

Financial Services, Inc. John Hancock Variable Life Insurance Company is a wholly owned subsidiary of John Hancock Life Insurance Company. This Order shall refer to all three entities collectively as “the Company”. The Company is authorized to transact business in Vermont under the following Certificates of Authority: 1328P (John Hancock Variable Life Insurance Company) and 1372P (John Hancock Life Insurance Company and, formerly, John Hancock Mutual Life Insurance Company).

3. On November 4, 2002 a final market conduct examination report was issued by examiners James Montgomery III and Robbie Kriplean entitled REPORT OF EXAMINATION OF THE MARKET CONDUCT AFFAIRS OF JOHN HANCOCK LIFE INSURANCE COMPANY AND JOHN HANCOCK VARIABLE LIFE INSURANCE COMPANY BY VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION (hereinafter “the Report”).

4. In accordance with the requirements of 8 V.S.A. § 3574(b), the Report was transmitted to the Company and the Company was afforded a reasonable period of time to submit a formal written response to the findings of the Report. The Company submitted a formal response (“the Response”),¹ discussed issues raised in the Report with the Department and provided additional information requested by the Department.

5. Pursuant to 8 V.S.A. § 3574(c), the undersigned Commissioner has fully considered the Report, the Company’s Response, and additional information provided.

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¹ The Company’s Response was inadvertently made to a draft market conduct examination report. However, the Company did review the final Report and the draft report and the final report were substantially similar. Thus, the Company’s response is sufficient to apprise the Department of the Company’s position.

CONCLUSIONS OF LAW

6. The Company has suggested numerous changes to the Report. Many of the suggested changes simply reflect a different writing style or an inconsequential difference in interpretation of Vermont law. To the extent this Order does not expressly adopt changes suggested by the Company, those suggested modifications are not adopted. Unless specified otherwise, the Department adopts the Report as it has been written.

7. On the title page of the Report and at page one, the examiners reference John Hancock Life Insurance Company and John Hancock Variable Life Insurance Company. The Company explains that in 1999, John Hancock Mutual Life Insurance Company converted from a mutual life insurance company to a stock-based life insurance company and in so doing, changed its name to John Hancock Life Insurance Company. (Response at page 3.) Because the examination period generally runs from December 31, 1997 to December 31, 2000, the Company suggests that John Hancock Mutual Life Insurance Company also be referenced as one of the companies examined.

The undersigned adopts the Company's suggestion. The title page shall include the name John Hancock Mutual Life Insurance Company as suggested in the Company's Response. Further, John Hancock Mutual Life Insurance Company shall be referenced at page 1 of the Report under EXAMINATION AUTHORITY. The undersigned further adopts the changes suggested by the Company to the HISTORY section of the Report (page 3).

8. The undersigned adopts the Company's suggestion (Response at page 1) to include its P.O. Box number on page 1 of the Report.

9. On page 1 of the Report, under the heading TIME FRAME, the examiners state the examination generally covers the period from December 31, 1997 to December

31, 2000. The Company asks that the time frame be amended to read “January 1, 1998” instead of December 31, 1997. The Company bases this request on the Department Market Conduct Chief’s February 11, 2001 letter which seeks documents from 1998 to 2000 in the initial data call. The undersigned declines to adopt the suggested change. The February 11 letter specifically states the examination period will be determined by the examiners. Further, the undersigned notes that an examination can include time periods other than those initially contemplated if the examiners determine expanding the scope of the examination is warranted under the circumstances.²

10. In the **COMPANY OVERVIEW – PREMIUM REPORTING** section of the Report (pages 4-5), the examiners note that the deposit funds reported by the Company for the three examination years were relatively large negative figures. The examiners also note a drop in reported life insurance premiums of over 20 million dollars from 1998 to 1999. In response to the examiners’ inquiry, the Company explained the unusual variances were attributable to Corporate Owned Life Insurance (COLI) premiums which are “highly variable and unpredictable” and not included in the Company’s sales reporting. (Report at page 4.) The Company explained the negative fund deposit numbers “are the result of the booking of retail fund deposit surrenders as return considerations.” (Report at page 4.) The examiners note the Company’s premium reporting methodology appears to be unique and recommend the methodology be reported to the Vermont Department of Taxes for review.

In response, the Company asserts the examiners’ commentary and conclusions regarding premium reporting appear to be based on a misunderstanding of the Company’s

² For the same reason, the undersigned declines to remove the word “generally” from this section of the Report (Report at page 1).

practices, compounded by the Company's misunderstanding of (and thus not entirely accurate response to) the examiners' inquiry during the exam. (Response at page 5.) The Company notes that premiums dropped dramatically because of a decline in life insurance premiums collected; the drop was primarily attributable to two COLI products which saw a decline of over 22 million in premiums collected.

Additionally, the Company explains the drop-off in annuity fund deposits is primarily due to fewer annuity sales in Vermont during the examination period, compounded by the Company's change in accounting practices to "more properly" (Response at page 5) record deposits on surrendered contracts as surrender benefits (rather than a reduction to current year fund deposits received). The Company further notes that, although some state tax departments impose tax liability in this type of situation, Vermont does not.

Upon consideration and consultation with members of the Department, the undersigned concludes the Company's premium reporting as noted in the Report requires no further action on the part of the Department or the Company. The examiners' recommendation and this portion of the report are not adopted.

11. In the **SALES AND MARKETING – ADVERTISING** section of the Report (page 5), the examiners note that the Company uses the following statistic in some of its advertising: "If you are 65, your chance of having a nursing home stay is 48.6%. There is a 71.8% chance you may need home health care." (Report at page 5.) The examiners assert this statistic could be misleading because the Company underwrites long term care and as such, the average person who qualifies for the Company's long term care coverage is not as likely to need nursing home care as the average population. The Report also

notes the Company was unable to provide proof that LTC-1416 (which includes the above statistic) was approved by the Department pursuant to Regulation 91-1 § 15. In conclusion, the examiners recommend “the Company immediately discontinue the use of LTC-1416 and/or other advertising containing similar wording and develop procedures to insure compliance with Vermont Regulation 91-1 § 15.” (Report at page 6.)

In response, the Company initially argues the Company was not required to submit LTC-1416 for approval as required by Regulation 91-1 § 15 because it was a Powerpoint presentation “intended for use with association principals to assist agents” in explaining certain benefits of the product. (Response at page 7.) As such, the Company argues, it was not intended to be used directly with the insurance buying public and as such, “not a consumer advertisement as defined pursuant to Regulation 71-1 § 1A.” (Response at page 7.)

Further, the Company disputes the examiners’ assertion that the statistic is misleading. Moreover, the Company notes that the statistic was used in various advertisements have been approved by the Department. Finally, the Company notes that LTC-1416 was discontinued in August 2002.

