent database and Wisconsin's agent website, the examiners found that the company did not consistently follow its procedure and process. Section Ins 6.57 (1), Wis. Adm. Code, regarding appointment of insurance agents by insurers, provides that

- Submission of an application for an intermediary-agent appointment shall initiate the appointment of an agent in accordance with s. 628.11, Stats. The application shall be submitted to the office of the commissioner of insurance and entered in the OCI licensing system in a format specified by the commissioner within 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted and shall show the lines of authority being requested for that agent.

Section Ins 6.57 (2), Wis. Adm. Code, provides that:

- notice of termination of appointment of individual intermediary in accordance with s. 628.11, Stats., shall be filed prior to or within 30

calendar days of the termination date with the office of the commissioner of insurance. Prior to or within 15 days of filing this termination notice, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative of the company and that he or she may not act as its representative. This notice shall also include a formal demand for the return of all indicia of agency.

15. Recommendation: It is recommended that the company revise its existing procedures to include an annual audit of its agent data base to better ensure the accuracy of the data to document compliance with the agent appointment provisions under s. Ins 6.57, Wis. Adm. Code.

The examiners requested from the company a random sample of 50 active and 50 terminated agent files for review. The examiners found that four of the 50 files did not contain a copy of the agent's Wisconsin license although the company's procedures provided that a copy was maintained in each agent's file. The examiners found that none of the 50 terminated agent files contained a copy of the required termination letter requesting the return of all company indicia. The company was subsequently able to produce the termination letters, which were found to be in compliance with the content requirements of s. Ins 6.57, Wis. Adm. Code. However, the template termination letters provided in response to the Producer Licensing interrogatories were not in compliance with the content requirements of s. Ins 6.57, Wis. Adm. Code, in that there was no demand for terminated agents to return all evidence of indicia to the company.

16. Recommendation: It is recommended that the company revise its agent termination procedures to ensure that termination letters comply with the return of indicia requirements of s. Ins 6.57 (2), Wis. Adm. Code.

In responding to questions in the producer licensing interrogatory concerning the handling of premium refund checks for Medicare supplement policies, the company included a procedure, "Collecting The Balance Of An Advance Mode Premium During

Policy Delivery," which provided that refund checks were sent to the Branch Offices for delivery to the insured by the agent. This practice is prohibited by s. Ins 3.39 (14) (b) Wis. Adm. Code, which requires that refund checks for Medicare supplement policies be mailed directly to the insured. When questioned regarding this procedure, the company produced a different written procedure that was state specific to Wisconsin and complied with s. Ins 3.39 (14) (b), Wis. Adm. Code, but the company was unable to provide any documentation to verify the history of the Wisconsin specific procedure and the document itself contained no dates or other identifiers.

17. Recommendation: It is recommended that the company, when drafting and implementing written procedures, create a record of the implementation of the procedure and maintain a record of any revisions to the procedure to better enable the OCI's examination of the company and to verify compliance with Wisconsin insurance laws and regulations.

The examiners reviewed the company's commission schedules for its Medicare supplement and long-term care insurance policies. No exceptions regarding the commissions reviewed were noted.

Advertising

The examiners reviewed the company's response to the OCI's marketing, sales, and advertising interrogatories, its advertising activities, policies and forms used by the company during the period of review and the company's advertising file.

The examiners reviewed a random sample of 50 advertisements in the company's advertising file, which included Medicare supplement, long-term care and life and annuity advertisements. The examiners also conducted a comparison of the Medicare supplement advertisements in the company's advertising file with the OCI's policy form database of Medicare supplement advertisements filed with the OCI. Section Ins 3.39 (15), Wis. Adm. Code, regarding filing requirements for advertising, requires that prior to use in this state, every issuer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement or Medicare cost policies. The company's agent agreement included a provision requiring prior approval of advertisement made, published or circulated by an agent. No exceptions were noted regarding the advertisements reviewed.

The examiners reviewed the company's Pro-Pack form 15298A Medicare Select, used by agents for clients applying for Medicare Select coverage. The form packet contained policy form 11647-WI, which contained grievance and complaint information used for Medicare Select policies. The examiners found that form 11647-WI did not contain the grievance and IRO language required by Wisconsin insurance laws and regulations, and contained the wrong address for the Office of the Commissioner of insurance.

18. Recommendation: It is recommended that the company revise its Medicare Select policy form to state that grievances will be

acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by s. Ins 18.03 (4), (6) and Ins 18.05, Wis. Adm. Code and s. 632.835, Wis. Stat.

The examiners requested a list of Medicare Supplement applications accepted and a list of Medicare Supplement policies issued with effective dates of January 1, 2006 through June 1, 2006. The examiners found four policies issued on policy form GR-A031HD or the High Deductible policy with a January 1, 2006 effective date. Section Ins 3.39 (5) (k), Wis. Adm. Code, provides that the high deductible plan may be issued only prior to December 31, 2005 or renewed thereafter in accordance with s. Ins 3.39 (29) (b) 1., Wis. Adm. Code. The company indicated that all four applications were processed and policies produced prior to December 31, 2005 but have January 1, 2006 effective dates.

