FLORIDA DEPARTMENT
OF
FINANCIAL SERVICES

TARGET MARKET CONDUCT REPORT

OF

GUARANTEE TRUST LIFE INSURANCE COMPANY

AS OF

MARCH 31, 2002

OFFICE OF INSURANCE REGULATION

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EXECUTIVE SUMMARY

INTRODUCTION

The Office of Insurance Regulation (OIR) formerly known as the Florida Department of Insurance selected Guarantee Trust Life Insurance Company, hereinafter referred to as the "Company" or "Guarantee Trust," for examination due to the volume of consumer complaints received relative to the Medicare Supplement and Home Health Care lines of business. During the scope of the examination period, from April 1, 2000 through March 31, 2002, the Division of Consumer Services received one hundred ten (110) complaints. In addition, the Company received three (3) written complaints directly.

COMPLAINT HANDLING

Of the Division of Consumer Services complaints received, 59% were related to premium rate increases, 8% to denial of premium refunds, and 6% to agent misrepresentation. The Company records all direct correspondence, both oral and written, in its database as service inquiries. Calls that would more accurately be recorded as complaints are not maintained in a separate log. Therefore, the examiner was unable to draw direct comparisons between Consumer Services complaints received and Company complaints received. The Company did record three (3) written grievances received directly from consumers during the scope of the examination.

FORMS AND RATES

Beginning in 1998, the Long Term Care/ Home Health Care policyholders experienced increased rates due to a Consent Order signed by the Company and the OIR, which called for graduated increases over a span of three (3) years. These increases were the result of adverse claims experience. Additional increases were approved in 2001 and 2002. During the scope of the examination, Home Health Care policyholders experienced a 100% increase in premiums with a cumulative effect of 134%. The standardized Medicare Supplement products also experienced steady increases totaling 45% with a cumulative effect of 52%. All rate increases were approved by the OIR.

AGENT ACTIVITIES

Complaints about certain agents allege that they misled seniors regarding the need to replace their Medicare Supplement policies as their current policy was no longer being issued or to enhance their benefits. Agents utilized by the Company wrote a total of 9,463 policies for a total earned commission of $4,333,440.96. Of the total policies written, 884 are currently active, and 4,066 lapsed or were cancelled within one (1) year from date of issue.

MARKETING AND SALES

Guarantee Trust currently markets individual Medicare Supplement policies and one Long-Term Care product in Florida, but the Company's marketing plan indicates a move toward group issued policies. Special risk and impaired risk Accident and Health products are also marketed in the State. The Company's direct marketing program of Life products represents 80% of its total sales in Florida. Guarantee Trust has guidelines in place for the sale of multiple products to any one consumer. All marketing materials have been approved by the OIR.

CANCELLATIONS AND PREMIUM REFUNDS

Guarantee Trust has procedures in place for calculating premium refunds based on the first month following a cancellation request.[1] Pursuant to Section 627.6741(4), Florida Statutes, interest is to be calculated using the short-rate table from the date of the requested cancellation. The Company failed to pay five (5) refunds in a prompt and timely manner pursuant to Section 627.482(1), Florida Statutes.

[1] For example, if the consumer made a cancellation request on January 19, 2003 – the cancellation would be effective February 1, 2003 assuming that the person paid month-to-month and the anniversary was the first day of the month.

SCOPE OF EXAMINATION

The Office of Insurance Regulation (OIR), conducted a limited scope market conduct examination of Guarantee Trust Life Insurance Company, hereinafter referred to as the "Company" or "Guarantee Trust" due to the number of complaints received by the Division of Consumer Services. Independent contract examiner, Ann M. McClain, CIE, FLMI, AIRC, AIAA, ARA, ACS, AIS, conducted the examination pursuant to Section 624.3161, Florida Statutes.

The examiner reviewed complaints and assessed compliance and overall procedures used by the Company to administer in-state and out-of-state Life, Major Medical, Medicare Supplement, and Long Term Care/Home Health Care in-force policies sold to Florida residents for the period of April 1, 2000 through March 31, 2002. The examination was conducted at the offices of Guarantee Trust Life Insurance Company located at 1275 Milwaukee Avenue, Glenview, Illinois 60025. The examination commenced on June 22, 2002, and the fieldwork concluded on August 30, 2002.

