REPORT OF MARKET CONDUCT EXAMINATION

THE MEGA LIFE AND HEALTH INSURANCE CO.

9151 GRAPEVINE HWY.

NORTH RICHLAND HILLS, TX 76180

AS OF AUGUST 31, 2003

BY

KANSAS INSURANCE DEPARTMENT

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a market conduct examination of The MEGA Life and Health Insurance Co. (MEGA). The examiners reviewed the company agent, advertising, complaint, and claims manuals. The exam team reviewed claim, and complaint files in the company's Administrative office in North Richland Hills, TX. A series of meetings were held with MEGA staff that focused on their current operations. To supplement and verify the understanding of how the company does business, a series of samples were selected for review to verify their procedures and practices in claims, underwriting and rating.

The exam team has made recommendations on several issues.

LIST OF RECOMMENDATIONS

Complaint Handling

1. The company needs to review its consumer complaint and grievance procedures with all Divisions to guarantee uniform compliance in communicating with insured persons and to avoid violating company business standards. Acknowledgement letters should be sent within three days and written decisions should be clearly explained and sent to the insured person within 30 days. *Several divisions have acknowledged efforts* to comply with these procedures.

2. One of the requirements for complaint and grievance records is to explain the disposition of each complaint. All data contained on the complaint register must be accurate and reflect the facts of each complaint. The company needs to review the use of disposition form and freelance letters to determine uniformity and compliance with Kansas statutes. *The Consumer Affairs Department has indicated that they have instituted 16 additional disposition codes to better explain the disposition of each complaint. This enhancement was implemented 1/1/04.*

Marketing and Sales

1. Within 30 days Mega must review their advertising procedures to insure that they are complying with Article 9, Advertising, of the Kansas Administrative Regulations.

2. Within 30 days, MEGA must complete the filing of the "Starbridge Employer Trust" filing with all the variable plan options along with the rate manual for these options per K.S.A. 40-216 and K.S.A. 40-2215(b). *MEGA has advised KID's A&H Division that there were no active accounts as of March 2005 and filed the seven options as being "Filed for Informational Purposes".*

3. Within 30 days MEGA must present to KID a plan to monitor the distribution of their advertising materials including how many times an ad is requested for use by an agent and the

manner in which the ad will be distributed to the consumers per K.A.R. 40-9-100, Section 17(A).

Claims

1. The SID Division must submit a plan to KID within 30 days detailing how they are going to receive enrollment information from the schools in a timely manner to insure the prompt adjudication of claims for students enrolled at a particular school that is participating in the SID program.

Mega has indicated that since the exam they have implemented extensive changes to the processes and procedures used by SID's Premium Accounting Department. SID believes that these changes regarding enrollment information will ensure the prompt adjudication of claims for student enrolled at schools covered by MEGA policies.

2. NRH needs to be more consistent in sending acknowledgement letters to consumers if they are unable to resolve the claim within the first ten working days of receipt of the claim.

MEGA's has indicated since the exam they have implemented program changes in which an acknowledgement letter is generated regardless of the status of the claim unless the claim has already been paid or denied.

3. MEGA needs to review their claim procedures to insure that claims are being processed in a timely fashion. This would include both the processing of a clean claim within 30 days and the final adjudication of a claim with in 15 days after the required information is received per K.S.A. 40-2442, (a)(1)(2).

4. MEGA needs to review their claim procedures to insure that claims that are not processed with in the time lines specified in the Prompt Pay Act, K.S.A. 40-2442, have interest paid according to K.S.A. 40-2442, (b).

Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

The MEGA Life and Health Insurance Co.)

9151 Grapevine Hwy.

North Richland Hills, TX 76180

hereafter referred to as “MEGA” or “the Company”, and the following report as such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor
Examiner in Charge

SCOPE OF REVIEW

A targeted market conduct examination of MEGA's, claims and complaints was completed to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

The examination included, but was **not limited to the following:**

COMPANY OVERVIEW

History and Profile
Company Operations and Management
Certificates of Authority
Internal Audit Procedures

COMPLAINT AND GRIEVANCE HANDLING

Record Keeping
Timely Response

MARKETING/SALES

Marketing & Advertising Materials
Agent's Materials

PRODUCER LICENSING

Agency Management
Agent Training

UTILIZATION REVIEW

CLAIMS

Claim Processing
Use of Outside Pricing Entities
Timeliness and Accuracy of Claim Payment
Proper Maintenance of Claim Files

SUMMARY OF REVIEW

The market conduct examination focused on MEGA. The testing and file review consisted of sampling from the Company's complaints and settled claim files in North Richland Hills, TX and KID's office in Topeka, KS.

The examination included a review of the Company's complaints and settled claim files from January 1, 2001 to August 31, 2003.

General topics were covered in Interrogatories submitted to the Companies for their written response. Subjects covered were Advertising, Agency Management, Complaints/Grievances, and Claims. The response received adequately addressed the issues presented.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

HISTORY

Originally incorporated as Etats Corp. in 1981, during 1982 the name was changed to Orange State Life and Health Insurance Company. In 1989, the name was again changed to U.S. Guardian Health Insurance Company and in 1990 the present title was adopted along with the company being re-domiciled from Florida to Oklahoma.

During 1990, the company assumed substantially all of the business of Mark Twain Life Insurance Corporation, an affiliate. During 1991, the company assumed blocks of individual ordinary life business from Underwriters National Assurance Company and Great Fidelity Life Insurance Company. During 1993, assumption of closed annuity block from Mutual Security Life Insurance Company. Effective December 31, 1995, the company assumed all of the life, accident and health business of its affiliates, First Life Assurance Company and Southern Educators Life Insurance Company.

Since the on-site portion of this exam took place, MEGA's Parent Corporation, UICI, has changed its name to HealthMarkets

BUSINESS REVIEW

UICI offers health and life insurance and selected financial services to niche consumer and institutional markets throughout the United States and Puerto Rico. Its insurance subsidiaries distribute the products primarily through the company's two dedicated agency field forces: UGA-Association Field Services and Cornerstone America.

UICI has exited multiple lines of business to refocus on its core operations. These exited businesses include sub-prime credit card, national motor club, workers' compensation, third

party administration, and special risk. Additionally, UICI recently announced its entrance into the senior market by offering long-term care and Medicare supplement insurance products. Going forward, UICI's mission will be to generate long-term shareholder wealth as a leading provider of health and life insurance and related products, and to serve the self-employed individual, senior citizen and student markets through dedicated distribution channels.

UICI"s domestic insurance companies include The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West) and The Chesapeake Life Insurance Company (Chesapeake). MEGA is domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in all states except New York.