19. Recommendation: It is recommended that the company comply with Wisconsin insurance law regarding limitations on issue dates of policies, such as the limitations under s. Ins 3.39 (5) (k), Wis. Adm. Code.

Electronic-Commerce

The examiners reviewed the company's response to OCI's electronic commerce interrogatory and the company's corporate website www.bankerslife.com and domains. The corporate website offered general information concerning the company's products and allowed visitors to request additional information on various products by completing a contact request form. Requests for additional information were forwarded to the appropriate local branch office for follow up contact. The company did not accept applications for coverage electronically and had no written electronic commerce marketing plan for possible future use.

The company maintained a log in and password protected website designed to allow agents access to claims, training guides commissions, policy information, regulatory updates and marketing materials. Agents were not allowed to create their own website advertising the company's products.

The company's Market Access Department was responsible for managing website content and the Distribution Technology Department was responsible for technical tasks associated with development and maintenance.

No exceptions were noted.

Policy Forms and Rates

The examiners reviewed the company's response to the OCI's policy forms & rates interrogatory and its policies, riders, applications, outlines of coverage, and replacement, reinstatement and suitability forms that were used or in effect during the period of review. The company's Product Approval and Compliance Department was responsible for form filings and for initial rate filings. The department also had oversight over compliance with state and federal insurance laws and regulations, filed all forms, new product rates and advertising for all product lines.

The company had approved tax-qualified and non-tax-qualified long-term care policies and nursing home and home health care insurance policies. The company had inflation protection and non-forfeiture benefit riders for these policies that met the requirements of s. Ins 3.46 (11) and (19) (a), Wis. Adm. Code.

The company filed during the period of review a premium rate increase for its long-term care insurance policies effective beginning April 2006. The rate increase applied to its policy forms generally sold from 1988 through 2003. The company agreed to implement the 35% rate increase in two stages, a 20% increase in 2006 and the remaining percent a year later.

The company had approved Medicare supplement and Medicare select policies for use in Wisconsin. The company had filed during the period of review annual premium rate increases for its Medicare supplement policy forms.

Claims

The examiners reviewed the company's response to the OCI's claims interrogatory, claim procedure manuals, internal audit reports and explanation of benefit (EOB) and remittance advice (RA) forms, claim adjustment (ANSI) codes, and claim payment methodology. The claim review was limited to Medicare supplement, Medicare select, and long-term care insurance policies.

The company contracted with Family Caring Network (FCN) and integrated Assessment Services Network (IASN) for clinical assessment interviews as part of its requirement for coverage after it received an application for long term care insurance.

The company contracted with Olympic Health Management System, Inc., Bellingham, Washington for claims administration services. It contracted with Express Scripts, Inc. to service the prescription drug benefit under its Medicare supplement policies.

The examiners reviewed a random sample of 100 paid and 100 denied Medicare and Long Term Care claims processed during the period of review for compliance with Wisconsin's claim settlement, standardization and disclosure regulations. The examiners found that the company did not use as "claim adjustment reason codes" on the explanation of benefit (EOB) forms and remittance advice (RA) forms for its Medicare supplement and Medicare Select business the claim disposition codes of the American national standards institute accredited standards committee X12 (ASC X12), ANSI codes. Rather the company used standard paragraphs in letters to insureds that explained the actions of the company in adjusting claims. Section Ins 3.651 (3) (b) 4. I and (4) (a) 5. f, Wis. Adm. Code, provide that the EOB and RA forms

include for each claim on a single line each claim adjustment reason code, unless the claim is adjusted solely because of a deductible, copayment or coinsurance or a combination of any of them.

The examiners found that the company did not use the required format for its explanation of benefits (EOB) and remittance advice (RA) forms for its Medicare supplement and Medicare select business. Rather, it used a form attached to the claim checks, which contained some, but not all, of the information required by s. Ins 3.651 (3) and (4) Wis. Adm. Code.

20. Recommendation: It is recommended that the company use ANSI codes on the Explanation of Benefit (EOB) form sent to the claimant and the Remittance Advice (RA) form sent to providers for its Medicare supplement and Medicare Select business as required by s. Ins 3.651 (5), Wis. Adm. Code.

21. Recommendation: It is recommended that the company develop and implement the use of a Remittance Advice (RA) form for its Medicare supplement and Medicare select business that complies with all of the informational and format requirements of s. Ins 3.651 (3) (b) 4.b., d., i.; and (d), Wis. Adm. Code.

22. Recommendation: It is recommended that the company develop and implement the use of an Explanation of Benefits (EOB) form for its Medicare supplement and Medicare select business that complies with all of the informational and format requirements of s. Ins 3.651 (4) (a) 2.,3.,5.c.,e.,f.,g.,h.,i.;6.,7.,8., Wis. Adm. Code.

The examiners requested from the company a copy of its case management guidelines and criteria for long term care, nursing home and home health business. The company responded that it did not provide case management services. However, the examiners found that the company's organizational chart for the claims department showed a unit called "Case Management." The company indicated that the title of the department may be misleading in that the Case Management Department provided only limited patient care coordination, such as the names of qualified providers of service.

