

**FLORIDA DEPARTMENT
OF
INSURANCE**



**TARGET MARKET CONDUCT REPORT
OF
BANKERS LIFE AND CASUALTY COMPANY
AS OF
JUNE 30, 2000**

DIVISION OF INSURER SERVICES

**BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT REVIEW**

MARKET CONDUCT SECTION

**BY ROBERT D. FLEGE, CIE, CFE, FLMI, ALHC, AIRC, ASF, LPCS
INDEPENDENT CONTRACTOR ANALYST**

ROBERT D. FLEGE
CIE, CFE, FLMI, ALHC, AIRC, ASF, LPCS*
IMSA Certified Independent Assessor (98-00)
6888 Glen Arbor Drive
Florence, Ky., 41042

Phone No. (859) 283-5366
Fax No. (859) 283-0696

EMail: rflege@aol.com

January 9, 2001

Honorable Tom Gallagher
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32390-0300

Dear Commissioner Gallagher:

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated August 16, 2000 a Target Market Conduct Examination has been performed on:

Bankers Life and Casualty Company
222 Merchandise Mart Plaza
Chicago, Illinois
60654-2001

The report of such examination is herein respectfully submitted.

Sincerely,

Robert D. Flege
CIE, CFE, FLMI, ALHC, AIRC, ASF, LPCS
Independent Contract Analyst

***Certified Insurance Examiner (CIE), Certified Fraud Examiner (CFE)**
Fellow Life Management Institute (FLMI), Associate Life & Health Claims (ALHC)
Associate Insurance Regulatory Compliance (AIRC)
Associate in State Filings (ASF)
Legal Principles Claims Specialist (LPCS)
Past President - Insurance Regulatory Examiners Society (IRES)

TABLE OF CONTENTS

INTRODUCTION..... 4

SCOPE OF EXAMINATION 4

DESCRIPTION OF COMPANY 6

CERTIFICATE OF AUTHORITY 8

ADVERTISING 9

COMPLAINT HANDLING..... 12

PRODUCER LICENSING..... 14

CLAIMS..... 15

Disability Income 15

Hospital Indemnity 16

Convalescent Care..... 19

Long Term Care/Home Health Care Claims 20

Major Medical 23

Medicare Supplement Claims..... 26

ANNUITIES..... 29

CONSUMER RECOVERIES 32

CONCLUSION 33

FINDINGS AND RECOMMENDATIONS 34

INTRODUCTION

Bankers Life and Casualty Company hereinafter is generally referred to as “the Company” when not otherwise qualified.

This Target Market Conduct Examination was conducted by Robert D. Flege, CIE, CFE, FLMI, ALHC, AIRC, ASF, LPCS, an Independent Contract Analyst, representing the Florida Department of Insurance pursuant to Section 624.3161, Florida Statutes.

This Target Market Conduct Examination commenced on August 19, 2000, and concluded on January 11, 2001.

SCOPE OF EXAMINATION

This examination covers various phases of the Company’s operations in the State of Florida from January 1, 1997 through June 30, 2000, and subsequent information when required.

The purpose of this Target Market Conduct Examination was to determine if the Company’s practices and procedures conform to the Florida Statutes and the Florida Administrative Code.

Procedures and conduct of the examination were in accordance with the Department's Field Examination Guidelines and the Market Conduct Examiner's Handbook produced by the National Association of Insurance Commissioners (NAIC). The handbook standards of a seven percent (7%) error factor for claim resolution procedures and a ten percent (10%) error factor for other procedures were given consideration and applied where applicable.

The examination included, but was not limited to, the following areas of the Company's operation involving annuity policies, accident and health insurance policies, long-term care and Medicare supplement policies written by the Company or assumed and reinsured under Assumption Reinsurance Agreements, with particular emphasis on paid and denied claims:

1. Advertising/Agent Oversight
2. Claims Handling
3. Complaint Handling
4. Cancellations and Non-Renewals
5. Annuities

Files were examined on the basis of file content at the time of examination. Comments and recommendations were made in those areas in need of correction and improvement.

DESCRIPTION OF COMPANY

History

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

In 1935, John D. MacArthur purchased Bankers Life and Casualty Company. The former chairman of the board held management and financial control of the company 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, through a wholly owned subsidiary, Great Southern Life Insurance Company of Texas, acquired Bankers Life and Casualty Company from the MacArthur Foundation.