UICI manages its business through three segments: Insurance, Financial Services and Other Key Factors. The Insurance segment, which provides the vast majority of UICI's revenues and net income, includes the Self-Employed Agency (SEA), Group Insurance, Life Insurance, and the Senior Market divisions. SEA offers a portfolio of traditional indemnity and PPO health insurance products to self-employed individuals in 43 states and the District of Columbia. The traditional indemnity health insurance products are designed to limit coverage to the occurrence of significant events requiring hospitalization. However, each policy offers coverage modifications so the insurance may be tailored to meet the individual policyholder's needs. Overall, the health insurance products are primarily issued to members of various independent associations that endorse the products, such as the National Association for the Self-Employed and the Alliance for Affordable Services.

The Group Insurance includes UICI's previous Student Insurance Division and STAR HRG Division. The division's student insurance business markets health insurance coverage to students attending colleges and universities in the United States and Puerto Rico. UICI maintains an industry-leading market share for this business, and offers its products to more than 500 colleges, universities and associations. To a lesser extent, UICI markets to students attending kindergarten through grade 12 primarily in Washington, Florida, Arizona, Louisiana, Oklahoma and Texas.

UICI purchased STAR HRG in February 2002. This unit markets and administers limited benefit plans, such as medical, life, disability and dental, for entry level, high turnover, hourly employees. UICI's clientele includes over 550 corporate clients, some of whom are in the Fortune 500, and covers all U.S. geographic regions. Since the on-site portion of the exam CIGNA HealthCare purchased the Star HRG Division in July 2006

During 2001, UICI announced its entrance into the senior market by developing a portfolio of long-term care and Medicare supplement insurance products. To facilitate the distribution and administration of its new senior market products, UICI completed the purchase of a 50-percent interest in Seniors First, a Dallas-based career agency specializing in the sale of long-term care and Medicare supplement insurance products. Seniors First operates in eleven states in the Southwest and the Midwest. Also, UICI reached an agreement with CHCS Services, Inc., a subsidiary of Universal American Financial Corporation (NASDAQ:

UHCO), to serve as administrator for these products through June of 2003. Thereafter UICI will administer these products.

UICI's corporate Philosophy is to operate insurance companies that are closely aligned with their distribution source, such as the captive UGA – Association Field Services and Cornerstone America and various independent Managing General Agents. Each distribution source sells products that are insured or coinsured by one of the insurance subsidiaries. To build agent loyalty, reduce agent turnover, and increase tenure in the agency force, UICI uses a stock ownership program. In A.M. Best's opinion, UICI's dedicated agency force represents a key competitive advantage to the organization, which has been demonstrated through its strong sales results.

Table 1 shows the organization of UICI and its subsidiary Companies.

Table 2 shows the organization of the different departments within the Insurance Center of MEGA.

Tests for Company Operations/Management

Standard 1
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222, (a)(b)(c)(g).

> The company provided the exam team with the necessary records and documents in a timely fashion.

Standard 2
The company is licensed for the lines of business that are being written. K.S.A. 40-216.

> The Certificate of Authority was reviewed and found to be in order and the company was complying with it.

Standard 3
The company cooperates on a timely basis with examiners performing the examinations. K.S.A. 40-222, (c) (g).

> The company was cooperative and provided the exam team with the items requested within the time frames established for this exam.

COMPLAINTS & GRIEVANCE HANDLING

Complaint Procedure Requirements

MEGA has developed comprehensive procedures for Department complaints received by the Insurance Center Legal Department, Department complaints received by MEGA Divisions

and consumer complaints received by MEGA Divisions. Appeals and grievances are handled separately under different procedures and will be explained under Grievances.

DOI complaints received by the Insurance Center Legal Department
DOI complaints, envelopes and attachments are date stamped, imaged and routed to the Legal Indexer Queue for identification. A Complaint Coversheet form is filed and attached to the original complaint and the information is entered into the Legal Tracking System (LTS) where it is assigned a number. The complaint is then forwarded to the appropriate Division for a response. Follow-up letters and requests for information also are stamped, imaged, logged into LTS and forwarded to the appropriate Division.

Complaints received from an Insurance Department by a Division
A Complaint Coversheet form is filed and the information is entered into the LTS and assigned a number. A copy of the original complaint and its coversheet are forwarded to the Insurance Center Legal Department. All follow-up and interim correspondence is entered into the LTS and a copy is forwarded to the Insurance Center. The Division response and the completed complaint coversheet are forwarded to the Insurance Center for review and imaged onto the Master Complaint File. Reopen information is entered as a follow-up screen.

Consumer complaints received by a Division from a consumer or on their behalf
The complainant's envelope, letter and enclosures are date stamped on the date received by the company. A complaint coversheet is filed and attached to the original complaint. This information is entered into the LTS and assigned a number. The receive date logged onto the LTS should be the date the complaint was received by the company, not the date received by the Division. Each Division is responsible for maintaining each consumer complaint file.

An acknowledgement letter is sent to the complainant within three (3) days of receipt of the complaint including contact information. Follow-up letters and requests for additional information received by the Division are date stamped, logged into the Complaint Tracking System, and forwarded to the appropriate person for response.

Tests for Complaint Handling

Standard 1
All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404 (10).

> The complaint register was current and provided the categories as required under this statute. However, any activity or correspondence beyond the initial receipt and disposition was not recorded which made tracking the events of the complaint difficult.
>
> MEGA's Student Insurance Division was not aware of the "follow-up" capabilities allowed on the electronic complaint log but now has instituted new procedures to include all interim correspondence necessary to resolve the complaint.

Additionally, three DOI complaints had incorrect codes under "Disposition." The company coded these complaints as "Satisfactory Explanation Given" instead of "Corrective Action Taken" or "Claim Settled" or another more fitting description.

Type	Sample	Errors	%Pass
DOI Complaints	50	3	94%

The company passed Standard 1.

Standard 2
The company has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, 5(a) (b) and K.S.A. 40-22a 14 (c) (d).

The DOI complaint procedures are outlined in company policies.

The company passed Standard 2.

Standard 3
The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language.

Complaint handling errors are noted in other specific Standards.

Standard 4
The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6, 8(a) & 8(c).

Type	Sample	Errors	%Pass
DOI Complaints	50	3	94%

The company passed Standard 4.

Grievance Procedure Requirements

The company has a formal procedure for all grievances received from the various Health Benefit Plans issued and renewed by its Divisions. A distinction is made between grievances and adverse determinations. Written notice of the grievance procedure is sent when an insured person contests an adverse determination. The grievance procedure is divided into an Informal, Formal and Expedited Review sections.

The Informal Review provides for oral complaints submitted to the company within 60 days after a disputed event has occurred. The company must request additional information within 5 business days and respond to the insured person within 30 days after receiving all information.

The Formal Review includes a First Level available for either an insured person, a representative of that person or a provider for adverse determination cases and may be written. The company must acknowledge the grievance within three business days with contact information. An insured person may not attend the First Level meeting. The company must issue a written decision within 30 days after receiving the grievance including the right to request a Second Level Review.

