FLORIDA DEPARTMENT OF INSURANCE

MARKET CONDUCT REPORT OF EXAMINATION

OF
AMERICAN HERITAGE LIFE INSURANCE COMPANY

AS OF
DECEMBER 31,1996

DIVISION OF INSURER SERVICES

BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT

MARKET CONDUCT SECTION

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September 10, 1998

Honorable Bill Nelson
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32399-0300

Dear Commissioner Nelson:

Pursuant to the provisions of Section 627.3161, Florida Statutes, and in accordance with your Letter of Authority and the resolutions adopted by the National Association of Insurance Commissioners (NAIC), a Market Conduct Examination has been performed on:

American Heritage Life Insurance Company
1776 American Heritage Drive
Jacksonville, Florida 32224

at its Home Office in Jacksonville, Florida. The report of such examination is herein respectfully submitted.

INTRODUCTION

American Heritage Life, hereinafter is generally referred to as "the Company" when not otherwise qualified.

The last Market Conduct Examination conducted by the Florida Department of Insurance, hereinafter generally referred to as "the Department", was as of December 31, 1993.

This Market Conduct Examination commenced on January 15, 1998, and concluded on September 10, 1998.

SCOPE OF EXAMINATION

This examination covered the period of the Company's operation in the State of Florida from January 1, 1994, through December 31, 1996; and where considered appropriate, transactions and affairs subsequent to the examination period.

The purpose of this Market Conduct Examination was to determine if the Company's practices and procedures conformed with the Florida Statutes and the Florida Administrative Code.

Statistical information was included in this examination report. The National Association of Insurance Commissioners' Examination Handbook standards of 7% error ratio for claim resolution procedures and 10% error ratio for other procedures were applied. Any error appearing to be a pattern or a general business practice was included in this examination report.

The examination included, but was not limited to, the following areas of the Company's operation:

1. Sales Brochures and Advertisements
2. Appointment and Termination of Agents

3. Policy Forms, Rates and Underwriting
4. Claims and Complaint Handling Procedures

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 or improvement.

DESCRIPTION OF COMPANY

History

During the period under review, American Heritage Life Insurance Company was domiciled in the State of Florida and was a stock life insurance company that was a wholly-owned subsidiary of American Heritage Life Investment Corporation. The Company was licensed to transact insurance business in the State of Florida on September 11, 1956.

Certificate of Authority

The Company was authorized to write the following lines of business in the State of Florida, subject to compliance with all applicable laws and regulations of Florida:

Code 400-Life	Code 410-Group Life & Annuities
Code 440-Credit Life & Health	Code 441-Credit Disability
Code 450-Accident and Health	

Organizational Chart

The Company's organizational chart is shown on the following page.

TERRITORY AND PLAN OF OPERATION

American Heritage Life Insurance Company was authorized to transact insurance business in all states, Puerto Rico and U.S. Virgin Islands, with the exception of New York.

The Company marketed and serviced their products through the use of licensed agents and brokers.

During the period under review, the lines written were:

1. Life
2. Group Life
3. Credit Life
4. Credit Health (Disability)
5. Health

During the period under review, the Company did not write any lines of insurance business for which they were not authorized on their Certificate of Authority, as required by Section 624.401 (2), Florida Statutes.

SALES AND ADVERTISEMENTS

Marketing materials provided to the examiner representing all advertisements utilized by the Company were examined to determine conformity with Rule 4-150, Florida Administrative Code. No discrepancies were noted.

The Company maintained an advertising file in accordance with Rules 4-150.018 (1) and 4-150.119 (1), Florida Administrative Code.

The Company filed Certificates of Compliance for Advertising with its Annual Statements for 1994, 1995 and 1996 as required by Rules 4-150.018 (2) and 4-150.119 (2), Florida Administrative Code.