The undersigned rejects the Company’s argument that LTC-1416 did not need to be filed and approved by the Department under Regulation 95-1 § 15 because it was “intended for use with association principals to assist agents to explain the benefits [of the product]” and was “not for use with the insurance buying public.” Response at page 7. The definitions of Regulation 71-1 have limited, if any, bearing on Regulation 95-1. Further, the definition of “advertisement” in Regulation 71-1 is not limited to those things used with the insurance buying public. *See* Regulation 71-1 § 1A(3). Although neither

regulation requires the filing of training materials used internally only and which producers are expressly told not to use with the public, it is entirely unclear that LTC-1416 falls into this category. Further, the undersigned finds that, despite previous approval of use of this statistic, the statistic is misleading and shall no longer be allowed because it has the likelihood to mislead people who qualify for the insurance about the probability that they will actually need the long term care insurance. Thus, the undersigned adopts the examiners' recommendation (page 6 of the Report). The Company shall certify to the Department, no later than December 22, 2003, that materials which reference this statistic are no longer being used.

Nonetheless, even though the undersigned finds a violation of the Regulation has occurred, it appears the Company's misinterpretation of the law was made in good faith. Additionally, in light of the Department's previous approval of the use of the statistic, the undersigned concludes a penalty is not warranted.

12. In the **SALES AND MARKETING - CONVERSION OF MONTHLY DEBIT ORDINARY (MDO) TO REGULAR BILLED PREMIUM** section of the Report (page 7), the examiners outline an inquiry made to the Company concerning a change in billing practice that occurred in 1983. Despite five written requests, the Company did not answer the examiners' inquiry, in violation of 8 V.S.A. §§ 13 and 3565(b). The examiners' recommend the Company respond to the examiners' inquiry.

In response, the Company provides a response to the examiners inquiry. The Company further argues that its failure to respond to the examiners' inquiry did not constitute a violation of 8 V.S.A. § 3565(b) because the failure to respond was

“inadvertent.” As such, the Company requests removal of the entire section of the Report.

Upon consideration, the undersigned adopts the examiners’ recommendation. In the Response, the Company provided the information sought by the examiners. The Company’s response to the examiners’ inquiry does not indicate any impropriety concerning the failure to change the premium rates upon conversion to the MDO. However, the undersigned rejects the Company’s argument that a failure to respond to an examiners’ inquiry is not a violation of 8 V.S.A. § 3565. The statute requires a “timely” response. *See also* NAIC MARKET CONDUCT EXAMINERS HANDBOOK 414 (2002 ed). Instead of a timely response, the Company provided no response. Further, the Company provides no explanation as to how it could have failed to respond to five separate written inquiries.

The undersigned concludes this violation is appropriate for a \$10,000 administrative penalty.

13. Vermont law requires insurers to pay 6% interest on life insurance benefits from the date of death until the claim is paid. 8 V.S.A. § 3665(c)(2). In the section of the Report titled **SALES AND MARKETING - JOHN HANCOCK SIGNATURE ACCESS ACCOUNTS** (page 7), the examiners note that the Company does not comply with this regulation through the use of its Signature Access Accounts. The Company does calculate interest from the date of the insured’s death until the claim is “approved.” Once the claim has been approved, the funds are deposited in the Signature Access Account. Upon deposit into the account, the funds no longer accrue interest at the statutory rate. Upon deposit, a notification letter is mailed to the beneficiary along with checks allowing

access to the funds. The examiners note that the several day delay between claim approval and the date the checks are sent and the insured receives the checks (constituting payment of the claim) is a violation of 8 V.S.A. § 3665(c)(2).

The examiners recommend that the Company be “instructed to go back and recalculate and pay the additional interest due these beneficiaries, at least for claims settled during the examination period.” (Report at page 7.)

In response, the Company apparently argues that the benefits of providing a Signature Access Account justifies or otherwise mitigates the violation of the statute: “It is implicit, that the period immediately following the death of a loved one, is not necessarily an appropriate time to make an important financial decision. Yet for many beneficiaries, the need to make such decisions may be difficult to avoid. Under pressure to ‘do something’ with the death claim proceeds, a beneficiary might be rushed into a spending or investment decision which may not be appropriate in the long run. The Signature Access Account allows beneficiaries a framework in which they can make important financial decisions.” (Response at page 11.)

The undersigned does not dispute the purported benefits of the Signature Access Account. Nonetheless, the Company has failed to illustrate how the existence of the Signature Access Account makes statutory compliance impossible. The claim is not “paid” until the beneficiary has access to the proceeds. The Company puts forth no reason whatsoever for ceasing to pay statutory interest on the date of “approval” as opposed to the date the beneficiary is paid, as required by 8 V.S.A. § 3665.

The undersigned adopts the examiners’ recommendation, with the following clarifications. The Company is ordered to do an audit of claims paid to beneficiaries of

policies issued in Vermont who received benefits from January 1, 1998 through the date of this Order. The audit shall be as described in Paragraph 37 below. Upon review, the Department will determine whether refunds are required and whether an administrative penalty is appropriate.³ The audit report shall be provided to the Company no later than December 22, 2003. For purposes of the audit, the Company shall calculate statutory interest from the date of the insured's death until three days after the checks are mailed to the beneficiary. In the future, the Company shall pay statutory interest as required by the statute – from the date of the insured's death until three days after checks are sent to the beneficiary (or an earlier date if the beneficiary has actual access to the insurance proceeds prior to three days after the checks are mailed).

14. In the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES** – **Individual Life Claims** section of the Report (page 9), the examiners note that the Company's computer system does not appear to have any means of calculating the 12% penalty interest as required by 8 V.S.A. § 3665(d).

In response, the Company challenges the assertion that the “judgment rate allowed by law” is 12%, and asserts that the judgment rate cannot be easily established since it “fluctuates over time as determined by Vermont's legislature.” (Response at page 13.) In any event, the Company argues, when penalty interest is due, “it is the Claim Examiner's responsibility to manually calculate the amount due based on the rate specified in the reference materials used in the Claims Services area.” *Id.*

³ As noted below, the Company shall be entitled to appeal further action taken by the Department after receipt of the information required pursuant to this Order. Thus, if the Company chooses not to appeal this Order, it shall have waived the right to object to preparing the audit, but the Company shall still be entitled to appeal the undersigned's decisions concerning additional action necessary in light of the audit results.

The undersigned rejects the Company's assertion that 8 V.S.A. § 3665(d) does not obligate the Company to pay 12% interest on claims which have not been paid within 30 days. *See* 9 V.S.A. § 41a. Further, the judgment rate allowed by law in Vermont has been 12% since at least 1980, thus the Company's argument that the rate "fluctuates" so often that it could not be programmed into the computer system lacks merit. However, there is no statutory or other requirement that penalty interest be calculated by a company's primary interest calculation program and the Company's stated procedure of leaving it up to the Claims Examiner to pay penalty interest is not a *per se* violation of the statute.

Nonetheless, the Company must verify that penalty interest is, in fact, calculated by the Claims Examiner. To that end, the Company shall produce the "reference materials used in the Claims Service area" (see Response at page 13) which explain to responsible Claims Examiners when and how to calculate the penalty interest. Further, upon review of the audit described in Paragraph 37 below, if the Department determines that the Company did not pay penalty interest on late paid claims, the undersigned reserves the right to take additional action as necessary, including imposing administrative penalties.

