

**FLORIDA DEPARTMENT
OF
INSURANCE**

**TARGET MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2000**

NATIONAL STATES INSURANCE COMPANY

**1830 Craig Park Court
St. Louis, Missouri 63146**

NAIC Company Code 60593

EXAMINATION PERFORMED BY AN INDEPENDENT CONTRACT ANALYST

**Donald R. Koelker, CIE, FLMI, ALHC, AIRC
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FOR

THE FLORIDA DEPARTMENT OF INSURANCE

**DIVISION OF INSURER SERVICES
BUREAU OF MARKET CONDUCT
LIFE AND HEALTH SECTION**

***EXAMS, Inc.
PO Box 250783
Daytona Beach, FL 32125***

October 10, 2000

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

Commissioner Gallagher:

Pursuant to the provision of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated May 1, 2001 a Target Market Conduct Examination has been performed on:

National States Insurance Company
1830 Craig Park Court
St. Louis, Missouri 63146

The examination was conducted at the Company's Corporate Headquarters located at 1830 Craig Park Court, St. Louis, Missouri 63146. The Examination covered the period from January 1, 1999 through December 31, 2000.

The following Independent Market Conduct Contract Analyst respectfully submits the results of the examination.

Sincerely,

Donald R. Koelker, CIE, FLMI, AIRC, ALHC
Independent Market Conduct Contract Analyst

**MARKET CONDUCT
EXAMINATION REPORT
OF
NATIONAL STATES INSURANCE COMPANY
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Executive Summary

Introduction

The Department selected the National States Insurance Company (“National States” or “Company”) for a target market conduct examination due to the number of complaints received by the Department. During the selected scope period of January 1, 1999 to December 31, 2000 for the examination, the Department received 232 complaints through its Division of Consumer Services regarding the sale and administration of National States products. National States received an additional 40 complaints directly from its policyholders totaling 272 complaints during the scope of the examination.

The nature of these complaints was also of concern to the Department. The Company primarily markets home health care products, and long-term care products to the senior market. The average age for the insured in the selected sample of agent sales was 80 years of age. The company has reported that the actual average age is 72 based on the entire population. The company asserts that this is comparable to other companies writing health business in the senior market.

The Department has received complaints regarding the agents utilized by National States to sell these products to the elderly. In the past two years, the Department has suspended the license of one agent for nine months, and another agent received a complete revocation of his license. Although not officially sanctioned, eight (8) National States’ agents have received a Letter of Guidance warning notice about their conduct, and the Department is currently investigating the operations of four (4) other National States agents. National States was not aware of the Department’s action with respect to the latter 12 agents.

Types of Complaints Against the Company

The specific types of complaints received by the Department were disproportionately related to agent handling issues. Of the 232 DOI complaints, the Department classified twenty-five (25) or ten percent (10%) as agent issues. However, the nature of the Department's reporting system is to select the one "main" issue based on the initial complaints. After the examiner's review of the 232 DOI complaints, the examiner concluded that as many as 77 of these complaints (34%) could be related to agent issues.

The discrepancy between the Department's figure and the examiner's finding can be attributed to multiple issues contained within one complaint. Several of the complaints had multiple issues and the examiner identified and listed all issues contained in the complaint. Using either classification method, this represents a high number of agent complaints relative to other companies examined by the Department.

Specific Practices

Given the types of complaints, and the nature of the complaints listed above, the Department targeted the specific issues of complaints and agent issues for National States' marketing of home health care and long-term care products to the elderly.

Multiple Sales

While the examiner was on site, the Bureau of Agent and Agency Investigation made a request for the examiner to review the health products sold by two specific agents. The two agents sold fifty-three (53) health products during the year 2000. Moreover, the examiner noticed that the people who purchased these 53 policies had, on average, purchased 3.7 insurance products from the Company in the past. This could imply the marketing of unsuitable products to consumers, as some of these policies have overlapping policy coverages, and therefore, the consumer does not gain the full benefit of multiple policies. In one instance, policyholder (HNF-3-0903156) purchased 14 previous policies from agents of the Company. There is no documentation in the file to indicate that the General Agent or the Company monitored or discouraged this practice.

The Company's underwriting file showed the non-active and current policies written for the applicant, but no correspondence to question the agents why they were re-selling the same policy to the same policyholder.

The Company asserts that this case reflects an error by the Underwriting Department in that the number of lapsed policies exceeds the limits that are allowed under the Company's underwriting rules. The Company assures the Department of Insurance that this particular policyholder's records have been marked so the Company will accept no more coverage from her.

