

MARKET CONDUCT EXAMINATION REPORT  
ON  
BANKERS LIFE AND CASUALTY INSURANCE  
COMPANY

NAIC Company Code 61263  
Chicago, Illinois

AS OF  
April 30, 2007

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## EXECUTIVE SUMMARY

A multistate examination was conducted on Bankers Life and Casualty Insurance Company, hereinafter referred to as "Company," and Conseco Senior Health Insurance Company. Both companies are subsidiaries of Conseco Inc. Holding Company System. The multistate examination was coordinated with the National Association of Insurance Commissioners' (NAIC) Market Analysis Working Group and was conducted on behalf of 39 participating states under the leadership of Pennsylvania, Florida, Illinois, Indiana and Texas. The onsite examination of Bankers Life and Casualty Insurance Company was conducted in Chicago, Illinois simultaneously with the onsite examination of Conseco Senior Health Insurance Company in Carmel, Indiana. For clarity of reporting, separate Reports will be issued on each Company.

The purpose of the multistate examination was to determine if both companies were maintaining appropriate business practices, especially in the long term care insurance lines.

The examination of both Companies focused on areas of Complaint Handling and Long Term Care (LTC) and Home Health Care (HHC) Claim Handling. Since Conseco Senior Health Insurance Company no longer writes new business, the focus on marketing and sales activities was restricted to Bankers Life and Casualty Insurance Company and included all product lines. The examination included a review of the Company's activities in all states, with the Lead States of Pennsylvania, Florida, Illinois, Indiana, and Texas overseeing the daily examination activities.

The Company self-reported a number of issues that had been identified prior to the initiation of this examination through complaints, internal audits and other state market conduct examinations. The predominant issue of Bankers Life and Casualty Company was in the sales and marketing area, specifically in the annuity line of business. The Company has continually expressed its interest in entering into a Corrective Action Plan with participating states to address the specific sales and marketing issues, self-identified issues and any additional issues identified and verified as a result of the examination.

Based on the Company's self-reporting, prior market conduct examination reports and the large population of data files identified, a random sampling of selected files based on certain criteria was utilized to select the files reviewed for this examination.

In order to provide for a complete, efficient and expeditious review of the sampled files from all jurisdictions, the Lead States and the Company agreed the review was to be conducted based on the Company's compliance with NAIC standards. Where compliance determination required more specific state timelines (days), the examiners would apply the timelines applicable to Pennsylvania Regulations.

While there were claim issues identified, the examiners found the issues were confined to the timeliness aspect of the claims adjudication process. The Company generally had adequate procedures for claims handling. The predominant areas of concern were found in the Complaint Handling, and Marketing and Sales areas.

For each of the cited exceptions in the report, recommendations have been made to address the issues and concerns noted by the examiners. Accordingly, the results of operational improvements implemented by the Company, which occurred after the examination period (i.e., after April 30, 2007), are not reflected in the data contained in this Report. Details of the corrective actions taken by the Company to address the findings of this review are listed in the Company Response section of this Report.

## INTRODUCTION

An examination was conducted on Bankers Life and Casualty Company, at the Company's offices located in Chicago, Illinois, from July 9, 2007 through October 26, 2007. Preliminary work for the examination and subsequent review and follow-up was conducted at the examination offices of Insurance Regulatory Insurance Services, Inc.

The examination included a review of the Company's activities in multiple jurisdictions. This multistate examination represents 39 states with the Lead States of Pennsylvania, Florida, Illinois, Indiana, and Texas overseeing the daily examination activities. The examination firm of Insurance Regulatory Insurance Services, Inc., Philadelphia, Pennsylvania, was selected to conduct the examination of this Company on behalf of all participating states.

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

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

## SCOPE OF EXAMINATION

The examination was conducted pursuant to the authority granted by the participating states. A complete list of participating states and the applicable statutory authority may be found in Appendix A. The experience period covered in this report is January 1, 2005 through April 30, 2007, unless otherwise noted. The purpose of this examination was to determine compliance by the Company with the insurance laws and regulations of the participating states.

The examination relied on standards included in the NAIC *Market Conduct Examiners Handbook* and focused on the Company's operation in areas such as: Consumer Complaints, Marketing and Sales, and Claim Handling Practices and Procedures. The Company was requested to identify the universe of files for each segment of the review. Based on the Company's self-reporting, prior market conduct examination reports and the large population of data files identified, a random sampling of selected files based on certain criteria was utilized in some sections to select the files reviewed for this examination.

## COMPANY HISTORY AND LICENSING

### Company Formation

Bankers Life and Casualty Company started as a mutual assessment company formed in 1932. The Company was consolidated with Standard Life Insurance Company and Hotel Men's Mutual Benefit Association of the United States and Canada. The oldest predecessor company, Hotel Men's Mutual Benefit Association of the United States and Canada, commenced business on January 17, 1879 and was incorporated on April 6, 1880 in Illinois. Standard Life Insurance Company was formed as a stock company in 1942.

In 1935, John D. MacArthur purchased Bankers Life and Casualty Company. Management and financial control of the Company was held by the former Chairman of the Board until his death on January 6, 1978. As stipulated in his will, control of the Company was then transferred to The John D. and Catherine T. MacArthur Foundation, an Illinois not-for-profit corporation for the benefit of charity. On October 30, 1984, I.C.H. Corporation, a Louisville, Kentucky holding company, acquired the Company through an I.C.H. wholly-owned subsidiary, Great Southern Life Insurance Company of Texas.

Conseco Capital Partners, L.P. formed the Bankers Life Holding Corporation to acquire Bankers Life and Casualty. On November 9, 1992, the Bankers Life Holding Corporation acquired all outstanding common stock of the Company from I.C.H. As of this report, Bankers Life and Casualty Company is a wholly-owned subsidiary of Bankers Life Insurance Company of Illinois, an immediate life insurance holding company, which, in turn, is owned by Conseco, Inc. based in Carmel, Indiana. As a holding company, Conseco, Inc. is a separate legal entity that is distinct and apart from its subsidiary insurance operations. Bankers Life and Casualty Company operates as an independent company and is regulated as a separate company.

On January 1, 2000, Certified Life Insurance Company, a Conseco subsidiary, merged into the Company. The Company assumed all of the inforce business of Certified Life Insurance Company.

