FLORIDA DEPARTMENT
OF
INSURANCE

TARGET MARKET CONDUCT REPORT

OF

GUARANTEE RESERVE LIFE INSURANCE COMPANY

AS OF JUNE 30, 2000

DIVISION OF INSURER SERVICES
BUREAU OF MARKET CONDUCT
LIFE & HEALTH SECTION

JAMES T. HOLLAND, CIE, CFE
INDEPENDENT CONTRACT EXAMINER

JACK MCDERMOTT, CIE, FLMI, ARM
FLORIDA DEPARTMENT OF INSURANCE

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March 15, 2001

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

Dear Commissioner Gallagher,

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Letter of Authority and the resolutions adopted by the National Association of Insurance Commissioners (NAIC), Jim Holland, a contractor for the state of Florida, conducted a Target Market Conduct Examination has been performed on:

GUARANTEE RESERVE LIFE INSURANCE COMPANY
530 RIVER OAKS WEST
CALUMET CITY, IL 60409

The examination was conducted at the Company's Home Office located at the above address in Calumet City, Illinois. The Department's Life & Health Examination Unit performed additional analysis subsequent to the contractor's submitted report. The report of the examination is respectfully submitted.

Jack T. McDermott, CIE, FLMI, ARM
Florida Department of Insurance

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SCOPE OF EXAMINATION

The Florida Department of Insurance (Department) conducted a limited scope target market conduct examination of Guarantee Reserve Life Insurance Company, hereinafter referred to as the Company. Independent contract examiner, James T. Holland, CIE, CFE, conducted the examination pursuant to Section 624.3161, Florida Statutes. After submitting the report, the Florida Department's Life & Health Market Conduct Examination Unit conducted additional analysis under the direction of Jack McDermott, CIE, Management Review Specialist.

This examination covers the period from January 1, 1997 through June 30, 2000; and where considered appropriate, transactions and affairs subsequent to the examination period were reviewed. The examination commenced on October 10, 2000, and the contractor, Jim Holland, concluded the fieldwork on January 5, 2001.

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 National Association of Insurance Commissioners (NAIC) Market Conduct Examiners Handbook.

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

- Advertising and Misrepresentation
- Billing and Posting
- Claims Denials
- Claims Handling
- Suitability

All files were examined on the basis of file content at the time of examination. Comments and recommendations were made in those areas for correction or improvement.

HISTORY

On October 13, 1933, Guarantee Reserve Life Insurance Company, domiciled in Indianapolis, Indiana, was licensed as an Indiana mutual assessment company to issue life and accident and health contracts on the assessment plan.

On December 8, 1952, the Company received its Certificate of Authority to write the business of life insurance in the State of Florida. In 1963, the corporate name was changed to "Guarantee Reserve Life Insurance Company."

During its existence, the Company has acquired the business of the following companies:

Guarantee Reserve Life Insurance Company, Hammond, Indiana (1949)
Arcadia National Life Insurance Company, Chicago, Illinois (1949)
Progressive Life Insurance Company, Indianapolis, Indiana (1951)
National Protective Insurance Company, Kansas City, Missouri (1953)
Safety Drivers Insurance Company, Kansas City, Missouri (1959)
Life Insurance Company of America, Wilmington, Delaware (1962)
Old Liberty Insurance Company, Chicago, Illinois (1962)
Commerce Insurance Company, Chicago, Illinois (1962)
Stockman's Reserve Life Insurance Company, Bismark, North Dakota (1963)
National Protective Life Insurance Company, Hammond, Indiana (1964)

On December 26, 1984, the individuals holding 72.7% of the common shares of the Company transferred their shares to a personal holding company, GR Holding Co., a Delaware Corporation. The transaction did not result in any change in the investment policy, business, corporate structure, management or operation of the Company.

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:

400 Life

410 Group Life and Annuities

450 Accident and Health

All lines were written during the scope of the review, and reviewed by the examiner.

