State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

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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

DELTA DENTAL OF WISCONSIN, INC
2801 HOOVER RD
STEVENS POINT WI 54481

dated May 15, 2012, and served upon the company on July 2, 2013, 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 1st day of August, 2013.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

DELTA DENTAL OF WISCONSIN, INC.
STEVENS POINT, WISCONSIN

MAY 7-18, 2012

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May 15, 2012

Honorable Theodore K. Nickel
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conduct May 7, 2012 to May 18, 2012, of:

DELTA DENTAL OF WISCONSIN, INC.
Stevens Point, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Delta Dental of Wisconsin, Inc. (the company) is a non-stock, nonprofit service insurance corporation, licensed under ch. 613, Wis. Stat., established to provide dental care plans.

The company was incorporated on May 17, 1962, and commenced business on January 1, 1967. The company was initially named Wisconsin Dental Service, Inc. It changed its name to Delta Dental Plan of Wisconsin in 1978. In May 2005, the company amended its articles of incorporation to change its name to that presently used. The company's core business is dental insurance, including dental claims administrative services only (ASO). The company offers a variety of dental benefit products to Wisconsin-based groups and individuals and provides services to nearly 621,000 subscribers. The company owns two networks in Wisconsin, a Premier network and a Preferred Provider Organization (PPO) network.

The company offers a variety of benefit plans, on both insured and self-insured basis, including traditional indemnity plans and preferred provider organizations. The company

no longer writes capitated plans. Claim benefits are paid based on a fee-for-services and the payment method is based on using the maximum plan allowable charge (MPA).

The company is part of the nationwide Delta Dental Plan System. The Delta Dental Plan Association provides centralized advertising, business consulting, and other services to member plans. The company owns Wyssta, Inc., which was formed in 2005 to operate as a holding company. Wyssta, Inc. has three wholly owned subsidiaries: Wyssta Insurance Company, Inc., Wyssta Services, Inc., and Wyssta Investments, Inc.

The company was licensed to write only in Wisconsin during the period of review. The company reported written premiums in Wisconsin in 2009 and 2010 for dental policies only. The following tables summarize the lines of business, premium written, and benefits paid in Wisconsin for 2009 and 2010:

Wisconsin Premiums and Benefits Paid Summary

2010		
Line of Business	**Premium Written**	**Benefits Paid**
Dental Policies	$117,239,138	$98,830,864
Total	$117,239,138	$98,830,864

2009		
Line of Business	**Premium Written**	**Benefits Paid**
Dental Policies	$107,618,318	$91,282,178
Total	$107,618,318	$91,282,178

The company reported written premiums in 2009 and 2010 in the amount of $107,618,318 and $117,239,138, respectively.

The following tables summarize the premium written, incurred losses, and medical loss ratio in Wisconsin for 2009 and 2010.

Premium and Loss Ratio Summary

2010				
Line of Business	**Net Premium Income**	**% of Total Premium**	**Net Losses Incurred**	**Medical Loss Ratio**
Dental Only	$119,376,439	100.0%	$102,492,050	85.9%
Total	$119,376,439		$102,492,050	85.9%

2009

Line of Business	Net Premium Income	% of Total Premium	Net Losses Incurred	Medical Loss Ratio
Dental Only	$110,002,696	100.0%	$94,773,739	86.2%
Total	$110,002,696		$94,773,739	86.2%

The company is licensed as a life, accident and health insurer that writes dental only insurance.

Complaints

OCI received 44 complaints against the company between January 1, 2010, through December 31, 2011. A complaint is defined as "a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent." The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

2011						
Reason Type	Total	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Group A&H	13	1	0	11	1	0
Individual A&H	2	0	1	1	0	0
Misc. Health and Life	8	0	0	8	0	0
Total	23	1	1	20	1	0

2010						
Reason Type	Total	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Group A&H	21	0	0	20	1	0
Total	21	0	0	20	1	0

The company received the majority of its complaints in group insurance coverage. In 2011, the company received 8 miscellaneous health complaints. The examiners' review of the files indicates that the complaints were self-funded plans. The company received the majority of

its complaints in denial of claims and claim handling. The company was not on the above average complaint list in 2010 or 2011.