Another example of this practice involved policyholder (HHC-1-0933055) who purchased a Home Health Care Policy with a benefit of \$80 per day for Home Care Services required in the home. Two months later the same agent, Vincent Pedulla, sold the applicant a Long Term Care Nursing Home Policy, (PAL-1-0934904). This policy offers a Home Health Care Rider, which could have incorporated the \$80 per day Home Health Care benefit previously sold on the HHC-1 policy, thereby eliminating the need for two policies. This sales tactic cost the consumer \$1,752 more in annual premium for coverage that could have been combined into one policy. It also enriched the agent an additional \$701 in commission.

Cancellations

During the scope of the examination, the examiner reviewed fifty (50) policy files that had been cancelled. Eight (8) policies, (16%), were returned during the free-look period. Twenty-eight (28) policies (56%) of the sample were cancelled at the insured's request for reasons that included suitability of the coverage, economic burden, and in one case the agent alleged the policy was a tax-qualified product even though this product is not offered by the Company. The high number of returns could suggest that the policies were unsuitable or applicants were pressured into purchasing these products.

Underlying Reasons for Complaints

The number of complaints about agents, combined with corollary complaints of cancellations and return of unearned premium, indicate that the Company is not adequately conducting oversight of its agent force. The Company has also designed an agent commission

structure, that has since been altered, that could promote pressure selling and multiple-sales to individuals. The Company informed the examiner that the General Agent pays the selling agent forty percent (40%) commission based on the first year premium. When the agent submits an application with a check for the full annual premium to the General Agent, the General Agent gives the selling agent a commission check for that transaction less any outstanding charge-backs.

The examiner observed that in a majority of the sales, the agent requested the applicant to pay the premium on an annual basis even though the Company offers and encourages other payment options. In the past, for business sold on a monthly basis, the Company would only pay commission based on the amount of premium submitted with the application. The higher the submitted premium, the higher the commission the agent received upfront.

In an effort to encourage the agents to submit business paid by the monthly bank withdrawal payment mode, the Company now advances the commission calculated as if nine (9) months of the annual premium were submitted. The examiner believes this is a positive change in the agent commission structure.

Department Action

The Department took action in 1999 against agent Richard Cusano by suspending his license for nine months for misappropriating funds. Daniel Ianniello's license was revoked in 2001 for misrepresentation and deceptive practices committed before and during the scope of this examination. National States had never disciplined these agents before the Department acted. The agents no longer hold an appointment with National States.

Moreover, the Department has issued a warning (Letters of Guidance) to eight (8) National States agents since January 1, 1999, and have an additional four (4) agents under investigation for reasons varying from misrepresentation to falsification of records. As stated earlier, the Company was not aware of the Department's action on these 12 agents.

Company Agency Structure

Another potential problem contributing to the Company's lack of oversight of agents is that the Fidelity Assurance, Inc., the General Agent, is the only entity allowed to market products in the State of Florida. This creates a potential conflict of interest in that the president of this agency, Melvin Gross, also is a stockholder in National States. Presently, he owns less than ten percent (10%) of National States stock and sits on the Board as a director of the Company.

This conflict of interest may explain why the Company has not provided periodic oversight, or participated in the discipline of its Florida General Agent workforce. Despite twenty-six (26) agent complaints to the Department, two (2) disciplined agents, and twelve (12) ongoing investigations by the Department, there has never been an audit of the General Agent undertaken by the Company.

Recommendation

National States must recognize that it is responsible for overseeing the conduct of its agents. The Company should perform quarterly audits of the General Agent to identify problems associated with the Fidelity Assurance, Inc. agency. These audits should include a review of agent training, analysis of agents who have disproportionate numbers of cancellations, as well as an analysis of agents with a disproportionate number of complaints.

Furthermore, the Company needs to reprimand, discipline, or terminate agents as appropriate in cases where the Department has taken action, or, who have been found to be in violation of good business practices in the marketing of their products.

The Company may consider asking Melvin Gross, the General Agent, to divest himself or put in trust the Company stock he owns, and resign his director position on the Company Board of Directors. The general agent should submit to the Company, a monthly report on agent production, commissions, and justification for repeat and multiple sales to a client. Complaints received against specific agents and dismissals of agents should be part of the report.

Miscellaneous

The examination focused principally on agent conduct, however the examiner reviewed other issues. One of these is the Company's lack of response to implement a system to track and administer claim payments that trigger the Waiver of Premium clause included in the long-term care and home health care policies. When the Company has paid a benefit under these types of policies for a period of ninety (90) consecutive days, it is required to waive the payment of premiums that come due during the continuance of the period of confinement.