On December 17, 2002 Conseco, Inc. filed for permission to reorganize under Chapter 11 bankruptcy protection. Conseco, Inc. completed its reorganization and emerged from Chapter 11 bankruptcy on September 10, 2003.

### Licensure

A list of the participating states and the date the Company was authorized to conduct business in each state is included in the Appendix A. The Company is authorized to do business in Canada, the District of Columbia and all states except New York.

### Product Offerings

Bankers Life and Casualty Company markets a wide variety of accident and health products including Medicare Supplement and Long Term Care products. The Company also markets a

variety of life insurance and annuity products, including traditional and term life, universal life, fixed annuities and equity-index annuities.

In its December 31, 2006 annual statement filed with the NAIC, the Company reported nationwide premiums and annuity considerations for life and accident and health contracts in the amount of \$2,493,704,139. There were 531,220 life insurance contracts, 635,089 individual accident and health policies, 23 group accident and health policies, 6,470 immediate annuities, and 158,023 deferred annuities inforce as of December 31, 2006. The Company's website and marketing materials state the Company is "focused exclusively on the needs of senior Americans."

The Company primarily markets its products through the use of a career agent system associated with branch sales offices operated by the Company. The company has approximately 1,600 agents working in 134 branch sales offices.

#### Previous Market Conduct Examinations

Prior to the initiation of this multi-state examination, the Company had been the subject of market conduct examinations conducted by ten states.

## METHODOLOGY

There are three general categories of sampling techniques used during examinations: generic, random sample and electronic. A "generic" review is conducted through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner. A "random sample" review is conducted through direct review of a random sample of files using sampling methodology described in the NAIC's *Market Conduct Examiners Handbook*. An "electronic" review is conducted through the use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically evaluates 100% of the records of a particular type. The sampling techniques used are based on a ninety-five percent (95%) confidence level. This means that there is a ninety-five percent (95%) confidence level that the error percentages shown in the various standards tested are representative of the entire set of records from which it was drawn.

After utilizing selection criteria, representative of the percentage of claims paid/denied from each state, the sampling technique used in this examination was the random sample method.

The focus for this multi-state examination was on Complaint Handling, Marketing and Sales of all products and Claims Handling (Paid and Denied) practices for LTC Insurance. From a universe of 4,663 complaints, the examiners randomly sampled and tested 150 complaints. From a universe of 479,689 policies issued, a random sample of 100 files was selected and reviewed. Of the 72,281 policies declined or rejected, a random sample of 50 files was selected and reviewed. From a universe of 374,263 Paid/Denied Claims, representing all jurisdictions, a selection criteria was utilized to select files from all jurisdictions based on the percentage of actual number of claims paid/denied from each jurisdiction. As a result of the selection criteria utilized, a total of 650 claim files were randomly selected for review.

During the course of the examination and after reviewing 116 paid claim files and 308 denied claim files, it became apparent that any further review and findings of the remaining sampled claim files would be redundant. The Lead States and the Company agreed that the findings in the reviewed files, along with the Company's self-reported findings would be sufficient to verify the Company's claims compliance issues.

Examination Standards from the NAIC's *Market Conduct Examiners Handbook* were applied to each of the areas tested. Observations and recommendations where indicated, are presented for each of the standards tested. Where compliance determination required more specific state timelines (days), the examiners applied the timelines applicable to Pennsylvania insurance regulations.

## COMPANY OPERATIONS/MANAGEMENT

**Standard: Records are adequate, accessible, consistent, orderly and comply with record retention requirements.**

The Company provided its *Standard Operating Procedures* (SOP) related to record retention. According to the Company's record retention SOP, all of the records and documentation needed to perform the examination should have been readily available.

During the course of the examination the company was frequently unable to provide requested records or documentation, or unable to provide the requested information in a timely manner.

**Standard: The company cooperates on a timely basis with examiners performing the examinations.**

The Company had all complaint and rejected files available when the examiners arrived. Shortly after the examination team's arrival, the Company provided the issued files and several batches of claim files. Claim files were provided through out the course of the examination.

As the sample files were reviewed, a request log was established to track inquires made of the Company. Initially, the Company was allowed a three business day timeframe to respond to inquiries. After receiving a number of inquiries from the complaint files review, the Company could not meet the three day response time in all cases. As a result, the response time was extended to five days. By the end of the examination, the Company had made a number of requests for response time extensions.

## COMPLAINT HANDLING

The examination included two phases of Complaint Handling review. Phase I included the analysis of electronic complaint data. Phase II included a review of a random sample of 150 complaint files, from a universe of 4,663 complaints received nationwide during the experience period. For the purposes of this examination, examiners relied on the following NAIC definition of a complaint: "A complaint is a written communication primarily expressing a grievance."

### Phase I – Analysis of Electronic Complaint Data

The examiners analyzed two files of complaint data received from the Company for the period January 1, 2005, through December 31, 2006. The first file contained 2,484 complaints handled by Company Consumer Relations. The second file contained 1,355 complaints handled by Company Customer Service and the Branch Sales Offices. The examiners found that the Company failed to maintain complete and accurate complaint data as required for the 2005-2006 period.

The Company was given specifications for submitting complaint data in the data call document entitled Multistate Examination Plan dated May 10, 2007. The data call listed 19 data fields required for each complaint along with a description of what the data in each of those fields should represent.

Analysis of the Consumer Relations file found that the Company did not submit the data as specified in the data call. The Company did not use the data field "CmpRes" to represent the reason for the complaint. Instead, the Company stated it had used the data field "CmpRes" for data that represented the "Area of the Company" for which the complaint was involved. The data field "CmpRsl" was used for data representing the type of complaint rather than for complaint resolution data as stipulated in the data call. The examiners found no complaint resolution data for any of the complaints in the Consumer Relations file.

The data in the Consumer Relations file was also found to be incomplete. The examiners determined that a substantial number of the records were missing the Agent Code. Additionally, some records were missing valid policy numbers, Complaint Source, Coverage Type, data regarding the manner in which the complaint was transmitted to the Company and the data the Company used to track the Area of Company for which the complaint was involved.

Similar problems were found during the analysis of the Customer Service-Branch Sales Office (CS-BSO) file. The examiners found that a substantial number of the records were missing the Agent Code. All of the records were missing the Complaint Source and the data regarding the manner in which the complaint was transmitted to the Company.