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

The primary areas reviewed were as follows:

- Consumer Complaint Handling;
- Forms and Rates;
- Agent Activities;
- Marketing and Sales; and,
- Cancellations and Premium Refunds.

DESCRIPTION OF COMPANY

Guarantee Trust Life Insurance Company is a mutual company domiciled in the State of Illinois. The family-owned Company was incorporated May 16, 1936, and commenced writing business on June 16, 1936. The Company's subsidiaries are:

- Century Senior Services, which markets long term care products for companies other than Guarantee Trust;
- Concierge Management Company, L.L.C., which markets non-insurance discount programs such as prescription discount cards;
- Cornerstone Senior Services, L.L.C., which is a general agency marketing long-term care products for Guarantee Trust;
- Guarantee Management Services, L.L.C., which provides accounting and oversight of the subsidiaries; and,
- Guarantee Security Life Insurance Company of Arizona, an Arizona domiciled insurance company.

Guarantee Trust sold SeniorsFirst L.L.C., which marketed Guarantee Trust long-term care products, in January 2002.

Guarantee Trust is licensed to do business in forty-nine (49) states, the District of Columbia, and Puerto Rico. The Company markets Long Term Care, Medicare Supplement, and Life products to seniors primarily through independent agents, and whole and term Life products through direct marketing. Guarantee Trust also markets a special risk blanket Accident and Health insurance product to select groups such as schools, universities and churches. The Company markets impaired risk products through agreements with eighteen (18) different insurers and impaired risk brokerage firms.

SUMMARY OF MARKET RANKING IN FLORIDA

Year	Line Of Business	Policies In-Force	Florida Premium	% Of Total Florida Premium	Ranking Of Florida Premiums To Total Written Nationally
2000	Life & Annuities	38,613	$5,263,968	30%	3rd
	Accident and Health	12,998*	$12,027,561	70%	3rd
Total		51,611	$17,291,529	100%	
2001	Life & Annuities	35,401	$5,130,725	29%	2nd
	Accident and Health	11,642*	$12,774,742	71%	5th
Total		47,043	$17,905,467	100%	
1st Quarter 2002	Life & Annuities	33,763	$1,416,212	25%	2nd
	Accident and Health	11,917*	$4,159,279	75%	3rd
Total		45,680	$5,575,491	100%	

*Policy In-Force count for Accident and Health includes group, credit, non-cancelable, guaranteed renewable, non-renewable for stated reasons, other accident only, and all other.

CERTIFICATE OF AUTHORITY

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

- Life
- Group Life and Annuities
- Credit Life/Health
- Credit Disability
- Accident and Health

Based on complaints received by the Division of Consumer Services, the examination focused on the Life, Medicare Supplement, and Long Term Care/Home Health Care lines of business.

COMPLAINT HANDLNG

Guarantee Trust maintains a detailed log of all complaints received from the Division of Consumer Services pursuant to Section 626.9541(1)(j), Florida Statutes, and produced all records, except one policyholder file, requested by the examiner. The Company produced the three (3) written complaints or grievances that were received directly.

DIVISION OF CONSUMER SERVICES COMPLAINTS

The Company has written guidelines in place for the handling of all complaints received from any state insurance department. These procedures require all complaints to be handled within ten (10) days, but does allow for some exceptions. The complaints that were not resolved within ten (10) days involved either a delay in receiving agent responses or the need for upper management assessment. The one complaint that required more than thirty (30) days for resolution was an investigation into agent misrepresentation.

The following chart illustrates the Company's response time for handling DOI complaints:

DOI COMPLAINT TIME STUDY

Days Open	Number	Percentage
0 – 10	82	74.5%
11– 30	27	24.5%
Over 30	1	0.9%
TOTALS	110	100.0%

The Company utilized the "14-day" guideline for determining the timeliness of complaint resolutions. The Company reported in its analysis that 14 of the 110 cases were resolved in greater than 14-days.

The examiner reviewed all 110 complaints received by the Company from the Division of Consumer Services and determined that the primary complaint issue was the increase in premiums.