The examiners found that the company provided information to the OCI for inclusion in the OCI's 2004 and 2005 *Long-Term Care Insurance Approved Policies in Wisconsin* booklets indicating that care coordination and case management were included as a basic benefit in policy forms GR-N350 and GR-N380. The examiners found that the company provided to the OCI for inclusion in its 2006 *Long-Term Care Insurance Approved Policies in Wisconsin* booklet information indicating that care coordination and case management were provided as a basic benefit in policies GR-N520 and GR-N550. The company reported that the person who completed the survey felt that the OCI definition of Care Coordinator and Case Management were similar so included both in the survey although the policy does not have language regarding case management. Policy forms GR-N520 and GR-N550 contained the definition of Patient Care Coordinator. The definition indicated that the coordinator was qualified by license, training or experience to help the Family Member select providers of care and services best suited for the type of care or treatment needed.

23. Recommendation: It is recommended that the company resubmit information to the OCI regarding its long term care policies for inclusion in the OCI's *Long-Term Care Insurance Approved Policies in Wisconsin* booklet.

24. Recommendation: It is recommended that the company institute a process, including verifying information sent to the OCI for inclusion in its consumer guides, and assigning oversight of the reporting.

New Business and Underwriting

The examiners reviewed the company's response to the OCI's new business & underwriting interrogatories, rating manuals, underwriting manuals, applications, premium, lapse and termination notices, suitability guidelines, agent medical underwriting guide, submission rules and training manual.

Medicare Supplement Insurance

The examiners reviewed a random sample of 50 not taken Medicare supplement applications. The examiners found three applications dated in 2006 for policy form GR-A031(99) and prior to the date the 2006 outline of coverage for the policy form had been submitted and approved by the OCI. Section Ins 3.39 (4) (b), Wis. Adm. Code, provides that an outline of coverage be provided to all applicants at the time application is made that properly describes the policy as issued.

25. Recommendation: It is recommended that the company develop and implement marketing and underwriting processes and procedures requiring that the company have approved outlines of coverage per calendar year prior to marketing or accepting applications for the corresponding Medicare supplement policy form in order to comply with s. Ins 3.39 (4) (b), Wis. Adm. Code.

The examiners reviewed a random sample of 50 not issued Medicare supplement new business applications. The examiners found three applications where the applicant indicated they were replacing coverage but no replacement form was completed. The company reported that it did not require replacement forms when the applicant was requesting to change from one of the company's policies to another. Section Ins 3.39 (23) (c) and (d), Wis. Adm. Code, requires that upon determining that a sale will involve replacement, an insurer shall furnish the applicant prior to issuance or delivery of the Medicare supplement or Medicare cost policy or certificate, a notice

regarding replacement of accident and sickness coverage. One copy of the notice signed by the applicant and the agent shall be provided to the applicant and an additional signed copy shall be retained by the issuer.

The examiners found four applications written by its agents and submitted to the company more than 90 days before the applicants turned age 65. The company's underwriters declined coverage for the applications. Section Ins 3.39 (25) (d), Wis. Adm. Code, provides that an agent may not take and an issuer may not accept an application from an insured more than 3 months prior to the insured becoming eligible.

26. Recommendation: It is recommended that the company develop and implement underwriting processes and procedures requiring completed replacement forms for all replacements, to document compliance with s. Ins 3.39 (23) (c) and (d), Wis. Adm. Code.

27. Recommendation: It is recommended that the company provide notice to its agents that internal replacements require notification to the applicant regarding replacement and completion of the company's replacement form.

28. Recommendation: It is recommended that the company develop and implement procedures to better ensure that applications are not taken by agents or accepted by the company more than 90 days before an applicant turns age 65 to comply with s. Ins 3.39 (25) (d), Wis. Adm. Code.

The examiners reviewed a random sample of 50 issued Medicare supplement policies. The examiners found 28 applications from open-enrollment applicants where the company used and the applicants completed medical records release authorization forms. The company reported that the same application kit was used for open enrollment and underwritten applications. The company reported that although open enrollment applicants completed and signed the application forms that stated "DO NOT COMPLETE QUESTIONS 6 AND 7 IF GUARANTEED ISSUE", its underwriting department did not collect medical information on applicant's who were in open

enrollment status, and therefore should not have completed this portion of the application. The examiners found that agents were not making it clear to applicants that they did not have to complete the authorization portion of the form and that the company's underwriting department was not contacting or providing instructions to the agents when the information was not required. Section Ins 3.39 (4m), Wis. Adm. Code, regarding open enrollment, provides that an issuer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement coverage, Medicare cost or Medicare select policies permitted under subs. (5) , (7) and (30) or riders permitted under sub. (5) (i) for which an application is submitted prior to or during the 6-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B or the month in which an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 on any of the following grounds: Health status; Claims experience; Receipt of health care; Medical condition.

29. Recommendation: It is recommended that the company cease using medical authorization forms for Medicare supplement applicants in an open enrollment period in order to document compliance with s. Ins 3.39 (4m), Wis. Adm. Code.

The examiners found that when taking applications for Medicare supplement policies agents used the company's questionnaire entitled: "Fact Finder" that requested detailed medical and financial information of Medicare supplement applicants. The company maintained that this questionnaire was not part of the application submission documents but rather was used to determine the additional coverage or changes to existing coverage that may be appropriate. The company stated that if an agent inadvertently submitted the completed questionnaire to the company with the Medicare

supplement application, the application was reviewed without regard to any medical information disclosed in the questionnaire. The examiners found that the company's use of the "Fact Finder" for Medicare beneficiaries applying for Medicare supplement coverage during their open enrollment period resulted in beneficiaries inadvertently disclosing medical information that was not required and that its Fact Finder was a marketing tool to gather information regarding beneficiary finances.

