FINAL ORDER
Effective: 11-22-10

BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF KANSAS

In the Matter of	)	
TRUSTMARK INSURANCE COMPANY AND	)	Docket No. 4235-MC
TRUSTMARK LIFE INSURANCE COMPANY	)	

ORDER

Pursuant to the authority conferred upon the Commissioner of Insurance in K.S.A. 40-222, Sandy Praeger, the duly elected, qualified and serving Commissioner of Insurance hereby adopts the Kansas Insurance Department's Report of Market Conduct Examination of Trustmark Insurance Company and Trustmark Life Insurance Company (collectively "Trustmark") as of October 25, 2010, (attached herein as Attachment A) by incorporating the same in its entirety with specific findings stated as follows. This Order shall become effective as a Final Order, without further notice, upon the expiration of the fifteen (15) day period if no request for a hearing is made, pursuant to K.S.A. 77-542.

Findings of Fact

1. The Commissioner of Insurance has jurisdiction over this matter pursuant to K.S.A. 40-222.
2. The Kansas Insurance Department ("KID") completed a targeted market conduct examination of Trustmark. A significant portion of the examination focused on information that was provided through the Third Party Administrator, Harrington Health. The period of examination was January 1, 2007 through June 30, 2009.
3. On or about February 25, 2010, the Examiner-in-Charge provided Trustmark with a draft of the Market Conduct Examination with request for Trustmark's response in the form of written comments, additions, or acceptance.
4. Trustmark responded with written comments regarding the draft report.

5. The Kansas Commissioner of Insurance has since fully reviewed said Kansas report which is attached herein as Attachment A.
6. Tests for Grievance and Appeals Procedures.
    a. Standard 2 reviews to ensure that the insurer documents grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.
        i. Harrington Health's "Complaints, Grievances and Appeals" procedures call for one level of appeal, Harrington Health's log indicates that there is a 2nd level of appeal, and there are numerous references in their files about a 2nd level of appeal. The written appeal process to the certificate holder must include reference to these procedures per K.S.A. 40-22a09a.
        ii. Trustmark failed standard 2.
    b. Standard 4 reviews a health insurer's conduct for first-level reviews of grievances in compliance with applicable statutes, rules and regulations. KID sampled 48 claim files from Trustmark and 48 claim files from Harrington Health.
        i. Trustmark had four appeals that did not have an acknowledgement sent to the certificate holder within 10 working days. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

ii. Trustmark had five appeals that took over 30 days from the receipt of the appeal until the EOB was issued showing the final claim payment amount. This is a violation of K.S.A. 40-2442(a).

iii. Trustmark had one file that did not have a decision to either uphold or reverse the claim denial within 15 days after receipt of the additional information. This is a violation of K.S.A. 40-2442(a)(d).

iv. Trustmark had two files that had the wrong information provided to the insured regarding their appeals rights. This is a violation of section 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

v. Harrington Health had forty-one files that did not have contact with the certificate holder or provider within 10 days of receipt of the appeal. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

vi. Harrington Health had thirty-eight files that did not have a response to the certificate holder within 30 days of receipt of the appeal. This is a violation of K.S.A. 40-2442(a).

vii. The company failed standard 4.

c. Standard 5 reviews the health insurer's conduct for second-level reviews of grievances in accordance with statutes, rules and regulations. KID sampled two Trustmark files and fifteen Harrington Health files.

i. Thirteen Harrington Health files did not have contact with the certificate holder or provider within 10 days of receipt of the appeal.

This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

ii. Eight Harrington Health files did not have a response to the certificate holder within 30 days of receipt of the appeal. This is a violation of K.S.A. 40-22a09a.

iii. Four 2nd level appeals were reprocessed and the money was paid to the provider on behalf of the certificate holder; interest was not paid on the claims that took over 30 days to reprocess from the date of receipt of the Level 2 appeal per K.S.A. 40-2442(a)(b).

iv. One claim had no documentation to substantiate Harrington Health's final decision and communication to the certificate holder. This is a violation of section 4 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

v. Six 2nd level appeals had the denial of the claim upheld and did not advise the certificate holder in the 2nd level denial letter of their right to file for an external review. This is a violation of K.A.R. 40-4-42a.

vi. The company failed standard 5.

