GOLDEN RULE INSURANCE COMPANY

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	April 27, 2009 through July 17, 2009
EXAMINATION OF:	Golden Rule Insurance Company
LOCATION OF EXAMINATION:	7440 Woodland Drive Indianapolis, Indiana 46278
PERIOD COVERED BY EXAMINATION:	January 1, 2008 through December 31, 2008
EXAMINERS:	John J. Staples Max R. Weaver Examiner-In-Charge

INDEX

I. SUMMARY

1. The Company was criticized under 215 ILCS 5/500-80 for payment of commission for one (1) policy to one (1) producer who was not duly licensed.

2. The Company was criticized under 215 ILCS 5/224(l)(l) for failure to provide notice to the insured's beneficiary of the availability of interest at the rate of 9% on the total amount payable unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss.

3. The Company was criticized under 215 ILCS 5/224(l)(l) for failure to pay the correct amount of interest on eight (8) life claims for benefits that were not paid within 15 days, resulting in underpayments totaling $3,682.06. Prior to the termination of the examination, the Company provided the examiners with proof of payment for all additional interest due.

4. The Company was criticized under 215 ILCS 5/224(l)(l) for one (1) death claim involving a group issued life policy, later converted to an individual life policy. Since the claim was not paid within 15 days interest was due, while the interest had been calculated it had been calculated incorrectly. The interest due was from date of death to the date of late payment. It was determined based on the correct recalculation of the claim that this person's claim had been underpaid by $90.84.

5. The Company The Company was criticized under 215 ILCS 5/234.1 for failure to provide and/or explain to the policy owner all options available under the non-forfeiture provision of the life insurance contract when the Notice of the Enactment of a Non-Forfeiture Option was required to be sent and maintained.

6. The Company was criticized under 50 Ill. Adm. Code 919.50(a)(1) for failure to include the Notice of Availability of the Department of Insurance with the reasonable written explanation for denying benefits.

7. The Company was criticized under 50 Ill. Adm. Code 919.70(a)(2) for failing to provided the claimant of the Notice of Availability of the Department of Insurance on letters sent as a reasonable written explanation for the delay in claims processing.

II. BACKGROUND

Golden Rule Insurance Company (the "Company") began on November 16, 1940 and commenced business January 7, 1941. The Company was originally incorporated as St. Anthony Life Insurance Company, in 1962 it assumed the name of Congressional Life Insurance Company, and the present title was adopted in 1977. The Company was licensed to do business in Illinois on June 23, 1961. The Company was redomesticated from Illinois to Indiana during 2006. The Company is licensed in the District of Columbia, Guam and all States except New York.

III. METHODOLOGY

The Market Conduct Examination places emphasis on evaluating an insurer's systems and procedures used in dealings with insureds and claimants.

The following categories are the general areas examined:

1. Producer Licensing and Production Analysis
2. Non-Forfeiture Analysis
3. Claims Analysis
4. Policy Forms and Advertising Material Analysis
5. Complaint Analysis

The review of these categories is accomplished through examination of producer files, cash surrendered policies, extended term insurance and reduced paid-up insurance, policy forms, endorsements and riders, underwriting methods and advertising materials. Each of these categories is analyzed for compliance with Department of Insurance Rules and Regulations and applicable state law.

The report concerns itself with improper practices performed with such frequency as to indicate general business practices. Individual criticisms are identified and communicated to the insurer but are not cited in the report if not indicative of a general trend, except if there were underpayments and/or overpayments in claims surveys or undercharges and/or overcharges in underwriting surveys.

The following methods were used to obtain the required samples to assure a methodical selection.

Producer Licensing and Production Analysis

Populations for producer file analysis were determined by whether or not the producers were licensed by the State of Illinois. New business listings were retrieved from company records selecting newly solicited applications reflecting Illinois address for applicants.

Non-Forfeiture Analysis

The non-forfeiture analysis population was determined by policies having had the non-forfeiture clause enacted during the survey period.