30. Recommendation: It is recommended that the company cease using the "Fact Finder" questionnaire when agents are soliciting any Medicare beneficiary for Medicare supplement coverage to ensure compliance with the marketing standards of s. Ins 3.39 and Ins 3.39 (4m), Wis. Adm. Code.

In reviewing the sample of Medicare supplement issued policies, the examiners found the following errors in the application process:

- One application for an applicant applying during open enrollment indicated that the application was for new coverage rather than an open enrollment application.
- One application contained an application date of August 2, 2005 for an application that was processed on May 5, 2005.
- One application indicated applicant requested an issue date of February 1, 2002 for an application that was signed on November 10, 2005.
- One application originally signed by the applicant on September 22, 2005 was not submitted by the Branch Sales Office until October 26, 2005 thus requiring the applicant to resign the application on November 11, 2005.
- One application in open enrollment contained responses to medical questions even though the application provided that applicants in their open enrollment period should not complete these questions.

Section 623.34, Wis. Stat., provides that no person who is or should be licensed under chs. 600 to 646, no employee or agent of any such person may make or cause to be made any communication relating to an insurance contract, the insurance business, any

insurer or any intermediary which contains false or misleading information, including information misleading because of incompleteness.

31. Recommendation: It is recommended that the company review and update as necessary its agent instructions for submitting applications, and its new business and underwriting procedures and schedule and document training it deems necessary to ensure that applications for coverage are properly completed in compliance with s. 628.34, Wis. Stat.

32. Recommendation: It is recommended that the company include as a procedure step for its internal audits the review of applications to document that unnecessary application information is not obtained or retained and that applications are timely submitted in order to document compliance with s. Ins 3.39 (4m), Wis. Adm. Code.

Long-Term Care Insurance

The examiners reviewed a random sample of 50 long-term care issued files and 50 declined applications.

The company contracted with two vendors as part of its underwriting process for long-term care insurance applications to conduct face-to-face interviews of applicants age 72 to 89. The company provided a copy of document provided to agents, form 14712-5, titled "Annual Premium Rates and Submission Rules for Tax Qualified Home Health Care Policy GR-N400 and Home Health Care policy GR-N410", policies that were marketed in Wisconsin beginning October 1, 2001. The examiners found that page two of the form indicated that an attending physician statement was required for all persons age 80-84. The company acknowledged that it did not investigate with an exam, assessment or medical report home health applications for ages 75-79 applicants. Section Ins 3.46 (10) (a), Wis. Adm. Code, provides that no insurer may issue a long term care policy to an applicant 75 years of age or older, unless prior to issuing they obtain one of the following: a copy of a physical exam, an assessment of functional capacity, an attending physician statement or copies of

medical records. The definition of a long-term policy as found in s. Ins 3.46 (3) (e), Wis. Adm. Code, includes home health care policies.

The examiners found that page four of form 14712-5 provided that reinstatement of home health care policies was allowed through age 84 and 11 months subject to the rules shown in the booklet and the policy's reinstatement provision, and that policies lapsed 181 or more days would not be reinstated. The document did not inform agents of the requirements of s. Ins 3.46 (15) (a), Wis. Adm. Code, which requires that as part of the application, an insurer shall obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a notice of lapse or termination or sign a waiver of these rights.

33. Recommendation: It is recommended that the company update its written guidelines to require that prior to issuing a home health care policy it obtain a copy of a physical exam, or an assessment of functional capacity, or an attending physician statement or copies of medical records in order to comply s. Ins 3.46 (10) (a), Wis. Adm. Code.

34. Recommendation: It is recommended that the company update its written guidelines to address the requirement that the company obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a lapse or termination notice or sign a waiver of these rights to ensure compliance with s. Ins 3.46 (15) (a), Wis. Adm. Code.

The examiners found that the company's suitability guidelines met the minimum standard under s. Ins 3.46 (16), Wis. Adm. Code, and that it used a Long-Term Care Insurance Personal Worksheet that contained, at a minimum, the information in the format contained in Appendix 2. The examiners documented that the issued and declined application files reviewed included the personal worksheet completed by the applicants as required by s. Ins 3.46, Wis. Adm. Code. The examiners also documented that when the company determined that the applicant did

not meet its financial suitability standards, or if the applicant declined to provide the information, the company's files contained a suitability letter similar to that in s. Ins 3.46, Appendix 4, Wis. Adm. Code.

The examiners documented that the company filed reports with the OCI for the period of review regarding rescissions as required by s. Ins 3.46 (10) (c), Wis. Adm. Code.

Life & Annuity Insurance

The examiners reviewed the company's responses to the OCI's new business & underwriting interrogatories, underwriting and rating manuals, applications, premium, lapse and termination notices for Individual Life and Annuity products. The examiners also conducted interviews with the manager of the Annuity New Business section, the company's Associate General Counsel and the Territory Vice-President for Wisconsin, as well as the company's agent training managers.