Bankers Life Holding Corporation was formed by Capital Partners, L.P., to acquire Bankers Life and Casualty Company. On November 9, 1992, Bankers Life Holding

Corporation acquired through a subsidiary, Bankers Life Insurance Company of Illinois, all of the outstanding shares of common stock of Bankers Life and Casualty Company from I.C.H. Corporation. Bankers Life and Casualty Company today is a wholly owned subsidiary of Bankers Life Insurance Company of Illinois, an intermediate life insurance holding company, which, in turn, is owned by Conseco, Inc. based in Carmel, Indiana.

CERTIFICATE OF AUTHORITY

The Company is authorized to transact insurance in the State of Florida, subject to compliance with all applicable laws and regulations of Florida.

Certificate of Authority, No. 91-36-0770740, was issued on May 1, 1946.

ADVERTISING

The Company provided advertising and sales materials, buyer's guides, producer training manuals and training videos as well as advertising and sales materials utilized by the Company and their agency force during the time frame of the examination.

Long Term Care

Long Term Care Advertising appearing on the Bankers Life and Casualty Company website (<http://bankerslife.com/products.htm>) showed advertising that had not been filed with the Department as required by Section 627.9407, Florida Statutes and Rule 4-157. In a memo dated October 5, 2000, Nancy Hjort, Consumer Relations, asserted that the materials appearing on the website effective June 30, 2000 have now been filed.

Medicare Supplement

Medicare Supplement Advertising appearing on the Bankers Life and Casualty Company website (<http://bankerslife.com/products.htm>) showed advertising that had not been filed with the Department as required by Section 627.6735, Florida Statutes and Rule 4-157. In a memo dated October 5, 2000, Nancy Hjort, Consumer Relations, asserted that the materials appearing on the website effective June 30, 2000 have now been filed.

Findings

Failure to file Long Term Care Advertising materials constitutes a violation of Section 627.9407, Florida Statutes and Rule 4-157. The Company agrees to this violation in a memo from Nancy Hjort, Consumer Relations, dated October 5, 2000.

Failure to file Medicare Supplement Advertising Materials constitutes a violation of Section 627.6735, Florida Statutes and Rule 4-157. The Company agrees to this violation in a memo from Nancy Hjort, Consumer Relations, dated October 5, 2000.

Misrepresentation

Agent Robert T. Lee DOI File #1690

In a letter, dated August 2, 2000, Agent Lee distributed a testimonial letter to approximately six hundred and eighty-four (684) retired teachers of the Okaloosa Florida School System containing the following statement, “According to Robin Collins of the Florida Retirement System offices in Tallahassee, there are only 4 companies approved statewide for Long-Term Care coverage. They are AFLAC, Bankers Life and Casualty Company, Fortis and Life & Health Investors of America...”

Agent Lee distributed this letter along with other advertising materials identifying himself as an agent for the Company.

Agent Lee is currently a licensed agent in the State of Florida and appointed by the Company to represent them.

Finding

This action constitutes a violation of Section 626.9541(1)(b), Florida Statutes, which prohibits making, circulating, or placing before the public in the form of a circular, pamphlet or letter an advertisement which contains any assertion, representation or statement with respect to the business of insurance which is untrue, deceptive or misleading. Although the Company did not approve the text or circulation of this letter, the Company is responsible for the oversight of its agents and is therefore in violation of Section 626.9541(1)(b), Florida Statutes. It should be further noted that the Department's Market Conduct Investigation Unit has intervened with the Company and its Tallahassee, Florida office/agency location regarding violative advertising practices on two (2) occasions, in February of 2000 and August of 2000. Case Numbers 1618 and 1690 respectively. The agents have been referred to the Department's Bureau of Agent and Agency Investigations.

COMPLAINT HANDLING

Department of Insurance Complaints

The Company has Complaint Procedures in place. The Company maintains Complaint Logs for complaints received from the Department of Insurance. During the time frame of the examination a total of two hundred and two (202) complaints were received by the company. A review of fifty (50) files indicated an average response time of (12) days. No violations were noted.

Consumer Complaints

The Company has Complaint Procedures in place and maintains Complaint Logs for complaints received directly from consumers. The Company advised that their guidelines were for timeliness in responding to policyholder complaints. Nancy Hjort, Consumer Relations advised, in a memo dated October 17, 2000, that the Company's procedure is to acknowledge a complaint within fifteen (15) working days and to resolve the complaint within thirty (30) days after the acknowledgment. During the time frame of the examination, the Company received fifty-two (52) complaints directly from consumers. These fifty-two (52) files were reviewed and indicated an average response time of forty-one (41) days. The response to twenty-one (21) of these complaints was in excess of the forty-five (45) day deadline promulgated by the Company and therefore indicates a failure to comply with adopted complaint-handling procedures.