The Formal Review, Second Level continues the grievance process for insured persons who are not satisfied with the outcome at the First Level or a Utilization Review Appeal decision. Within ten business days after receiving this request, the company must respond with information about contacts, gathering information from the company, attending and presenting a case at the meeting and representation by attorneys for the person and the company. The panel will not include previous panel members or other personnel involved in this claim. Providers on the panel will have appropriate expertise.

The Second Level Review Panel must schedule and meet within 45 days after receiving a request for the meeting and the insured person must be notified of the meeting at least 15 days in advance. The insured person may attend this meeting. A written decision must be given to the insured person within seven business days after the review panel meeting and the procedure outlines numerous items that must be contained in the company response including the telephone number and address of the Kansas Insurance Department.

An Expedited Review is held when timelines for the other levels would jeopardize the life or health of the insured person. The insured person, a representative or a provider acting on behalf of the insured person may submit this request orally or in writing. An appropriate clinical peer must evaluate the case. This review must be conducted and its decision communicated to the insured person within four days and a written confirmation must follow within two working days.

If the Expedited Review decision is unsatisfactory, a written grievance may be submitted. Grievance records are maintained by the Legal Department.

Tests For Grievance Procedures

Standard 1
The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the carrier.

> The company maintained a current list of grievances and was reviewed by the examiners. While not all files were handled according to company policies, grievances and complaints appeared to be defined and resolved through their written procedures. Errors are noted in other specific Standards.

Standard 2
The health carrier documents grievances and establishes and maintains grievance procedures in compliance with statute, rules, and regulations.

The company has developed a detailed and precise complaint procedures manual used to train personnel as they handle complaints. However, the company response to two grievance error messages indicated that, "It is the Company's goal to respond to complaints within 30 days, not a requirement." The Grievance Procedure requires a 30-day response and the Complaint Procedure sets a "goal" of 14 days. Perhaps the confusion lies in the definition of complaint and grievance. Nonetheless, 58 and 46 days seem too long for these two particular grievances.
The company passed Standard 2.

Standard 3
A health carrier files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

N/A

Standard 4
The health carrier conducts first level reviews of grievances in compliance with statutes, rules, and regulations.

Type	Sample	Errors	Passed
Company Grievance Procedure	32	16	50%

The company failed Standard 4.

- In eight cases the Company failed to acknowledge the complainant within 3 days.

- In five cases the Company failed to notify the complainant of a written decision within 3 days.

- In two cases the file lacked adequate documentation per K.A.R. 40-1-34, 4.

- In one case failed to comply with K.S.A. 2404 (10).

The STAR HRG Division notified the exam team that it has taken steps to ensure that procedures are now in place to ensure compliance with the three-day notification requirement.

Standard 5
The health carrier conducts second level reviews of grievances in accordance with statutes, rules, and regulations.

The list of sample grievances did not reveal any second level grievances filed during the exam period.

The company passed Standard 5.

Standard 6
The health carrier handles grievances involving adverse utilization review determinations in compliance with statutes, rules, and regulations.

The list of sample grievances did not reveal any adverse utilization review determinations filed during the exam period.

Standard 7
The health carrier has procedures for and conducts expedited appeals in compliance with statutes, rules, and regulations.

The list of sample grievances did not reveal any expedited appeals filed during the exam period.

Recommendation for Complaints and Grievances

1. The company needs to review its consumer complaint and grievance procedures with all Divisions to guarantee uniform compliance in communicating with insured persons and to avoid violating company business standards. Acknowledgement letters should be sent within three days and written decisions should be clearly explained and sent to the insured person within 30 days. *Several Divisions have acknowledged efforts* to comply with these procedures.

2. One of the requirements for complaint and grievance records is to explain the disposition of each complaint. All data contained on the complaint register must be accurate and reflect the facts of each complaint. The company needs to review the use of disposition form and freelance letters to determine uniformity and compliance with Kansas statutes. The Consumer Affairs Department has indicated that they have instituted 16 additional disposition codes to better explain the disposition of each complaint. This enhancement was implemented 1/1/04.

MARKETING AND SALES

The exam team reviewed the company's marketing and advertising materials. The Company has an in-house advertising department to develop their sales brochures, scripts and slicks for the print media.

The Company's Regulatory Compliance Department is responsible for reviewing and approving all advertising and marketing materials. All agent-created advertisements must also be approved by the Compliance Department prior to use.

To expedite MEGA's review of ads for their agency force, they have developed a Checklist for Advertising materials that the agents submit to the company. Their Compliance Department will review these proposed advertisements for compliance with Regulation 40-9-100 and MEGA's Advertising Guidelines.

Tests for Marketing and Sales

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations. K.A.R. 40-9-100.

The exam team reviewed a sample of 446 documents from all 3 divisions.

Division	Items Reviewed	Errors	Passed
NRH Div	395	55	
SID	36	3	
STAR	15 documents on the website	0	
Total	446	58	87%

SID Division
- Three ads made reference to specific deductibles, policy terms or benefits without also listing relevant exclusions and limitations. This is violation of K.A.R. 40-9-100, Section 6, Guidelines 6-A(8), 6-B(1).

NRH Division
- Thirteen agent ads had the captioned advertising material referring to the A.M. Best rating system. These violate K.A.R. 40-9-100, Section 16 which states, in part, "An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation." The company indicates that it has since revised two ads and discontinued the remainder of the forms.

- Eight agent ads violated K.A.R. 40-9-100, Section 6A(1), Guideline 6-A(1)(37) which provides, "An…advertisement which is designed to produce leads either by use of a coupon or a request to write the company or a subsequent advertisement prior to contact must include information disclosing that an agent may contact the applicant if such is the fact…" The company indicates that it has since discontinued these ads.

- Five agent ads violated K.A.R. 40-9-100 Section 6 Guideline 6A(8)B(1). This regulation prohibits advertisements from listing benefits, cost or periods of time without also listing relevant exclusions and limitations. The company indicates that it has since discontinued these ads.

- Thirteen agent ads violated K.A.R. 40-9-100 Section 6.A(1) Guideline 32. This regulation prohibits the marketing of a common type of policy or combination of benefits as “new”, “unique”, “a bonus”, “a breakthrough” or implies the policy is otherwise unusual. In this regard the statements about being singled out for rate changes and cancellation appear to violate this regulation. All individual policies sold in this state are renewed and canceled on a class basis. The company indicates that it has since discontinued these ads.

- One agent ad violated KAR 40-9-100, section 11 which states that an advertisement shall not make incomplete comparisons of insurance policies and benefits. The company indicates that it has since discontinued this ad.

- Six agent ads violated KAR 40-9-100, section 11, guideline 11 which prohibits comparison of non-comparable policies and provides that ads shall not unfairly minimize competition nor disparage competing types of insurance. The company indicates that it has since discontinued these ads.

- One agent ad violated KAR 40-9-100, section 11, guideline 11 which states, in part, “Advertisements which state or imply that an insurer’s premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.” The company indicates that it has since discontinued this ad.