Claims Analysis

Claim surveys were selected using the following criteria:

1. Paid Claims – Payments for coverage made during the survey period.

2. Denied Claims – Denial of benefits for losses not covered by policy provisions during the survey period.

3. Individual or Franchise Claims –Determine whether the contracts were issued to an individual or on a franchise basis.

   All claims were analyzed for compliance with policy provisions, endorsements, applicable sections of the Illinois Insurance Code (215 ILCS) and the Illinois Administrative Code (50 Ill. Adm. Codes).

Illinois Department of Insurance Complaints

The Company was requested to provide all files relating to the complaints received via the Department of Insurance as well as those received directly from the insured or his/her representative. A copy of the complaint register was also requested.

The examination period for the Department of Insurance Complaints was January 1, 2006 through December 31, 2008.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	% REVIEWED
Producer Production Analysis			
Producer Production	1,031/8,023	1,031/8,023	100
Terminated Producers	3	3	100
Non-Forfeiture Analysis			
Life Cash Surrender	73	57	78
Extended Term Insurance and Reduced Paid-Up	6	6	100
Claims Analysis			
Paid Individual Life	145	72	50
Paid Group Life	3	3	100
Paid Annuity Death Settlements	19	19	100
Paid Individual Major Medical	3,161	119	4
Denied Individual Major Medical	245	88	36
Paid Group Major Medical	360	91	25
Denied Group Major Medical	3,464	118	3
Paid Association Health	28,903	120	1
Denied Association Health	7,424	120	2
Paid Hospital/Medical/Surgical	1,916	119	6
Denied Hospital/Medical/Surgical	3,464	118	3
Paid Medicare Supplement	31,442	120	1
Denied Medicare Supplement	1,392	117	15
Paid Franchise Major Medical	220	47	21
Denied Franchise Major Medical	120	44	37
Paid Long-term Care	19	19	100
Denied Long-term Care	8	8	100
Policy Forms and Advertising	21	21	100
Complaint Analysis			
Department of Insurance Complaints	111	111	100
Consumer Complaints	144	144	100

IV. FINDINGS

A. Producer Licensing and Production Analysis

1. A review of the three (3) producers terminated for a cause produced no criticisms.

2. A review of producer production records resulted in one (1) criticism. The criticism was made under 215 ILCS 5/500-80 for payment of commission to a producer not duly licensed at the time the application was taken.

B. Non-Forfeiture Analysis

1. Life Cash Surrender

   The review of the life cash surrendered policy files produced no criticisms.

   The median for surrender was five (5) days.

2. Extended Term and Reduced Paid-Up Insurance

   A review of six (6) extended term and reduced paid-up policy files produced a general criticism under 215 ILCS 5/234.1 for failure to provide and/or explain to the policy owner all options available under the non-forfeiture provision of their life insurance contract when the Notice of the Enactment of a Non-Forfeiture Option was required to be sent and maintained. One hundred percent of the files reviewed were found to be in noncompliance with the referenced statute.

3. Annuity Cash Surrender Analysis

   A review of the annuity cash surrender files produced no criticisms.

   The median for surrender was 12 days.

C. Claims Analysis

1. Paid Individual Life

A review of 72 paid individual life claim files produced two (2) general criticisms and eight (8) individual criticisms.

The first general criticism of 25 or 35% of the files was made under 215 ILCS 5/224(l)(l) for failing to disclose to the beneficiary at the time of claim that 9% interest will accrue on claims not paid with in 15 days of receipt of proof of loss.

The second general criticism was made under 50 Ill. Adm. Code 919.70(a)(2) which involved 17 or 45% of the claim files for failing to provide to the beneficiaries the required Notice of Availability of the Department with the letter explaining the reason for the delay in processing their claim.

Eight (8) claim files were individually criticized under 215 ILCS 5/154.6(d) and 5/224(1)(l) when interest was paid at a rate of 3% instead of the statutorily proscribed 9% rate of interest on life benefits not paid within 15 days. The amount of underpaid interest totaled $3,682.06. Prior to the termination of the examination, the Company provided the examiners with proof of payment for all additional interest due.

Three (3) of the eight (8) referenced claims were criticized for interest underpayments on death benefits for individuals who were insured under a life insurance contract purchased and issued while residing in Illinois, subject to Illinois statutes and regulations. The individuals later died while residing in another state or country and interest paid on those benefits was not settled in accordance with Illinois statutes or the statutorily proscribed rate of interest 9%.