The following indicates the response time for consumer complaints:

Calendar Days	No. of Consumer Complaints	Percentage
0-45	31	60%
45-60	14	27%
Over 60	7	13%
Totals	52	100%

Finding

Response to twenty-one (21) consumer complaints was not within the guidelines set forth by the Company. This error factor is sufficient to establish a violation of Section 626.9541(1)(i)(3)(j) inasmuch as the violations were committed with such frequency as to indicate a general business practice. Nancy Hjort, Consumer Relations, in a memo dated January 4, 2001, agrees with this assertion.

PRODUCER LICENSING

The Company provided a listing of 1,382 active and terminated agents and managers who represented the Company from January 1, 1997 to June 30, 2000.

The examiner determined that all 1,382 agents listed had a valid Florida license for the period in which they represented the Company.

CLAIMS

Disability Income

Paid Claims

The examiner reviewed a random sample of twenty-five (25) of the 1,929 paid claims received during the time frame of the examination to determine compliance with Florida Statutes and Regulations. There were no exceptions noted.

Time Study Paid Disability Income Claims

Calendar Days	Number of Claims	Percentage
0-45	25	100%
46 – 120	0	0
121 and over	0	0
Totals	25	100%

The average time to process a paid claim was six (6) days.

Denied Claims

The examiner reviewed a random sample of twenty-five (25) of the 313 claims denied during the time frame of the examination. The examiner determined that denials were justified according to policy provisions. There were no exceptions noted.

Time Study Denied Disability Income Claims

Calendar Days	Number of Claims	Percentage
0-45	25	100%
46 – 120	0	0
121 and over	0	0
Totals	25	100%

The average time to process a denied claim was seven (7) days.

Hospital Indemnity

Paid Claims

The examiner reviewed a random sample of fifty (50) of the 1,046 claims paid during the time frame of the examination to determine compliance with Florida Statutes and Regulations. Three (3) files were found to be unacceptable indicating an error factor of six percent (6%). This is within the acceptable error ratios as established by the National Association of Insurance Commissioners (NAIC).

Time Study Paid Hospital Indemnity Claims

Calendar Days	Number of Claims	Percentage
0 – 45	47	94%
46 – 120	1	2%
121 and over	1	2%
Incomplete File	1	2%
Totals	50	100%

The average time to process a paid claim was fifteen (15) days.

Findings

1 Violation – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination. Provider billing statements were missing from the file. Nancy Hjort, Consumer Relations, in a memo dated October 18, 2000, agrees with this assertion.

2 Violations – Section 627.613(6), Florida Statutes. The Company failed to include applicable interest when making late payment of claim. Nancy Hjort, Consumer Relations, in a memo dated October 20, 2000, agrees with this assertion and a check in the amount of \$5.49, covering applicable interest, has been forwarded. In the other instance, Nancy Hjort, Consumer Relations, in a memo dated October 18, 2000, agrees

with this assertion and a check in the amount of \$8.80, covering applicable interest, has been forwarded.

The two (2) claims involving payment of applicable interest were:

1. Policy/Claim Number: 640,131,959/735252
2. Policy/Claim Number: 800,519,830/075780

2 Violations – Section 627.613(2), Florida Statutes. The Company failed to make payment within forty-five (45) days of receipt of a claim. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

The two (2) claims involving late payment were:

1. Policy/Claim Number: 640,131,959/735252
2. Policy/Claim Number: 800,519,830/075780

Denied claims

The examiner reviewed a random sample of fifty (50) of the 1,066 claims denied during the time frame of the examination. The examiner determined that denials were justified according to the policy provisions. There were no exceptions noted.

Time Study Denied Hospital Indemnity Claims

Calendar Days	Number of Claims	Percentage
0 – 45	50	100%
46 – 120	0	0
121 and over	0	0
Totals	50	100%

The average time to process a denied claim was eight (8) days.

Convalescent Care

Paid Claims

The examiner reviewed a random sample of twenty-five (25) of the 133 claims paid during the time frame of the examination to determine compliance with Florida Statutes and Regulations. There were no exceptions noted.

