OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER

August 21, 2002

JOHN W. OXENDINE
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

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FLOYD BUILDING
2 MARTIN LUTHER KING, JR., DRIVE
ATLANTA, GEORGIA 30334
(404) 656-2056 TDD# (404) 656-4031
www. gainsurance.org

VIA CERTIFIED MAIL - 7001 0360 0000 5302 9451
RETURN RECEIPT REQUESTED

James Harold Chandler, President
UNUMProvident Corporation
1 Fountain Square, Floor 6 North
Chattanooga, TN 37402-1330

Re: Report of Market Conduct Examination as of November 30, 2000
UNUM Life Insurance Company of America
The Paul Revere Life Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Casualty Insurance Company

Dear Mr. Chandler:

This proposed examination report is being transmitted to you in accordance with O.C.G.A. § 33-2-14(c).

Furnishing of this examination report under O.C.G.A. § 33-2-14 in no way limits the authority, responsibility, or rights of the Georgia Insurance Department under any other code section of Title 33.

If you have any questions, please call me at (404) 651-6825.

Sincerely,

Donald F. Roof

Donald F. Roof, CFE
Director, Regulatory Services Division
Georgia Department of Insurance

DFR/dp

Cc: Chief Deputy Commissioner Justin K. Durrance

Office of Commissioner of Insurance

JOHN W. OXENDINE

REPORT OF THE TARGET MARKET CONDUCT EXAMINATION OF

UNUM LIFE INSURANCE COMPANY OF AMERICA

THE PAUL REVERE LIFE INSURANCE COMPANY

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

PORTLAND, MAINE

AS OF NOVEMBER 30, 2000

HUFFTHOMAS

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OFFICE OF
INSURANCE AND SAFETY FIRE COMMISSIONER

JOHN W. OXENDINE
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

August 24, 2001

SEVENTH FLOOR, WEST TOWER
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ATLANTA, GEORGIA 30334
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Honorable John W. Oxendine
Commissioner of Insurance
Georgia Department of Insurance
Seventh Floor, West Tower
2 Martin Luther King Jr. Drive
Atlanta, Georgia 30334

Dear Commissioner Oxendine:

Pursuant to your authority delegated under the provisions of the Official Code of Georgia Annotated O.C.G.A. § 33-2-11 and in accordance with your instructions, a target market conduct examination of the business practices and affairs has been conducted on:

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

The Paul Revere Life Insurance Company
18 Chestnut Street
Worchester, Massachusetts 01608-1528

Provident Life and Accident Insurance Company
1 Fountain Square
Chattanooga, Tennessee 37402-1330

and

Provident Life and Casualty Insurance Company
1 Fountain Square
Chattanooga, Tennessee 37402-1330

hereinafter referred to as "UNUM," "PRLIC," "PLAIC" and "PLCIC," respectively, or "UNUMProvident Companies" or the "Company" collectively. The examination was conducted at the primary location of the books and records of each company as listed above. The report on examination is herewith respectfully submitted.

SCOPE OF EXAMINATION

This target market conduct examination of the Company covered the period from January 1, 1999 through November 30, 2000 and included a review of material events which occurred subsequent to the examination date and noted during the examination.

This examination was conducted pursuant to the provisions of O.C.G.A. § 33-2-11 and in accordance with procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners (NAIC) and/or consistent with the predetermined market conduct program presented to and approved by the Georgia Department of Insurance (Department).

The purpose of this market conduct examination was to determine the Company's ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with specified sections of the Georgia Insurance Code and Regulations and the procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners. This report is confined to comments on matters which involve departures from laws, regulations or rules or which are deemed to require special explanation or description.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures were performed in each phase:

1. A maximum sample size was calculated for each population of files to be tested using a formula with a 95% confidence level and $\pm$ 5% error rate.

2. Random file numbers, equal to the maximum sample size were generated, using ACL software, to select the files for review from each population listing provided by the Company.

3. A portion of each maximum size sample of random numbers generated was selected for initial review.

4. The Company's procedural manuals and/or memoranda were evaluated and each file was then reviewed with the results of testing for various attributes recorded in the examination workpapers.

5. The Company responded to a series of questions or written inquiries regarding the results of the files being examined.

This examination was comprised of the following three phases:

Company Operations and Management
Complaints
Claims Practices

COMPANY OPERATIONS AND MANAGEMENT

HISTORY

Company Operations and Management Standard # 1 – *Prepare a history/profile of the company.*

UNUM Life Insurance Company of America

UNUM Life Insurance Company of America was incorporated under the laws of the State of Maine on August 24, 1966 and commenced business on September 3, 1966 as Community Life Insurance Company; the present title was adopted in 1986. UNUM is a continuation of the Unionmutual Stock Life Insurance Company.

The Paul Revere Life Insurance Company

The Paul Revere Life Insurance Company was incorporated under the laws of the Commonwealth of Massachusetts on June 10, 1930 and commenced business July 10, 1930. On March 27, 1997, Provident Companies, Inc. acquired the Paul Revere Corporation.

Provident Life and Accident Insurance Company

Provident Life and Accident Insurance Company was incorporated under the laws of the State of Tennessee on May 24, 1887, as a stock company and commenced business May 25, 1887.

Provident Life and Casualty Insurance Company

Provident Life and Casualty Insurance Company incorporated under the laws of the State of Tennessee on October 17, 1951 and commenced business on January 1, 1952. PLCIC is a New York marketing arm of the UNUMProvident Corporation.

The Companies' boards of directors each consisted of six members, the same for all companies, for the period under examination, as reported in the annual statements as of December 31, 1999 and 2000, and were as follows:

James Harold Chandler	Floyd Dean Copeland	James Leander Moody, Jr.
Elaine Debra Rosen	Burton Erhard Sorensen	Thomas Ros Watjen

There were four major officers who managed the operations of each Company, consisting of the same officers, for the period under examination as reported in the annual statements as of December 31, 1999 and 2000 as follows:

James Harold Chandler	Chairman, President and Chief Executive Officer
Floyd Dean Copeland	Executive Vice President
Elaine Debra Rosen	Executive Vice President
Thomas Ros Watjen	Executive Vice President

PROFILE

On June 30, 1999 Provident Companies, Inc. and UNUM Corporation merged creating the ultimate parent UNUMProvident Corporation. UNUMProvident Corporation also owns Genex Services, Inc., which provides claim medical and investigative support to its affiliated insurance companies.

The Company is initiating a marketing campaign to bring all products under the UNUM brand name. Individual disability products are distributed through independent insurance brokers and agents, marketing agreements with other insurance companies, associations and financial institutions. Employee benefits products are distributed through brokers, benefits consultants, and a direct sales force.

UNUM Life Insurance Company of America

UNUM is licensed in the District of Columbia, Puerto Rico and all states except New York and specializes in group disability (long-term and short-term), individual disability, individual and group long-term care, group life, and group accidental death and dismemberment. Its products are marketed through the independent agency system, which consists of agents and brokers contracted through general agents, as well as direct marketing through association groups and employer groups.

The Paul Revere Life Insurance Company

PRLIC was incorporated as a stock company and is authorized to write both life and health insurance in all fifty states, the District of Columbia and Canada. Disability insurance is the primary product line. PRLIC also markets individual life insurance, group life and dental insurance, and annuity products.

Provident Life and Accident Insurance Company

PLAIC is authorized to write both life and health insurance in all fifty states, the District of Columbia and Canada. Disability insurance is the Company's primary product line. It also markets individual life insurance, group life and dental insurance, and annuity products.

Provident Life and Casualty Insurance Company

PLCIC is a New York marketing arm of the UNUMProvident Corporation, which has focused its activities in the individual disability income market and offers the same

products as its affiliate, Provident Life and Accident Insurance Company. It is licensed to write business in the District of Columbia and thirty-one states including New York.

RECORDS ACCESSIBILITY

Company Operations and Management Standard # 2 – *Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. O.C.G.A. § 33-2-13.*

During this examination, certain deficiencies were noted within the records of the Company as follows:

- The Company's claim systems include a locator field which is intended to designate the adjustor and physical site of the claim file. It was determined this field was not always accurate.
- The Company is lacking controls in its electronic software systems. It was determined the various claims systems allowed for one claim to be entered multiple times which required the closing of claim records to eliminate the duplicate entries. This resulted in errors in reported claims opened and closed for the period under examination.
- Certain claim files did not include pertinent documentation regarding insurance coverage and/or policy information. The Company's claims procedures stipulate this documentation is to be included in the claim file.
- It was determined the Company does not routinely date stamp documentation received.

Due to the 1999 merger, the UNUMProvident companies have initiated a functional integration of key operating areas, including underwriting and claim processing, across companies and across product lines. Three integrated sites for claim processing were created in Portland, Maine; Chattanooga, Tennessee; and Glendale, California. Processing in Worcester, Massachusetts will be utilized for individual stand-alone policies only. The Company has represented this integration focuses upon an impairment based model which allows its claims professionals to be in a better position to know the issues in greater depth and to better assess vocational, medical and other factors of a specific disability.

The Company stated it maintains its records for seven years.

Due to the deficiencies noted, the Company violated O.C.G.A. § 33-2-13 (a).

UNUM Life Insurance Company of America

Certain deficiencies specific to UNUM were noted as follows:

- The Company did not include all pertinent documentation within its complaint files. For certain files, correspondence relating to the complaint was maintained in the policy and/or claim file.

- The Company was unable to locate four files from a total sample of 100 claim files selected for review by this examination.

Due to the deficiencies noted above, UNUM was in violation of O.C.G.A. § 33-2-13 (a).

The Paul Revere Life Insurance Company

Certain deficiencies specific to PRLIC were noted as follows:

- The Company did not include all pertinent documentation within its complaint files. For certain files, correspondence relating to the complaint was maintained in the policy and/or claim file.
- The Company was unable to locate two files from a total sample of 104 claim files selected for review by this examination.

Due to the deficiencies noted above, PRLIC was in violation of O.C.G.A. § 33-2-13 (a).

Provident Life and Accident Insurance Company

Certain deficiencies specific to PLAIC were noted as follows:

- The Company did not include all pertinent documentation within its complaint files. For certain files, correspondence relating to the complaint was maintained in the policy and/or claim file.
- The Company was unable to locate two files from a total sample of 112 claim files selected for review by this examination.
- The Company was unable to locate the claim file for one litigation file reviewed by this examination.