15. In the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES** – **Group Life and Disability Claims** portion of the Report, the examiners note the Company calculates interest on death benefits based on the residence of the beneficiary rather than the residence of the certificate holder. (Report at page 9.)

The Company does not respond to this portion of the Report.

The undersigned concludes 8 V.S.A. § 3665(c)(2) requires that if a policy is written in Vermont, the beneficiary, regardless of state of residence at the time of death of the insured, is entitled to 6% interest on death benefits. The statute specifically states “All payments of claims under policies of life insurance” (emphasis added) shall earn six percent interest. Courts have consistently held that the law of the state where a life insurance contract is entered into and where the insured resides at the time it was made is controlling as to the rights of the beneficiaries, rather than the law of the state in which the beneficiaries reside at the time of the insured’s death. *See, e.g.,* LEE R. RUSS, 4 COUCH ON INSURANCE § 58:5 (3d ed. 2003); *Martin v. John Hancock Mutual Life Insurance*, 56 F.Supp.2d 670 (S.D.W.Va. 1999); *Modarelli v. Midland Mutual Insurance Co.*, 226 N.E.2d 137, 139 (Ohio App. 1967).

As such, the Company is ordered to conduct an audit of all group life policies which were issued in Vermont and on which death benefits have been paid from January 1, 1998 until the date of this Order, as more fully described below in Paragraph 37. The Department reserves the right to require a refund and/or impose an administrative penalty based on the results of the audit.

16. In the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES** – **Date Stamping** section of the Report, the examiners note the Company does not date stamp the death certificate unless it is the only document received. (Report at page 9.) The examiners recommend the Company instruct its claims handling personnel to date stamp all pertinent file documents including the copy of the certified death certificate.

In response, the Company states it date stamps “at least one document in each packet of claim materials received.” (Response at page 14.) The Company further

explains that all documents received in a claims packet are “imaged” as one complete set which indicates the documents were received together and at the same time. As such, the Company asserts it is unnecessary to date stamp all documents.

Upon consideration, the undersigned is satisfied with the Company procedures as the Company has described them. Further, if a problem exists with the Company’s claims processing relating to dating of claim receipt, such problem should manifest itself during the Company’s audits required under this Order. At this time, the undersigned does not adopt the examiners’ recommendation. However, if the Company’s procedures result in an inability to prepare the audits required under this Order, the undersigned reserves the right to impose claims processing procedures as necessary for adequate record keeping.

17. On page 9, in the **CLAIMS PROCEDURES AND PROCESSING – CLAIMS AUDITS** section of the Report, the examiners note that on five separate occasions, the examiners requested information from the Company regarding whether the Company performed internal claims audits and, if so, what were the results of those audits. The Company did not answer the examiners’ inquiry, in violation of 8 V.S.A. § 3656(b). The examiners recommend the Company respond to the inquiry.

In response, the Company again argues that an inadvertent failure to respond to the examiners’ inquiry does not constitute a violation of 8 V.S.A. § 3656(b). Again, the Company does not explain the reason that no response was given to the examiners. Further, the Company does not, even now, respond to the examiners’ inquiry.

For the reasons discussed above in Paragraph 12, the undersigned rejects the Company’s argument that 8 V.S.A. § 3656(b) has not been violated because the

Company claims the lack of response was “inadvertent.” Further, in light of the fact that no justification is given for the failure to respond to five inquiries, the undersigned concludes a penalty of \$10,000 is appropriate.

Finally, the undersigned adopts the examiners’ recommendation and orders the Company to respond to the inquiry posed by the examiners. Such response shall be provided to the Department no later than December 22, 2003. However, the Company’s response concerning the self-audit shall be considered confidential examination work papers and shall not be subject to public disclosure.

18. On pages 10-11, in the **CLAIMS PROCEDURES AND PROCESSING – INDIVIDUAL PAID LIFE CLAIMS – Underpayment, Overpayment, and Untimely paid-underpayment** sections of the Report, the examiners note that the Company failed to apply the statutorily required interest on 4 of the 71 claims reviewed in violation of 8 V.S.A. § 3665(c)(2) and resulting in an underpayment of benefits (Claims # 813870, # 9005736, #800198, and # 9004740). The examiners further found one claim which appeared to have been overpaid (Claim # 900624) because of a systems bug. Additionally, the examiners discuss three policies (all owned by the same insured) where the claims were not paid in a timely manner, resulting in an apparent underpayment (Claim # 808260). The findings by the examiners, the Company’s response, and the analysis of the undersigned are summarized on the table attached hereto as Exhibit A.

The examiners conclude that they discovered 8 errors in a sample size of 71, resulting in an error rate of 11.3%. Applying this error rate to the entire population of 300 policies, the examiners estimate a total of 34 errors. As such, the examiners recommend that the Company review all individual Vermont claims during the examination period, recalculate the interest and make individual interest payments where appropriate.

In response, on the issue of failing to calculate interest at 6% resulting in an underpayment of benefits, the Company disputes interest was not paid as required on one of the four claims. Specifically, the Company asserts it calculated interest at 6% for 903

days (for a total of \$186.13) on claim # 813870. Thus, the Company disputes that Claim #813870 constitutes a violation of 8 V.S.A. § 3665.

The Company concedes interest was calculated at 5%, as opposed to 6%, on the other three claims (Claims #9005736, #800198, and # 9004740) . However, the Company asserts it has recalculated the interest and paid the difference on October 11, 2002.

The Company makes no response to the overpayment claim (Claim # 900624), except to suggest some style changes to the language contained in the Report.

Regarding the policies which may have not been timely paid (Report at page 10, policies associated with Claim #808260), the Company notes that one of the policies was paid in a timely matter. The Company notes that although the other claims were not paid in a timely manner, the Company calculated the penalty interest was calculated on the other two policies in question and paid to the claimant on October 11, 2002.

Finally, the Company disputes that 8 errors were discovered and instead asserts that the examiners only uncovered 5 errors. As such, the Company disputes the examiners' conclusion that an audit is warranted.

Upon consideration, the undersigned adopts the examiners' recommendation, subject to the modifications discussed below.

Regarding the issue of underpayment of Claim #813870, it appears the Company did calculate interest correctly on the claim and no violation occurred.⁴

On the other three claims on which the Company failed to calculate interest at 6% as required by statute, the Company concedes the violation, but notes it has recalculated interest correctly and paid the beneficiaries the difference. However, upon review by the Department, it was determined the interest calculations provided by the Company in its Response were incorrect.