DIVISION OF CONSUMER SERVICES COMPLAINT ANALYSIS

APRIL 1, 2000 THROUGH MARCH 31, 2002

Code	Description	2000	2001	2002	Total	Percentage
3A	Reason for change in premium	16	43	6	65	**59%**
3C	Refund of premiums	3	4	2	9	**8%**
2A	Misrepresentation	1	4	2	7	**6%**
3F	Miscellaneous	2	3	0	5	**5%**
1A	Denial of claim	2	1	1	4	**4%**
1B	Delayed Claim	0	1	3	4	**4%**
3E	Policy was cancelled or lapsed by company	2	1	1	4	**4%**
1C	Unsatisfactory payment	1	2	0	3	**3%**
2C	No evidence of insurance received. No policy delivery	1	2	0	3	**3%**
2D	Complaint against agent	1	1	0	2	**2%**
4A	Refusal to insure (new apps, reinstatements)	1	1	0	2	**2%**
2E	Miscellaneous	1	0	0	1	**1%**
3D	Explanation of benefits	1	0	0	1	**1%**
	Totals	**32**	**63**	**15**	**110**	**100%**

RATE INCREASES

Of the complaints received by the Division of Consumer Services, 59% were due to rate increases in the Company's Home Health Care and standardized Medicare Supplement products. The rate increase analysis will be covered in the forms and rates section of this report. All rate increases were approved by the OIR.

PREMIUM REFUNDS

The examiner determined complaints for failure to refund premium were question of fact issues regarding alleged agent misrepresentation and the cancellation request date. In two cases based on agent misrepresentation, the policyholders were requesting cancellations and full refunds more than one year after the policy was issued. Two requests for refund were due to policy replacements, but the policyholder made no formal request to the Company for cancellation. Two requests for refunds were for policies not written with Guarantee Trust. The five requests for refund due to alleged agent misrepresentation were honored and refunds were provided. The examiner found no Company violations based on the information provided.

ALLEGED AGENT MISREPRESENTATION

The examiner reviewed documentation within policyholder files to determine whether agent misrepresentation of policies occurred. Letters from the insureds alleged the agents told them their current policies needed to be replaced either because their current policy form was no longer being issued or to enhance their benefits. One case involved the purchase of an unwanted Life insurance policy. The Company's practice is to request the agent's summary of events and forward it to the Division of Consumer Services. The agent's account of the circumstances surrounding the sale was always the opposite of the insured's.

The Company honored all requests for cancellation and refunds, except in two cases where the insureds waited for one to two years before filing a complaint with the Division of Consumer Services.

COMPANY INQUIRIES

Pursuant to Section 626.9541(1)(j), Florida Statutes, the Company records all written complaints and grievances. Three (3) written complaints were received directly by the Company. Consumer calls are classified as inquiries, rather than complaints, and a separate log of these inquiries is not maintained. All contact directly from policyholders, whether in writing or by phone, is recorded directly into the policyholder database file as routine servicing, and a notation is made in the database describing the inquiry and resolution.

Company procedures require all inquiries to be resolved within thirty (30) days. The Company provided a printout of all inquiries received during the scope of the examination from which the examiner selected a random sample. The examiner conducted a time study based on the random sample to determine whether Company inquiries were resolved in a timely manner.

COMPANY INQUIRY TIME STUDY

Days Open	Number	Percentage
0 – 30	68	91%
31 – 60	6	8%
Over 60	1	1%
TOTALS	75	100%

As the classification system used to record Company inquiries does not parallel that of the Division of Consumer Services complaint classification system, the examiner requested a random sample from the printout provided that related to policy cancellations and claims delays. The policy cancellation inquiries included those requesting unearned premium refunds, surrendered and lapsed policies, and declined policy applications. Inquiries regarding rate increases were logged only as miscellaneous service calls and were not distinguished from other general inquiries. Therefore, the examiner was unable to identify and include rate increase inquiries in the random sample.

The examiner determined the inquiries in the sample reviewed were not complaints, but were service requests. The three (3) delayed payment of claims were related to coverage benefit issues and were resolved by clarifying the policy coverage or reassessing the claim for payment.

The examiner found one violation of Section 627.421(1), Florida Statutes, for failure to provide the insured with a policy within sixty (60) days. The Company was unable to locate one policyholder file, which is a violation of Section 624.318(2), Florida Statutes, for failure to produce requested documents.