AGENT APPOINTMENT,RENEWAL AND TERMINATION

When the Company received the renewal list of agents from the Bureau of Agent and Agency Licensing, additions and deletions were made as necessary. The renewal list of agents was returned to the Department with a Company check in compliance with instructions from the Bureau of Agent and Agency Licensing.

Twenty five (25) terminated agents' personnel files were examined to determine proper reporting by the Company. No discrepancies were noted. It was noted that the Company procedures require the use of Form DI4-39 when reporting terminated agents only for cause, as instructed by the Bureau of Agent and Agency Licensing.

Additional appointments were made as required by Section 626.341, Florida Statutes, when business was accepted from a licensed agent who was not previously appointed by the Company.

EXCESS OR REJECTED INSURANCE

The Company did not accept excess or rejected life and health insurance business from non-contracted agents, as defined by Sections 626.793 and 626.837, Florida Statutes.

POLICY FORM AND RATE FILINGS

The Company maintained a file containing copies of policies, rates, riders, endorsements and correspondence appropriate thereto of all forms filed and approved by the Department.

Company filings for 1994, 1995 and 1996 were reviewed to determine if policy forms being used by the Company had been stamped "filed" or "approved" by the Department as required by Sections 627.410,

627.6785 and 627.682, Florida Statutes and Rule 4-163, Florida Administrative Code. No discrepancies were noted.

UNDERWRITING AND RATE SURVEY

The underwriting and rate survey included an analysis of the following Company procedures:

1. Basic underwriting guidelines
2. Proper issuance of forms, riders and endorsements
3. Proper use of rates
4. Correspondence during the policy issue process
5. Unfair discrimination

APPLICATION REVIEW

Applications for life, health, and credit insurance were surveyed.

A random sample of four hundred sixteen (416) files, from a total population of ninety one thousand, seven hundred ninety-seven, (91,797) for 1994, 1995, and 1996, was reviewed.

Applications and related forms used were those filed and approved by the Department as required by Section 627.682, Florida Statutes.

All applications reviewed contained the insurer's name on the first page of the form as required by Section 627.4085, Florida Statutes.

Forty-two (42) applications reviewed did not contain the agent's name as required by Section 627.4085, Florida Statutes.

Forty-two (42) applications reviewed did not contain the license identification number as required by Section 627.4085, Florida Statutes.

INSURED'S RIGHT TO RETURN POLICY

A sample of thirty-four (34) files, from a total population of three hundred thirty-one (331), for 1994, 1995, and 1996, was reviewed.

The review indicated that the Company complied with Rules 4-154.003 and 4-157.018, Florida Administrative Code and Sections 626.99 (4)(a), 627.674 (4)(d), and 627.9407 (8), Florida Statutes. Refunds reviewed were handled in a timely manner.

REPLACEMENT OF INSURANCE

The Company maintained a life replacement register for 1996. The life replacement register for 1994 and 1995 could not be located for review as required by Rule 4-151.007 (3) (e), Florida Administrative Code.

Copies of "Notice to Applicant" regarding replacement of life insurance, comparative information form and proposed insurance and all sales proposals were maintained for 1996 as required by Rules 4-151.007 (3) (c) or (e), 4-151.008 (2) (a) and (b); and 4-157.016 (2), Florida Administrative Code. The Company did not maintain replacement records for 1994 and 1995.

Copies of 1996 "Notice to Applicant" were not being sent to existing insurers whose policies were being replaced within the

specified time as required by Rules 4-151.007 (3) (c) or (e), Florida Administrative Code.

Fifty (50) individual life insurance files, from a total population of one hundred nineteen (119) for the year 1996, were reviewed. Thirty-seven (37) discrepancies were noted.

There were no individual health replacements for the years under review.

One hundred (100) files, from a total population of three hundred twenty-eight (328) long-term care insurance for the years 1994, 1995, and 1996, were reviewed. No discrepancies were noted.