Time Study Paid Convalescent Care Claims

Calendar Days	Number of Claims	Percentage
0 – 45	25	100%
46 – 120	0	0
121 and over	0	0
Totals	25	100%

The average time to process a paid claim was thirteen (13) days.

Denied Claims

The examiner reviewed a random sample of twenty-five (25) of the 133 claims denied during the time frame of the examination. The examiner determined that denials were justified according to the policy provisions. There were no exceptions noted.

Time Study Denied Convalescent Care Claims

Calendar Days	Number of claims	Percentage
0 – 45	24	96%
46 – 120	1	4%
121 and over	0	0
Totals	25	100%

The average time to process a denied claim was eighteen (18) days.

Long Term Care/Home Health Care Claims

Paid Claims

The examiner reviewed a random sample of one hundred (100) of the 10,863 claims paid during the time frame of the examination to determine compliance with Florida Statutes and Regulations. Three (3) files were found to be unacceptable indicating an error factor of three percent (3%).

Time Study Paid Long Term Care/Home Health Care Claims

Calendar Days	Number of Claims	Percentage
0 – 45	97	97%
46 – 120	1	1%
121 and over	0	0
Missing or Incomplete Files	2	2%
Totals	100	100%

The average time to process a paid claim was eleven (11) days.

Findings

2 Violations – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination.

Nancy Hjort, Consumer Relations, in a memo dated October 27, 2000, agreed that Claim File No. 675899 was not available.

Nancy Hjort, Consumer Relations, in a memo dated September 29, 2000, agreed that provider bills, invoices, etc., were missing from Claim File No. 143863 and not available.

1 Violation – Section 627.613(2), Florida Statutes. The Company failed to make payment within forty-five (45) days of receipt of a claim. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

1 Violation – Section 627.613(6), Florida Statutes. The Company failed to include applicable interest when making late payment of claim. Nancy Hjort, Consumer Relations, in a memo dated October 2, 2000, agrees with this assertion. The total amount of interest due was less than \$5.00 so payment was not required. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

Denied Claims

The examiner reviewed a random sample of fifty (50) of the 2,081 claims denied during the time frame of the examination. The examiner determined that denials were justified according to the policy provisions. One (1) file was found to be unacceptable which would indicate an error factor of four percent (4%). Nancy Hjort, Consumer Relations, in a memo dated October 27, 2000, agreed that Claim File No. 477804 was not available.

Time Study Denied Long Term Care/Home Health Care Claims

Calendar Days	Number of Claims	Percentage
0 – 45	22	88%
46 – 120	2	8%
121 and over	0	0
Missing Files	1	4%
Totals	25	100%

The average time to process a denied claim was thirteen (13) days.

Findings

1 Violation – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination. Claim File No. 477804 was

missing. Nancy Hjort, Consumer Relations, in a memo dated October 27, 2000, agrees with this assertion.

Major Medical

Paid Claims

The examiner reviewed a random sample of one hundred (100) of the 14,483 claims paid during the time frame of the examination to determine compliance with Florida Statutes and Regulations. The examiner found seven (7) files to be unacceptable which indicates an error factor in excess of the minimum standards set forth by the National Association of Insurance Commissioners (NAIC). In one (1) instance the file material was not date stamped to document the date it was received by the Company. Five (5) files did not contain the applicable provider billing statements. Various documentation was missing from one (1) file.

Time Study Paid Major Medical Claims

Calendar Days	Number of Claims	Percentage
0 – 45	100	100%
46 – 120	0	0
121 and over	0	0
Totals	100	100%

The average time to process a paid claim was eight (8) days.

Findings

7 Violations – Section 624.318(2), Florida Statutes. The Company failed to produce files, or documentation in files was incomplete or missing.

Nancy Hjort, Consumer Relations, in a memo dated September 19, 2000, agrees with this assertion inasmuch as file material in Claim File No. 172800 was not date stamped to document the date received by the Company.

Nancy Hjort, Consumer Relations, in memos dated September 18 and September 19, 2000, agrees with this assertion inasmuch as provider billing statements and documentation was missing from six (6) Claim File Nos; 45869, 249348, 32606, 450360, 520503, and 752359.

Denied Claims

The examiner reviewed a random sample of one hundred (100) of the 10,645 claims denied during the time frame of the examination. Three (3) files were found to be unacceptable which indicates an error factor of three percent (3%). Provider billing statements were missing. The examiner determined that denials were justified according to the policy provisions.