Analysis of both the Consumer Relations and CS-BSO files revealed a marked increase in the number of complaints received from 2005 to 2006. The average number of complaints handled each month by Consumer Relations increased by over 50% from 2005 to 2006 while the CS-BSO file demonstrated a 150% increase during the same period.

The majority of complaints (97.5%) handled by Consumer Relations originated from state Departments of Insurance (DOI). Twenty states had 50 or more complaints indicating that the problems with the Company's procedures and practices are not limited to certain geographic or demographic populations. The examiners found that LTC (43.2%), Medicare Supplement (17.5%), Annuities (16.1%) and Life (15.8%) lines of business have the largest share of complaints by coverage type. Agent misrepresentation (12.5%), Agency Inaction (11.3%), Incomplete Proof of Loss (9%) and DNR/Rate Increase (13.1%) comprise the largest volume of complaints by reason type.

It appears that 100% of the complaints in the CS-BSO originated at the agency or company level as there is no data field for DOI tracking. Analysis of the CS-BSO file determined that 21 states had 25 or more of the 1355 reported complaints also indicating that the Company's complaints are not limited to certain Customer Service Centers or Branch Sales Offices.

The examiners found that LTC (44.1%), Medicare Supplement (23.5%), Annuities (13.7%) and Life (15.8%) comprise the largest share of CS-BSO complaints by coverage type.

The CS-BSO file utilized two data fields, "Category" and "CmpRes" to define the Reason for Complaint. Reason for Complaints was broken down into the following categories: Underwriting (4.3%), Sales (31.6%), Claims (39.4%), Policyholder Service (16.7%), Miscellaneous (7.2%) and Medicare Select Only (0.9%). In the Sales category the largest percentage of complaints was attributed to Agent Mishandling and Misrepresentation. In the Claims category the largest percentage of complaints related to Claim Denial.

While there was no complaint resolution data captured in the Consumer Relations file, the Company did provide resolution data in the CS-BSO file. The Company segregated its complaint resolution codes in this file into the following three categories: Corrective Action Taken (65.9%), No Action Necessary (15.6%) and Satisfactory Explanation Given to Complainant (18.5%).

The resolution data in the CS-BSO file was further broken out into sub-categories under each of the three categories. Analysis of the sub-categories defined under "Corrective Action Taken" found that the majority of complaints (445) were identified as "Other" (32.8% of all complaints recorded). The Company procedures for satisfactorily capturing this data should be enhanced as one-third of the complaint resolutions were undefined. The other "Corrective Action Taken" sub-categories which had a greater than 10 percent share of the overall complaint resolution data provided were "Premium Refunded" (12.1%) and "Claim Settled" (11.2%).

Of the sub-categories defined under "No Action Necessary", only "Contract Provisions" (10.8%) comprised a large percentage of the total complaints resolutions data captured.

The examiners were unable to do a complete analysis of agents with multiple complaints against them as the Company failed to identify the Agent in most of the complaints in the Consumer Relations file. Of the 728 complaints with Agent Codes, the examiners found that 2 agents had 6 complaints, 6 agents had 5 complaints, 9 agents had 4 complaints, 17 agents had 3 complaints and 57 agents had 2 complaints.

Only 371 records had identified Agent Codes in the CS-BSO file. The examiners found that 1 agent had 14 complaints (of which 9 annuity complaints were received on the same date), 1 agent had 6 complaints, 3 agents had 5 complaints, 7 agents had 3 complaints and 32 agents had 2 complaints.

The examiners estimate from this data that approximately 12% of the Company's agents were implicated in more than one complaint during the 2005-2006 period under review.

Based on the above findings, the examiners find that the Company's complaint tracking during the 2005-2006 period was inadequate. The Company failed to maintain complete and accurate complaint data in either the Consumer Relations or CS-BSO files. This failure made it imponderable to determine which agents had a high incidence of complaints, the actual reason for the many of the complaints or their ultimate resolution.

The examination of the complaint data was extended to include an analysis of two files of complaint data received from the Company for the period January 1, 2007 through April 30, 2007. The first file contained 517 complaints handled by Company Consumer Relations. The second file contained 307 complaints handled by Company Customer Service and the Branch Sales Offices.

The results of the analysis of the 2007 complaint data was similar to the results found for the 2005 through 2006 complaint data. Listing the details of the 2007 complaint data would be redundant.

#### Phase II – Complaint File Sampling Review

A random sample of complaint files was selected for review. During the examiners' review of 150 files, each file was evaluated to determine if the file met the standards in the NAIC *Market Conduct Examiners Handbook*. The specific standards and findings are summarized below.

<b>Standard: All complaints are recorded in the required format on the company complaint register.</b>
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An insurer is required to maintain a complete record of all the complaints received. The record must indicate the total number of complaints since the last examination, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

The Company was asked to provide a complete listing of complaints for the period of examination. During the complaint file review, the examiners noted several instances where complainants referenced previous complaint correspondence that had been sent to the Company.

Examiners were unable to locate evidence of the original complaint on the Company's complaint listing in five of the sampled files.

**Standard: The company has adequate complaint handling procedures in place and communicates such procedures to policyholders.**

The Company maintains complaint handling procedures for both complaints received within the home office and complaints received at a branch office. Complaints received at branch offices or directly from consumers are logged separately from the complaints received from a state DOI. Because complaint data is maintained in two separate systems, complaint trends may not be as readily identified as they could be if the data were maintained in a single system.

The Company creates acknowledgement letters through an automated system. The letters notify the complainant that his complaint has been received and the Company will respond accordingly. An actual copy of the letter provided is not maintained within the complaint file. The Company has initiated a project to begin storing copies of all acknowledgment letters.

**Standard: The company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules, and regulations and contract language.**

Each complaint reviewed was tested to determine if the Company responded to each item of interest raised within the Complaint. It was noted that the Company failed to fully respond to all issues in 9 of 150 complaint files reviewed.

**Standard: The time frame within which the company responds to complaints is in accordance with applicable statutes, rules, and regulations.**

For the complaint response timeliness review, each complaint was reviewed based upon the state specific complaint response requirement. The Company acknowledged it failed to timely respond to complaints in 23 of the 150 sampled files.