NONFORFEITURE OPTIONS AND AUTOMATIC PREMIUM LOANS

A random sample of one hundred fifty (150) nonforfeiture option files, from a total population of fifteen thousand, four hundred twenty-nine (15,429) Extended Term, Paid-Up Insurance and Automatic Premium Loans was requested for review. Files reviewed indicated the values and terms were correctly calculated and were processed in a timely manner.

A random sample of thirty-eight (38) Policy Loan Benefit files from a total population of six thousand, nine hundred eighty-four (6,984) was requested for review to determine if the interest charged was appropriate and within the statutory limits established by Sections 627.458 and 627.4585, Florida Statutes. Five (5) discrepancies were noted due to the Company's inability to provide complete records.

A random sample of thirty-seven (37) Cash surrenders of life or annuity policy files from a total population of four thousand two hundred and twenty-one (4,221) was reviewed to determine if

interest was paid after thirty (30) days in compliance with Section 627.482, Florida Statutes. No discrepancies were noted

In the event of non-payment of premium on a life policy, if the insured did not choose automatic premium loan as the non-forfeiture provision, the automatic option in the policy was used. The Automatic option in most cases was extended term insurance, except in the case of a rated policy. For a rated policy, the automatic option was paid-up insurance. The insured was sent a letter advising the option under which the policy had been placed. These procedures complied with the requirements of Section 627.476, Florida Statues, Standard Non-Forfeiture Law for Life Insurance.

A random sample of thirty (30) extended term files from a total population of one hundred eighty-six (186) files was requested for review. Thirteen (13) discrepancies were noted due to the Company's inability to provide complete records.

A random sample of eleven (11) paid up files from a total population of sixty-four (64) was requested for review. Six discrepancies were noted due to the Company's inability to provide complete records.

A random sample of thirty-four (34) automatic premium loan files was requested for review. No discrepancies were noted.

In conclusion, it was noted that twenty-four (24) of the one hundred fifty (150) NonForfeiture option files requested for review could not be located. This resulted in a violation of Section 624.318, Florida Statutes, for failure to maintain adequate and complete records.

CANCELLATIONS AND NONRENEWALS

A random sample of one hundred ten (110) individual health cancellations and non-renewals from a total population of one thousand three hundred sixty-seven (1,367) was reviewed.

In the event of cancellation, policyholders were promptly returned the unearned portion of any premium paid as required by Sections 627.6043 (2) and 627.6645 (4), Florida Statutes.

A random sample of sixty-one (61) credit life and credit disability files, was reviewed. All files reviewed were canceled and refunded as required by Rule 4-163.003, Florida Administrative Code.

CLAIMS ADMINISTRATION

The Company established claim settlement procedure to maintain control of all claims from the time of receipt to the time of final payment. Claims were reported to and handled in the Home Office of the Company with the exception of Long Term Care business. Long Term Care claims were administered by Wakely and Associates, Inc., a licensed third party administrator, in Clearwater, Florida.

The Claims Managers certified that they have read and understand Section 626.9541 (1)(i), Florida Statutes, relating to unfair claim settlement practices.

TIME STUDY FOR PAID AND DENIED CLAIMS

Claims were randomly selected and reviewed for compliance with:

1. Contract provisions
2. Timeliness and accuracy of payments
3. Supporting documentation
4. Unfair claim settlement practices

A time study for paid and denied claims was conducted to determine the "calendar days" required to process a claim after receiving proper proof of loss.

The term "calendar days" included Saturday, Sunday and holidays. Cycle time used in the analysis was for the following groups of days: 1-45, 46-120, 121 and over.

The population of processed paid and denied claims for the examination period reviewed is as follows:

Individual Life Claims - Paid

1994	202 Claims for	$ 4,566,536
1995	217 Claims for	$ 7,281,341
1996	230 Claims for	$ 3,897,980
Total	649 Claims for	$15,745,857

Individual Life Claims - Denied

1994	6 Claims
1995	8 Claims
1996	9 Claims
Total	23 Claims

Group Life Claims - Paid

1994	119	Claims for	$2,072,266
1995	103	Claims for	$2,039,427
1996	101	Claims for	$1,033,704
Total	323	Claims for	$5,145,397

Group Life Claims - Denied

There were no denied group life claims for the period under review.