The problem arises when a policy is paid in advance and the Company fails to refund the premium already paid. In the case of accounts paid by monthly bank withdrawals, the Company does not suspend the withdrawal of funds from the policyholder's bank account.

Another finding is the reduction of Home Health Care benefits without proper documentation and authorization from the attending physician. Six (6) complaints indicate the Company inappropriately reduced benefits for in-home care.¹ The examiner reviewed evidence showing that the Company, through its case management system, strives to reduce the benefit to a minimum of two hours per day, and in one case in direct conflict with the written order of the doctor.² This constitutes an unfair trade practice. The random sample of paid claims did not reveal this problem.

However, these are really corollary issues to the primary problem experienced by National States: The agent commission structure and lack of agent oversight by both the General Agent and the Company that can encourage multiple-sales and unsuitable sales of home-health care and long-term care products to Florida's elderly.

¹ S-9900-0069793, S-0001-0031204, S-0001-0023535, S-0001-0000429, S-9900-0043904, (S-9900-0056777 & S-0001-0001505).

¹ S-0001-0023534

² S-0001-0031204

PURPOSE AND SCOPE OF EXAMINATION

The Florida Department of Insurance (Department) conducted a limited scope target market conduct examination of National States Insurance Company, hereinafter referred to as NSI or the Company. Independent contact analyst, Donald R. Koelker, CIE, FLMI, ALHC, AIRC, conducted the examination pursuant to Section 624.3161, Florida Statutes.

This examination covers the period from January 1, 1999 through December 31, 2000 and was conducted at the corporate offices of the Company at 1830 Craig Park Court, St. Louis Missouri 63146. The on-site examination commenced on May 29, 2001 and was completed on August 31, 2001.

The purpose of this Target Market Conduct Examination was to:

- Determine the underlying cause of the complaints received by the Florida Department of Insurance;
- Identify potential trends indicative of questionable practices, deficient procedures and inappropriate oversight in conducting the business of insurance, and;
- Determine if the NSI's insurance business practices and procedures conform to the Florida Statutes and the Florida Administrative Code.

The examination was limited to assessing overall practices and procedures used by NSI between January 1, 1999 and December 31, 2000. The primary areas reviewed were as follows:

- Complaints
- Billing and Posting, Applications
- Cancellations and Terminations
- Claims Processing, Paid and Denied
- Agent Issues

Procedures and conduct of the examination are in accordance with Market Conduct Examiners Handbook promulgated by the National Association of Insurance Commissioners (NAIC). The Handbook Standards of a seven percent (7%) error factor for claim resolution procedures and a ten percent (10%) error factor for other procedures were given consideration and applied where applicable.

NSI has not assumed policies from other companies in the lines of business subject to this examination. Records and files were examined on the basis of content at the time of the examination. Comments and recommendations are made in those areas in need of correction and improvement.

COMPANY PROFILE

The National States Insurance Company located in St. Louis, Missouri, is a Missouri domiciled life and accident & health insurance company licensed in 37 states. The Company's 2000 Annual Statement shows that the Company reported \$26,799,270 in life premiums and \$64,831,949 in Accident and Health premiums nationwide. Florida premiums consist of \$1,971,065 in life and \$29,940,841 for accident and health premiums. Florida premiums comprised 34.8% of the total premiums written by the Company.

NSI is a stock company incorporated in the State of Missouri. The stock is privately held by a small group of investors and is not listed on any stock exchange. The Company was founded in 1964 and is licensed to sell Life, and Accident and Health products. The Company's Florida portfolio focuses on Long Term Care and Home Health Care Health products marketed mainly to senior citizens.

The Company contracts exclusively with Fidelity Assurance Inc., a General Agent, to market and distribute NSI products in Florida. This Agency is owned by Melvin Gross who presently serves as a Director of the Company. Mr. Gross is also a Stockholder in NSI. The agency has over 600 appointed NSI producers.

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

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

The Company did not offer group life, credit life/health/disability products in Florida during the period subject to this examination.

EXAMINATION FINDINGS

The examination resulted in a total of nineteen (19) findings in which the Company was not in compliance with Florida Statutes and Regulations. The following is a summary of the examiner's findings and recommendations. The examiner reviewed the Company's business practices in the following areas to determine compliance with Florida Statutes and Administrative Code.