## MARKETING AND SALES

The marketing and sales portion of the examination included not only a sample file review of product underwriting, issuance and declined sections, but also included a limited review of advertising, sales materials, producer training materials and producer licensing and termination processes. From a universe of 479,689 policies issued nationwide, a random sample of 100 files was selected and reviewed. Of the 72,281 policies rejected or not-taken, a random sample of 50 files was selected and reviewed. A “Not-Taken” policy is a policy that was issued by the Company but the applicant decides not to accept the coverage. Each of the files selected for review were evaluated for compliance with standards in the NAIC *Market Conduct Examiners Handbook*. The applicable standards and specific findings are summarized below.

**Standard: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.**

The examiners did not pull a sample of advertising materials during the examination but reviewed advertising encountered during the review of issued and rejected files. There were no exceptions to advertising statutes, rules, and regulations noted.

**Standard: Company internal producer training materials are in compliance with applicable statutes, rules, and regulations.**

Review of the Company’s complaints which lead to a review of Company internal training materials identified potential violations in the sales of LTC policy forms N250 and N280.

The Company announced in February 2006, a 35% premium increase effective in April 2006. There was a spike in the total number of complaints associated with these policy forms beginning in February 2006. During the period of February 1, 2006 through October 31, 2006, the Company received 194 complaints from consumers covered under the N250 and N280 forms. “Did not renew/rate increase” was cited as the reason in 141 (72.7%) of these complaints.

In some of the complaints reviewed, the complainants alleged that agents misrepresented policy provisions by telling applicants that its LTC premium would increase only in the event of a federal or state mandated change that affected the nature of the Company’s assumed risk. Documented statements of the agents and complainants in some of the complaint files substantiated this allegation.

**Standard: Company communications to producers are in compliance with applicable statutes, rules, and regulations.**

The Company communicates with its producers/agents through various media including bulletins, emails and telephone. The Company maintains an agent training department which provides assistance to agents ranging from product information to tracking agent training.

**Standard: Records of terminated producers adequately document reasons for terminations.**

The Company provided a listing of producers that were active at any time during the examination period. Contained in the listing was appointment information, including appointment termination dates and reason codes. The listing was sorted by termination codes and analysis conducted of the reasons for termination and the Company's process for the proper submission of appointment termination documentation was tested. The examiners found that the Company regularly submits appointment termination data to the state DOI's. Although the Company submits appointment termination data regularly, the Company does not submit notifications of termination for cause to the state departments in a timely manner.

Based on the Company's data, the examiners reviewed agents listed as terminated for cause by the Company against records in the NAIC's Producer Database. Although the examiners found the Company had terminated the agent appointments, the appointments were not terminated for cause. The Company submitted the following statement when asked why agents were shown as not terminated for cause. "Each of the agents were terminated for another reason initially and the original termination reason was sent electronically to the DOI via Appoint Pac. After legal investigated the allegation, they changed the termination reason to cause. Legal contacts the DOI via the attached letters and asks they change the producer's termination to cause. Agents Licenses receives a copy of the termination for cause letters sent to the producer and the DOI then updates the mainframe, PAL agent's record to show a termination for cause. Agents Licenses does not resubmit an appointment termination when the appointment had already been cancelled." The Company provided copies of letters sent to DOI's as evidence it notified the states of terminations for cause.

The examiners suggest there are two problems with the Company's process for handling terminations for cause. First, the timeframe between the original appointment termination submission and the notification of termination for cause is significant. As indicated by the Company's description, the agent appointments are immediately terminated by the company while Legal conducts an investigation. The examiners noted a significant time lapse of an average 117 days between the original dates of appointment termination in the Company's system when measured against the dates letters were sent to states. Second, the process followed by the Company does not ensure the accuracy of the records are submitted to the NAIC's Producer Database. This observation is made based upon the fact that none of the agents listed as terminated for cause in the Company's records were shown as having appointments terminated for cause in the NAIC system.

**Standard: Company has suitability standards for its products when required by applicable statutes, rules, and regulations.**

During the review of contracts issued, the examiners found several violations of the NAIC *Disclosure for Small Face Life Insurance Policies Model Act*. The Model Act requires an insurer issuing a small face amount policy (less than \$15,000) to provide a disclosure to the applicant in instances where the cumulative policy premiums may exceed the face amount during the term of the policy. The insurer is required to disclose the length of time until the cumulative policy premiums paid exceed the face amount of the policy.

The examiners noted eight small face amount life policies in the Issued sample that met the criteria under the Model Act and cited the Company for failing to provide the required disclosure. The Company agreed with the finding in one file where the policy was issued in a state that had adopted the Model. In the remaining seven cases, the Company disagreed with the finding because each policy was issued in a state that has not adopted the Model.

Another area of concern identified during the Marketing and Sales review was the large number of life insurance policies that are issued as Modified Endowment Contracts (MECs). It is the examiners' experience that most insurance companies issue a very small percentage of life insurance policies as MECs in consideration of the tax ramifications when a policyholder takes a loan or distribution from such a contract.

The Company provided statistical data indicating that 26% of all permanent life insurance policies written during the examination period were issued as MECs. In comparison to other insurance companies, this is considered high.

The examiners also find that the Company's Modified Endowment Contract brochure appears to be inconsistent with its sales practices. The brochure proclaims a MEC to be a useful selling tool for marketing to consumers with a large amount of cash to purchase a single premium life insurance contract.

Examination of the Company's issued files, however, revealed that many of the policies issued as MECs are Senior Whole Life products with monthly premium payment plans. This finding is supported by data provided by the Company indicating that 32.5% of its Traditional Life plans written during the examination period were issued as MECs.

**Standard: Policy issuance and insured requested cancellations are timely.**

The Company issues policies in a timely fashion. Many of the files in the policy sample were issued on the same day the application was received at the Company.

The timeliness related to returning of requested premiums upon cancellation do not appear to be handled as effectively. The examination team reviewed a sample of rejected applications. Of the 50 files reviewed, the examiners found two rejected applications in which the premiums were not returned for 70 and 76 days.

**Standard: All correspondence directed to the company is answered in a timely and responsive manner by the appropriate department.**

The Company has a significant volume of correspondence on a daily basis. The examination team took a physical tour of the Company's mail room facilities. The Company maintains two locations in downtown Chicago. All correspondence received is sent to a central location for processing. The mail may not be processed on the same day as received and could take up to 48 hours to be delivered to the appropriate recipient. According to the Company, special processing is granted to any correspondence sent from a regulatory agency to Compliance.

