FLORIDA DEPARTMENT OF INSURANCE

TARGET MARKET CONDUCT EXAMINATION REPORT

OF

UNUM LIFE INSURANCE COMPANY OF AMERICA

AS OF

MARCH 31, 2001

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

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May 16, 2005

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

Commissioner Gallagher:

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated July 27, 2001 a Target Market Conduct Examination has been performed on:

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

NAIC COMPANY CODE 62235

The examination was conducted at the offices of the Company located at 2211 Congress Street, Portland, Maine. The report of such examination is herein respectfully submitted.

Sincerely,

Debora Finn, AIE, FLMI
Independent Contract Analyst

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Executive Summary

The Department selected Unum Life Insurance Company of America (Unum) for a targeted market conduct examination due to an increased number of complaints being filed with Consumer Service offices located throughout the State of Florida. The reasons stated for filing the complaints were varied, however a majority of complaints expressed dissatisfaction with claim denials and processing delays related to disability income claims.

Based on the number of complaints related to claim denials and delays, the areas examined were limited to a review of claims and complaint administration for disability income policies only.

The previous market conduct examination conducted by the Department was a comprehensive examination covering the period January 1, 1991 through December 31, 1993. The prior examination was the first examination conducted by the Department. The previous examination did not include findings of non-compliance with Florida laws or regulations related to claim or complaint processing and there were no follow-up issues required to be addressed during this examination.

Several factors contributed to the increase in consumer complaints regarding claim delays and denials. First was the procedural handling of group long-term claims. In many instances, a group policy will include benefits for both short-term and long-term disability, however a single claim is filed to obtain benefits. The provisions in short-term and long-term coverage may vary considerably and may have differences in policy provisions. The same policy may include maximum short-term benefits paid weekly for 13 weeks with no exclusions for pre-existing conditions and long-term benefits, paid monthly, that exclude pre-existing conditions. For example, an individual on disability for 20 weeks recovering from an operation that resulted from a pre-existing condition would be paid weekly benefits for 13 weeks, then be denied coverage for long-term

benefits because of a pre-existing condition. The examiner determined that Unum's approval and distribution of short-term benefits may have created false expectations on the part of the policyholder that, once payments had begun, benefits would continue throughout the disability. Additionally, because Unum did not require claimants to submit separate claims for long-term benefits, they failed to provide prompt notification to the insured that additional information was needed to process the claim.

The examiner determined Unum failed to adopt and implement standards for the proper investigation of claims, and failed to include prompt notification to the insured of any additional information necessary for the processing of a claim in violation of §626.9541(1)(i)(3)(a and g), Florida Statutes.

A second factor determined to contribute to the increase in consumer complaints was Unum's merger with Provident Corporation effective July 1, 1999, which formed the largest disability insurer in the world. Prior to the merger, Unum was the largest insurer of group disability income business and Provident was the largest provider of individual disability income business. In 1997, Provident acquired Paul Revere Corporation, another leading disability income carrier. While UnumProvident subsidiaries maintain separate identities, certain administrative functions were consolidated upon execution of an administrative services agreement signed subsequent to the merger. The volume of activities merged between the subsidiaries, along with procedural changes implemented within the claims function, were determined to have contributed to delays in claim processing.

A third finding related to complaints linked processing delays to inappropriately denied claims. A review of complaints indicated Unum overturned four out of twenty-one (19%) denied claims upon receiving the insured's complaint. Internal Unum memorandums found in two of the files indicate initial denials were inappropriate because the decision to deny failed to consider medical treatment received by the insured after the investigation had been initiated. That is, records used to make the claim decision were not current at the time, and more current records should have been requested and

reviewed prior to making a decision to deny the claim. The examiner determined the finding to be one of the underlying causes of complaints received by the Department.

The examiner recommends Unum take corrective action to ensure that:

- policyholders who submit claims under terms of the comprehensive policy receive prompt written notice of differences in the short-term and long-term provisions of their policy, information on how policy benefits will be processed under the claim, and any additional information that the policyholder needs to submit to process the long-term claim;
- pre-existing investigations begin promptly on claims Unum considers likely to result in long-term disability in order to reduce unnecessary claim processing delays; and
- appropriate and timely review of current medical records are done prior to making claim decisions, particularly when the claim process involves a justifiable but lengthy investigation.

Scope of Examination

The Florida Department of Insurance (Department) conducted a limited scope market conduct examination of Unum Life Insurance Company of America, Inc, hereinafter referred to as Unum or the Company. Independent contract analyst, Debora Finn, AIE, FLMI, conducted the examination pursuant to §624.3161, Florida Statutes.