Annuity Suitability

2003 Wisconsin Act 261, provides that recommendations for the purchase or exchange of annuities made beginning November 1, 2004 comply with the provisions of s. 628.347, Wis. Stat., regarding suitability of annuity sales to senior consumers. The statute provides that insurers and, under certain circumstances, agents maintain a suitability compliance program for the sale of annuities to seniors age 65 and over, and prohibits unsuitable sales of annuities to senior consumers.

The examiners found that the company took steps to comply with s. 628.347, Wis. Stat. by developing an annuity suitability questionnaire to collect information concerning an individual's financial goals and situation, and by identifying certain

inconsistent or problematic responses to alert the individuals who process new annuity applications of a product's possible unsuitability. The company began using this form for all annuity sales to consumers age 65 and older effective November 1, 2004, and for annuity sales to all ages effective August 1, 2006. The company also developed training materials designed to help agents better determine a suitable annuity sale, and instruct them on the new annuity suitability requirements in Wisconsin that were sent to all Wisconsin agents and agencies in September, 2004. The materials became part of the company's annuity Agent Guide, and were used in mandatory classroom and online training provided new agents through the Bankers Learning Network. The examiners reviewed the materials, and found that they provided important guidelines and standards that agents should follow when determining the suitability of an annuity sale.

The company provided the examiners a copy of a compliance procedural memorandum from March 5, 2005, the purpose of which was to provide documentation for implementation of procedures to comply with the new senior protection in annuity transactions regulation. The memorandum stated that the suitability of annuity sales would be assessed in the field and would be confirmed at the home office. The memorandum included underwriting guidelines concerning annuity suitability that were given to new business processors to use when reviewing annuity applications and annuity suitability questionnaires, and determining whether the policy was suitable for the applicant's needs. The memorandum provided only general guidelines that the new business processors should follow when reviewing the annuity suitability questionnaire. These included checking that all the questions on the form were answered, and whether the questions asking whether the applicant understood the nature of the annuity or that

there may be surrender penalties in transferring funds to a new annuity were answered affirmatively. Although the procedural memorandum stated that new business processors should ask themselves questions such as "Is the annuity appropriate given the future needs of the consumer?", and "Does the client have sufficient monthly income or other assets to live comfortably?" the memo provided no written standards that new business processors should apply or use when making such determinations. The company stated to the examiners that the manager of the annuity new business team had instructed new business processors to refer all new applications where an annuity was replacing an existing policy and the applicant would be incurring a surrender charge of 5% or more on the prior policy, to the team supervisor. Effective August 17, 2006, if the applicant was placing greater than 50% of his/her assets in an annuity, or if there was any information on the annuity suitability questionnaire that would question the suitability of the sale, the new business processors were instructed to refer the application to the team supervisor. The supervisor further reviewed the application and determined whether a statement from the branch sales manager or applicant was required to support the suitability of the sale. The company also stated that its new business processors were instructed to review the new application and the information on the annuity suitability questionnaire to determine whether the applicant would have sufficient monthly income or assets to meet the applicant's monthly expenses, and whether the withdrawal and annuitization provisions of the applied for annuity were adequate relative to the applicant's future needs. However, the examiners found that the annuity suitability questionnaire completed by the applicant did not ask for information concerning the applicant's monthly expenses that would be necessary for

the new business processor to make such a determination. Without this additional information and written procedures and guidelines instructing new business processors on how to analyze the application and information in the questionnaire to determine suitability, crucial information necessary to make a suitability determination could be missed or overlooked.

The procedural memorandum stated that all annuity applications deemed to be unsuitable sales by new business processors or team supervisors were to be rejected with the code, "7V – Applicant doesn't meet suitability requirements." The company stated that during the period of review, January 1, 2004 to June 30, 2006, the company issued 3,603 annuities, of which 1,001 or 27.8% involved replacement, yet, beginning November 1, 2004, no annuity applications were declined with the reason code, "7V."

The examiners concluded that the company did not have sufficient agent oversight and supervisory control with respect to new annuity sales. Although the company appeared to have substantial training materials with respect to the marketing and suitability of annuities to seniors, the company lacked sufficient procedures to adequately confirm that annuity sales were suitable for consumers' needs. The company's annuity suitability questionnaire failed to obtain sufficient financial information for its new business processors to make a determination whether the sale was suitable, new business processors lack formal written guidelines and procedures to implement limited suitability standards that were used to make such determinations, and the company lacked appropriate procedures to record and monitor consumer complaints that involved agent sales practices and suitability of annuity products. The

examiners found that the company needs to develop and implement procedures to more consistently and thoroughly review applicants' financial information so it can better determine the suitability of a sale through formal written standards.

35.Recommendation: It is recommended that the company develop and implement comprehensive written procedures and guidelines for its new business processors to use to determine the suitability of an annuity sale to a senior consumer to ensure compliance with the requirements of s. 628.347 Wis. Stat.

36.Recommendation: It is recommended that the company review and amend its Annuity Suitability Questionnaire, form LA-16298, to include additional information concerning the applicant's current and future financial needs, including monthly expenses, and any other information that is reasonably appropriate for determining the suitability of the sale as required by s. 628.347 (2) (b), Wis. Stat.