Due to the deficiencies noted above, PLAIC was in violation of O.C.G.A. § 33-2-13 (a).

Provident Life and Casualty Insurance Company

No deficiencies specific to PLCIC were noted.

Company Operations and Management Standard # 3 – *The insurance company cooperates on a timely basis with examiners performing the examination. O.C.G.A. §§ 33-2-11, 33-2-12 and 33-2-13.*

An initial request for information was provided to the Company prior to the commencement of the on-site examination testing and review. The majority of this information was not available upon arrival by the examination staff. The Company had provided copies of all complaint files for the period under examination; during the review of these documents, it was noted referenced documents and/or correspondence were not included.

Concurrently, the Company initiated discussions with the Department regarding documents deemed to be attorney/client privileged and confidential. The Company indicated to the examination staff claim and litigation files would not be delivered until the confidentiality issue was resolved, which resulted in delays to the examination process.

On February 22, 2001, the Company became the subject of an Order Compelling the Production of Records, Books, Papers, and Other Documents which required the Company's compliance with the provisions of O.C.G.A. §§ 33-2-11 and 33-2-13. Subsequently, on February 28, 2001, the Company and the Department reached an agreement on a process for the identification and recording of documents deemed to be privileged and confidential.

The examination noted continual delays in obtaining requested information as follows:

- The Company did not provide data files containing claim data information for the period under examination until June of 2001 for UNUM and PLAIC and May of 2001 for PRLIC and PLCIC. Additionally, the information as of December 31, 1999 was not reconciled to the reported data on the 1999 Georgia State Page. The data files and reconciliation had been requested in December of 2000. The Company represented it ran queries on its current claims database systems as year-end historical data was not maintained; subsequently, the Company retracted this representation and stated year-end files were created and maintained. The Company had not reloaded its year-end files onto the computer systems to generate the requested data files.
- As noted above, the Company was not able to readily provide a reconciliation of the claims data files to the amounts reported on the 1999 Georgia State Page. The Company represented this type of request was unusual for a market conduct examination and required multiple steps to accomplish the task. Through discussions with the financial reporting personnel of the Company, the examiners determined the Company does routinely perform such reconciliations of the general ledger to the claims systems at the appropriate time, such as December 31. As the Company had utilized multiple queries on its database systems, which utilized current information, the Company was required to perform additional reconciliation processes.
- The Company did not provide complete files for the review of claim and litigation files. It was determined certain documentation relating to the Company's litigation files were maintained by external counsel. Delays were encountered in obtaining such information for review by this examination.
- The Company referred certain inquiries relating to litigation files to external counsel. This resulted in delays in obtaining such responses and applicable supporting documentation.
- The Company provided a letter of representation, which was significantly modified from the sample provided by this examination.

The Company was in violation of O.C.G.A. § 33-2-13(a) as it did not make requested documents readily accessible to this examination.

COMPLAINTS

COMPANY COMPLAINT PRACTICES AND PROCEDURES

The Company has policies and procedures in place for Consumer Complaint handling. The Company defines a complaint as any written communication primarily expressing a grievance. These communications may come from an insurance department, policyholder, applicant, insured, claimant or intermediary. The Company has chosen to track certain oral communications when an individual has telephoned the Customer Relations Unit directly to file a formal complaint or calls a senior officer directly with a grievance about their insurance contract.

A Customer Relations Coordinator located in Portland, Maine, processes complaints. When the complaint comes in it is date stamped, a response due date is determined, the area(s) involved with the dispute is notified by e-mail or telephone and a Consumer Action Notice (CAN) is completed. A complaint number is assigned and the complaint is logged into the tracking system. The complaint is forwarded to the Complaint Resolver for response.

For non-insurance department complaints, an acknowledgement letter to the complainant is prepared on the appropriate company stationery and is sent under the signature of an officer or Customer Relations Coordinator.

Within 24 hours of receipt by Customer Relations, the complaint is mailed to the appropriate Complaint Resolver for resolution. A Complaint Resolver represents each business unit within the insurance company. The Complaint Resolver is responsible for researching and responding to the complaint within the required time. If a complaint has been forwarded to a Complaint Resolver and the insured has filed a lawsuit, the Complaint Resolver immediately notifies the Customer Relations Coordinator and forwards the complaint directly to the Legal Department.

The Company responds to complaints filed with state departments of insurance in accordance with applicable state regulations. The Complaint Resolver is responsible for providing a reply within the specified time. The Company procedures indicate a response to a non-insurance department complaint is required within ten business days from the initial day the letter is received at the Company. If the Complaint Resolver is unable to reply to a state insurance department within the required period, the Resolver must contact the Customer Relations Coordinator, in Portland, Maine, at least two days before the due date. The Customer Relations Coordinator will contact the insurance department, request an extension and notify the Resolver of the new due date.

For an oral complaint received by the Customer Relations Unit, the call is documented and forwarded to the appropriate Complaint Resolver immediately. A return call from the Complaint Resolver is required within 24 hours from receipt of the call. A written response is required ten business days from receipt of the call, if appropriate.

The Company has an appeals process in place for claimants that would like to appeal a denial.

The Company provided listings and copies of the non-insurance and State Department of Insurance complaints for January 1 through December 31, 1999 and January 1 through November 30, 2000. All long-term disability complaints for this period were reviewed.

COMPANY COMPLAINT REGISTER

Complaint Handling Standard # 1 – *The complaints are recorded in the required format on the company complaint register.*

The Company maintains an automated complaint register by state. The complaint register was provided, which identified all complaints received relating to residents of the State of Georgia for the period under examination. Only long-term disability complaints, both group and individual, were reviewed and compared to the listing from the Georgia Department of Insurance. The Company's complaint register identifies the complaint number, justified complaint, insured name, complainant name, policyholder name, policy number, insurance department file number, source, division, department, date received, date responded, number of days, nature of complaint and resolution.

UNUM Life Insurance Company of America

UNUM did not list or provide the file for one complaint included in the records of the Department. The records of the Department indicated a claimant had appealed UNUM's decision and had provided a copy of the appeal to the Department. UNUM represented it did not consider the appeal letter to be a complaint and, therefore, had not established a complaint file. The records of the Department did not indicate any action had been required.

The Paul Revere Life Insurance Company

No exceptions were noted during the review of PRLIC's complaint register.

Provident Life and Accident Insurance Company

PLAIC did not produce a file for one complaint included in the records of the Department. In response to an examination inquiry, PLAIC identified a claim associated with a long-term disability policy for the named complainant. No records of communications with the Department on this claim were identified by PLAIC. The Department's records indicated PLAIC's denial of a claim was upheld.

PLAIC was in violation of O.C.G.A. § 33-2-13.

Provident Life and Casualty Insurance Company

PLCIC had no complaints for the period under examination.

COMPLAINT RESOLUTION

Complaint Handling Standard # 2 – *The company took adequate steps to finalize and dispose of the complaints in accordance with applicable state laws and regulation and contract language. O.C.G.A. § 33-6-34.*

UNUM Life Insurance Company of America

UNUM took adequate steps to finalize and dispose of all complaints during this examination period.

The Paul Revere Life Insurance Company

PRLIC took adequate steps to finalize and dispose of all complaints during this examination period.

Provident Life and Accident Insurance Company

PLAIC took adequate steps to finalize and dispose of all complaints during this examination period.

Provident Life and Casualty Insurance Company

PLCIC had no complaints for the period under examination.

Complaint Handling Standard # 3 – *The complaint files are adequately documented. O.C.G.A. §§ 33-2-13 and 33-6-34.*

The Company's maintenance system on complaints lacks efficiency. Numerous files were not adequately documented. Inquiries were prepared to obtain additional information which should have been included in the completed complaint file; it was determined the information was maintained in the policy and/or claim file rather than the complaint file.

The Company was in violation of O.C.G.A § 33-2-13(a).

UNUM Life Insurance Company of America

UNUM provided copies of all complaints under examination as reported on its complaint registers. A sample of the copied documents was compared to the original complaint file. One exception was noted, the missing document was not significant.

The Paul Revere Life Insurance Company

PRLIC provided copies of all complaints under examination. A sample of the copied documents was compared to the original complaint file; no exceptions were noted.

Provident Life and Accident Insurance Company

PLAIC provided copies of all complaints under examination. A sample of the copied documents was compared to the original complaint file; no exceptions were noted.

Provident Life and Casualty Insurance Company

PLCIC had no complaints for the period under examination.

Complaint Handling Standard # 4 – *Assess reversals of the company's position.*

UNUM Life Insurance Company of America

Department of Insurance Complaints

A total number of 50 Commissioner Complaints were reviewed for the period of January 1, 1999 through November 30, 2000. Listed below are the results of this review. The results are broken down into 1) overall results and 2) denial results and are classified by the NAIC designation codes.

OVERALL RESULTS BASED ON REASON AND DISPOSITION CODE

Reason Code	Total Number	%
0805 - Premium and rating	1	2%
0810 - Refusal to insure	2	4%
1005 - Unsatisfactory settlement offer	1	2%
1015 - Denial of claim	26	52%
1020 - Coordination of benefits	2	4%
1025 - Delays	9	18%
1035 - Other (Claims handling)	7	14%
1120 - Other (Policyholder service)	1	2%
N/N - None noted	1	2%
Total	50	100%

There were 26 complaints for "Denial of Claim"; nine complaints filed were for "Delays"; seven were classified as "Other (Claims Handling)"; one fell into the classification of "Other (Policyholder Services)"; one was "Unsatisfactory

Settlement/Offer"; two were for "Refusal to Insure;" and one complaint was filed regarding "Premium and Rating." Two complaints involved coordination of benefits. The reason code for one complaint was not identified.

Disposition Code	Total Number	%
1205 - Policy issued/restored	1	2%
1208 - Compromised settlement-resolution	2	4%
1210 - Additional payment	2	4%
1230 - Claim settled	5	10%
1255 - Delays resolved	7	14%
1295 - Company position upheld	27	54%
1310 - Other	5	10%
N/N - None noted	1	2%
Total	50	100%

UNUM's position was upheld on 27 complaints. The claims were settled on five complaints, and two resulted in compromised settlement/resolution. The seven delays were resolved. Five complaints' dispositions were classified as "other." UNUM issued a policy for one complaint. Additional payments were made on two complaints. The disposition code for one complaint was not identified.