The following is a table showing the percentage of Company business written in Florida by line of business:

	1997	1998	1999
Individual Life	8.18%	9.00%	9.25%
Individual Health	5.92%	6.07%	6.04%
Group Life	5.76%	4.53%	4.49%

Advertisements / Agent Representations

The examiner reviewed the Company's advertisements to determine if the Company is in compliance with Florida Statutes and the Florida Administrative Code. The examiner viewed the Company's Internet site (http://www.grlic.com[1]) and reviewed 121 packets of promotional mailings and fliers and 13 television commercial scripts that were in use during the examination period of January 1, 1997 to June 30, 2000.

The examiner selected 15 policy forms used by the Company from its active forms listing for review, and traced the application and policy forms to the active forms listing. The examiner also reviewed all 41 agent complaint files.

The examiner performed the following examination procedures:

- Reviewed the Company's advertising materials to ensure compliance with relevant sections of the Florida Statutes and Florida Administrative Code.

- Affirmed that agents were licensed and properly appointed by the Company and that notices of termination of agent's appointments were reported to the Department.

- Determined if the Company is exercising adequate control of its agents and agency marketing and complaints regarding misrepresentation.

- Determined if the advertisements addressed in the prior closed investigation file (#1562) have been terminated.

- Determined whether the Company makes multiple sales to individuals of the same product or duplicate coverage.

[1] As of March 1, 2001, the website was inactive. The site states, "Guarantee Reserve: This site is currently under construction. Check back soon."

FEDERAL GOVERNMENT REFERENCES IN ADVERTISING

During the scope period, the Company disseminated advertisements and policy applications containing narratives and logos referencing the Federal Government.

The Company provided the examiner with copies of 79 "Inquiry Program Lead Cards" ads that it disseminated in Florida from January 1, 1997 through June 30, 2000. All of the ads reference a governmental agency.

Section 624.9541(1)(a)(9) prohibits using "any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person." Rule, 4-150.114(2), F.A.C., requires that, "No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols, or physical materials used by agencies of the federal government or of this State …"

The Company's ad references referred to "Social Security". As such, a reasonable person could be misled into thinking that the Federal Government was involved in the insurance activities of the Company.

The Company was in violation of Section 626.9541(1)(a)(9), Florida Statutes (Statute) and Rule 4 – 150.104 and 4 – 150.114 (Rules) during the scope of the examination.

James G. Hertz, the Company's Assistant Vice President and General Counsel signed a Consent Order on October 10, 2000, issued by the Treasurer and Insurance Commissioner of the State of Florida. Paragraph 3 of the Consent Order cites in part as follows, "the Department determined that GUARANTEE committed the following violation of the Florida Insurance Code:

a. Violation of Rules 4 – 150.104, and 4 – 150.114, Florida Administrative Code, and Section 626.9541, Florida Statutes (FS). Producing and disseminating advertisements that (a) deceive and mislead prospective insureds into believing that the materials are from or endorsed by the federal government, (b) sets out information required to be disclosed conspicuously in a type size that is smaller than the expression 'SOCIAL SECURITY', and (c) utilize words or other devices which are similar to those used by governmental agencies". Paragraph 6. (c) cites as follows, "The insurer has ceased using replacement advertising referred to in paragraph 3 and shall not use the same replacement advertising again in the future."

The examiner did not find any evidence that the Company continues to use Social Security references in its advertisements subsequent to the consent order.

EVIDENCE OF INSURABILITY IN ADVERTISING

The examiner's review yielded five advertisement packets containing Ad materials offering modified benefit whole life policies. The Ads state that there is "No health qualifications", "No medical exam!" and "No health questions to answer."

The Company is in violation of Rule 4 – 150.107 (2) (b), Florida Administrative Code (Rule) regarding advertisement of its modified benefit whole life policies, since such advertisements require no evidence of insurability as a condition for issuance.

This Rule prohibits the use of the phrases, "no medical examination required", "no health questions asked," and phrases of a similar import in a misleading manner when policy benefits are limited.

The Company should comply with Rule 4 – 150.107 (2) (b), Florida Administrative Code.