Life & Annuity Replacement

The examiners reviewed the company's responses to the OCI's Life and Annuity Replacement interrogatory. The examiners reviewed a random sample of 100 applications for individual life and annuity policies issued and denied during the period of review. The examiners found one instance in which the replacement notice required by s. Ins 2.07 (3) (b), Wis. Adm. Code, was not included with a new application that indicated replacement was involved. The company indicated that the processor should have pended the application until the required form was received as required by s. Ins 2.07 (5) (a) 4., Wis. Adm. Code. The examiners also reviewed a random sample of 10 files involving high volume annuity replacement.

Although the company, in response to the OCI's interrogatory request, explained its procedures on handling applications where replacement was involved, the company had no written procedures or guidelines for its new business processors that referenced the specific requirements of Wisconsin replacement regulations contained in

s. Ins 2.07, Wis. Adm. Code. The agent training materials relating to life and annuity replacements that the company provided the examiners also did not reference the specific requirements of Wisconsin replacement regulations and replacement notice contained in s. Ins 2.07, Wis. Adm. Code.

The company provided the examiners information concerning the number and percentage of life and annuity policies issued that involved internal and external replacement as well as the total number of issued life and annuity policies for each year during the period of review, 2004 to 2006. The examiners noted that the percentage of new policies issued that involved replacement had increased from 2004 to the end of the period of review in 2006. The percentage of new life policies involving replacement increased from 3.3% to 16%. The percentage of new annuity policies involving replacement increased from 21.5% to 31.6% during the same period. The company did provide the examiners sample copies of the life and annuity replacement reports it created on a monthly and quarterly basis that showed the volume of internal and external replacements as compared to the total life and annuity issued business for each branch sales office and at the company level. The company indicated that the replacement reports were circulated to company personnel, including the divisional vice presidents.

A watch list of branch sales offices with more than 33% replacements in any given quarter was prepared and reviewed by Agency Relations. The report was also sent to Territory Vice Presidents so they could monitor individual branch offices in their territory. Additionally, the quarterly reports were sent to Internal Audit, Consumer Relations, Compliance, and Consec Tax.

The company stated that Agency Services required the branch office manager of offices exceeding 33% replacements to provide a written response identifying the reasons for the replacement activity trends and confirming the replacement business submitted by the office was in the best interest of the customers. In addition, there was a report that identified individual agents exceeding 33% replacement with 10 or more issued policies for a quarter. The company indicated that the appropriate Branch Sales Manager and Agency Relations Department reviewed the individual sales for agents on the agent watch list.

When reviewing the report for the first quarter of 2006, the examiners identified nine agents with replacement percentages over 33% within one particular sales office that as a whole had only a 25.7% replacement percentage. Due to the high number of individual agents exceeding 33% replacement activity, the examiners asked whether the Branch Sales Manager was required to provide an explanation of the high replacement activity. The company responded that although the Branch Sales Manager and Agency Relations Department would have reviewed the individual sales for the agents on the watch list, the Sales Manager was not required to provide an explanation why there were so many individual agents within the office with excessive replacement percentages, since the Branch Office's total replacement percentage was less than 33%.

The examiners found that the company lacked formal written procedures for the internal processing of applications involving the replacement of existing life and annuity coverages. Although the company had processes and training in place for

agents regarding replacement situations, it did not have internal written procedures for employees to follow when handling replacement applications.

37. Recommendation: It is recommended that the company develop and implement comprehensive written procedures for the internal processing of life and annuity applications that involve the replacement of existing life and annuity coverages to ensure compliance with the Wisconsin specific requirements of s. Ins 2.07 (5), Wis. Adm. Code.

38. Recommendation: It is recommended that the company develop and implement written procedures and materials for training its agents on the specific Wisconsin replacement requirements of s. Ins 2.07, Wis. Adm. Code.

Company Operations & Management

The examiners reviewed the company's response to the OCI's company operations & management interrogatory, and its network and provider agreements.

The examiners reviewed the company's contracts with Family Caring Network (FCN) and Integrated Assessment Services Network (IASN), which provide clinical assessment interviews of applicants for its long-term care insurance products. The examiners also reviewed the company's contract with Olympic Health Management System, Inc., which provides administrative services for its Medicare select policy.

Beginning January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) contracted with plan sponsors to provide Medicare Part D prescription drug plan (PDP) coverage as part of the Medicare program. The company chose not to contract with CMS as a Part D PDP plan sponsor. However, the company teamed with Covenant Health Care whereby the company's agents marketed three different AdvantraRX Medicare Part D prescription drug plans (PDP). Company agents that market the Coventry PDP must be contracted with KF Agency, the paymaster for PDP commissions.

The OCI questioned the company regarding complaints it had received regarding the operation of a prelicensing education school for agents operating under the name of Bankers Life & Casualty Prelicensing Education School. The company reported that there was no relationship between Bankers Life & Casualty Company and the prelicensing school other than the fact that the school's operator was a company branch sales manager. The company indicated that it had not authorized the agent to use the company name and was not aware of the situation until the August 17, 2006

meeting with the OCI. The company indicated it instructed the branch sales manager to discontinue the school immediately and to forward all material related to the school's operation to the company for review and approval before continuing the program.