Individual Health Claims - Paid

1994	13,249	Claims for	$6,504,862
1995	12,957	Claims for	$6,615,037
1996	12,784	Claims for	$6,859,364
Total	38,990	Claims for	$19,979,263

Individual Health Claims - Denied

1994	23,796	Claims
1995	24,826	Claims
1996	26,190	Claims
Total	74,812	Claims

Group Health Claims - Paid

1994	502,594	Claims for	$ 94,330,098
1995	131,144	Claims for	$ 21,002,215
1996	113,682	Claims for	$ 17,867,061
Total	747,420	Claims for	$133,199,374

Group Health Claims - Denied

1994	301,435	Claims
1995	54,188	Claims
1996	46,735	Claims
Total	402,348	Claims

Long-Term Care Claims-Paid

1994	0	Claims for	0
1995	0	Claims for	0
1996	2	Claims for	$12,291
Total	2	Claims for	$12,291

Long-Term Care Claims-Denied

There were no denied Long-Term Care Claims for the period under review.

Credit Life Claims-Paid

1994	680	Claims for	$ 8,402,878
1995	1,154	Claims for	$10,465,776
1996	1,152	Claims for	$10,419,297
Total	2,986	Claims for	$29,287,951

Credit Life Claims-Denied

1994	32	Claims
1995	33	Claims
1996	30	Claims
Total	95	Claims

Credit Health Claims-Paid

1994	2,608	Claims for	$ 3,520,184
1995	3,282	Claims for	$ 4,952,971
1996	3,517	Claims for	$ 5,861,078
Total	9,407	Claims for	$14,334,233

Credit Health Claims-Denied

1994	20	Claims
1995	28	Claims
1996	27	Claims
Total	75	Claims

Eight hundred twenty-five (825) claim files from the above-listed population were reviewed. The results of the review are as follows:

CALENDAR DAYS/PERCENTAGE OF CLAIMS

Individual Life Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	97	97%
46-120	2	2%
121 and over	1	1%
Total	100	100%

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

Individual Life Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	23	100%
46-120	0	0%
121 and over	0	0%
Total	23	100%

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

Individual Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

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

Individual Health Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	50	100%
46-120	0	0%
121 and over	0	0%
Total	50	100%

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

Group Life Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

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

Group Life Claims-Denied

There were no denied Group Life Claims during the period under review.

Group Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%

121 and over	0	0%
Total	100	100%

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

Group Health Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	50	100%
46-120	0	0%
121 and over	0	0%
Total	50	100%

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

Credit Life Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

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

Credit Life Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	50	100%
46-120	0	0%
121 and over	0	0%
Total	50	100%

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

Credit Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

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

Credit Health Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	50	100%
46-120	0	0%
121 and over	0	0%

Total	50	100%

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

Long-Term Care Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	2	100%
46-120	0	0%
121 and over	0	0%
Total	2	100%

The average time required to process a claim was five (5) days.

Long-Term Care Claims-Denied

There were no denied Long Term-Care Claims during the period under review.

An analysis of the claim study revealed the following:

1. A random sample of six hundred two (602) paid claim files from a total population of seven hundred ninety-nine thousand, seven hundred seventy-seven (799,777) was reviewed to determine if benefits were allowed according to the policy

contract as required by Section 626.877, Florida Statutes. No discrepancies were noted.

2. A random sample of eight hundred twenty-five (825) claim files from a total population of seven hundred ninety-nine thousand, seven hundred seventy-seven (799,777) was reviewed to determine if they had been processed in a timely manner as required by Section 627.613 and 627.657(2), Florida Statutes. No discrepancies were noted.