Billing and Posting

The examiner reviewed billing and posting of premiums to determine if the Company is accurately and timely posting policyholder premiums. The examiner reviewed a random sample of 133 policyholder listings from the Company's billing records for all Florida policyholders. The examiner traced the policyholders to the Company's master file records and performed other tests that the examiner deemed necessary. The examiner also reviewed the "Daily Billing Process Review" performed on June 8, 2000 by the Company's outside auditors on the newly installed "revised system". Furthermore, the examiner reviewed notices being sent to agents and letters to policyholders regarding changes of billing methods and premiums.

The examiner performed the following examination procedures:

- Verified that all policyholders are being treated fairly and not subject to discrimination.

- Ascertained that the Company is accurately and timely billing and posting payments for life premiums.

- Ensured that life and annuity products contract provisions comply with Florida Law.

As revealed by the examiner's review of policyholder complaints, the Company had been experiencing some problems in billing and posting of premiums after the installation of its new revised billing system in October 1999. According to a letter dated January 15, 2001 written by Willa Puckett of the Premium Accounting Department, the system was not mailing policyholder premium billings timely and the system could not properly record premium payments for policyholders with multiple policies. It should be noted that the Company has received complaints regarding incorrect billing for people with multiple

policies. Willa Puckett of the Premium Accounting Department said in her letter that "Effective February 1, 2001, Combined billing will be discontinued. Each policy will be billed on an individual basis in order to avoid any further misapplied premium problems."

James G. Hertz, Assistant Vice President and General Counsel by memorandum dated January 16, 2001, explained that the Company used a bank "for its lockbox processing for clients mailing their insurance premiums to the company." A particular individual "was a temporary worker in the lockbox area that had worked from January 2000 through July 2000." Part of this individual's "duties included processing premium payments for Guarantee Reserve Life Insurance Company. During the period in which he was employed," the individual "misappropriated over (750) money orders from Guarantee Reserve's lockbox and cashed these money orders at a nearby Currency Exchange. The identified items totaled $42,319.16."

The bank has provided the Company with "copies of the misappropriated money orders and Guarantee Reserve has been matching them to our customers. Some of the items are not legible and we have asked for better copies, but to date we have reconciled approximately 558 of the items. Of these 558 we believe approximately 30 are from Florida policyholders."

The examiner recommends that the Company exercise greater control over outside entities collecting premiums on its behalf. Routine reconciliation of records, on site visits and account analyses should be performed. Had the Company reconciled its records with those of its outside premium collection agents, reductions in premiums might have been noticed. On-site visits of the entity collecting premiums for the Company may have revealed weaknesses in internal controls. Furthermore, a reduction in the number of money orders might have been noticed sooner had the Company performed frequent account analyses.

The Company is implementing procedures to resolve this problem, including investigating all impending cancellations for non-payment of premiums, to assume that such

cancellations are not a result of the aforementioned misappropriation. In some cases, wherein the policyholder has a good record of paying premiums, the Company is crediting policies automatically if the policyholder says they paid by money order. The Company is reimbursing policyholders for money order tracer fees.

Of the 130 policyholder complaints that the examiner reviewed, there were 21 related to premiums, of which 7 were related to the billing processing system. The examiner determined that the Company adequately resolved the complaints.

Claims Denials

The purpose for testing claims denials was to determine if claims were legitimately denied based on policy language, and Florida law.

The examiner randomly selected (36) claims denied for medical misrepresentation from a population of (152). The examiner also reviewed all of the 18 "compromised" death claims resulting from medical misrepresentation. "Compromised" death claims are death claims that the Company has negotiated with the claimant to settle for half the amount of the face value of the policy. These are death claims wherein the deceased policyholder has had some prior medical history not shown on the policy application. The Company does not have standardized procedures for compromised settlement of death claims.

The examiner performed the following examination procedures:

- Verified that the Company has denied claims in compliance with the conditions stated in the policy contract.

- Ascertained that the Company has not been discriminatory in its claim denial practices.

- Verified that the Company's claim denials, based on pre-existing conditions, comply with Florida Statutes.

- Verified that the Company is in compliance with Florida Statutes regarding claims denials.

- Determined that the proper denial coding was used.

The Company denied (172) claims during the period of review, of which, (152) or (88.4%) are policy rescissions, pursuant to medical misrepresentations on policy applications.

