FLORIDA DEPARTMENT

OF

FINANCIAL SERVICES

Office of Insurance Regulation

TARGET MARKET CONDUCT REPORT

OF

BANKERS LIFE INSURANCE COMPANY

AS OF

July 11, 2003

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SCOPE OF EXAMINATION

The Office of Insurance Regulation (OIR or Office) formerly known as the Florida Department of Insurance conducted a limited scope target market conduct examination of Bankers Life Insurance Company, hereinafter referred to as Bankers Life or the Company. Independent contract analyst, Victor M. Negron, AIE, FLMI, conducted the examination pursuant to Section 624.3161, Florida Statutes.

This examination covered the period from January 1, 2001 through December 31, 2002 and was conducted at the administrative office of the Company at 10051 Fifth Street North, St. Petersburg, Florida 33702. The on-site examination commenced on April 28, 2003 and was completed on July 8, 2003. The examination was postponed on June 13, 2003 and resumed on June 30, 2003. The examination preparation and wrap up in Tallahassee took an additional five (5) days.

The purpose of this Target Market Conduct Examination was to:

1. Determine the underlying causes of the complaints received by the Division of Consumer Services regarding the Company's Credit Life & Disability business in Florida.
2. Identify potential trends indicative of questionable practices, deficient procedures and inappropriate decisions in conducting the business of insurance, and;
3. Determine if the insurance business practices and procedures of Bankers Life conform to the Florida Statutes and the Florida Administrative Code.

Procedures and conduct of the examination were in accordance with OIR's Field Examination Guidelines and the Market Conduct Examiner's Handbook produced by the National Association of Insurance Commissioners (NAIC).

The primary areas reviewed were as follows:

1. Consumer Complaint Handling (Credit Life & Disability)
2. Cancellation and Premium Refunds (Credit Life & Disability)
3. Claims Handling (Credit Life & Disability)

4. Claims Denials (Credit Life & Disability)
5. Producer Termination (Credit Life, Credit Disability and Annuities)
6. Marketing and Sales (Annuities)

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

COMPANY OPERATIONS/MANAGEMENT

Bankers Life Insurance Company was incorporated on April 24, 1973, and commenced business on May 9, 1973 under the laws of the State of Florida. The Company is a subsidiary of Bankers Insurance Group, a multi-line insurance holding company.

Bankers Life is licensed in the District of Columbia and thirty-two states. In 2002 Florida ranked second in premium volume countrywide.

Florida direct premiums written during the scope of this examination were as follows:

Year	Life Insurance	Annuity Considerations	Accident & Health
2001	3,270,365	6,603,393	2,310,357
2002	2,213,881	13,039,395	5,875,810

The Company's website can be accessed at www.bankerslifeinsurance.com.

Customer service and claims were handled directly by the Company. However, effective January 1, 2003, the Company contracted with Life of the South (LOTS) a third party administrator (TPA) located in Jacksonville, Florida, to service its business.

During the scope of this examination, the Company wrote a range of individual and family insurance products including individual permanent and term life, group life, credit life and disability, accidental death and annuities. Bankers Life discontinued writing annuities in July 2002, and also discontinued writing credit life and disability business on December 31, 2002.

Lines of business included in this examination were:

- credit life and disability
- annuities

CONSUMER COMPLAINT HANDLING

Consumer complaint handling was examined to determine the underlying causes of the complaints received by the Division of Consumer Services regarding the Company's Credit Life & Disability business in Florida, and whether or not the Company had and maintained adequate complaint-handling procedures in accordance with Section 626.9541(1)(j), Florida Statutes.

The examination of complaint handling was limited to reviewing the written correspondence received through the Division of Consumer Services and direct consumer complaints to the Company in 2001 and 2002 with respect to the Company's credit life and disability business. In order to assess the actual procedures used by Bankers Life to process complaints, 23 complaint files were reviewed.

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The examiner reconciled the Division of Consumer Services' list of complaints with the Company's list of complaints and confirmed that all complaints were listed.

The Company has established complaint-handling procedures and follows these procedures as required by Section 626.9541(1)(j), Florida Statutes. The procedures were found to be appropriate and complaints had satisfactory resolutions.