The examination covers the period from January 1, 1999 through March 31, 2001 and was conducted at the administrative offices of Unum located at 2211 Congress Street, Portland, Maine. The examination commenced on August 5, 2001 and the fieldwork concluded on November 9, 2001.

The purpose of the examination was to:

- Determine the underlying causes of the complaints received by the Department;
- Identify potential trends or practices that may be contributing to complaints regarding claim delays or inappropriate denials; and
- Determine if the Company's practices and procedures used to administer disability income business conformed 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 NAIC handbook standards of a seven percent (7%) error factor for claim resolution procedures and a ten percent (10%) error factor for other procedures were applied.

The areas reviewed were limited to claims and complaints for disability income business.

Company Profile

Unum is licensed in all states except New York, and is domiciled in the State of Maine. Florida business represented approximately five percent (5%) of Unum's 1999 and 2000 premiums. The Company is authorized to write the following lines of business in Florida:

- Life
- Group Life and Annuities
- Accident and Health
- Variable Annuities
- Variable Life

Unum is part of an insurance holding company group owned by Unum Holding Company and UnumProvident. UnumProvident is a non-insurance Delaware corporation formed effective June 30, 1999 with the merger of Unum Holding Company and the Provident Companies. The merger combined ownership of several carriers and insurance related service companies in the United States and abroad.

United States insurance company subsidiaries in the UnumProvident holding system are:

- Unum Life Insurance Company of America;
- First Unum Life Insurance Company of America;
- Colonial Life and Accident Insurance Company;
- The Paul Revere Life Insurance Company;
- The Paul Revere Protective Life Insurance;
- The Paul Revere Variable Annuity Insurance Company;
- Provident Life and Accident Insurance Company; and
- Provident Life and Casualty Insurance Company.

With the exception of Unum Life Insurance Company of America (Unum) and Provident Life and Accident Insurance Company (Provident), the carriers listed above are fully owned by UnumProvident. Unum is owned 82.72% by Unum Holding Company and

17.28% by UnumProvident. Provident is owned 85.9% by UnumProvident, 10.1% by Paul Revere Life Insurance Company and 4.0% by Unum.

With the exception of Colonial Life and Accident, the carriers listed above have entered into a general services agreement whereby UnumProvident provides the carriers with virtually all:

- Managerial and Administrative Support; and
- Marketing and Product Support.

The examiner noted that the State of Maine approved various filings made on behalf of Unum pursuant to the merger which included the general services agreement.

The purpose of the general services agreement was to create seamless and efficient operations between certain UnumProvident subsidiaries while promoting the new UnumProvident brand. Pursuant to the merger, there were no assumption reinsurance agreements between Unum and any subsidiaries, and each carrier maintains its separate identity. However, upon UnumProvident subsidiaries signing the administrative agreement, certain operations of the subsidiaries were consolidated and the claim inventories were combined.

Claim Handling

The examination of claims included a review of both paid and denied disability income claims. The categories of claims reviewed included short-term disability, long-term disability and individual disability. Below is a brief description of Unum's disability policies, claim procedures, and applicable laws followed by a separate discussion of examination findings related to paid claims and denied claims.

Short-Term and Long-Term Disability

Short-term disability policies are sold to employer groups and provide coverage for accident or injury that result in loss of income to the insured employee. The policies include elimination periods of a specified number of days for sickness and zero days for an accident. The elimination period is the period of continuous disability before any benefits are paid. The policy may include a pre-existing provision. The benefit period varies between policies, but generally extends for 13,26, or 52 weeks. Once liability has been established, Unum distributes checks to the insured on a weekly basis.

Long-term disability policies are sold to eligible groups and provide coverage for accident or injury that result in loss of income and functional inability to work to the insured employee. The policies include elimination periods of 30, 60, 90 or 180 days, and include a pre-existing provision. The maximum payment period varies according to contract. Once liability is established, Unum distributes checks to the insured on a monthly basis. Unum routinely investigates long-term disability claims to verify disability and re-certifies on-going disability claims. In circumstances where there are lengthy ongoing investigations, Unum will issue payment to an insured while reserving the right to recover payment if the investigation results in no finding of liability.

The short-term and long-term disability policies issued by Unum are group contracts sold to eligibile groups. The group policies issued to private employers are typically offered by the employer to the employee in the establishment of an employee health or welfare

plan that is governed by the Federal Department of Labor under the Employee Income Retirement Security Act (ERISA). In most cases, the employer contributes to or completely pays the premium for ERISA health plan benefits. The ERISA plans are required to be filed with the Department of Labor. Departmental jurisdiction governing ERISA plans and group disability income policies is limited to §626.9541, Florida Statutes, Unfair methods of competition and unfair or deceptive acts or practices. Generally, policies issued to governmental units are governed by the Department. However, jurisdictional issues may arise when policies are issued through an Out-of-State group trust which would be governed by the jurisdiction where the trust is located. It should be noted that, for purposes of this examination, the differences between ERISA policies and non-ERISA policies involve the insured's right to appeal denied claims. Under ERISA, the insured must file an appeal within 60 days of the denial. The Company must respond within 60 days or, if additional time is necessary, up to 120 days. It is Unum's policy to grant similar appeal rights to non-ERISA claimants.