7. Tests for Claim Handling

a. Standard 1 reviews the initial contact by the regulated entity with the claimant is within the required time frame.

i. One large group paid claims out of a sample of fifty and two large group non-payment claims out of a sample of fifty did not have an acknowledgement letter sent within 10 working days after receipt

of a claim. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

ii. Fifteen small group paid claims out of a sample of one hundred and thirteen small group non-payment claims out of a sample of fifty did not have an acknowledgement letter sent within 10 working days after receipt of a claim. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

iii. Thirty-six Harrington Health 2008 paid claims out of a sample of one hundred did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

iv. Twenty-three Harrington Health 2009 paid claims out of a sample of ninety-nine did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

v. Seventeen Harrington Health non-payment claims out of a sample of fifty did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of section

6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

vi. Eight Harrington Health 2009 non-payment claims out of a sample of fifty did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

vii. The company failed standard 1.

b. Standard 3 reviews to ensure that claims are resolved in a timely manner.

i. One large group paid claim out of a sample of fifty and three large group non-payment claims out of a sample of fifty took over 30 days to pay a claim or adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

ii. Two small group paid claims out of a sample of one hundred took over 30 days to pay a claim. This is a violation of K.S.A. 40-2442(a)(b).

iii. Three individual non-payment claims out of a sample of forty-eight took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

iv. Twenty-three Harrington Health 2008 paid claims out of a sample of one hundred took over 30 days to pay the claim. This is a violation of K.S.A. 40-2442(a)(b).

v. Nine Harrington Health 2009 paid claims out of a sample of ninety-nine took over 30 days to pay the claim. This is a violation of K.S.A. 40-2442(a)(b).

vi. Eight Harrington Health 2008 non-payment claims out of a sample of ninety-nine took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

vii. Three Harrington Health 2009 non-payment claims out of a sample of fifty took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

viii. The company failed standard 3.

c. Standard 6 reviews claims to ensure they are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

i. Out of a sample of fifty claims, one claim did not have interest paid when there was a delay in processing as required by K.S.A. 40-2442 and one claim did not have interest paid when it was re-adjudicated due to an earlier processing error as required by K.S.A. 40-2442.

ii. One claim out of a sample of fifty had all benefits misapplied to the deductible. This is a violation of K.S.A. 40-2,105.

iii. Out of a sample of one hundred Harrington Health 2008 paid claims, twenty-three claims were not adjudicated within 30 days, and interest was not paid to the insured as required by K.S.A. 40-2442(b)(d)(2) and one claim was reprocessed due to an error, but interest was not

included on the additional amount paid to the insured as required by K.S.A. 40-2442(b)(d)(2).

iv. Out of a sample of ninety-nine claims, nine Harrington Health 2009 paid claims were not adjudicated within 30 days, and interest was not paid to the insured as required by K.S.A. 40-2442(b)(d)(2) and one claim had incorrect benefit limits applied to the claim as required by section 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

v. One Harrington Health 2008 nonpayment claim out of a sample of fifty had incorrect benefit limits applied to the claim. This is a violation of section 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

vi. One Harrington Health 2009 non-payment claim out of a sample of fifty had the deductible misapplied. This is a violation of section 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

vii. The company passed standard 6.

Applicable Law

K.S.A. 40-222 states, in pertinent part:

> (a) Whenever the commissioner of insurance deems it necessary but at least once every five years, the commissioner may make, or direct to be made, a financial examination of any insurance company in the process of organization, or applying for admission or doing business in this state. In addition, at the commissioner's discretion the commissioner may make, or direct to be made, a market regulation examination of any insurance company doing business in this state.

K.S.A. 40-2442 states, in pertinent part:

(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of accident and sickness insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:
(1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or
(2) Additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of accident and sickness insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(d) Within 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:
(1) Such insurer refuses to reimburse all or part of the claim; and
(2) specifies each reason for denial. Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of 1% per month.

K.A.R. 40-1-34 states, in pertinent part:

Section 4.

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5.

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
C. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.
D. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.
E. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
F. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6.

A. Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
B. Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.
C. An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
D. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

K.S.A. 40-22a09a states, in pertinent part:

(a) Every health insurance plan for which utilization review is performed shall include a description of the health insurance plan's procedures for an insured to obtain an internal appeal or review of an adverse decision. This description shall include all applicable time periods, contact information, rights of the insured and available levels of appeal. If the health insurer uses

a utilization review organization, the insured shall be notified of the name of such utilization review organization. The health insurance plan shall provide an insured with written or electronic notification of any adverse decision, and a description of the health insurance plan's internal appeal or review procedure, including the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto. The health insurance plan also shall notify the insured of the insured's right to waive the second appeal or internal review and proceed directly to the external review as provided in K.S.A. 40-22a14 and amendments thereto.