The median for payment was 17 days.

2. Paid Group Life

A review of the three (3) paid group life claims resulted in one (1) individual criticism. The criticism was under 215 ILCS 5/154.6(d) and 5/224(l) for failure to pay interest on benefits from date of death to the date of late payment. The policy was originally a group policy that the Company determined had been converted to an individual policy. The claim, when paid, included 315 days of 9% interest from date of claim receipt 6/13/07 to 4/23/08 and was in the amount of $776.72. The interest should have been calculated from date of death, May 8, 2007, or 351 days, which resulted in the claim being underpaid by $90.84.

No median could be established.

Prior to the termination of the examination the Company provided the examiners with the proof of payment to the beneficiary.

3. Paid Annuity Death Settlements

The review of paid annuity death settlement claim files produced no criticisms.

The median for payment was 18 days.

4. Paid Individual Major Medical

A review of 119 paid individual major medical claim files produced no criticisms.

The median for payment was 11 days.

5. Denied Individual Major Medical

The review of denied individual major medical claim files produced no criticism.

The median for denial was 13 days.

6. Paid Group Major Medical

The review of paid group major medical claim file produced no criticisms.

The median for payment was 11 days.

7. Denied Group Major Medical

   The review of denied group major medical claim files produced no criticisms.

   The median for denial was five (5) days.

8. Paid Association Health

   A review of paid association health claim files produced no criticism.

   The median for payment was 11 days.

9. Denied Association Health

   The review of denied association health claim files produced no criticisms.

   The median for denial was 11 days.

10. Paid Hospital/Surgical

    A review of paid hospital/surgical claim files produced no criticisms.

    The median for payment was 12 days.

11. Denied Hospital/Surgical

    The review of denied hospital/surgical claim files produced no criticisms.

    No median for payment was 13 days.

12. Paid Medicare Supplement

    The review of paid medicare supplement claim files produced no criticisms.

    The median for payment was eight (8) days.

13. Denied Medicare Supplement

    The review of denied Medicare supplement claim files produced a general criticism under 50 Ill. Adm. Code 919.50 for failure to include a Notice of Availability of the Department of Insurance with the letter sent explaining the reason for denial.

    The median for denial was 10 days.

14. Paid Franchise Major Medical

A review of the paid franchise major medical claim files produced no criticisms.

The median for payment was 14 days.

15. Denied Franchise Major Medical

A review of the denied franchise major medical claim files produced no criticisms.

The median for denial was seven (7) days.

16. Paid Long-Term Care

The review of the paid long term care claim files produced no criticisms.

The median for payment was 15 days.

17. Denied Long-Term Care

The review of eight (8) denied long term care claim files produced a general criticism under 50 Ill. Adm. Code 919.50(a)(1) for failing to provide the claimant with Notice of Availability of the Department of Insurance on the written explanation of the basis for denying the claim. One hundred percent of the files reviewed were found to be in noncompliance with the referenced regulation.

The median for denial was 15 days.

D. Policy Forms and Advertising

The review of policy forms and advertising material produced no criticisms.

E. Complaint Analysis

1. Department of Insurance Complaint Analysis

The analysis of 111 Department of Insurance complaint files produced no criticisms.

The median for response was seven (7) days.

2. Consumer Complaint Analysis

The analysis of the consumer complaint files produced no criticisms.

The median for response was six (6) days.

V. INTERRELATED FINDINGS

During the review of individual paid life claims it was revealed that the Company's claim department's standard practice is to pay interest on death claims based on the law of the insured's state of residence at the time of death. If the insured for example lived outside the United States at the time of death, the claim procedure called for interest to be based on the Company's standard contractual rate of interest at the time, which in 2008 was 3%.

Additionally, the Company maintains that Medicare claims denied for the fact that Medicare did not approve the service or it is not payable because Medicare has already paid the entire amount as not being a true benefit denial and therefore not subject to the required inclusion of a Notice of Availability of the Department of Insurance. The Department finds otherwise and informed the Company to include the referenced "Notice" on all claim communication concerning a claim delay, denial or a claim settlement amount that could be deemed by an insured to be an amount less than they might have expected.

VI. TECHNICAL APPENDICES