COMPANY INQUIRY ANALYSIS

APRIL 1, 2000 THROUGH MARCH 31, 2002

Code	Description	2000	2001	2002	Total	Percentage
DEC	Refund to beneficiary (death claims)	16	19	6	41	**41%**
UP	Refund unearned premium (health only)	15	17	2	34	**34%**
CF	Cancellation and request for premium refund	13	10	0	23	**23%**
CLAIM	Delayed payment	0	3	0	3	**3%**
	Totals	**44**	**49**	**8**	**101**	**100%**

FORM AND RATE FILINGS

Guarantee Trust currently has in-force policies for Life, Accident and Health, Medicare Supplement, and Long Term Care/Home Health Care products. Form and rate filings were reviewed to determine compliance of the filing and mandated coverage requirements pursuant to Sections 627.410(1), (6)(a), and (7)(a), 627.674, 627.9405 and 627.9406, Florida Statutes.

The examiner determined that all Life policy forms were filed with the OIR pursuant to Section 627.410(1), Florida Statutes, and all included the mandated benefits and provisions required under Section 627.452, Florida Statutes. Rates for Life products are not required to be filed for approval with the OIR.

As requested, the Company provided rate increase and form filing chronologies for each of its policy forms providing in-force medical coverage for Florida residents. Copies of the filing documentation for both forms and rates were provided and verified the information provided in the chronologies as to date of submission, rate of increase, and date of approval. Copies of annual rate certifications were also provided.

There are several Medicare Supplement, Major Medical, and Long Term Care/Home Health Care policy forms providing coverage to Florida residents that were issued in other states. There are thirty-one (31) such policy forms covering anywhere from one (1) to 383 policyholders. Only one policy form covers more than 125 insureds, and that is an out-of-state group catastrophic major medical policy form #89940 covering 383 insureds. Form #89940 was part of a lawsuit outside the scope of the exam; and, based on the outcome of the lawsuit no further filings have been made.

MEDICARE SUPPLEMENT AND LONG TERM CARE/HOME HEALTH CARE

Premium increases for Medicare Supplement and Long Term Care/Home Health Care represented 59% of the consumer complaints received by the OIR during the scope period of the exam. These increases were experienced by policyholders beginning in 1998, as the result of Consent Order #19885-97-CO signed by the OIR and Guarantee Trust. Due to adverse claims experience, the OIR allowed Guarantee Trust to implement rate increases over a three (3) year period on a pooled block of Home Health Care policy forms #93710, #87HHC, #90700, and #91700. This same block of business experienced additional increases in 2001 and 2002. All of the increases were approved by the OIR. All of the Company's standardized Medicare Supplement policy forms have experienced steady increases since 1997. The following table summarizes the increases experienced during the scope of the exam.

RATE INCREASE ANALYSIS
April 1, 2000 through March 31, 2002

Form Number	Plan	In-Force Policies	2000 Increase	2001 Increase	2002 Increase	Total Approved Percentage Increases	Total Cumulative Effect (based on $100 premium)
All forms	Life/Annuities	33,763	0%	0%	0%	0%	0%
All forms	Pre-standardized Medicare Supplement	79	0%	0%	5.2%	5.2%	5.2%
9240, 9242, 9541	Standardized Medicare Supplement	1,749	20%	17.5%	7.5%	45%	52%
93710, 91700, 90700, 87HHC	Home Health Care	1,946	20%	50%	30%	100%	134%
90100, 84150, 81150, 92100	Major Medical	2,042	20%	20%	10%	50%	58%

It should be noted that, as a result of the 1997 Consent Order, the Home Health Care policyholders also experienced a 30% increase in 1998 and a 20% increase in 1999.

The examiner requested that the Company provide the rate history and billing statements for seven (7) policyholders randomly selected from the Division of Consumer Services complaint log to verify rate increases were applied accurately. The examiner found no discrepancies between the approved rate increases and those shown through the rate histories and billing statements. The marketing materials made no promises regarding no premium increases.

AGENT ACTIVITIES

The examiner requested and received copies of the producer manual used by Guarantee Trust for the recruitment, training, appointment, and termination of agents. The Company utilizes a general agent agreement that clearly defines the Company's advertising policy, marketing guidelines and code of ethics.

The examiner reviewed the randomly selected files of one hundred (100) active agents and fifty (50) terminated agents from the scope period of the examination, April 1, 2000 to March 31, 2002. The random selection was based on company numbers assigned to agents and resulted in some duplication, as various agents were assigned more than one company identification number. As a result ninety-nine (99) active agent files and forty-three (43) terminated agent files were reviewed. The Company was unable to locate one (1) agent file, and other documentation (proof of licensure, agent applications, credit checks, and background checks) was missing from agent files, which is a violation of Section 624.318(2), Florida Statutes.