OVERALL RESULTS BASED ON UPHELD OR OVERTURNED DECISION

Original Position Upheld	Total Number	%
Yes	36	72%
No	8	16%
Not applicable	4	8%
None noted	1	2%
Open	1	2%
Total	50	100%

There were 36 complaints where UNUM upheld its position. The original position was not upheld on eight complaints. This attribute was not applicable on four complaints. This attribute was not identified on one complaint. UNUM is researching one complaint and a final determination had not been made.

OVERALL RESULTS BASED ON REQUEST FOR ADDITIONAL INFORMATION

Request for Additional Information	Total Number	%
Yes	27	54%
No	22	44%
Not applicable	1	2%
Total	50	100%

There were 27 complaints for which additional information was requested, and 22 complaints for which no additional information was requested. This attribute was not applicable for one complaint.

DENIAL RESULTS BASED ON UPHELD OR OVERTURNED POSITION

Denials	Total Number	%
Upheld	21	81%
Overturned	5	19%
Total	26	100%

There were 21 denials where UNUM upheld its position, and five on which UNUM overturned its position.

DENIAL RESULTS BASED ON REQUEST FOR ADDITIONAL INFORMATION

Denials	Total Number	%
With additional information	15	58%
Without additional information	11	42%
Total	26	100%

There were 15 denials for which additional information was requested, and 11 denials for which no additional information was requested.

DENIAL RESULTS BASED ON UPHELD OR OVERTURNED AND WITH OR WITHOUT ADDITIONAL INFORMATION

Denials	Total Number	%
Upheld with additional information	11	42%
Upheld without additional information	10	38%
Overturned with additional information	4	15%
Overturned without additional information	1	4%
Total	26	100%

There were 11 denials where UNUM upheld its position and requested additional information; there were ten denials where UNUM upheld its position and did not request additional information. There were four denials where UNUM overturned its position and requested additional information; UNUM had one denial that was overturned without additional information.

The denial, in which UNUM overturned its original position without additional information, was determined to be in violation of O.C.G.A. §33-6-34(6) as a reasonable investigation was not performed on the original claim submission by the complainant.

EXCEPTIONS NOTED IN COMPLAINT REVIEW

There were four complaints where UNUM performed additional investigation on pre-existing conditions to pay or deny benefits under long-term disability as compared to short-term disability. There was one complaint where UNUM elected to do full and final settlement. One complaint involved the classification by UNUM of the disability as a sickness rather than an injury, which resulted in benefits payable to the age of 65 versus benefits payable for life as would have been the case for an injury. There was one complaint where UNUM denied benefits based on the job description of the Dictionary of Occupational Titles and not the actual duties of the claimant. There were two complaints where UNUM agreed on short-term benefits and disagreed on long-term benefits.

Two claimants submitted complaints to the Department stating UNUM continued to request information that had already been submitted and that excessive delays were occurring. UNUM's complaint register indicated the complaint was not justified. Review of the complaint file by this examination identified documentation indicating there were periods of time when the claim files could not be located. For one complaint, the original claim form was acknowledged by UNUM on September 8, 1999 and rendered its determination on February 15, 2000. For the second complaint, UNUM received the claim form on March 8, 2000, offered a lump-sum settlement on July 19, 2000, and closed the complaint file on August 24, 2000.

For one complaint relating to delays, UNUM acknowledged the complaint was justified. UNUM had received forms from the claimant on May 18, 2000 but was not diligent in requesting additional information on a timely basis; requests for additional information were submitted by UNUM on July 18, 2000. The complaint file was closed on December 15, 2000.

UNUM was determined to be in violation of O.C.G.A. § 33-6-34 (3), (4), and (9).

Company Complaints

A total of 19 Company Complaints were reviewed for the period of January 1, 1999 through November 30, 2000.

OVERALL RESULTS OF INTERNAL COMPLAINTS

Reason Code	Total Number	%
1015 - Denial of claim	7	37%
1025 - Delays	6	32%
1035 - Other (Claims handling)	4	21%
1125 - Coverage question	1	5%
1129 - Abusive service	1	5%
Total	19	100%

There were seven complaints that related to denial of claim. There were six complaints relating to delays on claims. There were four complaints that were documented as "Other" relating to claims handling. There was one complaint where the claimant requested information regarding long-term disability and short-term disability coverage. One complaint was received regarding abusive behavior.

Disposition Code	Total Number	%
1207 - Advised complainant	1	5%
1230 - Claim settled	2	11%
1255 - Delays resolved	5	26%
1295 - Company position upheld	4	21%
1310 - Other (Claim handling)	7	37%
Total	19	100%

Five complaints had delays resolved. UNUM advised one complainant. Claims were settled on two complaints. UNUM's position was upheld on four complaints. The disposition on seven complaints was designated as "Other (Claim Handling).

OVERALL RESULTS BASED ON ORIGINAL POSITION UPHELD OR OVERTURNED

Original Position Upheld	Total Number	%
Yes	9	47%
No	2	11%
Not applicable	8	42%
Total	19	100%

There were nine complaints where UNUM upheld its position. There were two complaints where the original position was overturned. A disposition was not applicable on eight of the complaints.

OVERALL RESULTS BASED ON ADDITIONAL INFORMATION REQUESTED

Request for Additional Information	Total Number	%
Yes	4	21%
No	8	42%
Not applicable	7	37%
Total	19	100%

Additional information was requested on four complaints. UNUM did not request additional information of eight complaints. This attribute was not applicable for seven complaints.

DENIAL RESULTS BASED ON UPHELD OR OVERTURNED POSITION

Denials	Total Number	%
Upheld	6	86%
Overturned	1	14%
Total	7	100%

UNUM upheld its decision on six denials and overturned one denial.

DENIAL RESULTS BASED ON ADDITIONAL INFORMATION REQUESTED

Denials	Total Number	%
With additional information	3	43%
Without additional information	4	57%
Total	7	100%

There were three denials where UNUM requested additional information, and four denied complaints for which UNUM did not request additional information.

DENIAL RESULTS BASED ON UPHELD OR OVERTURNED POSITION AND WITH OR WITHOUT ADDITIONAL INFORMATION REQUESTED

Denials	Total Number	%
Upheld with additional information	2	29%
Upheld without additional information	4	57%
Overturned with additional information	1	14%
Overturned without additional information	0	0%
Total	7	100%

UNUM upheld their position on two denials where additional information was requested. There were four denials in which additional information was not requested and the Company upheld their original decision. There was one complaint where UNUM received additional information and overturned their position. There were no denials in which the decision was overturned without additional information.

EXCEPTIONS NOTED ON INTERNAL COMPLAINTS REVIEW

There was one complaint where UNUM denied a claim based on the job description that was provided by the employer. According to the employee, an incorrect job description was used; UNUM's denial was upheld.

One claimant filed a complaint regarding delays in receipt of benefit payments. On two different occasions UNUM stated to the claimant the payment had been mailed, when in fact the payment had not been issued. To remedy the situation, UNUM sent the payment by overnight express mail and a letter of apology to the claimant.

UNUM was in violation of O.C.G.A. § 33-6-34 (3) and (4).

The Paul Revere Life Insurance Company

Department of Insurance Complaints

A total number of 12 Commissioner Complaints were reviewed for the period of January 1, 1999 through November 30, 2000. The results are presented in the following tables and are classified by NAIC designation codes.

COMMISSIONER COMPLAINTS – OVERALL

Reason Codes	Total Number	%
1005 - Unsatifactory Settle/Offer	1	8%
1015 - Denial of Claim	7	58%
1025 - Delays	2	17%
1035 - Other	2	17%
Total	12	100%

The above table represents the Commissioner Complaints for January 1, 1999 through November 30, 2000 by the NAIC reason code. There were seven Commissioner Complaints that were denials, two regarding delays and one was an unsatisfactory settlement/offer. Two were determined to be related to claims handling although it was classified in the "Other" category per the NAIC reason code.

Disposition Codes	Total Number	%
1220 - Coverage Extended	1	8%
1230 - Claim Settled	1	8%
1255 - Delays Resolved	2	17%
1295 - Company Position Upheld	7	58%
1310 - Other	1	8%
Total	12	100%

PRLIC upheld its position on seven of the Commissioner Complaints filed during this examination period. PRLIC settled one complaint, resolved two delays and extended coverage for one complaint. One was categorized as "Other" per the NAIC disposition code.

Original Position Upheld	Total Number	%
Yes	9	75%
No	3	25%
Total	12	100%

PRLIC upheld nine of the Commissioner complaints and overturned the remaining three complaints of those reviewed for the examination period.

Additional Information Requested	Total Number	%
Yes	3	25%
No	9	75%
Total	12	100%

There were three complaints where additional information was requested. No additional information was requested for the remaining nine complaints.

COMMISSIONER COMPLAINTS - DENIALS

Denials	Total Number	%
Denials Upheld	5	71%
Denials Overturned	2	29%
Total	7	100%

For the complaints during this examination period, PRLIC had five denials that were upheld and two denials that were overturned.

Denials	Total Number	%
Denials with additional information	2	29%
Denials without additional information	5	71%
Total	7	100%

PRLIC had two denials where additional information was requested and five denials where additional information was not requested.

Denials	Total Number	%
Upheld with additional information	2	29%
Upheld without additional information	3	43%
Overturned with additional information	0	0%
Overturned without additional information	2	29%
Total	7	100%

PRLIC upheld two denials for which additional information had been requested and three denials for which no additional information had been requested. There were no denials with additional information and overturned and two denials were overturned for which no additional information had been requested.

There were two complaints where PRLIC had the claimant visit one of its doctors. The doctors provided by PRLIC decided the claimants were no longer disabled and the disability benefit payments were stopped based upon this decision. Upon the stoppage of benefit payments, both claimants filed complaints. One claimant was awarded benefit payments, which were later terminated. PRLIC closed the complaint as the claimant did not provide additional information. In response to the second complaint, PRLIC accommodated the claimant's request to see another doctor as the one selected by PRLIC

had seen the claimant several years prior. The prior visit to the doctor had resulted in a claim denial which was subsequently overturned upon appeal.

PRLIC was in violation of O.C.G.A. § 33-6-34(6) as a reasonable investigation was not conducted at the commencement of the claim review for the claim as PRLIC had overturned its original denial with no additional information.