Complaints

The examiner selected seventy (70) files from a population of two hundred thirty-two (232) Department of Insurance complaints. Seven (7) Company complaints, out of forty (40), that the Company received directly from the insured were also selected for a total of seventy-seven complaint cases reviewed. NSI maintains a log for complaints received from the Department separately from those received directly from policyholders and other non-Department sources.

The examiner found several areas of concern:

Agent Issues

- An Agent allegedly signed the application instead of the applicant. There were two (2) examples of this practice.³ The Department on July 30, 2001, revoked the license of one agent for this and other conduct. The consumer stated that the signature was not his. The Company took no further action. This is a violation of Section 626.9541(1)(k), Florida Statutes.
- An Agent answered application questions for the applicant and allegedly provided answers that were contrary to the applicant's actual answer. The Company has recently instituted a verification process in which each applicant is called and application questions are verified for accuracy. There were two (2) examples of this agent practice.⁴ The agent, Larry Krakow, was involved in both cases. His appointment was terminated by the Company on August 8, 2001 for multiple,

³ S-9899-0022091 & AI-96-1953-05

⁴ Company Log, Policy #HHC-1-0927625

unethical business practices. This is a violation of Section 626.9541(1)(k), Florida Statutes.

- An Agent failed to notify the Company to cancel a policy when requested to do so by the policyholder. There were two (2) examples of this type of complaint.⁵ In one instance, the agent admitted this was true and wrote a letter to the Company verifying his mistake. In the other instance the agent's appointment was terminated before the complaint was filed. This is a violation of Section 627.6043(2), Florida Statutes.

Company Issues

- The insured's request for cancellation and refund of unearned premium was not processed in a timely manner. This issue is also covered under the Cancellations/Terminations section. There were nine (9) examples of this practice in the complaint files.⁶ This is a violation of Section 627.6043(2), Florida Statutes.
- The Company continued to withdraw premiums from the insured's bank account while the Waiver of Premium policy benefit was in effect. This action by the Company is in conflict with their policy contract provisions and constitutes an unfair practice. There were three (3) examples in the complaints.⁷ This is a violation of Section 626.9541(1)(o)(2), Florida Statutes.
- The Company reduced Home Health Care benefits without proper documentation and in violation of the attending physician's written order. The Company requires a written order from a physician before a Home Health Care or Long Term Care claim is paid. This action by the Company is in conflict with their claim handling procedures and constitutes an unfair practice. There were three (3) examples.⁸ This is a violation of Section 626.9541(1)(i)(2), Florida Statutes.

⁵ AI-2127-2900

⁶ S-9899-0066253, S-9900-00011988, S-9899-0050109, S9899-0073184, S-0001-0006287, S-0001-0004739, S9900-0073290, S-0001-0011318, S-9900-0070214.

⁷ S-9900-0026999, AI-2310-3145.

- It appears the Company received a written complaint that was not recorded in their Complaint Log.⁹ This could be considered a violation of Section 626.9541 (1)(j), Florida Statutes, which requires that all complaints received by the Company be recorded in the complaint log. Since there were only a few instances of this occurring, the Company was not cited for a violation in this report.
- The Company could not provide the examiner with a formal printed Complaint Handling Procedure Manual. Mr. William Morrison, Vice President of Operations for the Company, acknowledged this in a memo dated October 11, 2001. He states that a Complaint Handling Procedure Manual will be created. The Department recommends as a good business practice that the Company maintain a complaint handling procedures manual.

The examiner recommends that the Company revise its complaint investigation and enforcement procedures to bring them into compliance with Florida insurance law. Agents are involved in a large percentage of the complaints received by the Company. There are thirty-one (31) examples in the Complaint files that indicate agent actions are not being monitored and appropriately investigated. The Company provides no active oversight of the General Agent and the appointments, training, supervision, discipline and termination of agents are left to the discretion of the General Agent.

The agency owned by Mr. Gross produces thirty five percent (35%) of the total premiums the Company writes nationwide. The Company has not taken any disciplinary action against its Florida General Agent, despite the level and severity of complaints.

⁸ S-9900-0069793, S-0001-0031204, S-0001-0023535, S-0001-0000429, S-9900-0043904, (S-9900-0056777 & S-0001-0001505).