- Five brochures violated KAR 40-9-100, section 11, guideline 11 which prohibits comparison of non-comparable policies and provides that ads shall not unfairly minimize competition nor disparage competing types of insurance. The company indicates that it has since discontinued these brochures.

- The same five brochures violated KAR 40-9-100 Guideline 6-A[4] which states, in part, “Illustrations which depict paper currency or checks showing an amount payable are deceptive and misleading and are not permissible.” The company indicates that it has since discontinued these brochures.

- The following comments pertain to one agent ad:

  1. The advertising material referred to the A.M. Best rating system. This violated K.A.R. 40-9-100, Section 16 which states, in part, “An...advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.”

  2. The material violated KAR 40-9-100, section 11, guideline 11 which prohibits comparison of non-comparable policies and provides that ads shall not unfairly minimize competition nor disparage competing types of insurance.

3. The material violated KAR 40-9-100 Section 6{A} 1 which prohibits statements that appear to be misleading and deceptive.

The company indicates that it has since discontinued this ad.

- One ad made reference to group. The Company is correcting this error.

- One ad made reference to a discount card program. The company has since corrected the wording.

The company was non compliant in this standard with an 87% compliance ratio.

Standard 2
Company internal producer training materials are in compliance with applicable statutes, rules and regulations.

The exam team reviewed the producer training materials and they were found to be in compliance with state statutes.

Standard 3
Company communications to producers are in compliance with applicable statutes, rules and regulations.

The exam team reviewed the communication documents that were sent by MEGA to their agents in Kansas and found them to be in compliance with state statutes.

Standard 5
Outline of coverages are in compliance with all applicable statutes, rules and regulations.

In reviewing the claims for MEGA, the coverage outlines for NRH and SID had been filed with KID. The STAR division wrote a group policy and utilized "variable material" to allow the policyholder to choose the most appropriate benefit levels for the plan. Only 3 of the 17 schedule of benefit plans from our claim sample had been filed and approved with KID. This is in violation of:

K.S.A. 40-216 Business prohibited until certain filings made; filing of contracts on behalf of insurer by rating organization or another insurer; suspension or modification of filing requirements by commissioner
(A)…."No contract of insurance or indemnity shall be issued or delivered in this state until the form of the same has been filed with the Commissioner of Insurance…." The policy is not delivered in Kansas.

And

K.S.A. 40-2215 Forms and premium rates, filing, regulation, violations, penalties.

(b) No group or blanket policy or certificate of accident and sickness insurance providing hospital, medical or surgical expense benefits shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto has been filed with the commissioner of insurance.

General Comments on Advertising Materials

MEGA indicated that it had

> …established and maintains a system of control over the advertising pieces used by the agents as required by Section 2, Guideline 2-B. The Company has established advertising guidelines which require agents to submit any advertisement they wish to use to the Company for approval prior to using such advertising. The Company maintains an advertising database through which it tracks adverting approved for use and the methods off distribution as required by Section2, Guideline 2-B. Once approved, advertising is maintained in a website accessible by the agents.
>
> The agents may download the approved advertising maintained on the website for use. As the approved advertising is available to all agents in the state through the website, the company does not have a means to track the number of times an advertisement may actually be used by agents. As a result, we [MEGA] are not able to provide you [KID] with an accounting of how many times the advertisements identified in Attachment 2 were distributed by agents.

K.A.R. 40-9-100, Section 17 requires that the company not only maintain an advertising file of complete file containing every printed, published, or prepared advertisement, but it must also note the manner and extent of the distribution. The company has failed to meet this regulation since it has no way to provide KID with how many times the advertisements were downloaded or who requested the materials and consequently has no way of noting the extent of the distribution of it's advertising materials.

> **K.A.R. 40-9-100, Section 17. Enforcement Procedures**
>
> A. *Advertising File.* Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised…

Recommendations:

1. Within 30 days Mega must review their advertising procedures to insure that they are complying with Article 9, Advertising, of the Kansas Administrative Regulations.

2. Within 30 days, MEGA must complete the filing of the "Starbridge Employer Trust" filing with all the variable plan options along with the rate manual for these options per K.S.A. 40-216 and K.S.A. 40-2215(b). *MEGA has advised KID's A&H Division that there were no active accounts as of March 2005 and filed the seven options as being "Filed for Informational Purposes"*.

3. Within 30 days MEGA must present to KID a plan to monitor the distribution of their advertising materials including how many times an ad is requested for use by an agent and the manner in which the ad will be distributed to the consumers per K.A.R. 40-9-100, Section 17(A).

PRODUCER LICENSING

NRH-Agent Recruitment
The Division offices recruit through various ways such as newspaper, Internet, word of mouth, job fairs (if applicable), and referrals. Division Leaders or Satellite District Leaders interview the prospective agent.

After the individual passes the necessary reference and background checks, the individual must take all state required classes. The Division and Satellite Leaders handle the new agent training.

When the license is issued, the company will then appoint the agent with the state.

SID-Agent Recruitment
New agents are recruited through job postings in the local paper, on the Internet, by word-of-mouth and through recruiters. Executive VP and COO and/or Senior VP interview prospective agents. The minimum requirement is a 4-year degree with some sales background.

After the prospective agent passes the necessary background checks, then the agent is appointed. New agents without a license are sent to a state approved class to prepare for taking the exam. The company provides any supplemental training as needed. Training for licenses is also available on-line.

There is no formal New Agency Training process. Executive VP and COO and/or Senior VP handle the training of new agents. The "company trainer" goes on the first few sales calls with the new agents and will go on any sales call requested by the new agent.

STAR-Agent Recruitment

The STAR Division uses Independent agents that are licensed and appointed by the Company. There is no formal training program for agents that market the STAR division products.

The exam team reviewed the training materials used by MEGA for their new agents.

MEGA has indicated that since the exam they have reviewed their training and instituted a new program called TTACC.

TESTS FOR PRODUCER LICENSING

Standard 1
Company records of licensed and appointed (if applicable) producers agree with department of insurance records. K.S.A. 40-4912.

Type	Sample	Errors	%Pass
NRH	50	0	100%
SID	13	0	100%
STAR	26	3	88%

NRH and SID passed and the Star Division failed Standard 1. The initial question concerned the dates of appointment; however there was confusion as to what Division of MEGA these agents were appointed in as well as when.

Standard 2
Producers are properly licensed and appointed (if required by state law) in the jurisdiction where the application was taken. K.S.A. 40-4914.

Type	Sample	Errors	%Pass
NRH	50	0	100%
SID	13	0	100%
STAR	26	0	100%

The Company passed Standard 2

Standard 3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable. K.S.A. 40-4913.

Type	Sample	Errors	%Pass
NRH	50	0	100%
SID	13	0	100%
STAR	26	0	100%

The Company passed Standard 3

Standard 4
The company's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Type	Sample	Errors	%Pass
NRH	50	0	100%
SID	13	0	100%
STAR	26	0	100%

The Company passed Standard 4

Standard 5
Records of terminated producers adequately document reasons for terminations. K.S.A. 40-4913.