Regarding the three untimely paid claims identified by the examiners, the Company concedes two of the policies were not paid in a timely manner and that penalty

⁴ Upon inquiry, the Company informed the Department the insured died in March 1996, but no claim was received until August 31, 1998. The Company paid benefits on September 14, 1998. Thus, although the claim was not paid for over 900 days after the death of the insured, the Company paid the claim in a timely manner as required by 8 V.S.A. § 3665. It appears the examiners belief that a violation had occurred was a result of the Company informing the examiners that it had paid interest on the claim at 5% , when it had actually calculated interest at 6% .

interest was not paid, although the Company asserts it paid the penalty interest upon discovery of the error. (Response at page 17.) The Company notes the policyholder's two other claims were paid in a timely manner and "[a]s such, no interest is due." (Response at page 17.) As such, the undersigned finds that two violations, not three as asserted by the examiners, occurred regarding the untimely payment.

The Company claims a total of only five violations occurred, whereas the examiners assert the number of violations is eight. A summary of the eight potential violations is attached hereto as Exhibit A. The undersigned concludes six violations occurred, although one resulted in overpayment of benefits to a consumer. However, even if only six violations occurred, the error rate would be 8.45%.⁶ Because 7% is the maximum error tolerance level suggested by the NAIC,⁷ the undersigned concludes that an audit is warranted. Additionally, the existence of only 300 claims and the fact the Company is required to perform a similar audit of its group policies mitigates the potential inconvenience of conducting the audit. The audit shall be as described below in Paragraph 37. Upon review of the audit results, the Department shall determine whether refunds and/or an administrative penalty are appropriate.

19. On page 11, in the **CLAIMS PROCEDURES AND PROCESSING – INDIVIDUAL PAID CLAIMS - Claim Irregularity** section of the Report, the examiners discuss Claim # 707752 wherein the Company received initial notice of the death of its insured on April 7, 1997. After receipt of notice of the death of the insured, the Company informed the claimant that it needed additional documents. There was no response until January 21, 1998. The examiners opine that the Company should have made follow up requests during the nine month period between receipt of the claim and receipt of the papers necessary to process the claim.

In response, the Company notes payment was made within 30 days of receipt of all the necessary documentation. Further, the Company asserts it was under no obligation, under the circumstances, to make any follow up request and that the examiners "subjective 'opinion' is inappropriate and misplaced." (Response at page 18.)

⁶ Even if only five violations are counted, the error rate is 7.0%.

⁷ NAIC MARKET CONDUCT EXAMINERS HANDBOOK 33 (2002 ed.).

Upon consideration, the undersigned adopts this portion of the Report. Further, the Company is mistaken that it is under no legal obligation to make a follow up inquiry under the circumstances. Pursuant to Regulation 79-2 §6 C, insurers must notify claimants every thirty days that an investigation regarding payment of a claim is ongoing.⁸

The Company is ordered to insure that its internal claims practices procedures set a reasonable time period for follow up on communications with the claimant. The Company is also ordered to verify that its claims practices procedures take into account the specific obligations imposed by Regulation 79-2. The Company shall certify in writing to the Department that it has complied with this portion of the Order. Such certification shall be received by the Department no later than December 22, 2003.

Further, the undersigned finds this matter is appropriate for the imposition of a \$1,000 administrative penalty. This penalty is justified by the length of time the Company allowed to pass without any follow-up and the fact that the claim was ultimately resolved by the claimant's attorney. The penalty shall be paid no later than ten days after the expiration of the appeal deadline of this Order.

20. In the **GROUP PAID LIFE CLAIMS** section of the Report (pages 13-15), the examiners discuss their review of the 17 group life claims paid during the examination period. The examiners note that on all 17 claims, the Company failed to pay the 6% interest required by 8 V.S.A. § 3665(c)(2). The examiners recommend "the Company pay the beneficiaries of those claims listed above the additional amounts of interest to which they are entitled." (Report at page 19.)

In response, the Company acknowledges that interest was not paid as appropriate and indicates it has paid interest on those claims where it was required. The Company notes that five of the claims involved policies issued outside of Vermont and as such, no interest was due under the applicable state statutes. The Company also indicates that the

⁸ Pursuant to the statute, the Company may not have been under an obligation to follow up with the insured if the initial correspondence unequivocally accepted the claim and merely sought payment instructions. However, the letter requested additional information and then stated "Upon receipt of the required document, we will then consider this claim further." Because the Company was investigating the claim, the requirements of Regulation 79-2 § 6 C applied and the Company was obligated to send thirty day follow up correspondence until the claim was resolved.

Claims area has now changed its procedures to comply with 8 V.S.A. § 3665 if the insured or the beneficiaries reside in Vermont at the time of death.

Upon consideration, the undersigned adopts the examiners recommendation. Although the Company has attempted to take corrective measures, such measures are inconsistent with its legal obligations. The Company shall implement procedures to calculate interest in accordance with 8 V.S.A. § 3665 when the policy was *issued* in Vermont. The Company is ordered to provide verification to the Department no later than December 22, 2003 that it has modified its interest calculation procedures to conform to Vermont law.

Further, the Company shall provide verification that it has paid appropriate interest on all group life claims paid between January 1, 1998 and the date of this Order in compliance with the statute. Such verification shall be in the form of the audit described below in Paragraph 37. Such audit shall include all group life claims paid from January 1, 1998 to the date of this Order on policies issued in Vermont. Such audit will by definition include the 17 claims discussed by the examiners and which the Company claims to have corrected. Upon receipt and review of the information provided, the Department shall determine if additional action is necessary.

21. In the section of the report entitled **GROUP PAID HEALTH CLAIMS – (Coinsured by UNICARE)** (pages 13-14) the examiners note that from a population of 3,864 group health claims, the examiners chose 54 samples to review. Of the 54 samples, 7 samples were not available. Of the 47 claims reviewed, 8 claims contained violations of 18 V.S.A. § 9418. The statute requires that claims subject to the statute be paid within 45 days and if the claim is not paid within the 45 days, the company must pay an interest penalty on the claim. Some of the claims contained more than one violation of the statute because the claim was not paid within 45 days and the Company did not pay interest on the claim. The Company was unable to provide the date of receipt of the claim on four of the claims sampled. As such, the examiners concluded that claims were received 23 days after the date of service, which was the average time for the other recorded claims. The examiners concluded that 14 violations had occurred for an error rate of 25.9% and that if this error rate was applied to the entire population of claim, the estimated number of violations would be 1,000.

The examiners recommend: “The Company should take steps to bring all of its group health claim procedures in conformity with statutes and regulations cited in this report. * * * A further effort should be made to locate the missing group health paid claim files and make corrections where necessary, as well as making additional payments to claimants where indicated.” (Report at page 27.)

In response, the Company does not dispute that violations occurred, but criticizes the examiners’ methodology and how the examiners chose to quantify the errors. The Company argues that in those cases where the Company was unable to establish the date it received the claim, the examiners should not have estimated the date receipt of claims in order to establish whether the claims were paid in a timely manner. The Company notes that of the 8 claims which had errors, the claims “relate to only 3 master case numbers.” (Response at page 22.) Further, the Company objects to the examiners counting two separate violations of the statute as two errors. “To cite an individual file for multiple violations of the same law, and to then total the violations, unfairly inflates the number of violations and paints an inequitable picture of the files truly at issue.” (Response at page 22.)