3. A random sample of one hundred (100) life claims from a total population of six hundred forty-nine (649) was reviewed to determine if the 11% interest, or interest at an annual rate equal to or greater than the Moody's Corporate Bond Yield Average-Monthly Average of as to the day the claims were received and not less than 8% on claims after January 1,1993 was paid in accordance with Section 627.4615, Florida Statutes. No discrepancies were noted.

4. A random sample of one hundred (100) individual health claims from a total population of thirty eight thousand, nine hundred and ninety (38,990) was reviewed to determine if the 10% interest due on certain claims was paid as required by Section 627.613(6), Florida Statutes. No discrepancies were noted.

5. A random sample of eight hundred twenty-five (825) claim files from a total population of seven hundred ninety-nine thousand, seven hundred seventy-seven (799,777) was reviewed to determine if the required Fraud Statement was included on the claims forms as required by Section 817.234 (1)(b), Florida Statutes. Two of fourteen (14) claim forms used by the Company failed to reference "felony in the third degree"

in its Fraud Statement resulting in an unacceptable error ratio of fourteen percent (14%).

During the course of this examination, the examiner received information indicating that the Company had a large backlog of pending claims. It was noted that the Company receives approximately thirty-two thousand (32,000) health claims each week on a nationwide basis, including claims administered on behalf of several large self-funded employer group plans. A review of claims handling systems and forty-seven (47) randomly selected claims revealed the Company begins the processing of claims within statutorily established timeframes. The Company's claims system provides for second, third and indefinite follow requests to the insured or provider, etc., with regard to pending claims. These are claims for which the Company has requested additional information, rather than formally denying the claim and closing the file.

CLAIMS LITIGATION

During the period under examination, the Company had litigated claims involving Florida insureds.

INSURER EXPERIENCE REPORTING

The Company filed Experience Report Forms DI4-272, DI4-273, DI4-274, DI4-275 and DI4-276 as required by Rule 4-163.012, Florida Administrative Code, regarding Credit Life and Disability Insurance.

COMPLAINTS

The Company maintained complaint-handling procedures as required by Section 626.9541(1)(j), Florida Statutes.

The Company maintained a complete record of all complaints received during the period under review as required by Section 626.9541(1)(j), Florida Statutes.

Two hundred thirteen (213) complaints (74%), from a total population of two hundred eighty-seven (287), for 1994, 1995 and 1996 were reviewed to determine the number of calendar days taken to resolve a complaint from the time of receipt to the final disposition. Calendar days included workdays, weekends and holidays.

The results of the review are as follows:

Calendar Days	Number of Complaints	Percentage
1-15	144	68%
16-30	53	25%
31 and over	16	7%
Total	213	100%

The average number of days to handle a complaint for the entire review period was fifteen (15).

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners were followed in performing the Market Conduct Examination of American Heritage Life Insurance as of December 31, 1996, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Jorge Rodriguez
Insurance Analyst II
Florida Insurance Department

FINDINGS AND RECOMMENDATIONS

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

Page 8 Comply with 627.4085, Florida Statutes, and require the agent's name on all applications.

Page 9 Comply with 627.4085, Florida Statutes, and require the agent I.D numbers are reflected on applications.

Page 9 Comply with 4-151.007(3)(e), Florida Administrative Code, to insure that the replacement register is properly maintained.

Page 10 Comply with 624.318, Florida Statutes, to insure that replacement records are properly maintained.

Page 10 Comply with 4-151-007 (3), Florida Administrative Code, to insure that "Notice to Applicant" forms are sent within five (5) working days time to the existing insurer whose policies are being replaced.

Page 12 Comply with 624.318, Florida Statutes, to insure that "Non-Forfeiture" records are properly maintained.

Page 25 Comply with 817.234(1)(b), Florida Statutes, to insure that the required Fraud Statement, referencing the "third degree felony" is reflected on all applications and claim forms.