GENERAL AGENT ISSUES

Guarantee Trust issues policies submitted by both appointed and unappointed agents. The examiner requested and received documentation that unappointed agents were submitting only excess or rejected applications. The examiner verified that pursuant to Sections 626.793 and 626.837, Florida Statutes, each unappointed agent submitted fewer than twenty-four policy applications per year, and that the applications were for impaired risk policies. During the scope of the examination a total of eight (8) impaired risk policies were sold by unappointed agents identified within the active and terminated agent samples.

The examiner determined that background checks were not performed on all appointed agents as required under Section 626.451(2), Florida Statutes. A memorandum dated May 14, 1999 confirmed that the Company is aware of the background check requirement for the State of Florida. As of January 2000, the Company began utilizing Experian to perform both background and credit checks. The examiner determined that, during the scope of the

examination, there were nineteen (19) active appointed agents for whom no background checks were performed. Failure to perform background and credit checks prior to appointing agents is a violation of Section 626.451(2), Florida Statutes. The Company corrected its procedures regarding background and credit checks prior to the scope of the exam, but did not check retroactively to ensure that all active agents had these checks.

After checking the Department of Financial Services database, the examiner determined that four (4) active agents writing business for Guarantee Trust, but were not licensed during the scope of the examination. The Company produced documents verifying these agents had not been active for seven to ten years and were licensed at the time they were appointed. However, the database printout provided the examiner revealed numerous agents on the active list that had not written business for the Company for several years. Failure to maintain accurate and up-to-date records is a violation of Section 624.318(2), Florida Statutes.

Individual agent files do not contain copies of consumer complaints, although the Company stated that it can track agent complaints within the consumer complaint database.

SPECIFIC AGENTS REVIEWED

Four complaints filed by policyholders (GTA #1036620, GTA #1046869, GTA #1046868, and GTA #1046037) against the same group of agents allege that the agents told them their current policies needed to be replaced either because their current policy form was no longer being issued or to enhance their benefits. The examiner did note a lack of persistency among a specific group of agents. A district manager discerned the practice of "clean sheeting," submitting applications showing no adverse health history, by one of the agents, which eventually resulted in the termination of the agent's appointment.

Although there is not enough evidence to find the company in violation of Section 626.9541(1)(l), Florida Statutes, the Company should note that they are "bound by the acts to the agent[s]" per Section 626.451(3), Florida Statutes.

MARKETING AND SALES

The Company's largest volume market in Florida is in the sale of Life insurance, but its greatest premium is in Accident and Health. Guarantee Trust currently has 33,763 in-force Life and annuity policies. By comparison, the Company has only 2,042 Accident and Health policies, 1,946 Long-Term Care/Home Health Care policies, and 1,828 Medicare Supplement policies. The large number of in-force Life policies is a result of the Company's direct marketing program, which represents 80% of the sales in Florida. A breakdown of the Company's market standing is provided in the Description of Company section of this report.

PREMIUM COLLECTION

Except for the mass marketed products, all premium is collected by the agent and submitted to the Company. The issued policy is sent to the writing agent to be delivered directly to the insured. Signed delivery receipts are not required and the examiner found few in the policyholder files. This procedure also applies to premium refund checks. According to a Company memo, "We do not have proof the policy was received by the policyholder. Our policies are generally mailed first class directly to the agent for delivery." This practice is does not ensure compliance with Section 627.421(1), and Section 627.6043(2), Florida Statutes. At least nine consumer complaints allege that they did not receive either the policy, or a premium refund, from the agent. The Examiner recommends that the Company should immediately establish and implement procedures to track the delivery of policies and premium refunds to the policyholder, including the date of receipt to ensure statutory compliance.

MARKETING MATERIALS AND AGENT TRAINING

The examiner reviewed the product brochures for all policy plans marketed in Florida to determine compliance with Sections 626.9541(1), 627.6743, and 627.9407, Florida Statutes, relative to the use of deceptive advertising. All marketing materials used by agents to market Medicare Supplement and Long-Term Care products were approved by the OIR pursuant to Sections 627.6735 and 627.9407(2), Florida Statutes. The marketing brochures

clearly identified the policy benefits, as well as exclusions and limitations. The application fees, as approved in the rate filings, were disclosed on the application forms and in the marketing materials.