⁹ S-0001-0023534

RESOLUTION OF COMPLAINTS

DAYS TO RESOLVE	NUMBER OF COMPLAINTS	PERCENTAGE OF COMPLAINTS
1-10 Days	38	49%
11-30 Days	21	27%
31+ Days	18	24%
TOTALS	77	100%

Billing and Posting

The examiner reviewed the application files using a random sample of fifty (50) files from a population of eleven thousand, one hundred sixty-five (11,165) policies that were issued during the period January 1, 1999 through December 31, 2000. The examiner tested the Company procedures for proper billing of filed and quoted rates for the policies issued and the amount of the check submitted with the application. The examiner also reviewed the subsequent billing for renewal to determine if the applicants were being treated fairly and not subject to unfair discrimination.

The examiner verified that at the time the application was submitted, the agent was licensed and appointed by the Company. The requirement for the agent to have their signature and license number on the application was also confirmed.

The examiner found two (2) areas of concern in this section dealing with producers.

- Applications submitted to the Company did not contain the license identification number of the producing agent. The four (4) examples were:

POLICY NUMBER	AGENT NAME
HHC-1-0936712	Applefield
MSO-1-0931213	Doolan
PAL-1-0924011	Adamovich
PAL-1-0924904	Doolan

- One application submitted to the Company had an illegible agent's name and license identification number. The policy number is (STC-1-0934547).

(This was within the permissible error ratio, and not considered a violation of Section 627.4085 (1), Florida Statutes. The examiner does recommend the Company address these omissions.)

The examiner recommended that the Company notify all Florida appointed agents of this requirement and in the future, monitor all submitted applications for compliance.

Mr. William Morrison, Vice President of Operations, sent a memo dated August 20, 2001 to all appointed Florida agents reminding appointees to include the license number and a legible name on all applications. Mr. Morrison also agreed that the Company would closely monitor this requirement during the underwriting process.

Cancellations/Declinations/Non-Renewals/Terminations

The examiner reviewed the cancellation, declinations, non-renewal and termination files in a systematically selected sample of fifty (50) files, from a population of seven-thousand, two-hundred forty eight (7,248) terminated policies for accident and health plans processed during the period of January 1, 1999 through December 31, 2000. The examiner reviewed the refund calculation methodology, calculated the timely execution of the request for cancellation, and verified cancelled checks for unearned premium refunds.

The examiner found one (1) area of concern in the review of cancellation/terminations.

- The Company does not promptly return unearned premium after the policyholder sends a cancellation request in writing. When the Company receives a request to cancel a policy, they send a form letter to the insured explaining the possible ramifications of canceling the coverage. The bottom of the form has a tear-off section, which is called the verification form. It states:

No___ Do not cancel my policy
Yes___ Cancel my National States coverage

The insured must mark the form and return it in a postage-paid envelope, even though they have already requested a cancellation and a return of their unearned premium. If the Company does not receive the form, no action is taken and the Company has no procedure to track and honor the original request. There were three examples of this practice in the fifty (50) files sampled.

POLICY NUMBER	DAYS TO RETURN UNEARNED PREMIUM
HNF-3-0830044	43
LBF-3-0868455	43
MBS-2-0731834	52

The Company took an average of twenty-two (22) days overall, to return unearned premium for the files sampled after the policyholder requested a written cancellation.

- During the review of the Billing and posting section there was an unearned premium issue. One insured with three policies died. The attorney for the estate notified the Company and requested any benefits or premium due. The Company returned the unearned premium (190) days later. No interest was paid. Mr. William Morrison, Vice President of Operations for the Company agreed in a memo dated August 21, 2001, that

there was an internal problem with the processing of the unearned premium and is instituting procedures to prevent this from happening in the future.

The following policies were affected:

POLICY NUMBER	DAYS TO RETURN UNEARNED PREMIUM
HNF-3-0849847	190
HNF-3-0841396	190-
STC-1-0934140	190

This is a violation of Section 627.6043 (2), Florida Statutes.

CLAIMS

Claims Paid

The examiner reviewed a random sample of one hundred (100) paid claim files from a population of one hundred, three thousand, eight hundred forty (103,840) processed from January 1, 1999 through December 31, 2000. One claim selected was from out of state. The examiner reviewed the claims to determine timeliness of payment, accuracy of processing, conformance to the requirements of the unfair trade practices, and entitlement to policy and State mandated benefits.

- The examiner requested the Company's claim procedure manuals, claim examiners training manuals, and claim bulletins. Mr. William Morrison, Vice President of Operations for the Company, stated in a memo dated October 11, 2001 that a Claims Handling Procedure Manual will be created.

There were no exceptions noted during the Paid Claims review. The sample tested showed that ninety-nine (99) percent of the claims were paid within forty-five (45) days. One claim selected was an out of state claim and was not included in the calculations.