(b) If the health insurance plan contains a provision for two levels of internal appeal or review of a health care decision which is adverse to the insured, the health insurance plan shall allow the insured to voluntarily waive such insured's right to the second internal appeal or review. Such waiver shall be made in writing to the health insurance plan and shall constitute the exhaustion of all available internal appeal or review procedures within the meaning of subsection (d) of K.S.A. 40-22a14 and amendments thereto.

(c) If an insured elects to request the second internal appeal or review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before a designated representative or representatives of the health insurance plan or utilization review organization at the second internal appeal or review meeting. If a majority of the designated representatives of the health plan or utilization review organization who will be deciding the second internal appeal or review cannot be present in person, by telephone or by other electronic means, at least one of those designated representatives who will be deciding the second internal appeal or review shall be a physician and shall be present in person, by telephone or by other electronic means. No physician or other health care provider serving as a reviewer in an internal appeal or review of an adverse decision shall be liable in damages to the insured or the health insurance plan for any opinion rendered as part of the internal appeal or review.

(d) All second internal appeals or reviews shall provide that the insured has a right to:

(1) Receive from the health insurance plan or utilization review organization, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to the insured's request for benefits;

(2) have a reasonable and adequate amount of time to present the insured's case to a designated representative or representatives of the health insurance plan or utilization review organization who will be deciding the second internal appeal or review;

(3) submit written comments, documents, records and other material relating to the request for benefits for the second internal appeal or review panel to consider when conducting the second internal appeal or review both before and, if applicable, at the second internal appeal or review meeting;

(4) prior to or during the second internal appeal or review meeting ask questions relevant to the subject matter of the internal appeal or review of any representative of the health insurance plan or utilization review organization serving on the internal appeal or review panel provided that such representative may respond verbally if the question is asked in person during an insured's appearance before the internal appeal or review panel or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

(5) be assisted or represented at the second internal appeal or review meeting by an individual or individuals of the insured's choice; and

(6) record the proceedings of the second internal appeal or review meeting at the expense of the insured.

(e) An insured, or the insured's authorized representative, wishing to request to appear in person before the second internal appeal or review panel consisting of the health insurance plan's or utilization review organization's designated representative or representatives shall make the request to the health insurance plan or utilization review organization within five working days before the date of the scheduled review meeting except that in the case of an emergency medical condition, such request must be made no less than 24 hours prior to the scheduled review meeting.

(f) The health insurance plan or utilization review organization shall provide the insured a written decision setting forth the relevant facts and conclusions supporting its decision within:

(1) Seventy-two hours if the second internal appeal or review involves an emergency medical condition as defined by subsection (b) of K.S.A. 40-22a13 and amendments thereto;

(2) fifteen business days if the second internal appeal or review involves a pre-service claim; and

(3) thirty days if the second internal appeal or review involves a post-service claim.

K.S.A. 40-2405 states:

> The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by K.S.A. 40-2403.

K.S.A. 40-2,105 states, in pertainant part:

> (a) On or after the effective date of this act, every insurer which issues any individual policy of accident and sickness insurance or group policy of

accident and sickness insurance to a small employer as defined in K.S.A. 40-2209d, and amendments thereto, which provides medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such small employer group policy, except as provided in subsection (d), which shall be limited to not less than 45 days per year for in-patient treatment of mental illness in a medical care facility licensed under the provisions of K.S.A. 65-429, and amendments thereto, and not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or substance use disorders in a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014, and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605, and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b, and amendments thereto. Such individual policy or such small employer group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for mental illness, alcoholism, drug abuse and substance use disorders subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses and treatment limitations as apply to other covered services, limited to not less than $15,000 in such person's lifetime, with no annual limits, in the facilities enumerated when in-patient treatment is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

K.A.R. 40-4-42a states:

(a) A written notification of an adverse decision shall be printed in clear, legible type and in at least 12-point type.

(b) The notice of adverse decision shall explain the principal reason for the adverse decision in language easily understood by a person with an eighth-grade reading level. An insurer may meet this requirement by omitting medical terminology that describes an insured's medical condition. The notice shall include the proper names of all impacted parties, telephone numbers, and addresses.

(c) The notice of adverse decision shall explain how an insured, as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, can initiate an external review with the commissioner. If an insured is eligible for an expedited review due to an emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, then the notice shall explain how an insured can initiate an expedited review.

(d) The notice shall explain that an insured may file for an external review with the commissioner within 90 days of receipt of a final adverse decision. The notice shall also list the Kansas insurance department's toll-free number.
(e) The notice of adverse decision shall describe how the insured can request a written statement of the clinical rationale and clinical review criteria used to make the adverse decision.