Individual Disability

Individual disability policies are typically sold to professionals such as doctors and lawyers to replace loss of income. The terms of these policies vary. Once liability has been established, Unum sends checks on a monthly basis. The policies may include pre-existing provisions and investigation procedures to re-certify an insured's disability at regular intervals.

In reviewing the individual disability claims, the examiner assessed compliance with §627.613, Florida Statutes, Time of payment of claims, as well as §626.9541(1)(i), Florida Statutes, Unfair claim settlement practices.

Paid Claims

The data file of paid disability claims included 19,432 claims paid between January 1, 1999 and March 31, 2001. The percentage of paid claims by type of coverage is presented in the following table:

CoverageType	Number of Claims	Percentage
Short-Term Disability	13,580	70%
Long-Term Disability	5,034	26%
Individual Disability	818	4%
Total Paid Claims	19,432	100%

The examiner randomly selected 100 paid claim files to review. The sample was reduced by four to 96 claims, because two of the files were found to be First Unum claims, and two were claims reinsured by Unum. The examiner reviewed paid claims to verify that both the payment and the payment date were in accordance with policy provisions. Additionally, the examiner conducted time studies to determine claim processing times. § 627.613, Florida Statutes, Time of payment of claims, reads in part:

> *(2)Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by the health insurer. If a claim or any portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within 45 days after receipt of the claim by the health insurer.*
>
> *(4) An insurer shall pay or deny any claim no later than 120 days after receiving the claim.*

The examiner used the processing standard of 45 days for non-contested claims and 120 days for contested claims throughout this report.

In all of the claim files reviewed, there were copies of communications Unum sent to insureds advising them of delays caused by the claim investigation. The processing times noted for paid claims is depicted in the following table:

Coverage Type	1-45 Days	46-120 Days	> 120 Days	Total
Short-Term	66	2	0	68
Long-Term	15	6	1	22
Individual	2	2	2	6
Total Claims	83	10	3	96

A review of processing times indicated 13% percent of claims were processed more than 45 days after the received date. Because Unum had communicated denials or reasons for delays to insureds on a timely basis, only claims processed more than 120 days after the receive date were considered late paid claims. The late paid claims were found to have been litigated claims, initially denied then later paid. The examiner concluded that all records sampled were in compliance with Florida laws.

Denied Claims

The examination of claim denials was conducted in order to determine if Unum appropriately denied claims in accordance with terms of the policy, and to assess whether communications to insureds regarding delays and denials were prompt. The examiner also completed a time study of denied claims.

The data file of denied claims included 2,114 claims denied between January 1, 1999 and March 31, 2001. The examination sample included 91 randomly selected denied claims. The percentage of denied claims by type of coverage is presented in the following table:

CoverageType	Number of Claims	Percentage
Long-Term Disability	1,196	57%
Short-Term Disability	805	38%
Individual Disability	113	5%
Total Denied Claims	2,114	100%

The reasons Unum denied claims are presented in the following table:

Reason For Denial	Percentage
Failure to Provide Information	20%
Elimination Period Not Satisfied	16%
Not Eligible for Coverage	16%
Pre-Existing Condition	14%
Not Disabled Own Occupation	14%
Other Miscellaneous (each less than 3%)	20%

Most of the group long-term claims reviewed were for a comprehensive policy that included both short-term and long-term coverage. Unum acknowledged all claims within three to five days via telephone contact with the claimant, and also sent an acknowledgement letter. Claims were then processed by the short-term claims unit, and applicable claims were transferred to the long-term unit four weeks prior to expiration of short-term benefits and the effective date of long-term benefits. At the time claims are transferred to the long-term unit, prior to expiration of the short-term disability coverage, Unum advises the claimant that additional information is necessary to investigate liability for long-term provisions of the policy. Unum treats short-term and long-term claims separately because benefits are processed on different systems, and assigns different claim numbers to each portion of the claim. Because there are differences in the two coverages, such as waiting periods and pre-existing provisions, the claim could be approved for short-term benefits and denied long-term benefits. However, because procedures did not require the claimant to file a separate long-term claim, the examiner determined Unum failed to provide timely notice to the claimant that a separate investigation would be conducted in order to establish liability under the long-term provisions of the policy. It was further determined that Unum's procedures may have created a false expectation on the part of policyholders that, once disability payments began, they would continue throughout the disability. The examiner determined that claim procedures failed to adopt and implement standards for the prompt investigation of

claims, and Unum failed to promptly notify the insured of any additional information necessary for the processing of a claim in violation of §626.9541(1)(i)(3)(a and g), Florida Statutes.