Type	Sample	Errors	%Pass
NRH	50	0	100%
SID	13	0	100%
STAR	26	0	100%

The Company passed Standard 5

UTILIZATION REVIEW

Tests for Utilization Review

Standard 1
The health carrier establishes and maintains a utilization review program in compliance with statutes, rules, and regulations.

MEGA Life and Health Insurance Company discontinued requiring its insureds to participate in a prospective or retrospective Utilization Review Program.

CLAIM HANDLING

Company Claim Processing Procedures:

MEGA markets a portfolio of traditional indemnity and PPO health insurance products to self-employed individuals in 43 states and the District of Columbia. The traditional indemnity health insurance products are designed to limit coverage to the occurrence of significant events requiring hospitalization. However, each policy offers coverage modifications so the insurance may be tailored to meet the individual policyholder's needs. Overall, the health insurance products are primarily issued to members of various independent associations that endorse the products, such as the National Association for the Self-Employed and the Alliance for Affordable Services. These claims are processed out of UICI's insurance Center in North Richland Hills, and this division is referred to as NRH.

Student Insurance Division (SID) markets health insurance coverage to students attending colleges and universities in the Kansas State University system. To a lesser extent, *MEGA* markets to students attending kindergarten through grade 12 in Kansas. These claims are processed in the Company's center in Oklahoma City.

The STAR Division markets and administers limited benefit plans, such as medical, life, disability and dental, for entry level, high turnover, hourly employees. *MEGA's* clientele includes a number of corporate clients with locations through out Kansas. These claims are processed in STAR's Division offices in Phoenix AR.

Tests for Claims (See Appendix I for the wording of the appropriate statute or regulation)

Standard 1
The initial contact by the company with the claimant is within the required time frame. K.A.R. 40-1-34, 6(a)(d) and K.S.A. 40-2442, (a)(1)(2), (b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	0	100%
Paid	50	0	100%
Total SID	100	0	100%

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	0	100%
Paid	45	0	100%
Total STAR	91	0	100%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	5	95%
Paid	100	17	83%
Total NRH	200	22	89%

- There were twenty two claims from the NRH division, where the claim was not acknowledged with in 10 working days per K.A.R. 40-1-34, 6(a).

SID and STAR passed Standard 1. NRH failed Standard 1.

Standard 2
Investigations are conducted in a timely manner. K.A.R. 40-1-34, Sections 7, 8(c) and K.S.A. 40-2442, (a)(1)(2), (b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	9	54%
Paid	50	3	94%
Total SID	100	12	88%

The twelve items that failed for the SID Division were all the result of the company pending the claim till they received notification from the school that the individual was eligible for the plan. This is a violation of K.S.A. 40-2442, (a)(1)(2).

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	1	98%
Paid	45	1	98%
Total STAR	91	2	98%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	0	100%
Paid	100	3	97%
Total NRH	200	3	99%

NRH and STAR passed Standard 2. SID failed Standard 2.

Standard 3

Claims are resolved in a timely manner. K.A.R. 401-34, 8(a)(c) and K.S.A. 40-2442, (a)(1)(2), (b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	8	84%
Paid	50	9	74%
Total SID	100	17	83%

There were sixteen claims for the SID Division that were not adjudicated within 30 days per K.S.A. 40-2442, (a)(1)(2).

There was one claim for the SID Division that was denied as duplicate and later paid. K.A.R. 40-1-34, 5(a).

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	4	91%
Paid	45	11	76%
Total Star	91	15	84%

- Five STAR Division claims were not adjudicated within 30 days. Per K.S.A. 40-2442 (a)(1)(2).

- Nine STAR Division claims were not adjudicated within 15 days after receipt of additional requested information. Per K.S.A. 40-2442, (d).

- One claim requested additional information, there was no additional activity and denied 87 days later. There was no additional contact or activity by the company. K.A.R. 40-1-34, 8(c).

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	10	90%
Paid	100	13	87%
Total NRH	200	23	88%

-One No Payment claim was not adjudicated within 15 days after receipt of additional requested information. Per K.S.A. 40-2442, (d).

-Nine No Payment claims were not adjudicated within 30 days. Per K.S.A. 40-2442 (a)(1)(2).

-Thirteen Paid claims were not adjudicated within 30 days. Per K.S.A. 40-2442 (a)(1)(2).

All Three divisions fail Standard 3.

Standard 4

The company responds to claim correspondence in a timely manner. K.A.R. 40-1-34 6(a)(d) and K.S.A. 40-2442, (a)(1)(2), (b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	0	100%
Paid	50	0	100%
Total SID	100	0	100%

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	0	100%
Paid	45	0	100%
Total STAR	91	0	100%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	0	100%
Paid	100	0	100%
Total NRH	100	0	100%

The company passed this Standard.

Standard 5

Claim files are adequately documented. K.A.R.40-1-34, Sections 4, 6(a), 8(b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	0	100%
Paid	50	1	98%
Total SID	100	1	99%

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	0	100%
Paid	45	3	91%
Total STAR	91	3	97%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	0	100%
Paid	100	0	100%
Total NRH	100	0	100%

The company passed this Standard.

Standard 6

Claims are properly handled in accordance with policy provisions HIPA and state law. K.A.R. 40 -1-34, Sections 5(a), 8, 9, K.S.A. 40-3110, K.S.A. 40-2,126 and K.S.A. 40-2442, (a)(1)(2), (b).

SID Division

Type	Sample	Errors	%Pass
No Payment	50	1	99%
Paid	50	2	96%
Total SID	100	3	97%

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	1	98%
Paid	45	1	98%
Total STAR	91	2	98%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	0	100%
Paid	100	0	100%
Total NRH	100	0	100%

The company passed this Standard.

Standard 7

Company claim forms are appropriate for the type of product.

SID Division

Type	Sample	Errors	%Pass
No Payment	50	0	100%
Paid	50	0	100%
Total SID	100	0	100%

STAR Division

Type	Sample	Errors	%Pass
No Payment	46	0	100%
Paid	45	5	89%
Total STAR	91	5	95%

NRH Division

Type	Sample	Errors	%Pass
No Payment	100	0	100%
Paid	100	0	100%
Total NRH	100	0	100%

The STAR Division indicated that prior to 11/02 their former Underwriter, CNA required a completed claim form. This was requested even though the provider submitted a completed HCFA form. The company has since changed its claim handling practices.

There were five claims during this time frame that were filed with a completed HCFA form and STAR still required the insured to complete claim form before the claim would be processed. This is a violation of K.S.A. 40-2253.

Standard 9

Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPPA and state law. K.A.R. 40- 1-34, 8(a)(b)(c).

The company passed this test.

Standard 10

Canceled benefit checks and drafts reflect appropriate claim handling practices.

The exam team did not specifically test for this Standard.

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. K.S.A. 40-2404, 9(f)(g).

The exam team did not specifically test for this Standard.