Company Complaints

Two internal complaints were reviewed for the period of January 1, 1999 through November 30, 2000. The results are presented in the following tables and are classified by the NAIC designation codes.

OVERALL INTERNAL COMPLAINTS

PRLIC's complaint log identified two internal complaints for the period of January 1, 1999 through November 30, 2000. The following tables are the results of the overall internal complaints reviewed.

Reason Codes	Total Number	%
1015 - Denial of Claim	0	0%
1025 - Delays	2	100%
Total	2	100%

Disposition Codes	Total Number	%
1255 - Delays Resolved	2	100%
Total	2	100%

The two complaints reviewed were considered delays under the claims handling process. The final dispositions were delays resolved.

Original Position Upheld	Total Number	%
Yes	0	0%
No	0	0%
N/A	2	100%
Total	2	100%

PRLIC did not determine a final position on the complaints for the delays. PRLIC had explained the reasons for the delays to the claimant rather than ruling to uphold decision. This attribute is shown to be not applicable for these complaints.

Additional Information Requested	Total Number	%
Yes	0	0%
No	2	100%
N/A	0	0%
Total	2	100%

A review of the two internal complaints revealed no additional information was requested.

INTERNAL COMPLAINTS - DENIALS

Denials	Total Number	%
Denial with additonal information requested	0	0%
Denials without additional information requested	0	0%
Total	0	0%

PRLIC did not have any denials which met the attribute criteria for upheld, overturned, or requesting additional information.

Provident Life and Accident Insurance Company

Department of Insurance Complaints

A total of 17 complaints relating to PLAIC were filed with the Department for the examination period, all were reviewed. The following tables present the results and are classified in accordance with NAIC designation codes.

COMMISSIONER COMPLAINTS - OVERALL:

Commissioner Complaints by Reason Codes:

Reason Codes:	Total Number	%
810 - Refusal to insure	1	6%
1005 - Unsatisfactory settlement	1	6%
1015 - Denial of claim	6	35%
1020 - Coordination of benefits	1	6%
1025 - Delays	5	29%
1115 - Delays/no response	1	6%
1117 - Information requested	1	6%
1125 - Coverage question	1	6%
Total	17	100%

The above table represents the Commissioner Complaints for January 1, 1999 through November 30, 2000 by NAIC reason code. There was one complaint where PLAIC refused to insure, one for an unsatisfactory settlement, six involving claim denials, one complaint relating to coordination of benefits, five involving claim delays, one complaint involving a delay in response, one requesting information, and one complaint involving a coverage question.

Commissioner Complaints by Disposition Codes:

Disposition Codes	Total Number	%
1210 - Additional payment	1	6%
1230 - Claim settled	2	12%
1253 - Information furnished	2	12%
1255 - Delay resolved	1	6%
1285 - Question of fact	1	6%
1290 - Contract provision	1	6%
1293 - Company in compliance	1	6%
1295 - Company position upheld	4	24%
1310 - Other	2	12%
0 - (open) Co. still investigating	2	12%
Total	17	100%

PLAIC made an additional payment to resolve one complaint, settled the claim on two complaints, furnished information to two complainants, resolved the delay for one complaint, denied the associated claim on one complaint based on a question of fact and refused to insure one complainant based on a contract provision. The disposition code stipulates PLAIC was in compliance on one complaint and involved "Other" resolutions

on two complaints. PLAIC's position was upheld on four complaints. Two complaints relating to claim denial remained open as of the date of this examination's review because PLAIC was conducting its review of the complaints and associated claim documents and had not made a final determination.

Overall Results Based On Upheld or Overturned Decision

Original Position Upheld	Total Number	%
Yes	7	41%
No	1	6%
N/A	7	41%
Under Appeal Review	2	12%
Total	17	100%

The original position of PLAIC was upheld in seven of the complaints and was overturned on one complaint. This attribute was not applicable on seven of the complaints. The appeals of two complainants were still under review by PLAIC at the time of this examination's review.

Overall Results Based on Request for Additional Information

Additional Information Required	Total Number	%
Yes	8	47%
No	5	29%
N/A	4	24%
Total	17	100%

In eight complaints, additional information was requested. No additional information was requested for five complaints. This attribute was not applicable on four complaints.

COMMISSIONER COMPLAINTS - DENIALS

Denial Results Based on Upheld or Overturned Position

Denials	Total Number	%
Denials Upheld	3	50%
Denials Overturned	1	17%
Denials Under Appeal Review	2	33%
Total	6	100%

Of the total of six denials, PLAIC upheld its decision on three of the complaints and overturned its original decision on one denial. A final determination had not been made on two complaints concerning claim denials as PLAIC was still conducting its review on these.

Denial Results Based on Request for Additional Information

Denials	Total Number	%
Denial with additional information	6	100%
Denial with out additional information	0	0%
Total	6	100%

Six denials were made with additional information and no denials were made without additional information being provided.

Denial Results Based on Upheld or Overturned Position With or Without Additional Information

Denials	Total Number	%
Upheld with additional information	3	50%
Upheld without additional information	0	0%
Overturned with additional information	1	17%
Overturned without additional informat	0	0%
Under appeal review	2	33%
Total	6	100%

In three complaints the denial was upheld after additional information was provided. There were no denials upheld without additional information. One denial was overturned with additional information. No denials were overturned without additional information. For two complaints, the appeals of the denials were still under review by PLAIC.

Company Complaints

A total of seven complaints were received by PLAIC for the period January 1, 1999 through November 30, 2000; all complaints were reviewed by this examination. Results of the review are presented in the following tables and classified in accordance with NAIC designation codes.

COMPANY COMPLAINTS - OVERALL

Company Complaints by Reason Codes:

Reason Codes	Total Number	%
1005 - Unsatisfactory settlement/offer	2	29%
1015 - Denial of claim	2	29%
1025 - Delays	1	14%
1117 - Information requested	1	14%
1130 - Other	1	14%
Total	7	100%

The above table represents internal complaints by NAIC reason code. Two complaints related to an unsatisfactory settlement offer, two complaints related to a denial of claim, one complaint was made due to a delay in the processing of the claim and one complaint was a request for information. One complaint was designated as "Other."

Company Complaints by Disposition Codes

Disposition Codes	Total Number	%
1207 - Advised complainant	2	29%
1210 - Additional payment	1	14%
1295 - Company position upheld	1	14%
1230 - Claim settled	2	29%
1253 - Information furnished	1	14%
Total	7	100%

For two of the complaints, PLAIC advised the complainant. PLAIC made additional payments on one complaint, upheld its position on one complaint, settled the claim on two complaints and furnished information on one complaint

Overall Results Based On Upheld or Overturned Decision

Original Position Upheld	Total Number	%
Yes	2	29%
No	2	29%
N/A	3	43%
Total	7	100%

PLAIC upheld its position on two complaints and overturned its original position on two of the complaints. This attribute was not applicable on three of the complaints.

Overall Results Based on Request for Additional Information

Additional Information Requested	Total Number	%
Yes	5	71%
N/A	2	29%
Total	7	100%

PLAIC requested additional information on five of the complaints. Additional information was not required or applicable on two complaints.

Denial Results Based on Upheld or Overturned Position

Denials	Total Number	%
Denials Upheld	1	50%
Denials Overturned	1	50%
Total	2	100%

PLAIC upheld its original position on one complaint and overturned its original position on one complaint involving denials of claim.

Denial Results Based on Upheld or Overturned Position With or Without Additional Information

Denials	Total Number	%
Upheld with additional information	1	50%
Upheld without additional information	0	0%
Overturned with additional information	1	50%
Overturned without additional informati	0	0
Total	2	100%

PLAIC requested additional information on the two complaints involving denial of claims. There were no complaints involving denial of claims where additional information was not requested. PLAIC upheld its denial on one complaint for which additional information had been requested. PLAIC overturned its denial on one denial after requesting and receiving additional information.

Provident Life and Casualty Insurance Company

PLCIC had no complaints for the period under examination.

CLAIM PRACTICES

SAMPLE METHODOLOGY

The UNUMProvident Companies provided data files representing paid and denied claims from each of the claims systems utilized. Utilizing ACL, this information was categorized and summarized. A sample was selected from each of the systems in accordance with the guidelines of the NAIC Examiners Handbook.

Additionally, during the review of complaints, certain files were identified for which the review of the associated claim files was necessary. These files were judgmentally selected and added to the sample selected through ACL.

CLAIMS MANUAL

The Company provided its claim manual for review by this examination. The manual is dated January 9, 2001 and is utilized for all affiliates covered by this examination. The Company represented the manual had been created subsequent to the 1999 merger forming the UNUMProvident Corporation and that there had been no previous claims manual for any of the companies.

It was determined a "Training Program," contained in a three-volume binder, was in existence prior to the claims manual. The Company represented this was not a claims manual and was utilized only for the training of new Customer Care Representatives. The Company further represented the training procedures had been used by one area of UNUM Life Insurance Company of America prior to the merger. This examination noted portions of the claims manual are incomplete, and the Company has not established a completion date.

The claims manual includes a section title "Database & Records Check Referral Procedures" which includes definitions and procedures for requesting information from various online database resources such as credit reporting agencies and for a check of public records, court records, income verification or other financial records. In a meeting with the examiners, the Company represented it would not have any reason to request or use a credit report or such other information as required by the above procedures. The Company further stated there are times when additional financial information will be requested relating to social security benefits, pension benefits and workers compensation benefits, which are used in determining benefit reduction(s) based on the contractual wording of the policy.

It was determined by this examination the obtaining of such credit reports is not in compliance with the Federal Fair Credit Reporting Act, 29 CFR 604 (3)(C)(2), which stipulates credit reports may not be obtained by insurance companies for the use of claim processing in accordance with the intent of Congress. In response to an examination inquiry, the Company stated it is in compliance with 15 U.S.C § 1681b(a)(2) and 16 CFR § 604 (2)(1) which allow a credit report to be obtained upon written authorization of the subject of the credit report. Such authorization is obtained by the Company upon its claim forms, which includes authorization for medical records and similar type information as well as financial information.

The Company utilizes Consulting Professional Accounts, "CPA teams," as defined in the claims manual to provide assistance with calculating, reviewing, recalculating Benefits Paid for reasons other than Social Security Disability Insurance, "SSDI," workers compensation awards and determining information to be obtained.