Claims Denied

The examiner reviewed a systematically selected sample of one hundred (100) denied claim files from a population of forty thousand, three hundred fifty-four (40,354), processed from January 1, 1999 through December 31, 2000. The claims were reviewed for the Company's overall claim handling practices to determine timeliness of denial, reason for denial including the applicability of non-covered services, mandated benefits, application of pre-existing conditions and the accuracy of processing.

There were three (3) areas of concern in the review of Denied Claims.

Multiple Sales

- The Company writes a Long-Term policy (PAL-1) that covers nursing home care. The policy application has an option to include a Home Health Care rider which pays up to \$100 per day depending upon the selection made by the applicant. The Company also offers a Home Health Care policy (HHC-1) with benefits up to \$100 per day. The insured was first sold a Home Health Care policy (# HHC-1-0933055) with an \$80 per day benefit. Two months later the agent returned and sold this eighty-eight (88) year old female a Long-Term Nursing Home Policy (# PAL-1-0934904) with a \$20 dollar a day Home Health Care benefit. This gives the insured a potential of \$100 a day Home Health Care benefit.

This multiple sale resulted in the insured paying \$1,752 more per year in premium than if the agent had sold her the Long Term Care policy with a \$100 a day Home Health Care rider. This would have eliminated the need for the original Home Health Care policy and combined the identical benefits into one policy. The agent did not take into account the needs, economics and suitability of this combination sale to the insured. The agent also benefited by making an additional \$701 in commission. This is a violation of Section 626.9541 (1)(a)(1), Florida Statutes. Although Mr. William Morrison, VP of Operations, disagreed with the examiner's observations in a memo dated August 27, 2001, he could offer no explanation for the agent's actions.

Waiver of Premium

- The Company's Home Health Care policy form (HHC-1) contains a waiver of premium contract clause. This clause waives the monthly premium after a benefit has been paid for ninety (90) days and continues as long as the condition exists. The Company failed to invoke this benefit and continued to collect premium from the insured despite the contract provision. The examiner brought this violation to the attention of the Company. The Company immediately paid the benefit plus interest to the policyholder (HHC-1-0915962). The amount of the payment was \$392.45, including interest. This is a violation of Section 626.9541(1)(o)(2), Florida Statutes. William Morrison, VP of Operations agreed with this finding in a memo dated August 28, 2001.

Claim Incorrectly Denied

- The insured submitted claims for reimbursement under a Cancer policy (SCO-1-0169198). The Company requested a pathology report, but no report was forthcoming. Two years later the pathology report was sent to the Company. The Company then requested a hospital bill, which had previously been received. The examiner brought this to the attention of the Company and the company responded by sending a check for the benefit due. There was \$113 interest due which the Company has not paid. William Morrison, VP of Operations agreed with this finding in a memo dated August 28, 2001 and attributed it to a claim processor error. This is within the established error ratios for Section 627.613(6), although the examiner recommends that the Company make this interest payment.

Consumer Recoveries

Recoveries Paid

As a result of this Target Market Conduct Examination of National States Insurance Company, payments have been made directly to or on the behalf of residents of the State of Florida in the total amount of seven hundred eighty two dollars and forty five cents (\$782.45).

Future Recoveries

It was also determined that an additional one hundred thirteen dollars (\$113) of future interest payments are due to or on behalf of residents of Florida for failure to pay claims in accordance with Section 627.613(6), Florida Statutes.

Conclusion

The target market conduct examination report on National States Insurance Company as of December 31, 2000, is respectfully submitted to the Honorable Tom Gallagher, Insurance Commissioner of the State of Florida.

The customary practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC) were followed, when possible, in performing this examination.

Respectfully submitted,

Donald R, Koelker, CIE, FLMI, AIRC, ALHC
Independent Contract Analyst

FINDINGS AND RECOMMENDATIONS

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

Page 13	Comply with Section 626.9541(1)(k), Florida Statutes to ensure that agents do not make misrepresentations on behalf of the insured on the insurance application.
Page 14	Comply with Section 627.6043(2), Florida Statutes, to accurately record a cancellation, and promptly return unearned premium.
Page 14, 21	Comply with Section 626.9541(1)(o)(2), Florida Statutes by not collecting excess premium.
Page 14	Comply with Section 626.9541(1)(i)(2), Florida Statutes, by not making material misrepresentations with the intent of effecting settlement on less favorable terms.
Page 20	Comply with Section 626.9851(1)(a)(1), Florida Statutes to ensure that agents do not misrepresent the benefits, advantages, conditions or terms of any insurance policy.