**Standard: All mandated disclosures for individual long-term care insurance are documented and in accordance with applicable statutes, rules, and regulations.**

The Company included all mandated disclosures in the files reviewed. The examiners did not note any exceptions in the issued files sample.

**Standard: All mandated definitions and requirements for group long-term care insurance are followed in accordance with applicable statutes, rules, and regulations.**

The Company presented six group policies for review. There were no exceptions noted in the review of these group LTC contracts.

**Standard: The company does not permit illegal rebating, commission cutting or inducements.**

The examiners did not find any instances of illegal rebating, commission cutting or inducements.

**Standard: Rejections and declinations are not unfairly discriminatory.**

A sample of 50 rejected applications was reviewed during the examination. The examiners did not find any evidence that the Company unfairly discriminated against any applicant.

**Standard: Rescission is not made for non-material misrepresentation.**

The Company identified seven LTC and HHC contracts that were rescinded during the examination period. During the review of these seven files, the examiners noted that one policy was actually withdrawn prior to issue and another was cancelled under the free-look provision.

The examiners found that the Company failed to follow its standard operating procedures in all five of the remaining rescission cases that occurred during the examination period. The Company's procedures require completion of an Agent Rescission/Reformation Questionnaire

which is to be signed by the Agent and Branch Manager. Examiners found that three files did not contain this required form while the other two files contained blank copies of the questionnaire.

As part of the rescission review, the examiners found that one contract was issued in violation of the NAIC LTC Model Regulation as well as the Company's LTC suitability policy. This contract was issued even though the assets listed on the LTC Personal Worksheet were under \$20K, and therefore, below the NAIC Model and Company's financial underwriting guidelines. An underwriting exception was also made for the applicant's height. When questioned about the contract, the Company stated that the underwriter should have sent a letter to the applicant explaining that the policy she applied for appeared to be unsuitable given her income and assets.

Each of the five contracts rescinded during the examination period were rescinded for undisclosed medical information at the time of application. Three of the contracts were rescinded as a result of a claim investigation. One contract was rescinded at the request of the contract owner who discovered discrepancies in the medical and financial information on the application. The other contract was rescinded during the underwriting process when applying for additional coverage.

Review of these files found that, in each case, the contract was issued without obtaining an Attending Physician Statement (APS) during the underwriting process. In three of the five files, the examiners found that the application listed at least one medication taken by the applicant or a "Yes" answer to one of the medical questions.

The examiners inquired in each case why the Company issued the contract without obtaining an APS. The Company admitted that Underwriting (UW) should not have issued the contract. In each of the other responses, the Company stated that the contract, as applied for, did not require UW to order an APS, Phone History Interview or Face-To-Face Assessment. Further, the Company states that the application contains comprehensive medical questions that provide the information the Company relies on to issue coverage.

As a result of the Company's practice of failing to obtain an APS on application for lower benefit multiplier LTC and HHC policies, all three of the contracts rescinded during claims investigation were underwritten at the time of claim.

**Standard: Pertinent information on applications that forms a part of the policy are complete and accurate and applications conform to applicable statutes, rules, and regulations.**

Throughout the examination, the examiners found documentation of the Company violating its SOP with regard to altered applications. The Company's procedures clearly state that any changes made on an application must be initialed by the applicant. Upon receipt of an application with a change, UW is instructed to ask for a corrected application page including the applicant's initials if the policy is being pended for other requirements. If there are no pending

UW requirements, the contract is issued as Out for Signature (OFS). This procedure was also documented in the LTC training DVD entitled, *Team Up to Make the Right Call*.

The examiners found that the Company failed to follow this established procedure. Many of the Complaints, Rejected Applications and Issued sample files contained applications with either changes not initialed by the applicant or changes initialed by the agent rather than the applicant.

### CLAIM HANDLING

From a universe of 374,263 Paid/Denied Claims, representing all jurisdictions, selection criteria for the claim sampling was developed to select files from all jurisdictions based on the percentage of actual number of claims paid/denied from each jurisdiction. A total of 650 claim files were randomly selected for review. During the course of the examination and after reviewing 116 paid claim files and 308 denied claim files, it became apparent that any further review and findings of the remaining sampled claim files would be redundant. The Lead States and the Company agreed that the findings in the reviewed files, along with the Company's self-reported findings would be sufficient to verify the Company's claims compliance issues.

During the examiners' review of the claim files, each file was evaluated to determine if the file met criteria in accordance with standards in the NAIC *Market Conduct Examiners Handbook*. Where compliance determination required more specific state timelines (days), the examiners applied the timelines applicable to Pennsylvania Regulations. The specific standards and findings are summarized below.

**Standard: The initial contact by the company with the claimant is within the required time frame.**

According to the Company, it maintains a system/process which automatically generates an acknowledgement letter ten days after a claim has been received. In the event the claim is paid or denied within 10 days, no letter is generated and the actual payment or denial serves as the acknowledgement.

The examiners found that the Company did not acknowledge receipt of a claim within the required time frame of 10 days in 2% of the Paid Claims files and 1% of the Denied Claims files reviewed for the entire examination period.

**Standard: Investigations are conducted in a timely manner.**

The Company's claim handling procedures were tested to determine compliance with this standard and with 31 Pa. Code, §146.6 which requires the Company to complete an investigation within 30 days of receiving the claim notice.

The examiners found that many of the denied claims were actually claims that should have been identified as rejected claims. These were claims submitted for expenses not covered, duplicate dates of service, not meeting the elimination period or under policies which had terminated or lapsed.

The examiners found that the Company did not complete the claim investigation within the time frame of 30 days in 63% of the Paid Claims files and 7% of the Denied Claims files reviewed for the entire examination period.

**Standard: Claims are settled and paid in a timely manner as required by statutes, rules and regulations.**

To determine the Company's compliance with this standard, the examination team referenced 31 Pa. Code §146.7(a) (1). According to this statute, the Company has 15 working days after receiving proof of loss to notify the claimant of the Company's plan to pay or deny coverage.

The practice of placing a claim on "hold" impacted the Company's compliance with this standard. The examiners found that there is no identifiable pattern to the number of times a file may be placed on hold, the reason why a claim was placed on hold or the number of days a claim is placed in hold status. The extensive use of the hold status impacts the timeliness of the claim adjudication process.