The claims manual includes a section entitled "GENEX Social Security Referral Procedure." The following is noted in the material of this section:

"UNUM has the right to reduce the disability benefit payment by the estimated amount of the Social Security benefit whether Social Security was applied for or not."

A review of the sample UNUM long-term disability policy provided by the Company notes in the section "WHAT ARE DEDUCTIBLE SOURCES OF INCOME?" the following statements:

"*With the exception of retirement payments UNUM will only subtract deductible sources of income which are payable as a result of the same disability.*" And "*We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.*"

Verification that actual practices comply with the terms of the policy was completed during the review of claim files.

CLAIMS ARE PROPERLY HANDLED

Claims Standard # 1 – *Claim files are handled in accordance with policy provisions and state law. O.C.G.A. §§ 33-3-33 and 33-6-34.*

UNUM Life Insurance Company of America

A total sample of 50 paid claims was selected for attribute testing by this examination. The following table presents the results:

Attributes Tested:	Yes		No		Totals	
	Count	%	Count	%	Count	%
Prompt investigation of claims	45	90%	5	10%	50	100%
Communications timely and substantive in form referencing policy provisions or exclusions	45	90%	5	10%	50	100%
Responds to claim correspondence timely	45	90%	5	10%	50	100%
File documentation supports Company decision	46	92%	4	8%	50	100%
Claim file handled in accordance with policy provisions and state statutes	47	94%	3	6%	50	100%
No evidence of unfair trade practices or discriminatory acts	49	98%	1	2%	50	100%
Claims not subsequently denied after payments began	49	98%	1	2%	50	100%
Staff reviewers qualified to make decision for initial denial	50	100%	0	0%	50	100%

Timeliness Testing	Time to Acknowledge		Acceptance or Rejection Time		Payment Time	
Number of Days	Count	%	Count	%	Count	%
0 to15 days	29	58%	3	6%	9	18%
16 to 30 days	9	18%	6	12%	5	10%
31 to 60 days	4	8%	11	22%	11	22%
61 to 90 days	3	6%	8	16%	10	20%
Over 90 days	1	2%	18	36%	11	22%
Not Applicable	4	8%	4	8%	4	8%
Totals	50	100%	50	100%	50	100%

This examination determined of the 50 claim files tested, 10%, or five claims were not promptly investigated. Communications timely or in a substantive manner, referencing policy provisions or exclusions did not occur on five claims, or 10% of the total sample. There were five claims, 10% of the total, for which responses to claim correspondence did not occur in a timely manner. The documentation in the files of four claims, 8% of the sample, did not support UNUM's decision. In three claim files, representing 6% of the total tested, the file was not handled according to the policy provisions or state statutes. One of the claim files reviewed, equaling 2% of the total, contained unfair trade or discriminatory acts. There was one claim file reviewed, 2% of the total, that was subsequently denied after payments were begun.

Acknowledgement of the claim by UNUM exceeded ninety days for one claim. Acceptance or rejection of the claim by UNUM exceeded ninety days for 18 claims. Remittance of benefit payments by UNUM for eleven claims exceeded ninety days. The timeliness attribute was not applicable and/or available for four claim files included in the sample selected, based upon the documentation contained in the claim files.

For one claim selected for review, UNUM was unable to locate and provide the entire claim file. The examiners' review of the partial file is included in the results presented.

Based upon the review of paid claims handling practices for the period under examination, it was determined UNUM had missing files; had poorly documented and incomplete files; failed to advise insured of the appeal process; failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications; and failed to implement procedures for the prompt investigation of claims.

UNUM was in violation of O.C.G.A. §§ 33-6-34 (2), (3), (4) and 33-2-13 (a); Federal Credit Reporting Act, 16 CFR 604 (3) (C) (2) and Title 29 CFR 2560.503 (e) (1) and (f), (g) (1).

The Paul Revere Life Insurance Company

A sample of 55 paid claims for the period under examination was selected for review. Attribute testing results are presented on the following table.

Attributes Tested:	Yes		No		N/A		Totals	
	Count	%	Count	%	Count	%	Count	%
Prompt investigation of claims	50	91%	5	9%	0	0%	55	100%
Communications timely and substantive in form referencing policy provisions or exclusions	50	91%	5	9%	0	0%	55	100%
Responds to claim correspondence timely	48	87%	7	13%	0	0%	55	100%
File documentation supports Company decision	48	87%	7	13%	0	0%	55	100%
Claim file handled in accordance with policy provisions and state statutes	46	84%	9	16%	0	0%	55	100%
No evidence of unfair trade practices or discriminatory acts	47	85%	8	15%	0	0%	55	100%
Claims not subsequently denied after payments began	50	91%	4	7%	1	2%	55	100%
Staff reviewers qualified to make decision for initial denial	42	76%	4	7%	9	16%	55	100%

Timeliness Testing	Time to Acknowledge		Acceptance Rejection Time		Payment Time	
Number of Days	Count	%	Count	%	Count	%
0-15 days	29	53%	9	16%	17	31%
16-30 days	11	20%	4	7%	6	11%
31 to 60 days	9	16%	8	15%	13	24%
61 to 90 days	3	5%	4	7%	7	13%
Over 90 days	1	2%	27	49%	10	18%
Not Applicable	2	4%	3	5%	2	4%
Totals	55	100%	55	100%	55	100%

It was determined five claims, representing 9% of the total sample, were found to have investigations or communications not effectuated in a timely manner. PRLIC failed to effectively communicate in a timely manner, referencing specific policy provisions, on five claims, 9% of the total sample. Failure to timely respond to claimant correspondence was noted in seven of the claim files, representing 13% of the sample. PRLIC's decisions were not supported by the documentation contained in seven claim files or 13% of the sample. A total of nine claims, representing 16% of the total sample, were not handled in accordance with policy provisions and/or state statutes. Unfair discriminatory practices were noted in eight claims, or 15% of the total. Benefits were denied after payments had been made on four claims, which is 7% of the total sample. Claim file documentation indicated an employee or representative of PRLIC with lesser qualifications than the attending physicians reviewed four claims, 7% of the total, and rendered a decision in direct conflict to the attending physician's diagnosis and recommendations.

In four claim files, PRLIC obtained consumer credit reports on the insured. In one claim, PRLIC gathered personal information on the insured prior to receiving authorization and failed to date stamp pertinent documents.

In one claim PRLIC failed to advise the insured in writing of the appeal process and closed the claim prior to advising that no further benefits would be paid, which was in violation of regulations under ERISA. In a second claim file, acknowledgment of the claimant's appeal was not identified.

Several files were incomplete. This examination was unable to determine if policy provisions were followed.

Acknowledgment of one claim exceeded ninety days. PRLIC exceeded ninety days in the acceptance/rejection of 27 claims. Initial payments on ten claims were made in excess of ninety days.

Based upon the review of paid claims handling practices for the period under examination, it was determined PRLIC had missing files; had poorly documented and incomplete files; failed to advise insured of the appeal process; failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications and failed to implement procedures for the prompt investigation of claims.

PRLIC was in violation of O.C.G.A. §§ 33-6-34 (2), (3), (4) and 33-2-13 (a); Federal Credit Reporting Act, 16 CFR 604 (3) (C) (2) and Title 29 CFR 2560.503 (e) (1) and (f), (g) (1).

Provident Life and Accident Insurance Company

A sample of 63 paid claims was reviewed by this examination. Results of attribute testing are presented in the following table:

	Yes		No		N/A		Totals	
Attributes Tested:	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Prompt investigation of claims	48	76%	14	22%	1	2%	63	100%
Communications timely and substantive in form referencing policy provisions or exclusions	55	87%	7	11%	1	2%	63	100%
Responds to claim correspondence timely	55	87%	7	11%	1	2%	63	100%
File documentation supports Company decision	54	86%	8	13%	1	2%	63	100%
Claim file handled in accordance with policy provisions and state statutes	53	84%	9	14%	1	2%	63	100%
No evidence of unfair trade practices or discriminatory acts	54	86%	8	13%	1	2%	63	100%
Claims not subsequently denied after payments began	55	87%	4	6%	4	6%	63	100%
Staff reviewers qualified to make decision for initial denial	33	52%	5	8%	25	40%	63	100%

Timeliness Testing	**Time to Acknowledge**		**Acceptance Rejection Time**		**Payment Time**	
Number of Days	**Count**	**%**	**Count**	**%**	**Count**	**%**
0-15 days	41	65%	5	8%	19	30%
16-30 days	9	14%	3	5%	1	2%
31 to 60 days	6	10%	9	14%	10	16%
61 to 90 days	0	0%	9	14%	11	17%
Over 90 days	2	3%	27	43%	8	13%
Not Applicable	5	8%	10	16%	14	22%
Totals	63	100%	63	100%	63	100%

This examination determined of the total sample of claim files tested, 22%, or 14 claims were not promptly investigated. For seven claims, or 11% of the total sample, PLAIC did not communicate timely or in a substantive manner, referencing policy provisions or exclusions. There were seven claims, 11% of the total tested, where PLAIC did not respond to claim correspondence in a timely manner. It was noted eight claim files, 13% of the total sample, did not contain adequate documentation file to support PLAIC's claim decision. On nine claim files, 14% of the total tested, the claim was not handled according to either the policy provisions or state statutes. Unfair trade or discriminatory practices by PLAIC were noted in eight of the claim files reviewed, representing 13% of the total. There were four claim files reviewed, 6% of the total sample, were noted to be subsequently denied after payments had commenced. An employee or representative of the Company with lesser qualifications than the attending physicians reviewed five claim files, 8% of the total sample, and rendered a decision in direct conflict to the physicians' diagnosis and recommendations.

Acknowledgment of two claims occurred in excess of ninety days. PLAIC's acceptance/rejection of 27 claims were excess of ninety days. Initial benefit payments occurred on eight claims in excess of ninety days.

It was noted PLAIC had denied one claim. The claimant filed two appeals, each of which resulted in a denial of the claim. The insured filed a complaint with the Department. In response to the complaint, PLAIC requested and obtained information from the insured's employer. In its response to the Department, PLAIC represented it was reversing its denial and commenced benefit payments. It was noted by this examination during the review of other claim files, PLAIC routinely contacted employers regarding claimants' employment requirements and status.

This examination noted one case where PLAIC practices varied significantly from its claims manual and practices noted in numerous claim files. One insured filed a claim for disability from maladies of an unknown origin. Documents within the claim file indicate the insured was an employee of an associated insurance agency office. PLAIC approved, paid the claim, and allowed the insured to submit an annual attending physician statement.