Conclusions of Law

Based upon the Findings of Fact enumerated in Paragraphs #1 through #7 and the Applicable Law cited above,

IT IS, THEREFORE, ORDERED BY THE COMMISSIONER OF INSURANCE:

1. The Commissioner of Insurance has jurisdiction over this matter pursuant to K.S.A. 40-222.

2. The Kansas Insurance Department's ("KID") Report of Market Conduct Examination of Trustmark as of June 30, 2009, is herein adopted in its entirety.

3. Trustmark's failure to comply with the requirements of Tests for Grievance and Appeals Procedures Standard 2 constitutes violations of K.S.A. 40-22a09a.

4. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty of Two Thousand Dollars and No Cents ($2,000.00) for the above-stated violations of K.S.A. 40-22a09a.

5. Trustmark's failure to comply with the requirements of Tests for Grievance and Appeals Procedures Standard 4 constitutes violations of sections 5 & 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34 and K.S.A. 40-2442(a)(d).

6. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty in the amount of Two Thousand Five Hundred Dollars and No Cents ($2,500.00) for the above-stated violations of K.S.A. 40-2442 and K.A.R. 40-1-34.

7. Trustmark's failure to comply with the requirements of Tests for Grievance and Appeals Procedures Standard 5 constitutes violations of sections 4 & 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34, K.S.A. 40-22a09a, K.S.A. 40-2442(a)(b) and K.A.R. 40-4-42a.

8. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty in the amount of Three Thousand Five Hundred Dollars and No Cents ($3,500.00) for the above-stated violations of sections 4 & 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34, K.S.A. 40-22a09a, K.S.A. 40-2442(a)(b) and K.A.R. 40-4-42a.

9. Trustmark's failure to comply with the requirements of Tests for Claims Handling Standard 1 constitutes violations of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

10. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty in the amount of Four Thousand Dollars and No Cents ($4,000.00) for the above-stated violations of section 6 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34.

11. Trustmark's failure to comply with the requirements of Tests for Claims Handling Standard 3 constitutes a violation K.S.A. 40-2442(a)(b)

12. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty in the amount of Two Thousand Dollars and No Cents ($2,000.00) for the above-stated violation of K.S.A. 40-2442(a)(b).

13. Trustmark's failure to comply with the requirements of Tests for Claim Handling Standard 6 constitutes violations of section 5 of the NAIC Unfair Claim

Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34, K.S.A. 40-2,105 and K.S.A. 40-2442(a)(b).

14. Pursuant to K.S.A. 40-2,125(a)(1), Trustmark shall pay a monetary penalty in the amount of Two Thousand Dollars and No Cents ($2,000.00) for the above-stated violations of section 5 of the NAIC Unfair Claim Settlement Practice Model Regulation as adopted by K.A.R. 40-1-34, K.S.A. 40-2,105 and K.S.A. 40-2442(a)(b).

IT IS SO ORDERED THIS 2ND DAY OF NOVEMBER 2010, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

_/s/ Sandy Praeger_____
Sandy Praeger
Commissioner of Insurance

BY:

_/s/ John W. Campbell_____
John W. Campbell
General Counsel

NOTICE OF RIGHTS

Trustmark is entitled to a hearing pursuant to K.S.A. 77-537, the Kansas Administrative Procedure Act. If Trustmark desires a hearing, the company must file a written request for a hearing with:

John W. Campbell, General Counsel
Kansas Insurance Department
420 S.W. 9th Street
Topeka, Kansas 66612

This request must be filed within fifteen (15) days from the date of service of this Order. If Trustmark requests a hearing, the Kansas Insurance Department will notify the company of the time and place of the hearing and information on the procedures, right of representation, and other rights of parties relating to the conduct of the hearing before the commencement of the same.

If a hearing is not requested in the time and manner stated above, this Order shall become effective as a Final Order upon the expiration of time for requesting a hearing, pursuant to K.S.A. 77-613. In the event that Trustmark files a petition for judicial review, pursuant to K.S.A. 77-613(e), the agency officer to be served on behalf of the Kansas Insurance Department is:

John W. Campbell, General Counsel
Kansas Insurance Department
420 S.W. 9th Street
Topeka, Kansas 66612

CERTIFICATE OF SERVICE

The undersigned hereby certifies that he served the above and foregoing Order and Notice of Rights on this 2nd day of November, 2010, by causing the same to be deposited in the United States Mail, registered mail with return-receipt requested postage prepaid, addressed to the following:

Mr. David McDonough
President
Trustmark Insurance Company
Trustmark Life Insurance Company
400 N. Field Dr.
Lake Forest, IL 60045

_/s/ Jennifer R. Sourk_____
Jennifer R. Sourk
Staff Attorney