Line of business managers provide training for agents whenever new products are introduced. The primary focus of the training is on the policy, advertising, application, underwriting guide and other solicitation materials so the agents are fully aware of the state and company requirements for the products. Agents are provided written instructions regarding obtaining a signed statement by the applicant acknowledging the policy will replace an existing policy, and leaving with the applicant a copy of all sales proposals used for the presentation whenever writing a replacement for Life insurance. Guidelines for selling Medicare Supplement and other health policies are included as part of the agent's contract and are specific to the selling of multiple policies and replacement policies.

PRODUCTS MARKETED BY AGENTS

The Company is marketing only one Home Health Care policy in the State of Florida. Policy Form #93710 is marketed through Century Senior Services, L.L.C., a Guarantee Trust subsidiary. The product has been marketed as part of the benefits package of the U.S. Senior Health Care Association, which offers other benefits such as prescription drug discounts, hearing and vision care programs, travel and rental car discounts, motor club services, etc. Annual membership dues are $72. This individual policy can be underwritten without membership, and it can be renewed without renewing the association membership.

Guarantee Trust also markets impaired risk policies through insurance brokers and other insurance companies.

MASS MARKETED PRODUCTS

Guarantee Trust has both term Life and whole Life products that are direct marketed to the public via television, mail leads, premium notice promotions, and customer service requests. The general marketing technique is to offer the first month's premium at only $1. The insurance requires no medical exam and the applications have only three (3) basic health

questions. The policies are guaranteed renewable. Face amounts in $5,000 increments up to $20,000 are available on the Life products and vary depending on age of the applicant. Direct Marketing represents a majority of the Company's new business in the State, 79% in 2000 and 80% in 2001.

The Company markets special risk excess health insurance policies that are available to students. These policies are non-renewable and are valid during the school year with the option to purchase summer coverage, as well as Life insurance. The brochures clearly identify the policy benefits as being excess insurance. These programs are mass marketed with the applications being sent directly to Guarantee Trust.

MARKETING PROCEDURES & MULTIPLE SALES

The examiner determined that, although procedures indicate agent activities are monitored, marketing methods utilized by agents are not monitored closely nor is persistency for individual agents tracked. On the Life product side, persistency reports are run quarterly at the product level. Only if persistency falls below pricing assumptions for individual product lines, are details such as agent/agency, modal factors, age, and face amount reviewed. On the health product side, persistency is not reviewed at the agent level. Duration persistency by product line is reviewed within the Accident & Health Profitability report.

The Company has underwriting guidelines regarding the number of multiple policies that can be issued to any one policyholder. A policyholder may not be issued more than three (3) cancer policies; coverage under hospital confinement policies combined may not exceed $200 per day and may not duplicate riders; only one accident disability policy may be issued; and maximum face amounts on Life policies vary depending on the policy type and age of the applicant. The examiner recommends that the number of multiple policies written by individual agents be monitored and tracked for persistency and possible misrepresentation of benefits.

An internal audit performed by the Company found no problems with the Company's commission schedules.

CANCELLATIONS AND PREMIUM REFUNDS

The examiner reviewed the policies and procedures for processing lapsed and cancelled policies, including the method used to determined premium refunds. All requests for cancellation must be in writing and signed by the policyowner. In the case of the death of the policyowner, the request must be accompanied by a copy of the death certificate.

The Company failed to produce two (2) policyholder files, which is a violation of Section 624.318(2), Florida Statutes.

The examiner reviewed a random sample of one hundred (100) lapsed policyholder files, from a total population of 9,570, to determine if proper notification was provided to the policyholders. Company procedures require that a first billing notice be generated and mailed twenty-two (22) days before the policy due date. If the payment is not received within ten (10) days after the due date, a reminder is generated and mailed. At the same time, the policy is moved to lapsed status. A lapse notice is generated and mailed with a reinstatement form and a request for payment. The Company defines "lapse date" as the last day the premium will be applied by OCR (optical character recognition) as "on time." The "lapse date" is determined by the guidelines for the individual products and varies from 36 days to 90 days.