The Company further objects to the examiners extrapolation of the error rate over the entire claims population to establish an estimate concerning the number of violations. The Company cites the NAIC MARKET CONDUCT EXAMINERS HANDBOOK 31 (2002 ed.) for the argument that it was “inappropriate for the examiners to have extrapolated the violation rate to the entire population of claims.” (Response at page 22.) Ultimately, the Company states it will “make every effort to pay additional interest due.” (Response at page 22.)

The undersigned does not find the Company’s arguments compelling. It is the Company’s responsibility to insure compliance with the statute – if the Company does not track the date a claim is received, it has no ability to verify claims are being paid in a timely manner. However, even if those claims where the date of receipt could not be established were not counted as errors, the error rate still exceeds acceptable tolerance levels.

The fact that some of the mishandled claims came from the same “claim number” does not mitigate the violation. Further, 8 V.S.A. § 9418 imposes multiple obligations on

health insurers. Each failure constitutes a violation. However, even if each improperly handled claim were only counted once, the error rate for the sample population is 17.02% which is in excess of acceptable tolerance levels.

Additionally, the undersigned finds the Company's argument that extrapolation of the error rate to the entire population of health claims is "inappropriate" to be totally unfounded. As a preliminary matter, the NAIC MARKET CONDUCT EXAMINERS HANDBOOK is a guide only. Vermont law clearly allows examiners to diverge from the HANDBOOK guidelines as they deem appropriate. 8 V.S.A. § 3573. Nonetheless, the examiners methods are in compliance with the HANDBOOK. The Company argues the guidelines require that an entire population must be examined or no inferences can be drawn. In light of the fact that the chapter cited is called "Sampling" it seems unlikely that the guidelines could be understood to disallow sampling as an acceptable method for examination. In fact, the language quoted by the Company (and that language following it in the HANDBOOK) expressly provides that inferences may be made, so long as samples are chosen from an appropriate population. Further, the HANDBOOK clearly contemplates extrapolation: "Generalization or extrapolation of results *beyond the field of files from which the sample is selected* is not acceptable." HANDBOOK at page 33 (emphasis added). In this situation, the examiners did exactly as the HANDBOOK contemplated: they took a statistical sample of the population and then extrapolated the error rate discovered in the sample across the population from which the sample had been drawn.

The undersigned adopts this portion of the Report, but does not adopt the examiners' recommendation. Instead, the undersigned orders the Company to pay the additional interest due, as it indicated it will in its Response. This will require an audit of the entire claim population referenced in the Report and a report to the Department concerning the results of that audit. The Company shall report to the Department on the results of the audit no later than December 22, 2003. The report shall include the following information: the date the claim was received, the date the claim was paid, the amount of the claim, the amount paid, the interest paid (if any), the interest which should

have been paid,⁹ the policy number and the claim number. This report shall be provided to the Department electronically, in an Excel spreadsheet. After review of the audit results, the Department shall determine whether penalties, as provided for under 8 V.S.A. § 9418(f), are warranted.

22. In the **UNDERWRITING – HIV TESTING** section of the Report, the examiners noted 18 violations of 8 V.S.A. § 4724(20) relating to HIV testing out of a sample of 90. (Report at page 16.) As such, the examiners recommend the Company revise its procedures with respect to the requirements of 8 V.S.A. § 4724 (20) in order to ensure compliance with the statute.

In response, the Company notes that as a result of the examiners findings, the Company has made various changes to its procedures and has also reminded agencies that are geographically close to Vermont that when writing business in Vermont, they are obligated to follow the requirements of the statute.¹⁰

Upon consideration, the undersigned adopts the examiners recommendation. The undersigned further finds this matter appropriate for the imposition of a \$10,000 penalty. Although 8 V.S.A. § 4746 allows imposition of \$1,000 penalty per violation, it does not appear the violations were the result of intentional misconduct and therefore imposition of less than the maximum penalty is appropriate.

23. In the **POLICY LOAN INTEREST** section of the Report (page 19), the examiners note an apparent violation of 8 V.S.A. § 3731(7)(B). The policy loan provision contained in Form 96 LTUL provides for an adjustable loan rate calculation method which charges the maximum variable interest rate permissible under the statute. However, the policy form also provides that “the increase in credited rate is applied only to amounts of Account Value in excess of indebtedness.” (Report at page 19, quoting Section 6 “Increase in Credit Rate” of the policy.) The insured is charged the maximum allowable interest rate on the borrowed funds and then charged an additional fee by being deprived of the full credited rate (on the borrowed funds).

⁹ Consistent with the statute and Department policy, the interest penalty shall be calculated at 12% simple interest on the amount owing on each claim for each day over 45 days for which the claim was not paid. Interest on the penalty which was owing, shall be calculated at the judgment rate (12%) on the penalty owing from the date the penalty should have been paid (the day the claim was paid) until the date the penalty is paid.

¹⁰ The Company also again asserts that sampling and extrapolation are inappropriate. (Response at page 23.) These arguments are rejected for the reasons discussed above in Paragraph 21.

Thus, the examiners note that since the maximum interest rate is already charged, the Company violates the statute by imposing an additional cost on the loan by depriving the insured of the full credited rate on the amount of the indebtedness. The examiners recommend that the “Company pay any persons who were credited with a lower amount, by virtue of their having a policy loan, the difference between the amount they were actually credited and the amount they would have been credited had they not taken out a policy loan.” (Report at page 19.) Further, the examiners recommend a change in the Company’s procedures to prevent borrowers from being credited with less interest than non-borrowers in the future.

In response, the Company argues that 8 V.S.A. § 3731 is silent on the allowable interest rate charged on the loaned portion of the account value and therefore no violation occurred. (Response at page 27.) Further, the Company argues that in order to make money on the transaction, it must eliminate the credited interest rate on the loaned funds because those funds are not earning money in investments.

Upon consideration, the undersigned rejects the Company’s argument, but nonetheless does not adopt the examiners’ recommendation. The fact that 8 V.S.A. § 3731 does not explicitly regulate the interest rate credited on the loaned portion of accounts does not alter the fact that the Company is effectively exceeding the interest rate allowed by 8 V.S.A. § 3731(7)(B) by imposing additional costs on the loan beyond the maximum allowable interest rate. Further, the Company’s argument that it will not be able to make the transaction profitable without exceeding the legal interest rate lacks merit.

Although the Company’s arguments are not compelling, the undersigned has reservations about applying the examiners’ interpretation of the law in this instance. The Company forms providing for the excessive interest have been approved by the Department and as such, penalizing the Company for utilization of the forms is not justified. Although approval of forms does not prevent the Department from sanctioning an entity for using those forms when they clearly violate Vermont law, in this situation the law is complex and there is room for competing reasonable interpretations. As such, the undersigned concludes a market conduct exam is not the appropriate forum for resolution of this issue.

The undersigned adopts this portion of the report, but does not adopt the examiners' recommendation. As such, no further action by the Company is necessary on this issue. The Department may examine this issue further in the future and require the withdrawal of these forms, but not at this juncture.