The examiners found that the Company did not pay or deny claims within the required time frame of fifteen (15) working days in 52% of the Paid Claims files and 15% of the Denied Claims files reviewed for the entire examination period.

**Standard: The company responds to claim correspondence in a timely manner.**

This standard was measured based on compliance with 31 Pa. Code §146.5(c), §146.7(c) and §146.6. In most instances, the examiners found that the only acknowledgment of claim correspondence was a claim payment or denial letter. Company responses to claimant communications were not evidenced in the files reviewed.

The examination team did not note any files where the Company had requested additional time to investigate the claim.

**Standard: Claim files are adequately documented.**

The documentation presented by the Company was sufficient to support the examiners' findings. Information not initially produced by the Company was available from the Company's document imaging system. Claim forms, care notes, physician statements, etc., related to proof of loss were provided upon request. System generated letters, explanation of benefits, acknowledgement letters, and system generated checks could be generated but with current dates. The Company is

aware of this limitation and has a systems initiative underway to retain these documents with the original dates.

**Standard: Claim files are handled in accordance with policy provisions and state law.**

The Company offers several HHC and LTC policy forms that feature a Restoration of Benefits provision. This provision restores the policy's maximum benefit for any one Period of Expense when a family member no longer requires or receives Qualified Long Term Care Services for 180 consecutive days for the same cause or causes for which a previous Period of Expense began.

During the review of claims denied during the examination period, the examiners found that when the maximum benefit was paid under a contract containing this provision, the Company's letter accompanying the final payment does not adequately describe the Restoration of Benefits feature available to the policyholder. The language the Company uses when a maximum benefit has been paid under a contract simply instructs the insured to, "Please review your policy to see if additional benefits may be due after a specified period of time has passed during which you have had no care for the cause or causes of this claim. This review of your policy will help you decide if you want to keep it." The letter does not refer to the provision by name or instruct the policyholder where in the contract he will find information regarding these additional benefits.

**Standard: Company claim forms are appropriate for the type of product.**

The Company maintains a series of claim forms for all products. The claim form package has increased from 4 to 13 pages between 2005 and 2007. According to the policy language, claim forms are not required for the consumer to submit a claim. The claimant may submit a written proof of loss in lieu of an actual claim form.

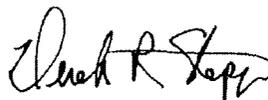
While Medicare Supplement claims were not reviewed under the scope of this examination, Medicare Supplement was reviewed as part of the sales and marketing review. The examination team noticed that the Medicare Supplement contracts contain confusing claim procedure information referencing multiple Company mailing addresses.

**Standard: Canceled benefit checks and drafts reflect appropriate claim handling practices.**

The Company informed the examination team that it could not provide actual check copies and that recreated checks would have a current date. Due to this limitation, the Company was asked to provide 10 cancelled checks. The examiners compared the check copies to the system payment information. The dates paid and the amounts paid from the claim work sheet reconciled and agreed with the check copies provided.

CONCLUSION

The examination was conducted by Derek Stepp, Debra Boothby, Keith Perry, Beverly Dale, Michael Pate, Heather Stepp and Brian Dunn, and is respectfully submitted.



Derek R. Stepp  
Market Conduct Examiner-in-Charge



Shelly Schuman  
Market Conduct Supervising Examiner

## RECOMMENDATIONS

The recommendations made below identify and summarize the corrective measures the lead states find necessary to address the issues and concerns found and detailed in the Report. These recommendations are general in nature. For a more detailed corrective action plan, refer to the settlement agreement document. The listing of these recommendations does not take into consideration any actions that the Company has initiated subsequent to the examination period.

1. The Company must review and revise current complaint handling policies and procedures to collect, maintain and retain appropriate documentation. The Company's policies and procedures should ensure compliance with record retention statutes, rules and regulations of each specific state.
2. The Company must maintain a formal complaint register. The register must contain sufficient data to ensure compliance with complaint retention statutes, rules and regulations of each specific state.
3. The Company must review and revise complaint handling policies and procedures to communicate complaint procedures to the policyholders, to address all issues of a complaint and to address these issues in a timely and proper manner. The Company's policies and procedures should ensure compliance with complaint handling statutes, rules and regulations of each specific state.
4. The Company must review and revise all internal producer training materials to ensure producers disclose correct and accurate information at the time of application, especially in the Long Term Care Insurance market.
5. The Company should enhance the producer training program nationwide, eliminate any producer transaction thresholds regarding complaints and producer sales misconduct and add corporate management oversight to the local agency compliance process.
6. The Company should enhance producer training to ensure compliance with the suitability and disclosure requirements for all annuities and insurance products.
7. The Company should review and enhance internal audit and compliance procedures which provides for: the evaluation of compliance with all statutes and regulations dealing with sales and marketing, periodic reviews of consumer complaints to determine patterns of improper practices and regular reporting to senior officers and the board of directors or an appropriate committee with respect to any significant findings.
8. The Company should review and revise the producer termination policies and procedures to ensure appropriate processing and referral of producers terminated for cause. The Company's policies and procedures should ensure compliance with producer termination statutes, rules and regulations of each specific state.

9. The Company should review and enhance all policy and procedures regarding life insurance and annuity suitability and disclosure requirements to ensure compliance with all statutes, rules, and regulations of each specific state.
10. The Company should review procedures on processing of rejected applications to ensure timely premium refunds.
11. The Company must review and follow its policies and procedures related to rescissions to ensure compliance with all statutes, rules, and regulations, including those that prohibit post claims underwriting.
12. The Company should review and revise current underwriting practices that are inconsistent with the Company's documented written procedures to ensure applications are complete and accurate and conform to applicable statutes and regulations of each specific state.
13. The Company should review and revise its maximum benefit claim denial letters to include details and explanation of the restoration of benefits provision in the contract.
14. The Company should review and revise its Medicare Supplement contract language to clarify the claims handling process.
15. The Company must review and revise procedures to ensure that claim investigations are completed timely and if additional investigation is required, to provide the claimant appropriate status letters to explain the reason for the delay. The Company's policies and procedures should ensure compliance with claim handling statutes, rules and regulations of each specific state.
16. The Company must review and revise procedures to ensure that claims are settled and paid timely. The Company's policies and procedures should ensure compliance with claim handling statutes, rules and regulations of each specific state.

## APPENDIX A

The following is a list of states and the state's applicable statutory authority for conducting an examination.