Based upon the review of paid claims handling practices for the period under examination, it was determined PLAIC had missing files; had poorly documented and incomplete files; failed to communicate specific policy provisions or exclusions to insureds; failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications; and failed to implement procedures for the prompt investigation of claims.

PLAIC was in violation of O.C.G.A. §§ 33-6-34 (2), (3), (4) and 33-2-13 (a); Federal Credit Reporting Act, 16 CFR 604 (3) (C) (2) and Title 29 CFR 2560.503 (e) (1) and (f), (g) (1).

Provident Life and Casualty Insurance Company

For the period under examination, PLCIC paid benefits on 22 claims. All claim files were reviewed by this examination. Results of the attribute testing are presented in the following table:

	Yes		No		N/A		Totals	
Attributes:	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Prompt investigation of claims	20	91%	2	9%	0	0%	22	100%
Communications timely and substantive in form referencing policy provisions or exclusions	20	91%	2	9%	0	0%	22	100%
Responds to claim correspondence timely	20	91%	2	9%	0	0%	22	100%
File documentation supports Company decision	20	91%	2	9%	0	0%	22	100%
Claim file handled in accordance with policy provisions and state statutes	20	91%	2	9%	0	0%	22	100%
No evidence of unfair trade practices or discriminatory acts	20	91%	2	9%	0	0%	22	100%
Claims not subsequently denied after payments began	21	95%	1	5%	0	0%	22	100%
Staff reviewers qualified to make decision for initial denial	21	95%	1	5%	0	0%	22	100%

Timeliness Testing	**Time to Acknowledge**		**Acceptance Rejection Time**		**Payment Time**	
Number of Days	**Count**	**%**	**Count**	**%**	**Count**	**%**
0-15 days	14	64%	9	41%	5	23%
16-30 days	1	5%	2	9%	4	18%
31 to 60 days	4	18%	3	14%	2	9%
61 to 90 days	2	9%	4	18%	3	14%
Over 90 days	1	5%	4	18%	4	18%
Not Applicable	0	0%	0	0%	4	18%
Totals	22	100%	22	100%	22	100%

Two claims, representing 9% of the total sample, were found to have investigations or communications not effectuated in a timely manner. PLCIC failed to effectively communicate in a timely manner, referencing specific policy provisions, on two claims,

9% of the total sample. Failure to timely respond to claimant correspondence was noted in two of the claim files, representing 9% of the sample. PRLIC's decisions were not supported by the documentation contained in two claim files or 9% of the sample. Two claims, representing 9% of the total sample, were not handled in accordance with policy provisions and/or state statutes. Unfair discriminatory practices were noted in two claims, or 9% of the total sample. Benefits were denied after payments had been made on one claim, which is 5% of the total sample. Claim file documentation indicated an employee or representative of PRLIC with lesser qualifications than the attending physicians reviewed one claim, 5% of the total sample, and rendered a decision in direct conflict to the attending physician's diagnosis and recommendations.

File documentation indicated PLCIC offered a lump sum prior to investigation of claim to one insured. In one file, no written acknowledgement of the claim was identified and acknowledgment occurred with the first benefit payment which was made in excess of ninety (90) days after receipt of the claim form. The medical records were requested sixty-three (63) days after the claim was received.

It was noted PLCIC represented to one claimant that filing for Social Security Disability Benefits was required. Policy language allows PLCIC to offset benefit payments by estimated SSDI benefits, but the policy language does not stipulate such filing is required of the insured.

PLCIC's acknowledgment on one claim exceeded ninety days. Acceptance/rejection exceeded ninety days on four claims. The initial benefit payment exceeded ninety days on four claims.

Based upon the review of the paid claims for the period under this examination, it was determined PLCIC failed to acknowledge with reasonable promptness pertinent communication; failed to implement procedures for the prompt investigation and settlement of claims; failed to effectuate prompt, fair and equitable settlement of claim in which liability had become reasonably clear; delayed paying claim without conducting a reasonable investigation; obtained consumer credit reports as a part of its claim processing.

PLCIC was in violation of O.C.G.A §§ 33-6-34 (2), (3), (4) and (6); Federal Fair Credit Reporting Act, 16 CFR 604 (3) (C) (2).

DENIED AND CLOSED WITHOUT PAYMENT

Claims Standard # 2 – *Denied and closed-without-payment claims are handled in accordance with policy provisions and state law and not with such frequency as to indicate a general business practice to engage in such activity. O.C.G.A. §§ 33-6-33 and 33-6-34.*

UNUM Life Insurance Company of America

A total sample of 50 denied claims was selected for attribute testing by this examination. The following table presents the results:

Attributes Tested:	Yes		No		N/A		Totals	
	Count	%	Count	%	Count	%	Count	%
Prompt investigation of claims	42	84%	8	16%	0	0%	50	100%
Communications timely and substantive in form referencing policy provisions or exclusions	43	86%	7	14%	0	0%	50	100%
Responds to claim correspondence timely	44	88%	6	12%	0	0%	50	100%
File documentation supports Company decision	40	80%	10	20%	0	0%	50	100%
Claim file handled in accordance with policy provisions and state statutes	43	86%	7	14%	0	0%	50	100%
No evidence of unfair trade practices or discriminatory acts	46	92%	4	8%	0	0%	50	100%
Claims not subsequently denied after payments began	46	92%	4	8%	0	0%	50	100%
Staff reviewers qualified to make decision for initial denial	45	90%	4	8%	1	2%	50	100%

Timeliness Testing	Time to Acknowledge		Acceptance Rejection Time	
Number of Days	Count	%	Count	%
0-15 days	22	44%	8	16%
16-30 days	3	6%	7	14%
31 to 60 days	2	4%	6	12%
61 to 90 days	0	0%	5	10%
Over 90 days	1	2%	20	40%
Not Applicable	22	44%	4	8%
Totals	50	100%	50	100%

This examination determined of the 50 claim files tested, 16%, or eight claims were not promptly investigated. In seven of the claims files reviewed, 14% of the sample tested, the Company did not communicate timely or in a substantive manner, referencing policy provisions or exclusions. There were six claims, 12% of the total, for which responses to claim correspondence did not occur in a timely manner and the documentation in the files of ten claims, 20% of the total sample, did not support UNUM's decision. In seven claim files, representing 14% of the total tested, the file was not handled according to the policy provisions or state statutes. Four of the claim files reviewed, equaling 8% of the total, were considered to have unfair trade or discriminatory acts. There were four claim files reviewed, 8% of the total sample, that were subsequently denied after payments were begun. An employee or representative of UNUM with lesser qualifications than the attending physicians reviewed four claim files, 8% of the total, and rendered a decision in direct conflict to the attending physician's diagnosis and recommendations.

There was one claim for which acknowledgement time of the claim by UNUM exceeded 90 days. There were 20 claims for which UNUM exceeded 90 days to accept or reject the claim. Acknowledgment time for 22 claims was not applicable or available based upon the documentation with the claim files. Rejection time was not applicable or available for four claims.

Based upon the review of denied claims handling practices for the period under examination, it was determined UNUM had poorly documented and incomplete files; failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications and failed to implement procedures for the prompt investigation of claims.

UNUM was in violation of O.C.G.A. §§ 33-6-34 (2), (3), (4) and 33-2-13 (a); Federal Credit Reporting Act, 16 CFR 604 (3) (C) (2) and Title 29 CFR 2560.503 (e) (1) and (f), (g) (1).

The Paul Revere Life Insurance Company

A sample of 49 denied claims involving residents of the State of Georgia were reviewed. The results of attribute testing are presented in the following table:

Attributes Tested:	Yes		No		N/A		Totals	
	Count	%	Count	%	Count	%	Count	%
Prompt investigation of claims	37	76%	8	16%	4	8%	49	100%
Communications timely and substantive in form referencing policy provisions or exclusions	38	78%	7	14%	4	8%	49	100%
Responds to claim correspondence timely	40	82%	5	10%	4	8%	49	100%
File documentation supports Company decision	37	76%	8	16%	4	8%	49	100%
Claim file handled in accordance with policy provisions and state statutes	41	84%	4	8%	4	8%	49	100%
No evidence of unfair trade practices or discriminatory acts	42	86%	3	6%	4	8%	49	100%
Claims not subsequently denied after payments began	42	86%	3	6%	4	8%	49	100%
Staff reviewers qualified to make decision for initial denial	40	82%	5	10%	4	8%	49	100%

Timeliness Testing	Time to Acknowledge		Acceptance Rejection Time	
Number of Days	Count	%	Count	%
0-15 days	32	65%	4	8%
16-30 days	7	14%	4	8%
31 to 60 days	4	8%	2	4%
61 to 90 days	0	0%	8	16%
Over 90 days	0	0%	15	31%
Not Applicable	6	12%	16	33%
Totals	49	100%	49	100%

In accordance with the NAIC Examiners Handbook, a sample of 50 claims was initially selected. It was determined one file selected involved litigation, the claim file was reviewed in conjunction with the litigation file.

This examination determined of the 49 claim files tested, eight claims, or 16% of the total, were not promptly investigated. Timely communication or in a substantive manner, referencing policy provisions or exclusions, did not occur on 14% or seven claims. There were five claims, 10% of the total, for which responses to claim correspondence did not occur in a timely manner and the documentation in the files of eight claims, 16% of the sample, did not support PRLIC decision. In four claim files, representing 8% of the total tested, the file was not handled according to the policy provisions or state statutes. Three of the claim files reviewed, equaling 6% of the total sample, were considered to have unfair trade or discriminatory acts. There were also three claim files reviewed, 6% of the total sample, that were subsequently denied after payments were begun. An employee or representative of PRLIC with lesser qualifications than the attending physicians reviewed five claim files, 10% of the total, and rendered a decision in direct conflict to the attending physician's diagnosis and recommendations.

In one claim, there is no documented handling of the claim for eight months. In its response to an examination inquiry, PRLIC admitted it had not acknowledged receipt of the claim.

For one claim PRLIC received a premium payment but failed to provide a re-instatement application or letter advising the insured of the status of coverage. The Company did not address the issue of policy lapse in a timely manner.

In one claim, the claim form and employer verification were received in July 1998 and the claim was not opened until March 1999. The Company represented it was in telephone phone contact in September 1998. This contact was two months after receipt of the claim form.