Pursuant to the policy contract, the Company has the prerogative to investigate and rescind its insurance policy within a two-year contestable period, if it finds misrepresentations on the application.

The examiner found many instances of applicants not accurately completing questions on policy applications regarding their medical history. The examiner's review of (36) denied death claims and all (18) compromised death claims files indicated that the average age of the applicant was (69.9) years old.

A Company attorney responded "None" by memorandum dated December 15, 2000, in response to the examiner's question, "Does the Company perform or require its field supervisors to perform follow-up sales reviews and/or audits to see if medical and other information are being recorded properly, in view of the high level of denials?" Also, the examiner asked the Company, "Does underwriting consider the level of denials in determining the amount of investigation or procedures to be performed prior to providing coverage?" The Company's actuary's response by memorandum dated December 6, 2000, did not demonstrate that the Company had implemented procedures to address the accuracy of medical information on applications or any other procedures to lower policy rescissions.

The Company has not implemented any inter-office policies and procedures directed at reducing the number of rescissions that it is experiencing. Also, the Company has not

required its field sales representatives to perform any particular activity directed toward diminishing the number of rescissions pursuant to medical misrepresentations on applications.

The Company should create and implement a corrective action plan to reduce the number of rescissions, pursuant to medical misrepresentations on applications. The Company should re-evaluate its applications that do not contain responses to all relevant information.

The Company does not have standardized procedures on compromised death claim settlements. According to John P. Seneczko, a Company attorney, in a memorandum dated January 18, 2001, "While Guarantee Reserve sincerely believes that this claims handling philosophy assures that it will address claims made under its policies in a fair and just manner, it also realizes that any attempt to create any hard fast rules pertaining to when a claim should and should not be compromised would ultimately jeopardize this objective along with the open minded way it currently approaches its claims and thus be counterproductive."

However, not adopted and implementing standards for determining the partial claim payments could be considered a violation of Section 626.9541 (1) (i) 3a, Florida Statues (Statutes). The Statutes sets forth that "Failing to adopt and implement standards for the proper investigation of claims" is an unfair claim settlement practice.

The Company should adopt and implement standards for determining partial payment on death claims to ensure that policyholder and beneficiaries are treated fairly, and without discrimination.

Claims Handling

The purpose for the examiner's review of this item is to determine if the Company is handling claims in a timely manner and in accordance with policy provisions and Florida Statues. The examiner randomly selected (18) claim files from a comprehensive listing of Florida paid claims for the period of July 1, 1997 through June 30, 2000. Furthermore, The examiner randomly selected (63) paid claims from the Florida paid claims listing for a test of the interest on claims calculation and copies of the related cancelled checks. The Company is not issuing any Medicare supplemental policies in Florida. At the period ended June 30, 2000, there were 13 policies in force and no pending claims. Therefore, the examiner excluded Medicare supplement policies from this review.

The examiner performed the following examination procedures on claims handling:

- Verified that the Company's claims processing procedures meets applicable state laws, including unfair trade practices and unfair discrimination.

- Verified that the Company's claim liability, coverage concerns and claims payments are made accurately and in accordance with state requirements and policy provisions.

- Performed time studies to measure settlement time of claims.

- Determined if interest is paid on claims in accordance with Section 627.4615, Florida Statutes.

The Company's practice is to pay interest on death claims from the date that it receives all of the due proofs necessary to pay the claim up to the date of payment. The Statute requires payment of interest "from the date the insurer receives written due proof of death of the insured." Therefore, the Company is in violation of Section 627.4615, Florida Statutes regarding the application of interest on death claims.

If the written proof of death is received by the Company much earlier than the other required documents, then the Company must pay interest from the date it first received written proof of death, not at the later date of receiving other required documents.

The manner in which the Company calculates interest on death claim payments has been in effect for the period of review. According to a memorandum written by Jan Kooi, manager of the claims department, dated August 17, 1984. The memorandum reads that, "If a statute indicates interest is payable from receipt of proof of death, we will interpret it as meaning the certified copy of the death certificate and the claim forms, when necessary". Therefore, the financial impact and number of policyholders affected by this miscalculation are likely to be substantial.