Grievances

The company submitted annual grievance experience reports to OCI for 2010 and 2011 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as "any dissatisfaction with 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 including any of the following: provision of services, determination to reform or rescind a policy, or claim practices."

The company reported it received 2 grievances in 2010 and 12 grievances in 2009. The following table summarizes the grievances for the company for the last two years:

	2010		2009	
Category	**No.**	**No. Reversed**	**No.**	**No. Reversed**
Access to Care	-	-	-	-
Prior Authorization	-	-	-	-
Continuity of Care	-	-	-	-
Drug and Drug Formulary	-	-	-	-
Emergency Services	-	-	-	-
Experimental Treatment	-	-	-	-
Not Covered Benefit	-	-	4	-
Not Medically Necessary	-	-	-	-
Other	2	-	1	-
Plan Administration	-	-	4	-
Plan Providers	-	-	3	-
Request for Referral	-	-	-	-
Total	**2**		**12**	

The 2 grievances in 2010 were related to provider errors and member dissatisfaction of provider; both were compromised. The majority of the grievances in 2009 were related to not covered benefit and plan administration; no grievances were reversed.

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2010, through December 31, 2011. 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 in the areas of claims; policyholder service and complaints; grievances; marketing, sales and advertising; policy forms; producer licensing; provider; and company operations and management. The examination also included a review of compliance with 2009 Wisconsin Acts 28, dependent coverage under s. 632.885, Wis. Stat.

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

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claim administration processes and procedures, explanation of benefits (EOB), explanation of payments (EOP), claim adjustment reference codes, and claim methodology.

The company did not contract with any vendor for claims administration. On average, 91% of the claims were auto-adjudicated with over 63% of all claims submitted electronically from providers. The examiners found that the company no longer paid claims on a capitation basis. All claims were paid on a fee-for-service basis. The company utilized a claim methodology using maximum plan allowance (MPA) as the fee ceiling for claim payment. The MPA was the total dollar amount allowed under an individual or group contract for a specific benefit.

The examiners reviewed nine current dental terminology (CDT) codes for the Premier network and the PPO network. For each of the CDT codes, the examiners reviewed the database vendor, the number of reporting, the range of amounts billed the payment percentile, and the allowable amount. In addition, the examiners reviewed the CDT codes to ensure that the data was updated at least every 6 months and no data in the database was older than 18 months as required by s. Ins 3.60, Wis. Adm. Code. The examiners found that the company was compliant. The most recent updates for the nine CDT codes were February 1, 2012, and May 1, 2012.

The examiners reviewed a random sample of 50 paid claims that were processed in excess of 30 days to test for timely payments. Section 628.46, Wis. Stat., states that a claim is considered to be overdue if not paid within 30 days after the company has been furnished written notice of the fact of a covered loss and of the amount of the loss and all overdue payments shall bear simple interest at the rate of 12% per year. The examiners found the claims were processed within the time period of 30 days.

The examiners found the company's claim system erroneously processed 1 claim under the wrong dependent when that dependent had already met the annual benefit maximum. The claim was readjusted to process under the correct dependent. The claims administrator acknowledged this error and indicated that the company was in the process of correcting the system.

The examiners reviewed a random sample of 50 claims denied during the period of review. The examiners found 5 claims were denied because the services were not provided by a dentist in the network and no benefits were payable. In addition, the examiners reviewed 25 claims denied based on dependent eligibility. The examiners found 15 of the 25 dependent coverage denials contained explanation of payment reference code 106, which states that the claim cannot be processed until the company receives information about the full-time student status. The company indicated that it removed the full-time student eligibility requirement on contract renewal dates that occurred on or after January 1, 2010. The correct denial reference code should have been 103, which states that the service was rendered after termination of coverage. Section 632.885 (2), Wis. Stat., states that every insurer that offers health insurance coverage that provides dependent coverage of children shall provide coverage for any child of an applicant or insured as a dependent of the applicant or insured if the child is under the age of 26.