Standard 12

The company complies with the requirements of The NewBorns' and Mothers' Health Protection Act of 1996. K.S.A. 40-2,102.

The exam team did not specifically test for this Standard. In the normal review of the three division claims, any maternity claims would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 13

The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA). KSA 40-2,105a.

The exam team did not specifically test for this Standard. In the normal review of the three division claims, any mental health claims would have been reviewed and the examiner would have noted it. There were 2 SID claims that were referred back to the company to reprocess per K.S.A. 40-2,105a.

Recommendations:

1. The SID Division must submit a plan to KID within 30 days detailing how they are going to receive enrollment information from the schools in a timely manner to insure the prompt adjudication of claims for students enrolled at a particular school that is participating in the SID program.

Mega has indicated that since the on-site exam portion they have implemented extensive changes to the processes and procedures used by SID's Premium accounting Department. SID believes that these changes regarding enrollment information will ensure the prompt adjudication of claims for student enrolled at schools covered by MEGA policies

2. NRH needs to be more consistent in sending acknowledgement letters to consumers if they are unable to resolve the claim within the first ten working days of receipt of the claim.

MEGA's has indicated since the on-site exam portion they have implemented program changes in which an acknowledgement letter is generated regardless of he status of the claim unless the claim has already been paid or denied.

3. MEGA needs to review their claim procedures to insure that claims are being processed in a timely fashion. This would include both the processing of a clean claim within 30 days and the final adjudication of a claim with in 15 days after the required information is received per K.S.A. 40-2442, (a)(1)(2).

4. MEGA needs to review their claim procedures to insure that claims that are not processed with in the time lines specified in the Prompt Pay Act, K.S.A. 40-2442, have interest paid according to K.S.A. 40-2442, (b).

GENERAL COMMENTS

Complaint Handling

1. The company needs to review its consumer complaint and grievance procedures with all Divisions to guarantee uniform compliance in communicating with insured persons and to avoid violating company business standards. Acknowledgement letters should be sent within three days and written decisions should be clearly explained and sent to the insured person within 30 days. *Several divisions have acknowledged efforts* to comply with these procedures.

2. One of the requirements for complaint and grievance records is to explain the disposition of each complaint. All data contained on the complaint register must be accurate and reflect the facts of each complaint. The company needs to review the use of disposition form and freelance letters to determine uniformity and compliance with Kansas statutes. *The Consumer Affairs Department has indicated that they have instituted 16 additional disposition codes to better explain the disposition of each complaint. This enhancement was implemented 1/1/04.*

Marketing and Sales

1. Within 30 days Mega must review their advertising procedures to insure that they are complying with Article 9, Advertising, of the Kansas Administrative Regulations.

2. Within 30 days, MEGA must complete the filing of the "Starbridge Employer Trust" filing with all the variable plan options along with the rate manual for these options per K.S.A. 40-216 and K.S.A. 40-2215(b). *MEGA has advised KID's A&H Division that there were no active accounts as of March 2005 and filed the seven options as being "Filed for Informational Purposes"*.

3. Within 30 days MEGA must present to KID a plan to monitor the distribution of their advertising materials including how many times an ad is requested for use by an agent and the manner in which the ad will be distributed to the consumers per K.A.R. 40-9-100, Section 17(A).

Claims

1**.** The SID Division must submit a plan to KID within 30 days detailing how they are going to receive enrollment information from the schools in a timely manner to insure the prompt adjudication of claims for students enrolled at a particular school that is participating in the SID program.

Mega has indicated that since the exam they have implemented extensive changes to the processes and procedures used by SID's Premium accounting Department. SID believes that these changes regarding enrollment information will ensure the prompt adjudication of claims for student enrolled at schools covered by MEGA policies

2. NRH needs to be more consistent in sending acknowledgement letters to consumers if they are unable to resolve the claim within the first ten working days of receipt of the claim.

MEGA's has indicated since the exam they have implemented program changes in which an acknowledgement letter is generated regardless of the status of the claim unless the claim has already been paid or denied.

3. MEGA needs to review their claim procedures to insure that claims are being processed in a timely fashion. This would include both the processing of a clean claim within 30 days and the final adjudication of a claim with in 15 days after the required information is received per K.S.A. 40-2442, (a)(1)(2).

4. MEGA needs to review their claim procedures to insure that claims that are not processed with in the time lines specified in the Prompt Pay Act, K.S.A. 40-2442, have interest paid according to K.S.A. 40-2442, (b).

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by the Ms. Susan Johnson and the staff of The MEGA Life and Health Insurance Co.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Lyle Behrens Supervisor	Michael Grover Market Conduct Examiner	Mary Lou Maritt Market Conduct Examiner	Stacy Rinehart Market Conduct Examiner