The examiner calculated the processing time between the date the correspondence was received and the date the file was closed; and a review of the file was conducted to determine the nature of the correspondence and to determine if the Company responded appropriately. The Company's responses were found to be timely and appropriate in all instances. Response time was between 0 to 17 days. The average response time was 5 days.

No agent or agency had a disproportionate number of complaints. None of the complaints alleged any wrongdoing by agents.

There were two (2) complaints received directly by the Company. Both were complaints submitted by the Better Business Bureau. The resolution time for these complaints was three (3) and six (6) days.

The following table shows the top five (5) reasons for complaints:

Reasons	Number of Complaints	Percentage
Claim Denial (Pre-existing Condition)	11	48%
Reduction or discontinuance of benefits	4	17%
Claim Denial (no coverage)	3	13%
Premium Refunds	3	13%
Claim Delays	2	9%
Totals	**23**	**100%**

Claim Denial (Pre-existing Condition) (11)

In all instances, the claim file contained evidence demonstrating that the insured had a pre-existing condition listed in the eligibility statement that he/she had certified not having in the signed certificate of insurance.

Reduction or discontinuance of benefits (4)

Three (3) complaints were due to the claimant alleging that the Company had not fully paid their benefits. These three (3) cases involved policies with reducing term coverage where benefits reduce proportionately on a monthly basis until the time of death. The problem is that the amount of remaining coverage is lower than the amount owed at the time of death. The certificate of insurance clearly states how benefits are paid. The other complaint was due to a discontinuance of benefits for a disability where the Company stopped benefits after the first year. The policy defines total disability as follows: during the first 12 consecutive months, the insured is unable to perform the duties of his occupation at the time the disability occurred; and after the first 12 consecutive months, the insured is unable to perform the duties of any occupation for which he is reasonably qualified by education, training or experience to perform. In this case, the insured's doctor stated that he could engage in another occupation, therefore, benefits were discontinued.

Claim Denial (No coverage) (3)

In two of these cases, the Company had changed the policy benefits due to eligibility requirements. The insured's alleged that they were not aware of the changes. The files showed that endorsements were sent to the insureds with proof of mailing when the endorsements were processed. Bankers Life did not insure the other complainant.

Premium Refunds (3)

In one (1) instance the insured complained about the amount of return premium following cancellation of his policy. The issue had been resolved prior to the complaint being filed. This issue was due to an agent mistake in requesting an incorrect cancellation date. Another complaint alleged that the Company had not sent return premium to the creditor. The documentation showed the check was sent and had already cleared. It appears that this was an error by the creditor company. The other complaint alleged that the Company had not returned unearned premium to the insured. The file showed the Company requested information numerous times to process the cancellation and the insured never provided the requested information. This issue was resolved when the insured provided the requested information.

Claim Delays (2)

In both instances delays were justified as the Company was waiting for medical records. Claims were paid immediately after records were received.

The following recommendations are made to reduce the volume of complaints in the future:

1. If the Company resumes writing new credit life business, it is recommended that the Company send a notice to all new insureds advising them to carefully read the certificate of insurance, especially the eligibility statement section.
2. Send a letter to claimants when paying a reducing term policy claim, explaining how the Company arrived at the benefit amount.

CANCELLATION AND PREMIUM REFUNDS

Cancellation and premium refunds were reviewed to determine if the Company provided an adequate amount of advance notice of cancellations and to determine if policyholders received accurate and timely premium refunds for canceled policies in accordance with Rule 4-163.003, Florida Administrative Code and Sections 627.676 – 627.6845, Florida Statutes.

A refund is due in the event the debt is pre-paid or the insured requests the cancellation of coverage. If the insured requests the cancellation prior to the debt payoff, any refund is sent to the lienholder if the premium was originally included in the loan.

The Company's agents process the cancellations. The agents submit the cancellation documentation to the Company, which then verifies for the accuracy of premium refunds. Calculation of refunds depends upon the type of coverage. Reducing term and disability coverage refunds are made on the basis of the "Rule of 78ths[1]". Level term coverage is calculated on the average monthly premium basis or what is commonly known as the "pro-rata" method. All return premiums calculated at $1.00 or less are waived.