24. In the section entitled **LEGAL ACTIONS INVOLVING OTHER INSURANCE DEPARTMENTS** (Report at page 20), the examiners note the Company has failed to comply with Bulletin 30, which requires insurers to report legal actions taken against them in other states. The examiners also detail two significant actions taken by other states against the Company during the examination period. The examiners recommend the Company provide Bulletin 30 reports for the years 1998, 1999 and 2000.

In response, the Company does not dispute that it has inadvertently disregarded the requirements of Bulletin 30. The Company does, however, argue that the two actions discussed by the examiners were not required to be reported under Bulletin 30. The first action, the Company argues, did not trigger the obligations of Bulletin 30 because it did not involve an insurance department, but rather the Attorney General. (Response at 28.) The Company argues the second action was not reportable under Bulletin 30 because the stipulation did not allege a violation of a "law or regulation". (Response at 29.) The Company further notes that it has now submitted reports to the Department for 1998, 1999 and 2000.

Upon consideration, the undersigned adopts the examiners' recommendation with some clarifications discussed below. The Company has failed to comply with the Bulletin and must come into compliance. The undersigned has reviewed the Bulletin 30 submissions made by the Company and compared this information to that supplied by the NAIC. There are discrepancies.

In the Response, for 1998, John Hancock Life Insurance Company claimed it was the subject of four regulatory actions. (Response, Exhibit 11.) The Company did not report actions in North Dakota, Texas or an additional action in Nevada.¹¹ For 1999, John Hancock Life Insurance Company reported actions in Maryland, Illinois, Minnesota and Massachusetts. (Response, Exhibit 11.) However, the NAIC database also shows

¹¹ In its Response, the Company reported two actions in Nevada in 1998 – one involving a fine for \$150 and one involving a fine for \$500. The State of Nevada reported John Hancock Life Insurance Company paid an additional \$2,200 fine for failing to respond to a Department inquiry.

actions in South Carolina, Wisconsin, Virginia, Colorado and Washington. For 2000, there are no actions involving John Hancock Life Insurance Company which are not reported, except for the action in New York which is discussed below.

In the Response, for 1998, John Hancock Variable Life Insurance Company reported it was the subject of no legal actions. (Response, Exhibit 12.) However, the NAIC database indicates the John Hancock Variable Life Insurance Company entered into a consent decree in Texas involving its marketing and sales practices. For 1999, John Hancock Variable Life Insurance Company reported actions in Virginia, Massachusetts and Illinois. (Response, Exhibit 12.) The NAIC database indicates John Hancock Variable Life Insurance Company was also subject to regulatory action in Wisconsin and Washington. For 2000, John Hancock Variable Life Insurance Co. reported it was the subject of no regulatory actions in 2000. However, the NAIC database indicates actions against the company in Utah and West Virginia.

As for the Company's argument that the two actions noted in the Report were not subject to Bulletin 30, the undersigned agrees the Massachusetts action was not subject to Bulletin 30 reporting requirements because the action did not involve a state insurance department. The New York action, however, was subject to Bulletin 30 – even if the stipulation itself did not reference a specific violation, the payment of a penalty as a result of the action was subject to the reporting requirements. The Bulletin does not require that the specific settlement instrument reference a violation. Such an exceedingly narrow interpretation of the Bulletin would eliminate much of what the Bulletin is intended to accomplish. The Company's interpretation of the Bulletin is expressly rejected and the Company shall modify its compliance procedures accordingly.

The Company is ordered to comply with Bulletin 30. Compliance will include submitting accurate reports for the years 1998-2002.¹² If the Company believes information contained on the NAIC database may be incomplete or somehow inaccurate, the Department invites the Company to so inform the Department. The Bulletin reports and any required explanation shall be submitted to the Department no later than December 22, 2003.

¹² The Department has no record that the Company filed Bulletin 30 reports for 2001 or 2002.

25. In the **CONSUMER COMPLAINTS** section of the Report, the examiners note that the Company failed to include some statistical complaint information required by Regulation 76-1 § 5. (Report at page 21.) The examiners recommend the Company supply the omitted information in the correct format. (Report at page 21.)

In response, the Company indicates it inadvertently failed to include the required information and that on December 12, 2002 it submitted revised reports for the implicated entities.

Upon consideration, the undersigned adopts the examiners' recommendation. The Company has satisfied this particular recommendation and no further action is necessary.

26. In the **PRODUCER LICENSING** section of the Report, the examiners note two instances of agents writing applications for product for which they did not have a license. The examiners recommend the "Company should take steps to prevent any further producer licensing violations." (Report at page 22.)

In response, the Company does not dispute one of the violations, but asserts that one of the applications was filled out as an "informal application" while the agent's Vermont license application was pending. (Response at page 32.) The Company does not indicate when, or if, the policy was issued.

Upon consideration, the undersigned adopts the examiners' recommendation. Further, the undersigned expressly rejects the Company's argument that the statute was not violated. The statute requires a person must have a license before he or she can "sell, solicit or negotiate insurance." 8 V.S.A. § 4791(6).¹³ There is no exception for an "informal" application. An individual preparing an "informal" application is "soliciting" insurance and must have a license. Furthermore, the undersigned finds it alarming that the Company has a procedure in place (i.e. "informal" applications) facilitating the selling of insurance before licensure.

The Company shall report to the Department, no later than December 22, 2003, what steps it has taken to ensure that it has no additional producer licensing violations. The Company is further ordered to provide the Department with a list of all policies

¹³ This is the present licensing statute pertaining to insurance producers. The former licensing statute contained the same general requirements for insurance agents. See 8 V.S.A. § 4791 (1) (1993).

written from January 1, 1998 to December 31, 2000 which involved the use of an “informal application” such as the one at issue in the exam and to further provide the Department with any written policies it maintains relating to the “informal application” process referenced in the Company’s Response.

The undersigned finds these violations to be appropriate for the imposition of a \$2,000 penalty. This penalty reflects a \$1000 penalty for each violation discovered by the examiners. Upon review of the information provided pursuant to this Paragraph, the undersigned reserves the right to impose additional penalties for violations of Vermont’s producer licensing laws.

27. In the “**POLICY FORM FILINGS**” section of the Report, page 23-24, the examiners discuss their review of 36 Group Long Term Care (GLTC) issued policies. Of the sample, examiners noted in 31 cases the application form had not been filed with Vermont in violation of 8 V.S.A. § 4062 and Regulation 91-1 § 14. The examiners also discovered three files which did not comply with Regulation 91-1 § 11 (relating to application forms and replacement coverage).

The examiners noted the Company’s present life insurance form contains a provision which indicates interest on death benefits will earn interest “at the declared rate but not less than 3.5% a year”. The examiners note this provision violates 8 V.S.A. § 3665(c)(2), which prohibits interest rates below 6%. In conclusion, the examiners recommend the Company prepare amendments to each of its policies that permit an interest rate lower than that required in Vermont and file them with the Department for approval.