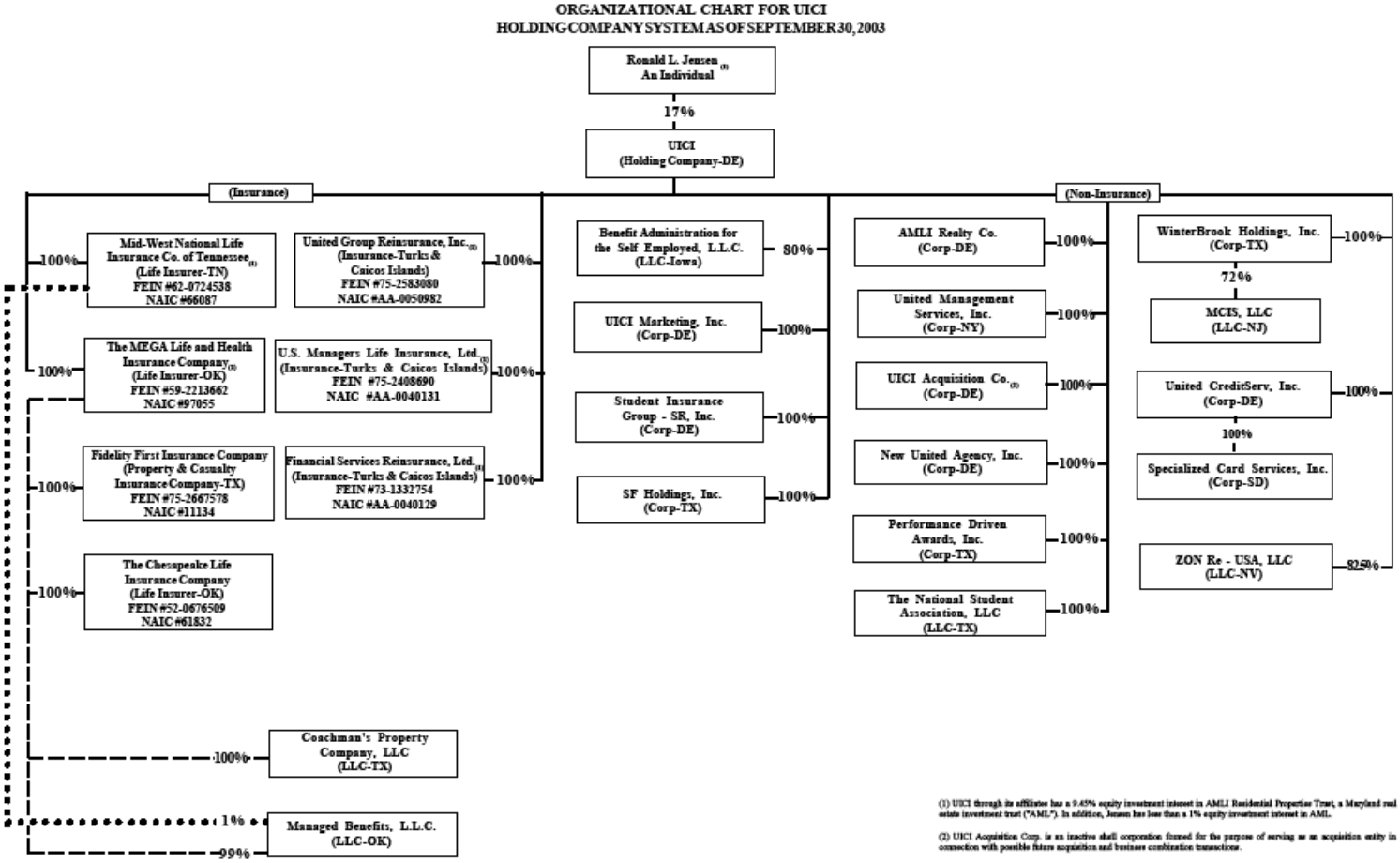
Accident & Health Division

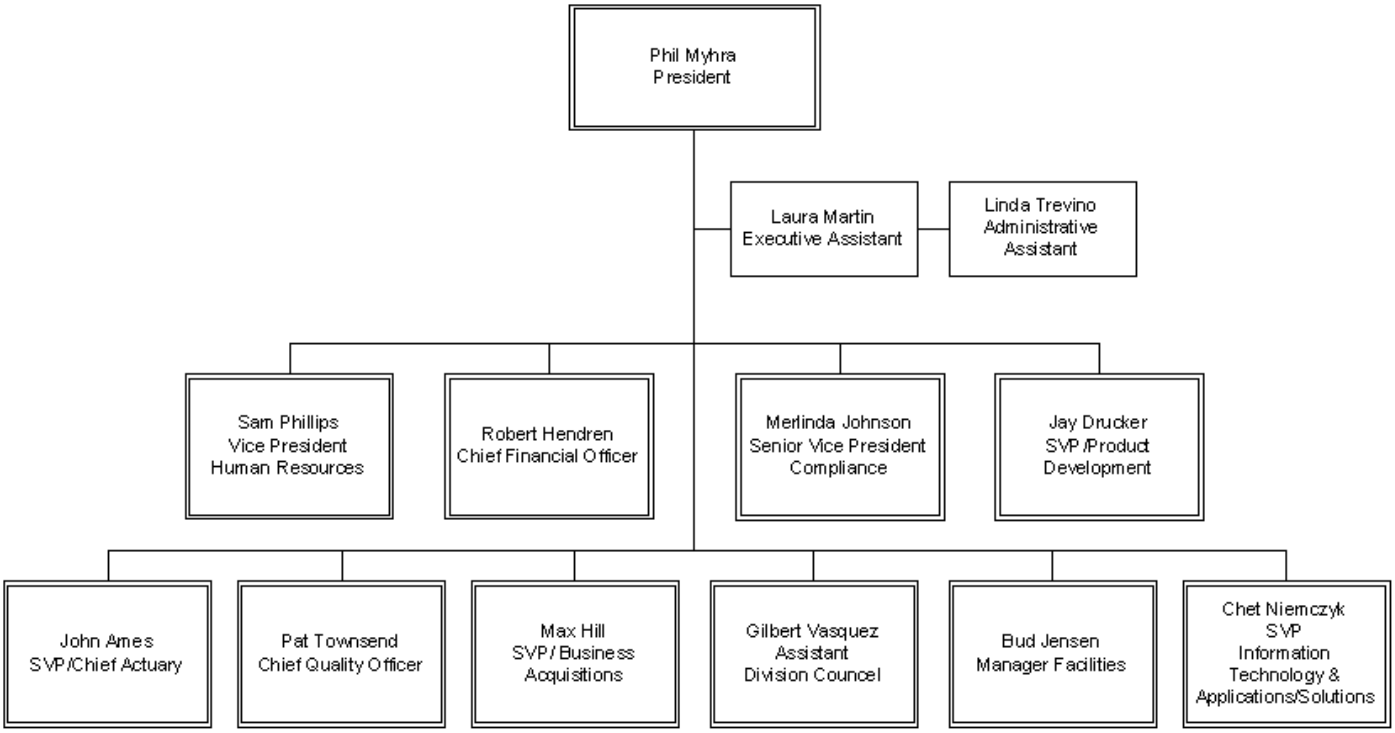
Mark McClaflin Policy Examiner	Barbara Torkelson Policy Examiner

Respectfully submitted,

_____

Lyle Behrens, CPCU, CIE, ARM


ORGANIZATIONAL CHART FOR UICI
HOLDING COMPANY SYSTEM AS OF SEPTEMBER 30, 2003
Ronald L. Jensen (1)
An Individual
17%
UICI
(Holding Company-DE)
(Insurance)
(Non-Insurance)
100%
Mid-West National Life Insurance Co. of Tennessee (1)
(Life Insurer-TN)
FEIN #62-0724538
NAIC #66087
United Group Reinsurance, Inc. (2)
(Insurance-Turks & Caicos Islands)
FEIN #75-2583080
NAIC #AA-0050982
100%
100%
The MEGA Life and Health Insurance Company (1)
(Life Insurer-OK)
FEIN #59-2213662
NAIC #97055
U.S. Managers Life Insurance, Ltd. (2)
(Insurance-Turks & Caicos Islands)
FEIN #75-2408690
NAIC #AA-0040131
100%
100%
Fidelity First Insurance Company
(Property & Casualty Insurance Company-TX)
FEIN #75-2667578
NAIC #11134
Financial Services Reinsurance, Ltd. (1)
(Insurance-Turks & Caicos Islands)
FEIN #73-1332754
NAIC #AA-0040129
100%
100%
The Chesapeake Life Insurance Company
(Life Insurer-OK)
FEIN #52-0676509
NAIC #61832
100%
Coachman's Property Company, LLC
(LLC-TX)
1%
99%
Managed Benefits, L.L.C.
(LLC-OK)
Benefit Administration for the Self Employed, L.L.C.
(LLC-Iowa)
80%
UICI Marketing, Inc.
(Corp-DE)
100%
Student Insurance Group - SR, Inc.
(Corp-DE)
100%
SF Holdings, Inc.
(Corp-TX)
100%
AMLI Realty Co.
(Corp-DE)
100%
United Management Services, Inc.
(Corp-NY)
100%
UICI Acquisition Co. (2)
(Corp-DE)
100%
New United Agency, Inc.
(Corp-DE)
100%
Performance Driven Awards, Inc.
(Corp-TX)
100%
The National Student Association, LLC
(LLC-TX)
100%
WinterBrook Holdings, Inc.
(Corp-TX)
100%
72%
MCIS, LLC
(LLC-NJ)
United CreditServ, Inc.
(Corp-DE)
100%
100%
Specialized Card Services, Inc.
(Corp-SD)
ZON Re - USA, LLC
(LLC-NV)
82.5%
(1) UICI through its affiliates has a 9.45% equity investment interest in AMLI Residential Properties Trust, a Maryland real estate investment trust ("AML"). In addition, Jensen has less than a 1% equity investment interest in AML.
(2) UICI Acquisition Corp. is an inactive shell corporation formed for the purpose of serving as an acquisition entity in connection with possible future acquisition and business combination transactions.