The Examiner recommends Unum take corrective action to ensure that:

- policyholders who submit claims under terms of the comprehensive policy receive prompt written notice of differences in the short-term and long-term provisions of their policy, information on how policy benefits will be processed, and any additional information that the policyholder needs to submit to process the long-term claim;
- pre-existing investigations begin promptly on claims Unum considers likely to result in long-term disability in order to reduce unnecessary claim processing delays.

The examination of denied claims indicated the following processing times:

Coverage Type	1-45 Days	46-120 Days	> 120 Days	Total
Short-Term	24	8	1	33
Long-Term	34	19	1	54
Individual	1	2	1	4
Total Claims	59	29	3	91

The three claims processed more than 120 days after they were received were in violation of § 627.613(4), Florida Statutes, which requires all claims to be paid or denied no later that 120 days after the received date. However, the 3% error rate did not exceed the 7% error ratio selected for this examination.

Complaint Handling

The examiner reviewed complaint handling to determine if the Company had procedures in place to record and resolve complaints in a timely manner in accordance with §626.9541(1)(j), Florida Statutes. Additionally, the examiner performed an analytical review of complaints to determine if practices and procedures utilized by Unum to process claims had contributed to claim delays or inappropriate denials and caused the increase in consumer complaints received by the Department.

The review of complaints included 50 randomly selected complaints received between January 1, 1999 and March 31, 2001. The sample was extracted from a data file of 204 complaints.

The sample indicated the following reasons were given for filing complaints:

Reason For Complaint	Files Reviewed	Percent of Total
Claim Denials	21	42%
Offsets for child support, social security	12	24%
Claim Delays	8	16%
Premium Increases	3	6%
Unprofessional Employee	3	6%
General Inquiry, Request for information	3	6%
Total Complaints Reviewed	50	100%

The examiner determined Unum appropriately recorded complaints and had procedures in place to process them timely. With the exception of one file, Unum resolved all complaints within 35 days.

Four of the twenty-one (19%) complaints regarding denied claims were overturned upon Unum's review of the files. While it is not uncommon for carriers to overturn claims

based on review of subsequent information, two claims were documented with internal memorandums indicating the original decision was inappropriate because Unum failed to consider the insured's medical condition and treatment at the time the claim decision was made. That is, the records used to make the claim decision were outdated and insufficient to support the denial in consideration of medical treatment the insured received after the investigation was initiated. Additionally, in cases where an investigation is particularly lengthy and leads to a denial decision, Unum should implement control procedures to ensure appropriate and timely review of the most current medical records are considered prior to making the claim decision.

Other problems noted by the examiner indicate the UnumProvident merger may have contributed to delays in claim processing. A previous discussion of the merger in the Company Profile section of this report referenced the merging of claim inventories between several UnumProvident subsidiaries. Subsequent to the merger, procedures have included continuous movement of claim inventories from one processor or facility to another in order to optimize workload efficiencies. It is likely that the increased volume of claim activity, along with procedural changes implemented subsequent to the merger, contributed to increases in claim processing time and an increase in consumer complaint activity received by the Department.

Conclusion

The target market conduct examination report on Unum Life Insurance Company of America 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 in performing this Target Market Conduct Examination with due regard to the Insurance Laws of the State of Florida.

The examiner wishes to express appreciation to the Company for the courtesy and cooperation provided throughout the examination.

Respectfully submitted,

Debora Finn, AIE, FLMI
Independent Contract Analyst

Findings and Recommendations

The table below presents examiner recommendations.

Page	Findings/Recommendations:
15	The examiner determined Unum failed to adopt and implement standards for the prompt investigation of claims, and failed to promptly notify the insured of any additional information necessary for the processing of a claim, in violation of §626.9541(1)(i)(3)(a) and (g) Florida Statutes. The Examiner recommends Unum take corrective action to ensure: • policyholders who submit claims under terms of the comprehensive policy, receive prompt written notice of differences in the short-term and long-term provisions of their policy and information on how the policy benefits will be processed; • pre-existing conditions investigations begin promptly on claims Unum considers likely to result in long-term disability in order to reduce unnecessary claim processing delays.
17	The examiner found Unum overturned two denied claims because the original decision to deny did not consider medical condition or treatment received after a claims investigation had been initiated. (These errors are within the acceptable error ratios as established by the NAIC.) The examiner recommends Unum implement control procedures to ensure appropriate and timely review of current medical records prior to making claim decisions, particularly when the claim process involves a justifiable but lengthy investigation.