PARTICIPATING STATE	EXAMINATION AUTHORITY CITE
ALABAMA	ALA. CODE §§27-2-20 through 27-2-27
ALASKA	ALASKA STAT. §§21.06.120 through 21.06.170
ARIZONA	ARIZ. ADMIN. COMP. R20-6-1701 through R20-6-1704; ARIZ. REV. STAT. ANN. §§20-142, 20-156 through 20-160.
ARKANSAS	ARK. CODE ANN. §§23-61-201 through 23-61-302
CALIFORNIA	CAL. INS. CODE §§730 through 738
COLORADO	COLO. REV. STAT. §§10-1-201 through 10-1-207
CONNECTICUT	CONN. GEN. STAT. §38a-14; CONN. GEN. STAT. §38a-8
DELAWARE	DEL. CODE ANN. tit. 18 §318 through 330
DISTRICT OF COLUMBIA	D.C. CODE §§31-1401 through 31-1407
FLORIDA	FLA. STAT §§624.3161 through 624.322
GEORGIA	GA. CODE ANN. §§33-2-11 through 33-2-16
HAWAII	HAWAII REV. STAT. §§431:2-301 through 431:2-308
IDAHO	IDAHO CODE §§41-219 through 41-230
ILLINOIS	215 ILL. COMP. STATS. 5/132.1 through 5/132.7
INDIANA	IND. CODE §§27-1-3.1-1 through 27-1-3.1-18
IOWA	IOWA CODE §§507.1 through 507.17
KANSAS	KAN. STAT. ANN. §§40-222
KENTUCKY	806 KY. ADMIN. REGS. §2:110; KY REV. STAT §§304-2.210 through 304.2-300
LOUISIANA	LA. REV. STAT. ANN. §§22:1301 through 22:1302
MAINE	ME. REV. STAT. ANN. tit. 24-A §§221 through 228
MARYLAND	MD. ANN. CODE Ins. §§2-205 through 2-215
MASSACHUSETTS	MASS. GEN. LAWS ch. 175 §4
MICHIGAN	MICH. COMP. LAWS §500.222
MINNESOTA	MINN. STAT §60A.031
MISSISSIPPI	MISS. CODE ANN. §§83-5-201 through 83-5-207
MISSOURI	MO. REV. STAT. §§374.202 through 374.207
MONTANA	MONT. CODE ANN. §§33-1-401 through 33-1-413
NEBRASKA	NEB. REV. STAT. §§44-5901 through 44-5910
NEVADA	NEV. REV. STAT. §§679B.230 through 679B.300
NEW HAMPSHIRE	N.H. REV. STAT. ANN. §400-A:37
NEW JERSEY	N.J. REV. STAT. §§17:23-20 through 17:23-26
NEW MEXICO	N.M. STAT. ANN. §§59A-4-4 through 59a-4-21
NEW YORK	N.Y. INS. LAW §§309 through 313
NORTH CAROLINA	N.C. GEN. STAT. §§58-2-131 through 58-2-136
NORTH DAKOTA	N.D. CENT. CODE §§26.1-03-19.1 through 26.1-03-19.7
OHIO	OHIO REV. CODE ANN. §§3901.07 through 3901.071; §3901.045; §3901.36

OKLAHOMA	OKLA. STAT. tit. 36 §§309.1 through 309.7
OREGON	OR. REV. STAT. §§731.300 through 731.316
PENNSYLVANIA	PURDON STATUTES: 40 P.S. §§323.1 through 323.8
RHODE ISLAND	R.I. GEN. LAWS §§27-13.1-1 through 27-13.1-7
SOUTH CAROLINA	S.C. CODE ANN. §§38-13-10 through 38-13-60
SOUTH DAKOTA	S.D. CODIFIED LAWS ANN. §§58-3-1 through 58-3-27
TENNESSEE	TENN. CODE ANN. §§56-1-408 through 56-1-413; TENN. CODE ANN. §56-1-401
TEXAS	CHAPTER 751 OF THE TEXAS INSURANCE CODE
UTAH	UTAH CODE ANN. §§31A-2-203 through 31A-2-205; UTAH INS. REG. R 590-150-1 through 590-150-4
VERMONT	VT. STAT. ANN. tit. 8 §§3563 through 3576
VIRGINIA	VA. CODE §§38.2-1317 through 38.2-1321.1
WASHINGTON	WASH. REV. CODE ANN. §§48.03.010 through 48.03.075; §48.02.065
WEST VIRGINIA	W.VA. CODE §33-20-12; W.VA. REGS. §§114-15-1 through 114-15-8
WISCONSIN	WIS. ADMIN. CODE §INS.50.50; WIS. STAT. §§601.43 through 601.45
WYOMING	WYO. STAT. §§26-2-116 through 26-2-131

COMPANY RESPONSE

Bankers Life and Casualty Company  
11825 N. Pennsylvania Street  
Carmel, IN 46082-1911



March 20, 2008

Mr. Daniel A. Stencosky  
Market Conduct Division Chief  
Commonwealth of Pennsylvania  
Insurance Department  
Bureau of Enforcement  
1326 Strawberry Square  
Harrisburg, PA 17120

Re: Pennsylvania Examination Warrant Number: 07-M12-032  
Report of the Market Conduct Examination of  
Bankers Life and Casualty Company

Dear Mr. Stencosky:

Please accept this letter as the response of Bankers Life and Casualty Company ("Bankers" or the "Company") to the Examination Report dated February 22, 2008. We request that this letter be included in any public dissemination of the Examination Report to allow readers of the report to have an understanding of our responses to the findings contained therein.

As discussed in this letter and in the attachments hereto, we are confident we have effectively addressed or are addressing the findings identified in the Examination Report. As we have discussed previously with you and other representatives of the Pennsylvania Insurance Department, we plan to resolve all remaining issues through the implementation of several procedural and system improvements. Many of these improvements have already been implemented and others will be implemented as agreed in the Regulatory Settlement Agreement executed by Bankers, Bankers' affiliate Conseco Senior Health Insurance Company, the Commissioner of the Florida Office of Insurance Regulation, the Director of the Illinois Division of Insurance, the Commissioner of the Indiana Department of Insurance, the Commissioner of the Pennsylvania Insurance Department, and the Commissioner of the Texas Department of Insurance.