Data provided through the database mail log and through policy history screen logs on the policy sample reviewed were found to be inconsistent. In some cases only the lapse date and the lapse notice date were recorded. In other cases the first notice date was recorded along with the lapse date, but no second notice or lapse notice were recorded. The policy history screen and mail log are the only documentation that notices were sent, as copies are not placed in policyholder files. The Company determined that the program used to pull the information from the database on lapsed policies for some reason did not retrieve the first notice information. First notice information was provided by hand for the examination sample. The Company explained the lack of second notice information for the period of 2000 and 2001 by stating that the Company performed a study to determine if second

notices increased the persistency of low premium products. In this study some policyholders received the usual second notice, while the others received only a coupon with the first notice that stated that it would be the only notification the policyholder would receive prior to the lapse notice. After review, the Company decided to reinstitute the second notice billing.

The notification mail logs revealed policies where lapse notices were not sent out within the Company's guidelines. These policies were Life products with annuity riders. When the Life policy lapsed, a letter was sent to the policyholder informing them of the lapse, but was not generated by the billing department. The lapse notice was not sent by the billing department until the policyholder requested payment of the annuity's cash value.

The examiner found the Company provided lapse notices as required under Florida Statutes. However, the examiner recommends that initial lapse notices for policies sent to policyholders with annuity riders be recorded within the billing department system to more accurately reflect the date of notification.

Policies returned during the "free look" period, rejected, or rescinded are considered never issued and premium is refunded in full. Policy cancellations at the request of the policyowner are refunded unearned premium, as are policies cancelled due to the death of the insured. Unearned premium is calculated by determining the effective date of cancellation or the date of death. Money is refunded as of the first month after the effective date of cancellation. Therefore, it is not actually refunded back to the date of the request, but counting from the first month after the request. The OIR determined that the unearned premium on health policies is required to be calculated on a daily basis back to the date of the requested cancellation. The Company is in violation of Section 627.6741(4), Florida Statutes, regarding Medicare Supplement as interest is to be calculated using the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued, to be computed from date of requested cancellation.

LIFE/HEALTH CANCELLATIONS SUMMARY

April 1, 2000 through March 31, 2002

Type Cancellation	Year Cancelled						Total Cancelled
	2000		2001		2002		
	Health	Life	Health	Life	Health	Life	
Cancelled by Request	162	34	171	47	32	10	**456**
Death Claim		126		151		41	**318**
Deceased/Premium Refund	207	83	231	101	39	23	**684**
Free Look	12	218	10	225	2	29	**496**
Declined - Medical History	2	243	3	255	1	52	**556**
Incomplete	1	385	1	502	1	76	**966**
Lapsed	848	3,167	929	3,601	218	805	**9,568**
Surrendered		498		647		141	**1,286**
Totals	**1,232**	**4,754**	**1,345**	**5,529**	**293**	**1,177**	**14,330**

The examiner determined five (5) cancellations of policies with cash values were not paid within thirty (30) days, and no interest was paid. This is a violation of Section 627.482(1), Florida Statutes, requiring interest be paid on all policies not refunded within thirty (30) days.

FINDINGS AND RECOMMENDATIONS

The following is a summary of the examiners' findings and recommendations

Page 12	**Section 627.421(1), F.S. –** Failure to provide the insured with a policy within sixty (60) days. Guarantee Trust should instruct agents to obtain signed delivery receipts for policyholder files to ensure receipt.
Page 12, 16, 20	**Section 624.318(2), F.S.** – Failure to provide records for examination. Failure to maintain accurate and up-to-date records. Guarantee Trust needs to review its database records to ensure that all information is correct.
Page 16	**Section 626.451(2), F.S.** – Failure to perform background and credit checks prior to appointing agents. Guarantee Trust should properly conduct and document all investigations into agents applying for appointment.
Page 21	**Sections 627.6741(4), Florida Statutes.** Interest is to be calculated by using the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued, to be computed from date of requested cancellation. The Company currently calculates premium refunds on a based on the due date of the next month following the requested cancellation.
Page 22	**Section 627.482(1), F.S.** – Failure to promptly pay premium refund and cash value upon surrender of policy. The Company should review all of its policy surrenders and determine whether refunds were made within thirty (30) days. Refunds not paid promptly shall include payment of interest. Guarantee Trust shall provide OIR a list of those policy surrenders identified as not paid timely and provide proof of interest paid.