The Company should review its claims to determine the actual date of receipt of written proof of death of the insured on claims paid during the period of the examination, and make the proper adjustments to the calculations of interest and make restitution to policyholders and beneficiaries.

The examiner notes that the Company should correct its procedures on paying interest on death claim payments to comply with Section 627.4615, Florida Statutes.

PREMIUM REFUNDS

The Company is not paying interest on premium refunds. The Company refunds premiums on death claims when it has determined that medical or other misrepresentations have been made on policy applications. Refunds are being made during the two-year policy contestable period. Because some refunds are made up to two years after the policy is issued, the related interest could be relatively substantial. The Company accumulates interest on other policyholder funds left in its care. Also, the Company charges interest on all policy loans to policyholders. Paying interest on fund accumulations is consistent with the Company's practice.

Fair and equitable treatment of individuals leaving funds on deposit with the Company for up to two years, dictate that those funds on deposit plus related interest should be returned, when the Company chooses to withdraw its coverage.

The examiner recommends that the Company immediately commence paying interest on refunded premiums for which it has elected to withdraw its insurance coverage.

Suitability

The purpose for the examiner's review of suitability is to determine that the Company is adhering to appropriate guidelines for advertising, marketing, and selling of products suitable to the needs of its policyholders. Also, the examiner determined if the Company encourages or discourages the selling of certain products to seniors, made multiple sales to individuals of the same or similar products, and determined if the underwriting guidelines place limitations on multiple sales, and limited coverage to ensure product suitability. The Company does not currently sell annuity products, and therefore, these were not reviewed.

The examiner randomly selected (29) policy files, and (23) policy underwriting files from the master file of active policies to review.

The examiner performed the following examination procedures:

- Verified product filing approval documentation.
- Verified the completeness of underwriting files.
- Reviewed the Company's underwriting guidelines and bulletins for appropriateness.
- Reviewed the Company's new business applications.
- Verified compliance with Section 626.9541 (1)(a), (b), & (k), Florida Statutes.
- Reviewed the Company's replacement and disclosure documents and declination procedures for compliance with Statutes.

The Company primarily writes whole life policies ranging from $2,000 to $10,000. The policies that were reviewed did not contain the following features: Non-forfeiture options, dividend options, or automatic premium loan options. The examiner noticed that underwriters primarily used the information placed by the applicant on the policy application to underwrite the coverage. Also, the examiner randomly selected (29) policies to perform a new business forms review. The sample indicates that the Company does disproportionately sell products to seniors.

The examiner did not find any exceptions during the examination of the items reviewed. However, as reported in the Claims Denial section of this report, the Company is experiencing a high level of rescissions resulting in claim denials due to medical misrepresentation on policy applications. Also, the Company has not formulated and implemented procedures directed at lowering the number of rescissions.

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 Guarantee Reserve Life Insurance Company as of June 30, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Jack McDermott
CIE, FLMI, ARM
Management Review Specialist

FINDINGS AND RECOMMENDATIONS

The following findings were made in the report.

Page

Advertising

9 The Company is in violation of Rule 4 – 150.107 (b), Florida Administrative Code (Rule) regarding advertisement of its modified benefit whole life policies, requiring no evidence of insurability as a condition for issuance.

Claims Denials

14 The examiner directed the Company to review its policies and procedures to create and implement a corrective action plan directed at reducing the number of rescissions, pursuant to medical misrepresentations on applications.

Claims Handling

15 The Company is in violation of Section 627.4615, Florida Statutes regarding paying interest on death claims.

The Company should review its claims to determine the actual date of receipt of written proof of death of the insured on claims paid during the period of the examination, and make the proper adjustments to the calculations of interest and make restitutions to policyholders and beneficiaries.

15-16 The Company is not paying interest on premium refunds. The Company refunds premiums on death claims when it has determined that medical or other misrepresentations have been made on policy applications. Refunds are being made during the two-year policy contestable period. Because some refunds are made up to two years, the related interest could be relatively substantial.

The examiner recommends that the Company immediately commence paying interest on refunded premiums.