The company indicated that it had down-sized, resulting in terminating personnel. It reassigned some responsibilities to other company personnel, and other responsibilities were assumed by its parent company, Consecro, Inc. Although at the time of the examination the company may still have been in the transition phase of reassignment of responsibilities, the examiners had concerns regarding whether the down-sizing of personnel would impact the company's ability to exercise sufficient oversight and supervision of its existing procedures and processes.

IV. CONCLUSION

This market conduct examination involved a targeted review of Bankers Life and Casualty Company's practices and procedures for the period January 1, 2004 to June 30, 2006. The lines of insurance reviewed included Medicare supplement, long-term care and individual life & annuity policies. The examination report contains 38 recommendations as regards the company's practices in all areas of operation.

V. SUMMARY OF RECOMMENDATIONS

Grievances & Independent Review (IRO)

- Page - 11 1. It is recommended that the company revise its form 16290-WI and remove the 60 day time limit imposed on policyholders to file a grievance in compliance with s. Ins 18.03, Wis. Adm. Code.
- Page- 11 2. It is recommended that the company revise its form 16290-WI to state that for any grievance the plan is unable to resolve within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides written notification to the insured that the insurer has not resolved the grievance; when resolution of the grievance may be expected and the reason additional time is needed to consider the grievance in order to demonstrate compliance with s. Ins 18.03 (6), Wis. Adm. Code.
- Page- 12 3. It is recommended that the company develop detailed and complete written procedures for the handling of grievances to include definitions of complaints and grievances consistent with the definitions in s. Ins18.01 (2) and (4), Wis. Adm. Code and s. 632.83, Wis. Stat.
- Page- 14 4. It is recommended that the company develop and implement grievance and complaint procedures for vendors that administer its Medicare Select policies to ensure compliance with s. Ins 18.03 (2) (c) 2., Wis. Adm. Code.
- Page- 14 5. It is recommended that the company audit OHMS's grievance process and procedures, and its process and procedures for recording and filing annual grievance reports with the OCI to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.
- Page- 14 6. It is recommended that the company require OHMS to use the definition of complaint and grievance in Wisconsin insurance law in order to accurately record and report grievances and to document compliance with s. Ins 18.01, Wis. Adm. Code.
- Page- 14 7. It is recommended that the company develop and implement written procedures for a compliance program for its Medicare Select vendor, including provisions to monitor, supervise and audit the performance of the vendor in carrying out the functions to ensure compliance with s. 632.83, Wis. Stat., and s. Ins 18.03 (1) (c) and 9.42, Wis. Adm. Code.
- Page- 15 8. It is recommended that the company implement paragraph 3WI within 90 days of adoption of the examination report to ensure compliance with s. Ins 18.11 (2), Wis. Adm. Code.

Page- 16 9. It is recommended that the company revise its form 16163-WI and remove the 60 day time limit imposed on policyholders to file a benefit appeal and to provide information in order to comply with s. 632.84, Wis. Stat.

Policy Holder Services & Complaints

Page- 18 10. It is recommended that the company review its complaint tracking system and make any changes necessary to ensure that all health insurance complaints are correctly identified and recorded in order to document compliance with s. Ins 18.01 (2) and s. Ins 18.06 (1) Wis. Adm. Code.

Page- 18 11. It is recommended that the company develop and maintain written complaint log tracking procedures to ensure that it has a system to accurately identify, collect, and record complaints involving annuity sales and contracts, as well as develop and maintain written procedures to conduct periodic reviews of the complaint log that are reasonably designed to assist in detecting and preventing violations relating to the suitability of annuity sales to senior consumers as required by s. 628.347 (3), Wis. Stat.

Page- 18 12. It is recommended that the company conduct an audit of its process for identifying, collecting, storing, and reporting complaints and file with the OCI a copy of its audit report in order to document compliance with s. 601.42, Wis. Stat.

Privacy & Confidentiality

Page- 21 13. It is recommended that the company implement a formal structure for reporting on privacy issues to the Board of Directors and others within the company that documents its reporting hierarchy and business unit participation in the privacy compliance process in order to document the company's compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

Page- 21 14. It is recommended that the company implement all of the unsatisfied recommendations in its 2004 internal privacy audit in order to document the company's compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

Producer Licensing

Page- 25 15. It is recommended that the company revise its existing procedures to

Include an annual audit of its agent data base to better ensure the accuracy of the data to document compliance with the agent appointment provisions under s. Ins 6.57, Wis. Adm. Code.

Page- 25 16. It is recommended that the company revise its agent termination procedures to ensure that termination letters comply with the return of indicia requirements of s. Ins 6.57 (2), Wis. Adm. Code.

Page- 26 17. It is recommended that the company, when drafting and implementing written procedures, create a record of the implementation of the procedure and maintain a record of any revisions to the procedure to better enable the OCI's examination of the company and to verify compliance with Wisconsin insurance laws and regulations.

Advertising

Page- 27 18. It is recommended that the company revise its Medicare Select policy form to state that grievances will be acknowledged within 5 days of receipt; to state that if the insurer has not resolved the grievance within 30 days of receipt the company may extend the review period for an additional 30 days and notify the policyholder of the extension and explain why an extension is needed and when resolution can be expected; to include a provision for the expedited review of grievances; and to include information on the independent review process as required by s. Ins 18.03 (4), (6), and Ins 18.05, Wis. Adm. Code and s. 632.835, Wis. Stat.