1. **Recommendation:** It is recommended that the company use the correct denial reference code to ensure that dependents are covered to age 26 as required by s. 632.885, Wis. Stat.

Managed Care

The examiners reviewed the company's response to OCI's managed care interrogatory and its policies and procedures regarding enrollee access, member handbooks, and provider agreement. The examiners also reviewed the company's credentialing and recredentialing procedure, credentialing committee minutes, dentist utilization review and quality assurance summary, and preauthorization procedure.

The examiners found that the company's Premier and PPO provider agreements did not contain a provision that required the contracting entity to promptly provide the insurer information necessary to permit the insurer to respond to complaints or grievances against the contracting entity as required by s. Ins 18.03 (2) (c) 2, Wis. Adm. Code.

2. **Recommendation:** It is recommended that the company include a provision in its provider agreement that requires the contracting entity to promptly provide the insurer the information necessary to permit the insurer to respond to complaints or grievances as required by s. Ins 18.03 (2) (c) 2, Wis. Adm. Code.

The examiners reviewed a sample of 25 active provider and 25 terminated provider contracts. The examiners compared the terminated providers to the company's most current paper copy directory and its web site to determine if any of the sampled terminated providers were still listed. No terminated provider appeared in the directory.

The examiners reviewed the company's credentialing procedure, credentialing committee minutes, and professional profile application. The providers were initially credentialed upon acceptance to the Premier and/or preferred provider option network and recredentialing occurs every 4 years. The credentialing procedure required that new and renewing dentists complete professional profile applications. The questions included malpractice claims, revoked license, disciplined by state board of dental examiners, and criminal offense. The examiners reviewed the credential committee minutes for compliance with its procedure and found that the minutes included a review of providers that were referred to the committee.

The company had a vice president and science officer position that met the requirement of a dental director as described in s. 609.34, Wis. Stat.

The examiners requested that the company provide a compliance plan and/or a written remedial action plan that addressed quality problems from participating providers. Section Ins 9.40 (3), Wis. Adm. Code, provides that an insurer offering a preferred provider plan shall develop procedures for taking effective and timely remedial action to address issues

arising from quality problems including access to and continuity of care from participating primary care providers. The examiners found that the company's remedial action plan did not contain documentation of timely corrections of access to and continuity issues identified in the plan as required by s. Ins 9.40 (3) (f), Wis. Adm. Code.

3. **Recommendation:** It is recommended that the company develop policies and procedures for taking effective and timely remedial action to address issues arising from quality problems as required by s. Ins 9.40 (3) (f), Wis. Adm. Code.

Grievances

The examiners reviewed the company's response to OCI's grievance interrogatory, its grievance policies and procedures manual, and its annual grievance reports for 2009, 2010, and 2011.

The examiners reviewed the grievance policies and procedures manual. The manual contained glossary of terms, grievance acknowledgment and notification procedures, grievance timeline and protocol, and letter templates. The examiners found that the definition of expedited grievance under the glossary of terms did not comply with s. Ins 18.05, Wis. Adm. Code, which provides that an expedited grievance shall be resolved as expeditiously as the insured's health condition requires but not more than 72 hours after receipt of the grievance. The examiners found that the PPO and Premier handbook contained a definition of expedited grievances; however, the company's grievance policies and procedures did not include steps and/or a process for handling an expedited grievance.

4. **Recommendation:** It is recommended that the company include the definition of expedited grievance in its Grievance Policies and Procedures Manual and a process to handle an expedited grievance to comply with s. Ins 18.05, Wis. Adm. Code.