Phil Myhra
President
Laura Martin
Executive Assistant
Linda Trevino
Administrative
Assistant
Sam Phillips
Vice President
Human Resources
Robert Hendren
Chief Financial Officer
Merlinda Johnson
Senior Vice President
Compliance
Jay Drucker
SVP /Product
Development
John Ames
SVP/Chief Actuary
Pat Townsend
Chief Quality Officer
Max Hill
SVP/ Business
Acquisitions
Gilbert Vasquez
Assistant
Division Councel
Bud Jensen
Manager Facilities
Chet Niemczyk
SVP
Information
Technology &
Applications/Solutions

APPENDIX I

A. -K.A.R. 40-1-34 - Unfair claims practices provides for the following guidelines to be met in the processing and investigation and settlement/denial of a claim:
   -Definitions, Sec. 3
   -File and Record Documentation, Sec. 4
   -Misrepresentation of Policy Provisions, Sec. 5
   -Failure to Acknowledge to Pertinent communication, Sec. 6
   -Standards for Prompt Investigation of Claims, Sec. 7
   -Standards for Prompt, Fair and Equitable Settlements Applicable to all Insurers, Sec. 8
   -Standards for Fair and Equitable Settlements Applicable To Auto Insurance, Sec. 9

-Kansas Automobile Injury Reparations Act (Payment of Benefits). K.S.A. 40-3110
-Unfair methods of competition or unfair and deceptive acts or practices. K.S.A. 40-2404
-Kansas Prompt Pay Act. K.S.A. 40-2442
-Interest Due On Insurance Settlements. K.S.A. 40-2,126

1. K.A.R. 40-1-34, Sec. 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in section 2 of the Unfair Trade Practice Act shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insure with respect to a claim;

(b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(c) "First party claimant" means an individual, corporation, association, or partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State.

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

(f) "Notification of claim" mean any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) "Worker's Compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

2. K.A.R. 40-1-34, Sec. 4 - File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his/her 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.

3. K.A.R. 40-1-34, Sec. 5. Misrepresentation of Policy Provisions

(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 sin 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.

4. K.A.R. 40-1-34, Sec. 6 - Failure to Acknowledge Pertinent Communications:

(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 acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement 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.

5. K.A.R. 40-1-34, Sec. 7 - Failure to Acknowledge Pertinent Communications

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

6. K.A.R. 40-1-34, Sec. 8 - Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(b) If a claim is denied for reasons other than those described in paragraph (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(f) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(g) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

B. K.S.A. 40-2404. Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies.* Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.

(3) *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) *Boycott, coercion and intimidation.* Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) *False statements and entries.* (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.

(7) *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for

any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(d) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for accident and health and life insurance to an applicant who is the proposed insured or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse, except as provided in subpart (v). "Abuse" as used in this subsection (7)(d) means one or more acts defined in subsection (a) or (b) of K.S.A. 60-3102 and amendments thereto between family members, current or former household members, or current or former intimate partners.

(i) An insurer may not ask an applicant for life or accident and health insurance who is the proposed insured if the individual is, has been or may be the subject of domestic abuse or seeks, has sought or had reason to seek medical or psychological treatment or counseling specifically for abuse, protection from abuse or shelter from abuse.

(ii) Nothing in this section shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is, has been or has the potential to be the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy.

(iii) No insurer that issues a life or accident and health policy to an individual who is, has been or may be the subject of domestic abuse shall be subject to civil or criminal liability for the death or any injuries suffered by that individual as a result of domestic abuse.

(iv) No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same

coverage solely because of physical or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles.

(v) Nothing in this section shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition has been caused by abuse, provided that:

(A) The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse;

(B) the fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and

(C) such underwriting or rating is not used to evade the intent of this section or any other provision of the Kansas insurance code.

(vi) Any person who underwrites or rates a risk on the basis of preexisting physical or mental condition as set forth in subsection (7)(d)(v), shall treat such underwriting or rating as an adverse underwriting decision pursuant to K.S.A. 40-2,112, and amendments thereto.

(vii) The provisions of subsection (d) shall apply to all policies of life and accident and health insurance issued in this state after the effective date of this act and all existing contracts which are renewed on or after the effective date of this act.

(8) *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *Failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) *Misrepresentation in insurance applications.* Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) *Statutory violations.* Any violation of any of the provisions of K.S.A. 40-276a, 40-1515 or K.S.A. 40-2,155 and amendments thereto.

(13) *Disclosure of information relating to adverse underwriting decisions and refund of premiums.* Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the time prescribed in such section.

(14) *Rebates and other inducements in title insurance.* (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of

value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in (14)(a).

(c) Nothing in this section shall be construed as prohibiting:

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

(e) No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.

(f) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) 20% or more of the gross operating revenue of that title insurer or title agent during the six full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.

(g) The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* (a) No person shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with and not more restrictive than the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation".

(b) Any rules and regulations adopted by the commissioner which implement article V of the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation" shall become effective on and after February 1, 2002.

(c) Nothing in this paragraph (15) shall be deemed or construed to authorize the promulgation or adoption of any regulation which preempts, supersedes or is inconsistent with any provision of Kansas law concerning requirements for notification of, or obtaining consent from, a parent, guardian or other legal custodian of a minor relating to any matter pertaining to the health and medical treatment for such minor.

C. K.S.A. 40-2442 Same; claims; procedures; rules and regulations.

(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

(c) After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not

reasonably possible to give such information within such time, provided such proof is furnished as soon as possible as defined (within the time prescribed) in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.

(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.

(e) The provisions of subsection (b) shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently.

(f) Any violation of this act by an insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions of this act or with such frequency as to constitute a general business practice shall be considered a violation of the unfair trade practices act in K.S.A. 40-2401 et seq. and amendments thereto.

(g) The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of the Kansas health care prompt payment act.

D. K.S.A. 40-2,126. Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.