There were 15,768 policies cancelled during the scope of this examination. Insured request cancellations totaled 15,121, and 647 were company rescissions.

The examiner reviewed a random sample of 100 from 15,768 cancelled policies. The Company provided adequate notice of cancellations, and premium refunds were promptly issued to policyholders. However, there were 28 instances in which premium refund differences were more than $1.00. The Company advised that its agents calculated premium refunds and sometimes the calculations were not accurate. The Company stated that as part of its procedures, a review of the agent's calculations is made and figures are corrected if differences exceed $20.00. The examiner requested the Company to provide a list of all cancellations, and such list included the amount calculated by the agent and the amount calculated by the Company. As a result of this list, the examiner determined that there were 2,297 policyholders with underreturns totaling $11,896. In addition, there were 936 policyholders with overreturns totaling $6,094. **Failure to comply with**

cancellation and refund requirements constitutes a violation of Rule 4-163.003, Florida Administrative Code.

Following notification of this oversight, the Company documented that it repaid the 2,297 policyholders subsequent to the examiner leaving the examination site, and submitted documentation of this repayment to OIR.

[1] The Company's manual refers to this as the Rule of 78ths.

CLAIMS

Claims Handling

This review was to verify that claims were handled in a timely manner and in accordance with policy provisions and state law. The examiner reviewed the Company's claims procedures, training materials and claims bulletins and determined that company standards exist and comply with state laws and contract provisions.

There were 1,085 paid/open claims during the scope of this examination. The following table shows the timeliness of settlement of claims:

Number of Days	Number of Claims	Percentage
1-30	539	50%
31-60	327	30%
61-90	113	10%
Over 91 days	106	10%

The examiner selected 50 from 1,085 claim files for review to determine if the claims had been settled in accordance with state laws and policy provisions. In all instances, the claims were handled properly. Claims within the contestable period take longer to process, as the Company obtains medical records before making a final decision. When the medical records were received, the claims were paid or denied immediately. There were some instances where the claims are in litigation.

The following table shows the timeliness of settlement of claims included in the sample selection:

Number of Days	Number of Claims	Percentage
1-30	25	50%
31-60	15	30%
61-90	5	10%
Over 91 days	5	10%

During the claims handling review the examiner noted that when a death claim is paid under a policy also including disability coverage that the death portion of the policy becomes fully earned. The disability portion should be cancelled and unearned premium refunded to the insured's beneficiary.

The examiner reviewed 10 files where the consumer had purchased both life and disability coverage. In 6 instances, the disability coverage was not canceled when the person died. The examiner requested the Company provide a list of all paid death claims, which also contained disability coverage to determine the extent of this problem. The examiner determined that 50 policies were not cancelled as required and the unearned premium owed totaled $9,543. **Failure to comply with cancellation and refund requirements constitutes a violation of Rule 4-163.003, Florida Administrative Code.**

Following notification of this oversight, the Company documented that it repaid the 50 policyholders (or their estates) subsequent to the examiner leaving the examination site, and submitted documentation of this repayment to OIR.

Claims Denials

This review verified that all claims were not denied improperly. There were 732 claims denied during the scope of this examination. Of these, there were 558 denied due to pre-existing conditions.

The examiner selected a random sample of 50 denied claims to verify compliance with state laws and contract provisions. There were 37 claims denied due to pre-existing conditions and 13 denied due to no coverage under the policy. The examiner verified that the 13 individuals did not have coverage and that the policy had lapsed.

With respect to claim denials due to pre-existing conditions, the claim files contained evidence demonstrating that the insured had a pre-existing condition listed in the eligibility statement and that he/she had previously certified not having such condition when the certificate of insurance was signed.

PRODUCER TERMINATION

This review determined if that the Company's producer terminations did not result in unfair discrimination against policyholders.