Time Study Denied Major Medical Claims

Calendar Days	Number of Claims	Percentage
0 – 45	99	99%
46 – 120	1	1%
121 and over	0	0
Totals	100	100%

The average time to process a denied claim was eight (8) days.

Findings

3 Violations – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination. Nancy Hjort, Consumer Relations, in memos dated September 21, 2000, agrees with this assertion confirming that provider billing statements were not available for Claim File Nos; 127100, 495052 and 270966.

Medicare Supplement Claims

Paid Claims

The examiner reviewed a random sample of one hundred (100) of the 1,384,013 claims paid during the time frame of the examination was to determine compliance with Florida Statutes and Regulations. The examiner found five (5) files to be unacceptable which would indicate an error factor of five percent (5%). Three (3) of the files were not legible and the Company was unable to produce provider billing statements pertaining to two (2) files.

Time Study Paid Medicare Supplement Claims

Calendar Days	Number of Days	Percentage
0 – 45	96	96%
46 – 120	0	0
121 and over	0	0
Missing Files or Not Legible	4	4%
Totals	100	100%

The average time to process a paid claim was six (6) days.

Findings

5 Violations – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination. Files were either missing or the Company was unable to present legible documentation.

Nancy Hjort, Customer Relations, in memos dated September 7, 2000 agrees with this assertion confirming that three (3) claims files were not legible, Claim Nos; 181079,

135658 and 114237. Nancy Hjort, Customer Relations, in memos dated September 6, 2000 agrees with this assertion confirming that provider billing statements were not available associated with Claim File Nos; 950185 and 206328.

Denied Claims

The examiner reviewed a random sample of one hundred (100) of the 10,863 claims denied during the time frame of the examination. The examiner determined that denials were justified according to the policy provisions. The examiner found three (3) files to be unacceptable which indicates an error factor of three percent (3%). This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

Time Study Denied Medicare Supplement Claims

Calendar Days	Number of Claims	Percentage
0 – 45	99	99%
46 – 120	0	0
121 and over	1	1%
Totals	100	100%

The average time to process a denied claim was ten (10) days.

Findings

2 Violations – Section 624.318(2), Florida Statutes. The Company failed to provide records and documents for the purpose of the examination. Claim materials and provider billing was missing from files. Nancy Hjort, Consumer Relations, in a memo dated September 25, 2000, agrees with this assertion inasmuch as Claim File No. 275527 could not be produced.

Nancy Hjort, Consumer Relations, in a memo dated September 25, 2000, agrees with this assertion inasmuch as the Company was unable to produce the provider billing statement associated with Claim File No. 353892.

1 Violation – Section 627.613(4), Florida Statutes. The Company did not pay or deny a claim within 120 days after receiving the claim. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

Nancy Hjort, Consumer Relations, in a memo dated September 25, 2000 agrees with this assertion and advises that the initial handling of the claim was an isolated error. Ms. Hjort advises that a Claim Review Department correspondent received the claim form and returned it to the policyholder and should have sent the claim form to the Claim Adjustment Department to create a claim record. When the form was returned later by the policyholder the claim was serviced and paid.

ANNUITIES

The Company provided advertising materials associated with the marketing of annuities as well as sample financial disclosure statements provided to policyholders. The examiner made inquiries to the Company about agent's sales practices, commissions and withdrawal charges.

Nancy Hjort, Consumer Relations, in a memo dated October 26, 2000, advised that it was the agent's responsibility to determine the needs of a prospect and the prospect's financial circumstances. The Company and agents utilize a Financial Realities fact finder as a tool for determining what products a prospective applicant may need or could afford. The use of the fact finder is not mandatory.

Ms. Hjort continues in the memo of October 26, 2000, as to suitability, that agents are required to complete a Code of Ethics course and are trained to sell only products suitable in light of the determined financial circumstances of a prospect.

In a review of the average age of the owner of an annuity at surrender, the examiner determined that the Company complies with the guidelines disclosed for the particular policy form as indicated in filings made with the Department of Insurance.