The examiners' review of the company's handbook grievance procedures indicated that a subscriber or covered dependent or the subscriber's or covered dependent's dentist may request a predetermination of benefits to obtain advance information on the possible coverage of dental procedures before dental procedures were rendered. The available coverage would

be calculated and printed on a predetermination of benefits form and copies of the form would be sent to the subscriber or covered dependent or the dentist. The examiners found that the company did not inform the subscriber and/or covered dependent of the right to file a grievance when a predetermination of benefits was denied. Section Ins 18.03 (2) (a), Wis. Adm. Code, requires an insurer to notify the affected insured of the right to file a grievance each time an insurer offering a health benefit plan denies a claim or a benefit.

5. **Recommendation:** It is recommended that the company include a notice in its predetermination of benefits form letter, of the right to file a grievance each time the company denies a benefit at the time of predetermination of benefits to comply with s. Ins 18.03 (2) (a), Wis. Adm. Code.

The examiners found that the annual grievance experience report the company submitted to OCI did not contain the correct number of grievances reported. Section Ins 18.06 (2), Wis. Adm. Code, states that an insurer shall provide information on all grievances received during the previous calendar year and reported to the commissioner by March 1 of each year. The company's grievance report for calendar year 2010 reported 2 grievances. The correct number of grievances was 6. The company indicated only the PPO network grievances were included in the report and that it did not include the Premier network grievances. The company acknowledged the error and indicated it would correct its internal procedures to update the reporting requirements.

6. **Recommendation:** It is recommended that the company implement a procedure to ensure that future reporting of the annual grievance experience report includes both PPO and Premier network grievances as required by s. Ins 18.06 (2), Wis. Adm. Code.

The examiners reviewed 10 grievances filed with the company during the period of January 1, 2010, through December 31, 2011. The examiners found 4 grievance files did not include a grievance acknowledgment letter and 1 file exceeded 5 business days. Section Ins 18.03 (4), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail a written

acknowledgment to the insured or insured's authorized representative. The examiners found 2 grievance files did not include a written notification for extension. Section Ins 18.03 (6), Wis. Adm. Code, states if an insurer is unable to resolve the grievance within 30 calendar days; the time period may be extended an additional 30 days if the insurer provides written notification to the insured and the insured's authorized representative. The company acknowledged that the grievance files did not include a grievance acknowledgment letter and written notification for extension and indicated that refresher training will be conducted with all members of the professional services team to ensure compliance with its grievance policies and procedures.

7. **Recommendation:** It is recommended that the company document its grievance files to include acknowledgment letters and written notifications of extension to comply with its Grievance Policies and Procedures Manual and as required by s. Ins 18.03, Wis. Adm. Code.

Marketing, Sales, and Advertising

The examiners reviewed the company's response to OCI's marketing, sales and advertising interrogatory, and advertising files.

The marketing department was responsible for the development of all sales materials, including print ads, web ads, brochures, sell sheets, TV commercials, agent e-mails, and trade-show materials. The sales department was responsible for all sales transactions and account management.

The company began offering its individual product called Clear policies in mid-2010. It contracted with Encara Corporation to market the product. The company also contracted with WPS to bundle individual dental plans with WPS's medical products. WPS was responsible for the sales and marketing of these products.

The company's group products between 2-4 subscribers are called Premier Plus PPO and Advantage PPO. For group plans with 5-49 subscribers, the products are called Axcess, Premier Plus PPO, Enhanced PPO, Savings PPO, and UltraSavings PPO. For groups over 50, the company allowed custom plan designs and did not have a standard product name.

The examiners reviewed a sample of 50 advertisements during the period of review. The examiners found 45 advertisements did not have a form number. Section Ins 3.27 (6), Wis. Adm. Code, states that an advertisement which is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The company acknowledged that it was not compliant with s. Ins 3.27 (6), Wis. Adm. Code, and indicated it would take corrective action with all advertising beginning July 1, 2012.

8. **Recommendation:** It is recommended that the company include a form number on an advertisement which is an invitation to apply or an invitation to inquire to comply with s. Ins 3.27 (26), Wis. Adm. Code.

Policy Form Filings

The examiners reviewed the company's response to OCI's policy forms interrogatory and the company's policy forms filed during the period of review.