Page- 28 19. It is recommended that the company comply with Wisconsin insurance law regarding limitations on issue dates of policies, such as the limitations under s. Ins 3.39 (5) (k), Wis. Adm. Code.

Claims

Page- 32 20. It is recommended that the company use ANSI codes on the Explanation of Benefit (EOB) form sent to the claimant and the Remittance Advice (RA) form sent to providers for its Medicare supplement and Medicare Select business as required by s. Ins 3.651 (5), Wis. Adm. Code.

Page- 32 21. It is recommended that the company develop and implement the use of a Remittance Advice (RA) form for its Medicare supplement and Medicare Select business that complies with all of the informational and format requirements of s. Ins 3.651 (3) (b) 4.b.,d.,l.;(d), Wis. Adm. Code.

Page- 32 22. It is recommended that the company develop and implement the use

of an Explanation of Benefits (EOB) form for its Medicare supplement and Medicare Select business that complies with all of the informational and format requirements of s. Ins 3.651 (4) (a) 2.,3.,5.c.,e.,f.,g.,h.,l.;6.,7.,8.,Wis. Adm. Code.

- Page- 33 23. It is recommended that the company resubmit information to the OCI regarding their long term care policies for inclusion in the OCI's *Long-Term Care Insurance Approved Policies in Wisconsin* booklet to show compliance with s. 628.34 (1), Wis. Stat.
- Page- 33 24. It is recommended that the company institute a process, including verifying information sent to the OCI for inclusion in its consumer guides, and assigning oversight of the reporting.

New Business & Underwriting

- Page- 34 25. It is recommended that the company develop and implement marketing and underwriting processes and procedures requiring that the company have approved outlines of coverage per calendar year prior to marketing or accepting applications for the corresponding Medicare supplement policy form in order to comply with s. Ins 3.39 (4) (b), Wis. Adm. Code
- Page- 35 26. It is recommended that the company develop and implement an underwriting processes and procedures requiring completed replacement forms for all replacements to document compliance of s. Ins 3.39 (23) (c) and (d), Wis. Adm. Code.
- Page- 35 27. It is recommended that the company provide notice to its agents that internal replacements require notification to the applicant regarding replacement and completion of the company's replacement form.
- Page- 35 28 It is recommended that the company develop and implement procedures to better ensure that applications are not taken by agents or accepted by the company more than 90 days before an applicant turns age 65 to comply with s. Ins 3.39 (25) (d), Wis. Adm. Code.
- Page- 36 29. It is recommended that the company cease using medical authorization forms for Medicare supplement applicants in an open enrollment period to ensure compliance with s. Ins 3.39 (4m), Wis. Adm. Code.
- Page- 37 30. It is recommended that the company cease using the "Fact Finder" questionnaire when agents are soliciting any Medicare beneficiary for Medicare supplement coverage to ensure compliance with the

marketing standards of s. Ins 3.39, Wis. Adm. Code and s. 3.39 (4m) Wis. Adm. Code.

- Page- 38 31. It is recommended that the company review and update as necessary its agent instructions for submitting applications and its new business and underwriting procedures and schedule and document training it deems necessary to ensure that applications for coverage are properly completed in compliance with s. 628.34, Wis. Stat.
- Page- 38 32. It is recommended that the company include as a procedure step for its internal audits the review of applications to document that unnecessary application information is not obtained or retained and that applications are timely submitted in order to document compliance with s. Ins 3.39 (4m), Wis. Adm. Code.
- Page- 39 33. It is recommended that the company update its written guidelines to require that prior to issuing a home health care policy it obtain a copy of a physical exam, or an assessment of functional capacity, or an attending physician statement or copies of medical records in order to comply s. Ins 3.46 (10) (a), Wis. Adm. Code.
- Page- 39 34. It is recommended that the company update its written guidelines to address the requirement that the company obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a lapse or termination notice or sign a waiver of these rights to ensure compliance with s. Ins 3.46 (15) (a), Wis. Adm. Code.
- Page- 44 35. It is recommended that the company develop and implement comprehensive written procedures and guidelines for its new business processors to use to determine the suitability of an annuity sale to a senior consumer to ensure compliance with the requirements of s. 628.347 Wis. Stat
- Page- 44 36. It is recommended that the company review and amend its Annuity Suitability Questionnaire, form LA-16298, to include additional information concerning the applicant's current and future financial needs, including monthly expenses, and any other information that is reasonably appropriate for determining the suitability of the sale as required by s. 628.347 (2) (b), Wis. Stat.
- Page- 47 37. It is recommended that the company develop and implement comprehensive written procedures for the internal processing of life and annuity applications that involve the replacement of existing life and annuity coverages to ensure compliance with the Wisconsin specific requirements of s. Ins 2.07 (5), Wis. Adm. Code.

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38. It is recommended that the company develop and implement written procedures and materials for training its agents on the specific Wisconsin replacement requirements of s. Ins 2.07, Wis. Adm. Code.

VI. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

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Respectfully submitted,

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