The following indicates the issue ages disclosed in filings, for instance:

Premium Type	Issue Ages
Flexible Premium Deferred – “premium tax waiver plan” deferred annuity	Qualified: 18 – 84 Age nearest Birthday Non-Qualified: 0 – 84 Age nearest Birthday
Flexible Premium Deferred – flexible premium retirement annuity	Issue Ages Qualified: 18 – 69 Age nearest Birthday Non-Qualified: 0 – 69 Age nearest Birthday
Single Premium Deferred – single premium deferred annuity	Qualified: 18 – 84 Age nearest Birthday Non-Qualified: 0 – 90 Age nearest Birthday
Single Premium Deferred with Bonus – deferred “bonus” annuity	Qualified: 18 – 84 Age nearest Birthday Non – Qualified: 0 – 84 Age nearest Birthday
Single Premium Immediate Annuity	Male and Female: 40 – 90 Age nearest Birthday

The following items are of particular note:

1. Commissions range from 1.5% to 3% depending on the product.
2. Nancy Hjort, Consumer Relations, states, in a memo dated October 26, 2000, “If the Annuitant dies, all of our annuity products pay the full value. No withdrawal charges apply.”
3. On Single Premium Deferred Annuities, the annuitant has a right to choose monthly income at any time. The Company complies with the needs of the annuitant and the policyholder can request income to begin as soon as thirty (30) days after issue; at any date before income is scheduled to begin; at the date income is scheduled to begin; or at a later date than specified in the policy.
4. An annuitant need not begin taking monthly income in order to receive money from the annuity. Withdrawals may be taken at any time and the annuity can be surrendered at any time.

There has been a documented instance where the Company practice as to determination of suitability was questioned. Department of Insurance Case #1644 involved a complaint regarding a Flexible Premium Annuity sold to Mr. Richard Guy at 82 years of age, Annuity No. 7,690,195. It was determined that Mr. Guy should receive a full refund including withdrawal charges and the Department confirmed the payment was made by the Company and funds received.

The examiner generally agrees with the company practices as regards determination of suitability, compliance with reasonable age at time of issue as disclosed in filings and payment procedures.

CONSUMER RECOVERIES

As a result of this Target Market Conduct Examination payments have been made to providers in the amount of fourteen dollars and twenty-nine cents (\$14.29) which represented interest due on two (2) claims, which were not paid within forty-five (45) days. Interest due one additional file was less than five dollars (\$5.00) and the Company was not instructed to process and make payment.

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC) were followed in performing this Target Market Conduct Examination of Bankers Life and Casualty Company as of June 30, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Robert D. Flege
CIE, CFE, AIRC, FLMI, ALHC, ASF, LPCS
Independent Contract Analyst

FINDINGS AND RECOMMENDATIONS

The following findings were made in the preceding pages of this report. The Company is directed to:

- Page 10 File Website Long Term Care Advertising materials in accordance with Section 627.9407, Florida Statutes and Rule 4-157.
- Page 10 File Website Medicare Supplement Advertising materials in accordance with Section 627.6735, Florida Statutes and Rule 4-156.
- Page 11 Cease Unfair Methods of Competition and Unfair or Deceptive advertising a violation of Section 626.9541(1)(b), Florida Statutes.
- Page 13 Comply with Section 626.9541(1)(i)(3)(j), Florida Statutes, by complying with adopted and implemented complaint-handling procedures.
- Page 16 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination.
- Page 16 Comply with Section 627.613(6), Florida Statutes. Implement procedures to assure that applicable interest is included in the late payment of claims. Two (2) violations. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).
- Page 17 Comply with Section 627.613(2), Florida Statutes. Implement claim handling standards to assure that all claims are paid within forty-five (45) days of receipt. Two (2) violations. This is within the acceptable error

factor as set forth by the National Association of Insurance Commissioners (NAIC).

Page 20 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination. Two (2) violations.

Page 20 Comply with Section 627.613(2), Florida Statutes. Implement claim handling standards to assure that all claims are paid within forty-five (45) days of receipt. One (1) violations. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

Page 21 Comply with Section 627.613(6), Florida Statutes. Implement procedures to assure that applicable interest is included in the late payment of claims. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).

Page 21 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination.

Page 23 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination. Seven (7) violations.

Page 25 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination. Three (3) violations.

Page 26 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination. Four (4) violations.

Page 27 Comply with Section 624.318(2), Florida Statutes. Implement record retention procedures to assure availability of records and documents for the purpose of an examination. Two (2) violations.

Page 28 Comply with Section 627.613(4), Florida Statutes. Implement claim handling procedures to assure that all claims are either paid or denied no later than 120 days after receiving the claim. This is within the acceptable error factor as set forth by the National Association of Insurance Commissioners (NAIC).