The examiners reviewed 67 policy form submissions used during the period of review. This included individual policies, master group contracts, outline of coverages, and group and individual enrollment applications and amendments. The examiners also reviewed 3 group enrollment applications provided by the company. The examiners found 1 form titled enrollment/change/waiver form for dental and/or vision coverage did not have a form number. No other exceptions were noted.

Policyholder Service and Complaints

The examiners reviewed the company's response to OCI's policyholder service interrogatory, complaint procedures, company complaint log, and all submitted complaints to OCI during the period of review. The examiners also interviewed the vice president of administration.

The examiners found that the company's internal procedure only addressed complaints referred to the company by OCI. 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. The examiners reviewed 26 complaint files. The examiners found that 23 of the 26 complaints were complaints received from OCI. There were 3 complaints tracked internally by the company. The interview with the vice president of administration indicated that the company utilized an integrated customer inquiry tracking system (CITS) to document customer calls and to document additional reviews of claims requested by members and providers. However, the company considered additional reviews of claims as inquiries and/or appeals and did not consider them complaints. The examiners noted that from their experience companies receive more complaints from their insureds than OCI receives involving the company and that 3 complaints is a very small number and not consistent with past experience.

9. **Recommendation:** It is recommended that the company review and revise its complaint process to ensure it captures in its complaint system all expressions of dissatisfaction expressed by the insured in order to comply with ss. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

Producer Licensing

The examiners reviewed the company's response to OCI's producer licensing interrogatory, agency agreement, new agent listing procedures, agent termination procedures, Vertafore (SIRCON) vendor agreement, and WPS joint venture agreement. The examiners also interviewed the administrative assistant in charge of agent licensing.

The company did not have a specific department that handled producer licensing. The administrative assistant was the sole member responsible for the management of agent contracts, agent appointments, terminations, maintenance of agent records, and filing of all pertinent data.

The examiners found that the company did not have an oversight process for monitoring and tracking agent complaints, allegations of misconduct or misrepresentation, or a process to terminate an agent for cause. The company took a position that, as it did not work with captive agents, it was not responsible for the acts of the agents. The company indicated it

had a process for handling complaints and terminations for its sales/account management staff. Section 628.40, Wis. Stat., provides that every insurer is bound by any act of its agent performed in this state that is within the scope of the agent's apparent authority. The statute does not distinguish among types of appointed agents.

10. **Recommendation:** It is recommended that the company develop an oversight process for monitoring and tracking agent complaints, allegations of misconduct, and/or misrepresentation in order to document compliance with ss. 628.40 and 631.09, Wis. Stat.

The examiners reviewed the company's administrative services procedure for agent terminations. The examiners found that the internal procedure only addressed agent terminations referred to the company by OCI, deceased agents, or agents no longer in business. The procedure did not include procedures for notifying OCI of its termination of an agent or the administration of this process. Section Ins 6.57 (2), Wis. Adm. Code, provides that notice of termination of a producer's appointment shall be filed with OCI prior to, or within 30 calendar days of the termination date. Prior to or within 15 days of filing this termination notice with OCI 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. The examiners also found that the administrative services termination procedure did not include a process to notify OCI when an agent was terminated for cause as required by s. Ins 6.57 (2) (a), Wis. Adm. Code, for the reasons listed in s. Ins 6.57 (2) (a) and (b), Wis. Adm. Code.

11. **Recommendation:** It is recommended that the company review and update its agent termination procedure, including notice to OCI, to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

The examiners reviewed 50 terminated agent files to document compliance with s. Ins 6.57 (2), Wis. Adm. Code. The examiners found that the company did not send a formal letter to notify an agent of his/her termination and request for return of indicia. The company

acknowledged that it was not compliant and indicated it would take corrective action beginning July 1, 2012, by sending formal written notices of termination.

12. **Recommendation:** It is recommended that the company amend its agent termination process to include providing written notice to the terminated agent in order to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

Company Operations and Management

The examiners reviewed the company's response to OCI's company operations and management interrogatory, its 2008 amended bylaws, board minutes, business continuity plan, Delta Dental Premier Dentist Agreement, Delta Dental PPO Dentist Agreement, and master group contract. The examiners also interviewed the vice president (VP) of administration and the chief financial officer (CFO).