One insured was informed the claim form was never received. It was determined the claim form was contained in the claim file.

PRLIC's acceptance/rejection of 15 claims, 31% of the total sample, exceeded ninety days.

Certain claims were not applicable to attribute testing. PRLIC had been advised of a claim, but the insured did not provide a claim form to continue the processing. These claims were closed.

Based upon the review of denied claims handling practices for the period under examination, it was determined PRLIC failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications; failed to implement procedures for the prompt investigation of claims; knowingly misrepresented to claimants relevant facts or policy provisions; refused to pay claims without conducting a reasonable investigation; had missing files; had poorly documented and incomplete files; failed to provide forms necessary to file a claim in a timely manner; and, when requested in writing, failed to affirm or deny coverage of claim within a reasonable time.

PRLIC was in violation of O.C.G.A. §§ 33-6-34 (1), (2), (3), (4), (6), (7), (11) and 33-2-13 (a).

Provident Life and Accident Insurance Company

A sample of 49 denied claims for the period under examination were reviewed. Results of the attribute testing are presented in the following table:

Attributes Tested:	Yes		No		N/A		Totals	
	Count	%	Count	%	Count	%	Count	%
Prompt investigation of claims	32	65%	4	8%	13	27%	49	100%
Communications timely and substantive in form referencing policy provisions or exclusions	32	65%	4	8%	13	27%	49	100%
Responds to claim correspondence timely	32	65%	4	8%	13	27%	49	100%
File documentation supports Company decision	32	65%	4	8%	13	27%	49	100%
Claim file handled in accordance with policy provisions and state statutes	32	65%	4	8%	13	27%	49	100%
No evidence of unfair trade practices or discriminatory acts	33	67%	3	6%	13	27%	49	100%
Claims not subsequently denied after payments began	32	65%	4	8%	13	27%	49	100%
Staff reviewers qualified to make decision for initial denial	31	63%	4	8%	14	29%	49	100%

Timeliness Testing	Time to Acknowledge		Acceptance Rejection Time	
Number of Days	Count	%	Count	%
0-15 days	26	53%	3	6%
16-30 days	5	10%	0	0%
31 to 60 days	0	0%	2	4%
61 to 90 days	0	0%	3	6%
Over 90 days	0	0%	23	47%
Not Applicable	18	37%	18	37%
Totals	49	100%	49	100%

In accordance with the NAIC Examiners Handbook, a sample of 50 denied claims was selected. It was determined that one claim was included on the paid data file as well as the denied claim data file provided to this examination. The attribute testing for that claim is included in the results presented for paid claims.

This examination determined of the 49 claim files tested, 8% or four claims were not promptly investigated. PLAIC did not communicate timely or in a substantive manner, referencing policy provisions or exclusions, on 8% of the total sample, or four claims. There were four claims, 8% of the total, for which responses to claim correspondence did not occur in a timely manner and the documentation in the files of four claims, 8% of the total sample, did not support PLAIC's decision. In four claim files, representing 8% of the total tested, the file was not handled according to the policy provisions or state statutes. Three of the claim files reviewed, equaling 6% of the total sample, evidenced unfair trade practices or discriminatory acts. Four claim files reviewed, 8% of the total sample, were subsequently denied after payments had been made. An employee or representative of PLAIC with lesser qualifications than the attending physicians reviewed four claim files, 8% of the total, and rendered a decision in direct conflict to the attending physician's diagnosis and recommendations.

It was determined PLAIC's acceptance/rejection occurred in excess of ninety days on 23 claims.

It was determined PLAIC had been notified of pending claims. Claim forms were provided to the insured. The completed forms were not submitted by the insured and PLAIC closed the claims without payments. Attributes tested were not applicable for these claims.

It was noted one claimant sought legal advisement upon the denial of the claim. Documents reviewed indicate PLAIC subsequently offered and the insured accepted a lump sum settlement on the disputed claim.

Based upon the review of denied claims handling practices for the period under examination, it was determined PLAIC failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear; failed to acknowledge with reasonable promptness pertinent communications; failed to implement procedures for the prompt investigation of claims; knowingly misrepresented to claimants relevant facts or policy provisions; refused to pay claims without conducting a reasonable investigation; had poorly documented and incomplete files; and, when requested in writing, failed to affirm or deny coverage of claim within a reasonable time.

PLAIC was in violation of O.C.G.A. §§ 33-6-34 (1), (2), (3), (4), (6), and 33-2-13 (a).

Provident Life and Casualty Insurance Company

PLCIC denied benefits on two claims within the scope of this examination. The results of the attribute testing are presented in the following table:

Attributes Tested:	Yes		No		N/A		Totals	
	Count	%	Count	%	Count	%	Count	%
Prompt investigation of claims	1	50%	1	50%	0	0%	2	100%
Communications timely and substantive in form referencing policy provisions or exclusions	1	50%	1	50%	0	0%	2	100%
Responds to claim correspondence timely	1	50%	1	50%	0	0%	2	100%
File documentation supports Company decision	1	50%	1	50%	0	0%	2	100%
Claim file handled in accordance with policy provisions and state statutes	1	50%	1	50%	0	0%	2	100%
No evidence of unfair trade practices or discriminatory acts	2	100%	0	0%	0	0%	2	100%
Claims not subsequently denied after payments began	1	50%	1	50%	0	0%	2	100%
Staff reviewers qualified to make decision for initial denial	1	50%	1	50%	0	0%	2	100%

Timeliness Testing	Time to Acknowledge		Acceptance Rejection Time	
Number of Days	Count	%	Count	%
0-15 days	0	0%	0	0%
16-30 days	0	0%	0	0%
31 to 60 days	0	0%	0	0%
61 to 90 days	0	0%	1	50%
Over 90 days	2	100%	1	50%
Not Applicable	0	0%	0	0%
Totals	2	100%	2	100%

Acknowledgment of the two claims by PLCIC exceeded ninety days. Additionally, the acceptance/rejection of one claim exceeded ninety days.

It was noted PLCIC delayed its investigation of the claim by requiring both a formal proof of loss and subsequent duplicate verification. Upon denial, the insured appealed by way of a faxed letter to PLCIC. PLCIC acknowledged receipt of the appeal in excess of fifty days after receipt of the faxed letter.

Based upon the review of denied claims handling practices for the period under examination, it was determined PLCIC failed to acknowledge with reasonable promptness pertinent communications; refused to pay claims without conducting a reasonable investigation; delayed the investigation of the claim by requiring both a formal proof of loss and subsequent verification that resulted in duplication in the claim form.

PLCIC was in violation of O.C.G.A § 33-6-34 (2), (6), (9) and (10).

ADEQUATE DOCUMENTATION

Claims Standard # 3 – *Claim files are adequately documented. O.C.G.A. §§ 33-6-13, 33-6-34 and 33-24-34.*

The Company's maintenance system on claims is lacking in efficiency. Certain files were not adequately documented. Inquiries were prepared to obtain additional information which should have been included in the completed claim file.

The Company's claim system does not accurately report the location site of its claims files. As an example, it was determined certain claim files were maintained in Chattanooga, Tennessee and/or Portland, Maine, while the system had shown these claim files to be in Worcester, Massachusetts.

It was also determined the Company's claim systems do not consistently contain information relating to dates for claims received and acceptance/rejection of claims by the Company. Additionally, the controls of the claims systems are not adequate. Multiple entries may be made for the same claim which requires closing of claim records to eliminate the duplications. Identification and verification of claims received and applicable disposition could not be readily obtained.

As presented in the results of attribute testing of paid and denied claims, certain files were found to be deficient in adequate documentation to support the Company's decision.

The Company was in violation of O.C.G.A. §§ 33-2-13(a), 33-6-34 (4), and 33-6-34 (9).

LITIGATION

Claims Standard # 4 – *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. O.C.G.A. §§ 33-6-33 and 33-6-34.*

UNUM Life Insurance Company of America

UNUM reported it was a party to 20 litigations involving residents of the State of Georgia for the period under examination. The results of the review of all files applicable to the lawsuits are as follows:

Attributes Tested:	Yes		No		Not Applicable/ Not Available		Totals	
	Count	%	Count	%	Count	%	Count	%
"Own occupation" definition	8	40%	7	35%	5	25%	20	100%
Claimant forced to file suit to recover	6	30%	9	45%	5	25%	20	100%
Claimant forced to ERISA	6	30%	9	45%	5	25%	20	100%
Premiums waived after disabled	1	5%	5	25%	14	70%	20	100%
Company position changed	4	20%	11	55%	5	25%	20	100%
Lump sum settlement offered	12	60%	3	15%	5	25%	20	100%
Denial based on pre-existing conditions	4	20%	10	50%	6	30%	20	100%
Forced to an in-house doctor	1	5%	13	65%	6	30%	20	100%
Decision based strictly on diagnosis	4	20%	9	45%	7	35%	20	100%
Decision based on examination	3	15%	10	50%	7	35%	20	100%
Consumer credit report obtained	1	5%	13	65%	6	30%	20	100%
Self reported diagnosis	0	0%	14	70%	6	30%	20	100%
Based on Social Security decision	0	0%	14	70%	6	30%	20	100%
File adequately documented	12	60%	3	15%	5	25%	20	100%

The litigation listing presented by UNUM included three lawsuits involving matters that were not associated with a long-term disability policy and, therefore, were not within the scope of this examination. UNUM was not a named party to one suit included on the listing provided. Additionally, UNUM had received the requisite notice under O.C.G.A. § 33-6-4 of a potential suit involving a long-term disability policyholder, but a complaint had not been filed as of the date of review by this examination. Results of attribute testing for these five litigations have been reported as "not applicable."

For one suit, several attributes were not applicable. Litigation involved the definition of income which was the basis for long-term disability benefits paid.

An examination of one claimant was not an applicable attribute for the issues involved in the litigation. UNUM denied continuation of benefits as the claimant no longer satisfied the policy definition of disability. UNUM initiated surveillance of the claimant and filed a countersuit under RICO.

Evidence of waiver of premiums after disability was not included in an additional eight litigation files.

UNUM appears to routinely enter into settlement agreements, regardless of the merits of the case, after the litigation process has ensued for a period of time. These settlement agreements involve a lump sum payment to the plaintiff/claimant with a release from and termination of the long-term policy(ies).