Because you and the other Lead Regulators have agreed to work with us to develop and implement plans to address the issues identified during the examination, we have chosen not exercise our right under 40 P.S. § 323.5 to submit detailed rebuttals and objections to any of the findings set forth in the Examination Report. However, the Company has identified concern in some instances regarding the applicability of certain Pennsylvania insurance laws to some of the alleged violations noted in the Exam Report. Although our decision not to submit such objections should not, and we understand will not, be construed as an admission of any of the findings set forth in the examination report, we acknowledge that certain aspects of the Company's claim, complaint handling, and marketing practices processes can be improved.

Despite our concerns with certain provisions of the Examination Report, like you and your colleagues, we believe market conduct examinations serve a useful purpose by identifying areas in the manner in which insurance companies do business that can be improved. In this instance, we believe that the examiners have identified certain areas of the Company's claim, complaint handling, and marketing processes that can be improved. We are committed to investing the necessary resources to bring about that improvement. For instance, we have made or will make the following changes in response to the recommendations appearing on pages 24-25 of the Examination Report:

**Recommendations 1, 2, and 3—Complaint Handling.**

The Company has implemented a new Inquiry Data Base ("IDB") effective January 1, 2008. All complaints are entered into this single database. This process will assist the Company in ensuring that complaints are addressed timely, efficiently and thoroughly; that proper and accurate explanations and information is provided to complaining parties; that complaints are processed within the required timeframes; and that complaint registers are properly maintained. The Company will also establish and maintain a complaint tracking and monitoring system designed to detect violations of Company policies and state and/or federal laws or regulations.

**Recommendations 4 and 5—Producer Training.**

The Company will ensure that all its current and future agents are properly trained on the required training modules such as products, underwriting, suitability, replacement, disclosure and compliance. Should any agent fail to successfully complete all of the specified training, the Company will not allow such agent to remain actively engaged in agent activities on behalf of Bankers until he or she successfully completes the required training. The Company will maintain training records to document the completion of the required training, including but not limited to the topics described herein and role playing to determine if the product being offered is suitable for a prospective customer. The Company will also monitor training conducted by all branch offices to ensure that training is completed in a timely fashion through reports and audits. The Company agrees that there will be no complaint threshold before corporate management oversees local agency compliance.

**Recommendation 6—Suitability Compliance.**

The Company has adopted and will continue to adhere to the NAIC model annuity suitability rules or state-specific suitability rules for all annuity sales, which includes the completion of a suitability form. Suitability training will be held and monitored as referenced in Recommendations 4 and 5.

**Recommendation 7—Enhancement of Internal Audit and Compliance Procedures.**

The Company reviews its internal audit and compliance procedures on a periodic basis and as necessary to respond to changes in the regulatory environments. Where those reviews demonstrate needed enhancements, the Company will implement those changes.

#### **Recommendation 8—Producer Termination Policies and Procedure.**

The Company is revising its termination procedure to include the following information in the letter sent to the appropriate regulatory body when it is determined a producer initially terminated for other than cause was terminated for cause:

- The date the producer's appointment was originally terminated;
- An identifier for the terminated producer that is recognizable by regulators; and
- A request for revision of the reason for the prior appointment termination to "termination for cause."

#### **Recommendation 9—Suitability Compliance.**

See response to Recommendation 6.

#### **Recommendation 10—Rejected Applications.**

The Company will review its policies and procedures related to rejected applications to ensure compliance with applicable statutes, rules and regulations.

#### **Recommendation 11—Rescissions.**

The Company's Underwriting Department currently requires a signature on every rescission by Underwriting management or the Underwriting's Audit team. All rescissions are logged by Underwriting's Audit team. Both the Underwriting Senior Director and Director participate in a group that has begun meeting regularly to discuss practices related to long term care underwriting and claims processes, including rescissions, with a goal toward employing best practices and looking for process improvements. Members of management from Actuarial and Claims are also a part of this group.

#### **Recommendation 12—Underwriting Practices.**

The Company's Underwriting Department is in the process of reinforcing underwriting practices with the Company's documented written procedures to ensure applications are complete and accurate and conform to applicable statutes and regulations of each specific state.

#### **Recommendation 13—Maximum benefit claim denial letters.**

The Company is in the process of revising its maximum benefit claim denial letter to more clearly explain the restoration of benefits provision available in some policies.

#### **Recommendation 14—Medicare Supplement contract language.**

The Company respectfully requests this recommendation be clarified. The only reference to Medicare Supplement contract language appearing in the Examination Report related to a statement that two contact addresses were provided for the Company's home office.

Our records show the Company's Medicare Supplement contracts list the Company's Home Office address as 222 Merchandise Mart Plaza, Chicago, IL on both page one of the policy and on the schedule page. If we have misinterpreted this recommendation, please advise of the correct interpretation.

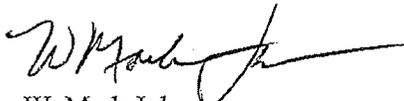
**Recommendations 15 and 16—Timely investigation and payment of claims.**

The Company has implemented several improvements to assist it in the timely investigation and payment of claims. Specifically, the Company's current workflow distribution system, BizFlow, provides us with reports that show us how long a claim has been in any given activity. These reports allow us to properly manage claims that are pending a complete investigation. We also balance the cycle time of new incoming mail and ending investigations by reviewing these reports and reassigning work to our adjusters on a daily basis. Additionally, we run an open 30-day report of open claims from the claim system to ensure investigations and claim payments remain timely and that no claim is left unattended. The Company is also in the process of implementing a new workflow system, Automatic Work Distributor (AWD), whose completed target implementation date is February of 2009<sup>1</sup>. This new workflow system has functionality that will allow us to track and monitor cases on a state-by-state basis that will allow us to ensure adherence to varying state-specific requirements.

We look forward to working with you in implementing this improvement plan for all jurisdictions that choose to participate in this process.

Thank you for your attention to this matter.

Sincerely,



W. Mark Johnson  
SVP, Chief Compliance Officer  
Bankers Life and Casualty Company

cc: Mr. Dennis Shoop  
Mr. Terrance Keating

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<sup>1</sup> This future date is a target date that reflects the Company's current implementation plans. The target date is subject to modification due to the happening of external events that could cause a delay. If it becomes evident to the Company that the target date must be extended, the Company will advise the Lead Regulators of the need for such an extension.