In response, the Company notes that in the 31 instances listed by the examiners where forms had not been filed with the Department, the forms were in fact filed with the Department. The Company claims that the examiners did not realize the forms had been filed with the Department because the forms were referred to by an internal number and not the form number filed with the Department. As noted, the examiners found three instances where the Company failed to comply with Regulation 91-1 § 11 (relating to applications and replacement policies). The Company argues that the examiners cited violation is too vague to respond to because Regulation 91-1 § 11 has many requirements. Nonetheless, the Company states each enrollment kit should have included

Form Number GLTC-ABC Supp 1-6/96 which has been approved by the Department. The form must be filled out by the applicant if the applicant intends to replace coverage. The Company attaches one copy of such an application as proof of compliance with the regulation.

Upon additional inquiry, the Company provided the Department with copies of the approved forms in support of its argument that the forms noted by the examiners had in fact been filed. Upon consideration and after consultation with members of the Department, the undersigned concludes that although the approved forms are similar, they are not sufficiently similar and, as such, the form discussed by the examiners should have been filed with the Department.

Regarding the three noted violations of Regulation 91-1 § 11, the undersigned rejects the Company's assertion that the Regulation contains too many requirements for the Company to show compliance with the regulation. Regulation 91-1 § 11 contains two fundamental requirements: 1) requiring that the application inquire whether the policy will replace an existing policy; and 2) imposing obligations pertaining to steps that must be taken in the event the policy is, in fact, a replacement. The Company has provided proof that, of the three files noted by the examiners, in at least one instance the prospective insured filled out a supplemental application which contained those questions provided by Regulation 91-1 § 11A. However, the Company provides no proof that after determining the insurance was going to replace existing insurance, the Company then complied with the requirements of § 11B, 11C or 11D. The Company is ordered to provide additional proof that the Regulation has been complied with no later than December 22, 2003.

Upon consideration, the undersigned concludes this matter is appropriate for the imposition of a \$2,000 administrative penalty. The Company is further ordered to file the forms in question for approval. The Company is ordered to provide the Department with an explanation of what steps it will take to ensure compliance with the law relating to form approval. Proof of such filing and compliance explanation shall be provided to the Department along with the other information provided in response to this Order, no later than December 22, 2003.

As to the issue of the Company's forms which provide for interest no less than 3.5%, the undersigned concludes the forms are in compliance with the law, so long as the actual interest accrued is in compliance with the law. As such, the undersigned does not adopt this recommendation and no further action is necessary by the Company on this forms issue.

28. On page 25, in the **EVENTS SUBSEQUENT TO THE EXAMINATION PERIOD – Vermont Mandatory Civil Union Endorsement** section, the examiners note the Company uses its own version of the required Vermont Mandatory Civil Union Endorsement which has not been approved by the Department, as required by Bulletin HCA 110 and Bulletin 128. The examiners recommend the Company take steps to bring all of its Vermont certificates in compliance with Vermont's Act Relating to Civil Unions and accompanying regulations.

In response, the Company objects the examiners are outside the scope of the examination period and this section is not appropriate for inclusion in the Report. (Response at page 37.)

Upon consideration, the undersigned adopts the examiners' recommendation. As noted above, the examiners are not bound by the general scope of the examination period and may look into matters outside that which was initially contemplated. The Company shall provide a description of steps the Company has taken to come into compliance with the Act Relating to Civil Unions. Such description should be provided no later than December 22, 2003.

The undersigned further finds this violation warrants the imposition of a \$2,000 penalty for use of forms not approved by the Department.

ORDER

Based upon the Findings of Fact and Conclusions of Law set forth above, **IT IS THEREFORE ORDERED** by the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration that the **REPORT OF EXAMINATION OF THE MARKET CONDUCT AFFAIRS OF JOHN HANCOCK LIFE INSURANCE COMPANY AND**

JOHN HANCOCK VARIABLE LIFE INSURANCE COMPANY BY VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION (which is incorporated herein by reference) shall be and hereby is adopted with the following modifications and clarifications:

29. For the reasons discussed in Paragraph 6 above, the undersigned rejects any proposed changes to the Report which are not expressly adopted below.

30. As discussed in Paragraph 7 above, the title page of the Report shall include the name of John Hancock Mutual Life Insurance Company as suggested by the Company. The name of John Hancock Mutual Life Insurance Company shall also be included on page 1 of the Report under **EXAMINATION AUTHORITY** in the manner suggested in the Company's Response.

31. As suggested by the Company, "Post Office Box 111" shall be included in the Company's statutory home office address.

32. The Company's proposed changes to the **HISTORY** section on page 3 the Report are adopted.

33. As discussed in Paragraph 10 above, the section of the Report entitled **PREMIUM REPORTING**, including the recommendations contained therein, is not adopted.

34. As discussed in Paragraph 11 above, the examiners' recommendation concerning discontinuing the use of LTC -1416 is adopted the Company shall certify compliance with the recommendation no later than December 22, 2003.

35. As discussed above in Paragraph 12, the examiners' recommendation concerning answering the inquiry about the change in billing procedures is adopted. The Company has adequately responded to the examiners' inquiry. However, an

administrative penalty of \$10,000 is appropriate in light of the Company's failure to respond to five written inquiries. Such penalty shall be paid within ten days of the expiration date of the appeal deadline of this Order.

36. As discussed in Paragraph 13 above, the undersigned adopts the examiners' recommendation contained in the '**SALES AND MARKETING – JOHN HANCOCK SIGNATURE ACCESS ACCOUNTS**' section (Report at page 8). The Company shall perform an audit and report to the Department as described more fully in Paragraph 37 below.

37. The Company shall perform an audit and issue a report to the Department. The audit shall be of all life insurance claims received from January 1, 1998 to the date of this Order arising out of policies issued in Vermont. For each claim, the Company shall report the date of death, the date the claim was received, the amount of insurance at the time of death, the amount paid to the beneficiaries, the date the check was mailed to the beneficiary, the amount that should have been paid if interest had been calculated in accordance with 8 V.S.A. § 3665, the policy number, the claim number and whether the Signature Access Account was used for payment of benefits. For the calculation of appropriate interest, the Company should note as more fully discussed above that pursuant to 8 V.S.A. § 3665(d) if a claim is not paid within 30 days of receipt, interest begins to run at 12%, not 6%, pursuant to 8 V.S.A. § 3665(c)(2). Thus, interest runs at 6% per annum from the date of death until the claim is paid if the claim is paid within 30 days of receipt. If the claim is paid more than 30 days after receipt, interest shall start to run at 12% on the 31st day. The report shall be provided to the Department no later than

December 22, 2003 and shall be transmitted both in hardcopy and electronically in the form of an Excel spreadsheet.

38. As discussed in Paragraph 14 above, discussing the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES – Individual Life Claims** section of the Report, the Company must verify that it is, in fact, paying 12% interest on untimely paid claims. The Company shall produce the reference materials consulted by the Claims Service Area instructing such personnel how to comply with the mandates of 8 V.S.A. § 3665(d). The Department shall review the results of the report described in Paragraph 37, above, and determine whether the Company has complied with 8 V.S.A. § 3665 and whether additional action is necessary.