The Company reduced the number of appointed agents due to the discontinuance of credit life and disability and annuity business in Florida. There were also a number of terminations prior to the discontinuance of these two (2) lines of business. The majority of these were due to low production. The examiner selected a random sample of 25 agents that were terminated during the scope of the examination to determine if the Company properly documented the reasons for termination. The files were properly documented and the appropriate notice was sent to OIR.

MARKETING AND SALES OF ANNUITIES

This review determined if advertising materials used by the Company and producers ensure that products sold to consumers are fairly represented, and to verify that sales of annuities were in compliance with state laws and regulations.

Most advertising materials used by the Company and producers featured senior citizens. It is obvious that seniors were the target market for annuity sales in the State of Florida. Interest rates offered by the Company in their advertising materials were as advertised.

The Company offered their producer incentives for production. These incentives included trips to Orlando, Florida and Atlantis Paradise Island. In addition, the Company also offered Omaha steaks, smoked turkeys, and baseball souvenir promotions.

The Company discontinued writing new annuity business in July 2002. There were 400 annuities in force as of December 31, 2002.

The following table shows a breakdown of Annuity Sales by issue age:

Age Band	Number of Policies	Percentage
65 and under	118	29%
66-70	56	14%
71-75	93	23%
76-80	78	20%
81-85	55	14%
Over 85	0	0%

This table clearly indicates that senior citizens were the prime recipients for the annuity sales.

Surrender charges vary by type of annuity. The following table shows surrender charges for the two types of annuities sold during the scope of this examination.

Flexible Premium Deferred Annuity **Single Premium Deferred Annuity**

Policy Year	Surrender Charge Percentage	Policy Year	Surrender Charge Percentage
1-3	12%	1-3	7%
4-6	10%	4	6%
7	9%	5	5%
8	8%	Thereafter	0%
9	7%		
10	6%		
Thereafter	0%		

There were only two (2) annuities surrendered during the scope of this examination. These two (2) annuity holders incurred $2,516.89 and $38,223.14 respectively in surrender charges. The same agent sold both annuities. This agent replaced a second annuity, and the funds were moved to Midland National Insurance Company in August 2002. Bankers Life advised that this agent was terminated in November 25, 2002. Five (5) annuities sold by this agent have been recently surrendered and three (3) more in the process of being replaced. The examiner referred this issue to Agent & Agency Investigations of the Florida Department of Financial Services for further review.

Of the 400 in force annuities, 368 were flexible premium deferred annuities and 32 were single premium deferred annuities. The Company had significantly higher commission schedules for flexible premium deferred annuities. Most of the business was written using this type of annuity. There were 12 instances where annuity holders were issued the same product they currently had rather than depositing funds in the existing annuity. The Company pays the same commission for additional deposits made to annuities during their first year. In all cases, the new annuities were issued within the first year, so the agent received the same commission if monies had been deposited into the existing annuity.

There were 49 annuities that were not funded and 36 returned during the free look period. The following table shows the top five (5) agents with unfunded/not taken annuities:

License Number	Number of Annuities
D066453	11
D042041	10
A070140	8
D040602	7
D032041	7

There were four (4) death claims paid during the scope of this examination. There were no surrender charges incurred for the death claims.

FINDINGS AND RECOMMENDATIONS

The following findings were made in the preceding pages of this report.

Page Number	Recommendation/Directive
Page 9	Send a letter to claimants when paying a reducing term policy claim, explaining how the Company arrived at the benefit amount.
Page 9	Send a letter accompanying any endorsement issued changing any policy benefits explaining in detail the change.
Page 10	The Company failed to accurately refund unearned premium for 2,297 policyholders totaling $11,896. **Failure to comply with cancellation and refund requirements constitutes a violation of Rule 4-163.003, Florida Administrative Code.** Subsequent Event: The Company provided documentation to OIR on August 4, 2003, that the monies were refunded to the consumers.
Page 13	The Company failed to refund unearned premium owed to 50 policyholders totaling $9,543. **Failure to comply with cancellation and refund requirements constitutes a violation of Rule 4-163.003, Florida Administrative Code.** Subsequent Event: The Company provided documentation to OIR on August 4, 2003, that the monies were refunded to the consumers.