The examiners found that the company's board minutes did not include any compliance discussion by the Board of Directors. In addition, the minutes did not include any compliance directives by the Board of Directors. The CFO and VP of administration indicated that, if a compliance matter arose, a discussion would be brought to the board.

The examiners reviewed the company's compliance program overview. The examiners requested the company provide compliance infrastructure and controls, identify the department responsible for ensuring compliance with Wisconsin insurance laws, and identify the principal officer in charge of compliance by name and title. The company indicated that it did not maintain a formal compliance infrastructure. The company's compliance was handled by a number of people within the organization. Although the company's compliance program overview indicated that the company conducted departmental review of policies and compliance audits on a periodic basis, the company indicated it had not conducted audits during the period of review.

IV. CONCLUSION

This market conduct examination involved a targeted market conduct examination of Delta Dental of Wisconsin, Inc.'s practices and procedures for the period from January 1, 2010, through December 31, 2011. This examination resulted in 12 recommendations in the areas of claims; managed care; grievances; marketing, sales and advertising; policyholder services and complaints; and producer licensing.

V. SUMMARY OF RECOMMENDATIONS

Claims

Page 7 1. It is recommended that the company use the correct denial reference code to ensure that dependents are covered to age 26 as required by s. 632.885, Wis. Stat.

Managed Care

Page 8 2. It is recommended that the company include a provision in its provider agreement that requires the contracting entity to promptly provide the insurer the information necessary to permit the insurer to respond to complaints or grievances as required by s. Ins 18.03 (2) (c) 2, Wis. Adm. Code.

Page 9 3. It is recommended that the company develop policies and procedures for taking effective and timely remedial action to address issues arising from quality problems as required by s. Ins 9.40 (3) (f), Wis. Adm. Code.

Grievances

Page 9 4. It is recommended that the company include the definition of expedited grievance in its Grievance Policies and Procedures Manual and a process to handle an expedited grievance to comply with s. Ins 18.05, Wis. Adm. Code.

Page 10 5. It is recommended that the company include a notice in its predetermination of benefits form letter, of the right to file a grievance each time the company denies a benefit at the time of predetermination of benefits to comply with s. Ins 18.03 (2) (a), Wis. Adm. Code.

Page 10 6. It is recommended that the company implement a procedure to ensure that future reporting of the annual grievance experience report includes both PPO and Premier network grievances as required by s. Ins 18.06 (2), Wis. Adm. Code.

Page 11 7. It is recommended that the company document its grievance files to include acknowledgment letters and written notifications of extension to comply with its Grievance Policies and Procedures Manual and as required by s. Ins 18.03, Wis. Adm. Code.

Marketing, Sales, and Advertising

Page 12 8. It is recommended that the company include a form number on an advertisement which is an invitation to apply or an invitation to inquire to comply with s. Ins 3.27 (26), Wis. Adm. Code.

Policyholder Service and Complaints

Page 13 9. It is recommended that the company review and revise its complaint process to ensure it captures in its complaint system all expressions of dissatisfaction expressed by the insured in order to comply with ss. Ins 18.01 (2) and 18.06 (1), Wis. Adm. Code.

Producer Licensing

Page 14 10. It is recommended that the company develop an oversight process for monitoring and tracking agent complaints, allegations of misconduct, and/or misrepresentation in order to document compliance with ss. 628.40 and 631.09, Wis. Stat.

Page 14 11. It is recommended that the company review and update its agent termination procedure, including notice to OCI, to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

Page 15 12. It is recommended that the company amend its agent termination process to include providing written notice to the terminated agent in order to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

VI. ACKNOWLEDGMENT

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.

Name	Title
Mary Kay Rodriguez	Insurance Examiner
Kevin Zwart	Insurance Examiner

Respectfully submitted,

Moua M. Yang, MBA, MCM
Examiner-in-Charge