39. As more fully discussed in Paragraph 15, discussing the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES – Group Life and Disability Claims** section of the Report, the Company shall conduct the audit of all group life policies as described in Paragraph 37 above. The Department shall review the audit results and determine whether additional action is necessary.

40. As discussed in Paragraph 16 above, pertaining to the **CLAIMS PROCEDURES AND PROCESSING – WRITTEN PROCEDURES – Date Stamping** section of the Report, the examiners' recommendation is not adopted. However, as noted, if the Company is unable to adequately furnish the audit information required under this Order, the undersigned may reconsider this ruling.

41. As discussed in Paragraph 17 above, pertaining to the **CLAIMS PROCEDURES AND PROCESSING – CLAIMS AUDITS** section of the Report, the examiners' recommendation is adopted; the Company must respond to the examiners' inquiry

concerning internal audits. This response is due no later than December 22, 2003. Such response shall be expressly deemed confidential examination work papers not subject to public disclosure. Further, the Company shall pay an administrative penalty of \$10,000 for failing to answer the examiners' inquiries. This payment shall be made within ten days of the expiration of the deadline to appeal this Order.

42. As discussed in Paragraph 18 above, pertaining to the **CLAIMS PROCEDURES AND PROCESSING – INDIVIDUAL PAID LIFE CLAIMS – Underpayment, Overpayment and Untimely paid – underpayment** sections of the Report, the undersigned adopts the examiners' recommendation. The Company shall perform an audit, as described above in Paragraph 37, of the three hundred individual paid life claims referenced by the examiners. Upon review of the audit results, the Department shall determine whether additional action is necessary.

43. As discussed in Paragraph 19 above, pertaining to the **CLAIMS PROCEDURES AND PROCESSING – INDIVIDUAL PAID CLAIMS – Claim Irregularity** section of the Report, the Company is ordered to insure that its internal claims procedures set a reasonable time period for follow up communication with a potential beneficiary after notice of the death of an insured. The Company is furthered ordered to insure that its claims procedures comply with Regulation § 79-2. The Company shall certify in writing to the Department that it has complied with this portion of the Order no later than December 22, 2003.

44. As discussed in Paragraph 19 above, the Company is ordered to pay a \$1,000 administrative penalty for violating Regulation § 79-2.

45. As discussed in Paragraph 20 above, pertaining to the **GROUP PAID LIFE CLAIMS** section of the Report, the undersigned adopts the examiners' recommendation. No later than December 22, 2003, the Company shall provide verification that its procedures have been modified to comply with Vermont law as discussed in Paragraph 20 above.

46. As discussed in Paragraph 21 above, pertaining to the **GROUP PAID HEALTH CLAIMS – (Coinsured by UNICARE)** section of the Report, the undersigned does not adopt the examiners' recommendation. Instead, the undersigned orders the Company to pay additional interest which is due, as the Company indicated in its Response it would do. As more fully described in Paragraph 21, above, the Company shall perform an audit of all group health claims made during the examination period. Audit results shall be provided to the Department no later than December 22, 2003. The audit report shall include the following information: the date the claim was received, the date the claim was paid, the amount of the claim, the amount paid, the interest paid (if any), the interest which should have been paid, the policy number and the claim number. This report shall be provided to the Department electronically, in an Excel spreadsheet. After review of the audit results, the Department shall determine whether penalties, as provided for under 8 V.S.A. § 9418(f), are warranted.

47. As discussed in Paragraph 22 above, pertaining to **UNDERWRITING – HIV TESTING**, the undersigned adopts the examiners' recommendation. However, it appears the Company has complied with the recommendation and no additional action is necessary. The Company shall pay a \$10,000 penalty for failure to comply with

Vermont's laws pertaining to HIV testing. Such penalty shall be paid within ten days of the expiration of the appeal deadline of this Order.

48. As discussed in Paragraph 23 above, pertaining to the **POLICY LOAN INTEREST** section of the Report, the undersigned adopts this portion of the report, but does not adopt the examiners' recommendation. No further action by the Company is required on this issue.

49. As discussed in Paragraph 24 above, pertaining to the **LEGAL ACTIONS INVOLVING OTHER INSURANCE DEPARTMENTS** section of the Report, the undersigned adopts the examiners' recommendation. The Company shall submit accurate Bulletin 30 reports covering the years 1998 to 2002. Such reports shall be provided no later than December 22, 2003.

50. As discussed in Paragraph 25 above, pertaining to the **CONSUMER COMPLAINTS** section of the Report, the undersigned adopts the examiners' recommendation. The Company has satisfied this recommendation and no further action is necessary.

51. As discussed in Paragraph 26 above, pertaining to the **PRODUCER LICENSING** section of the Report, the undersigned adopts the examiners' recommendation and orders the requested information be provided to the Department no later than December 22, 2003.

52. The Company shall pay a \$2,000 administrative penalty for the two producer licensing violations discovered by the examiners. This payment shall be made within ten days of the expiration of the deadline to appeal this Order.

53. As discussed in Paragraph 27 above, pertaining to the **POLICY FORM FILINGS** section of the Report, the Company shall file for approval the forms discovered by the examiners which had not been previously approved. The Company shall further provide to the Department an explanation of what steps it is taking to ensure that forms are properly filed for approval in accordance with the law. The Company shall further provide additional proof that it is complying the Vermont's replacement regulation, Regulation 91-1. All action required by this Paragraph shall occur no later than December 22, 2003. As further discussed above in Paragraph 27, the undersigned does not adopt that portion of the examiners' recommendation pertaining to amending policies which contain language stating policy interest shall be no less than 3.5% per year.

54. The Company shall pay a \$2,000 administrative penalty for the 31 form filing violations discovered by the examiners. This payment shall be made within ten days of the expiration of the deadline to appeal this Order.

55. As discussed above in Paragraph 28, the Company shall provide to the Department a description of steps the Company has taken to come into the Compliance with the Act Relating to Civil Unions. Such information shall be provided no later than December 22, 2003.

56. As discussed above in Paragraph 28, the undersigned orders the Company to pay a \$2,000 administrative penalty for use of forms not approved by the Department.

PURSUANT TO 8 V.S.A. § 3574(c), THIS ORDER AND REMEDIAL ACTION SET FORTH HEREIN MAY BE APPEALED TO THE COMMISSIONER BY FILING AN ADMINISTRATIVE APPEAL WITHIN

**THIRTY (30) DAYS OF THE DATE SET FORTH BELOW. FURTHER
REMEDIAL ACTIONS AND PENALTIES ORDERED UPON RECEIPT OF
INFORMATION ORDERED HEREIN MAY BE APPEALED WITHIN THIRTY
(30) DAYS OF SUBSEQUENT DECISIONS BY THE UNDERSIGNED.**

Dated at Montpelier, Vermont this ____ day of October, 2003.

Department of Banking, Insurance,
Securities and Health Care Administration

By: _____
John P. Crowley, Commissioner
Department of Banking, Insurance, Securities and
Health Care Administration