This examination determined six claimants were forced to institute litigation to receive benefits under the terms of the long-term disability policies.

On one suit, the claimant had been disabled due to an accident. UNUM denied continuing benefits for the claimant based upon recovery from the primary diagnosis; documentation contained evidence of a secondary diagnosis at the time of the accident. The claimant sought an appeal of UNUM's decision and was advised by UNUM to seek legal counsel for the filing of such appeal. Suit was subsequently instituted.

UNUM denied benefits for one claimant due to preexisting conditions. The claimant's attending physician stated the diagnosis utilized by UNUM was secondary to the actual cause of disability. The suit was settled for an amount substantially less than the liability calculated by UNUM, as evidenced with the documents reviewed.

Another litigation involved a denial based on preexisting conditions. UNUM had been paying disability benefits to the insured on one policy. Benefits were terminated when it was decided the insured could return to work. The documents evidence the insured was disabled for at least six months after benefits were terminated. The insured gained coverage under a second policy, under which a second disability claim was filed. UNUM denied benefits on the second claim due to preexisting conditions. The claimant was awarded Social Security Disability Insurance benefits subsequent to UNUM's claim denials. The insured instituted suit.

On one litigation, UNUM denied benefits as the elimination period had not been satisfied. UNUM's records note the claimant had appealed, produced evidence of an award of disability under Social Security and provided additional medical information. The documentation also contained evidence of UNUM's admission that it had not considered the additional information provided.

UNUM denied benefits to one claimant on the basis of preexisting conditions. This denial was based upon the determination that prior chiropractic services constituted medical treatment. Review of the documentation indicated UNUM imposed response dates that were more restrictive than the policy language while its review of documents was delayed beyond the requirements of ERISA. Proper notification of the extenuating circumstances for UNUM's delays was not identified. As noted in the litigation documentation provided, UNUM acknowledged internally it had not properly reviewed information obtained. Additionally, UNUM obtained consumer credit reports on the

claimant. The Federal Fair Credit Reporting Act does not allow for consumer reports to be obtained for claim processing under an insurance policy.

One suit was filed to obtain benefits based upon the proper year's wages as defined within the terms of the policy. The claimant had a recurrent disability. A second episode occurred approximately one and one-half months after the period stipulated within the long-term disability. The claimant had obtained a verbal assurance from UNUM that the claim would be handled "out-of-contract" for recurrent episodes. Documentation indicated this verbal assurance had been witnessed by a third party. The court found in favor of the claimant.

Based upon the review of all litigation matters for the period under this examination, it was determined UNUM failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear; compelled insureds to institute suits to recover benefits; refused to pay claims without a reasonable investigation; obtained consumer credit reports as a part of its claim processing; and did not provide proper notice and/or requests for delays in processing due to extenuating circumstances.

UNUM was in violation of O.C.G.A. § 33-6-34 (4), (5) and (6); Federal Fair Credit Reporting Act, 16 CFR 604 (3)(C)(2), and 19 CFR 2560.503 1(h)(2).

The Paul Revere Life Insurance Company

The Company reported it was a party to 23 litigations involving residents of the State of Georgia for the period under examination. The results of the review of all files applicable to the lawsuits are as follows:

ATTRIBUTES:	Yes		No		Not Applicable/ Not Available		Totals	
	Count	%	Count	%	Count	%	Count	%
"Own occupation" definition	20	87%	2	9%	1	4%	23	100%
Claimant forced to file suit to recover	4	17%	19	83%	0	0%	23	100%
Claimant forced to ERISA	8	35%	15	65%	0	0%	23	100%
Premiums waived after disabled	10	43%	7	30%	6	26%	23	100%
Company position changed	3	13%	19	83%	1	4%	23	100%
Lump sum settlement offered	10	43%	11	48%	2	9%	23	100%
Denial based on pre-existing conditions	5	22%	16	70%	2	9%	23	100%
Forced to an in-house doctor	6	26%	15	65%	2	9%	23	100%
Decision based strictly on diagnosis	3	13%	17	74%	3	13%	23	100%
Decision based on examination	9	39%	10	43%	4	17%	23	100%
Consumer credit report obtained	4	17%	19	83%	0	0%	23	100%
Self reported diagnosis	4	17%	17	74%	2	9%	23	100%
Based on Social Security decision	0	0%	20	87%	3	13%	23	100%
File adequately documented	19	83%	4	17%	0	0%	23	100%

PRLIC appears to routinely enter into settlement agreements, regardless of the merits of the case, after the litigation process has ensued for a period of time. These settlement agreements involve a lump sum payment to the plaintiff/claimant with a release from and termination of the long-term policy(ies).

Evidence of waiver of premiums after disability was not included in 13 of the litigation files.

This examination determined four claimants were forced by the Company to institute litigation to receive benefits under the terms of their long-term disability policies.

For one litigation, the associated claim file showed the insured performed dual duties in his occupation. The insured sustained injuries which required three surgeries to correct. PRLIC terminated the insured's benefits based upon one set of duties even though the insured's treating physician attested to his total disability. After PRLIC had terminated the insured's benefits, the insured had two of his three corrective surgeries. During this time, an IME and field report conducted for PRLIC indicated the insured was totally disabled. The insured was also awarded social security disability benefits. This litigation was settled by PRLIC and the insured.

Documentation within one litigation file showed the claim form submitted by the insured reported disability due to two conditions. The insured was released by the attending

physician for one condition only. PRLIC terminated residual benefits and argued benefits were not due as residual benefits are based upon the same injury or sickness which caused the total disability. The second condition stipulated on the claim form was not addressed. The insured timely filed an ERISA appeal, however PRLIC did not respond until approximately 100 days later. There was no evidence noted in the file that PRLIC provided the insured with written notice prior to the commencement of the extension as required under ERISA. The insured instituted litigation.

In one claim reviewed, PRLIC denied the claim stating the policy was not in force. PRLIC argued the policy never took effect quoting condition four from the signed application which reads, "The insurance applied for will not take effect unless the issuance and delivery of the policy and payment of the first premium occur while the health of the Proposed Insured remains as stated in the application." Due to an accident while conducting activity expressly excluded by endorsement in the policy, the claimant had a significant change in health between the time of his application and the effective date of the policy. PRLIC had not been apprised of this accident. Approximately four years after policy issuance, the insured was involved in an automobile accident and filed a claim for disability. During the investigation of this claim, PRLIC learned of the prior incident that had occurred before the effective date of the policy. PRLIC received all the claim information and issued their decision denying the claim. The Company used a premanifestation argument in its attempts to void the contract without regard to the incontestability clause contained in the policy. The insured had not misrepresented any facts within the application for insurance.

One claim file reviewed indicated PRLIC terminated the insured's benefits since his attending physician stated he should be able to return to work on a part-time basis. The policy did not contain a partial disability provision. The insured never returned to work and his condition worsened approximately two years later, at which time the insured again filed a disability claim. PRLIC denied this claim based on a field report, the interpretation of an IME performed by PRLIC and a paper review by PRLIC of the insured's medical records. In subsequent examinations performed by the attending physician, he stated unequivocally the insured was disabled from any full time or part time employment. PRLIC chose to disregard these attestations of disability and confirmed its denial by letter to the insured. Litigation was initiated. Settlement occurred subsequent to the death of the insured.

Based upon the review of all litigation matters for the period under this examination, it was determined PRLIC failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear, compelled insureds to institute suits to recover benefits, refused to pay claims without a reasonable investigation, obtained consumer credit reports as a part of its claim processing, misrepresented to claimants and insureds relevant facts or policy provisions, failed to adopt and implement procedures for the prompt investigation and settlement of claims, and did not provide proper notice and/or requests for delays in processing ERISA claims due to extenuating circumstances. The files on four (4) cases as originally received by this examination were not complete.

PRLIC was in violation of O.C.G.A. §§ 33-2-12(a) and 33-6-34(1), (3), (4), (5), (6); 16 CFR 604 (3)(C)(2); and 29 CFR 2560.503-1 (h)(1) and (2).

Provident Life and Accident Insurance Company

PLAIC reported it was a party to 33 litigations involving residents of the State of Georgia for the period under examination. The results of the review of all files applicable to the lawsuits are as follows:

	Yes		No		Not Applicable/ Not Available		Totals	
ATTRIBUTES:	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
"Own occupation" definition	25	76%	2	6%	6	18%	33	100%
Claimant forced to file suit to recover	14	42%	12	36%	7	21%	33	100%
Claimant forced to ERISA	13	39%	14	42%	6	18%	33	100%
Premiums waived after disabled	16	48%	9	27%	8	24%	33	100%
Company position changed	4	12%	21	64%	8	24%	33	100%
Lump sum settlement offered	13	39%	13	39%	7	21%	33	100%
Denial based on pre-existing conditions	2	6%	25	76%	6	18%	33	100%
Forced to an in-house doctor	5	15%	22	67%	6	18%	33	100%
Decision based strictly on diagnosis	11	33%	16	48%	6	18%	33	100%
Decision based on examination	14	42%	12	36%	7	21%	33	100%
Consumer credit report obtained	4	12%	22	67%	7	21%	33	100%
Self reported diagnosis	1	3%	26	79%	6	18%	33	100%
Based on Social Security decision	0	0%	26	79%	7	21%	33	100%
File adequately documented	17	52%	10	30%	6	18%	33	100%

The litigation listing, as presented by PLAIC, included five lawsuits involving matters that were not within the scope of this examination. Of the five suits mentioned above, one was a suit brought on a life policy and one was a suit brought on a health policy. Two of these suits involved PLAIC as policy administrator only and did not involve a liability of PLAIC. One suit was noted to have been closed in 1996 and was, therefore, outside the scope of the examination. The results of the attribute testing for these five litigations have been reported as "not applicable."

For one suit, all of the attributes were reported as not applicable. This litigation was filed on behalf of a disabled spouse ten years after disability benefits were terminated. The litigation was settled in favor of the Company.

One suit was shown to have several attributes listed as not applicable since the Company was not able to produce the litigation file for the examiner's review.

Evidence of waiver of premiums after disability was not included in nine of the litigation files reviewed. Of these, two of the claims were denied; therefore waiver of premium was not an applicable attribute. Three of the claims contained evidence the insured continued to work after filing for disability. Payment under partial or residual disability portion of the policy does not trigger the waiver of premium benefit; therefore this attribute was not applicable. Two of the files reviewed were group files and the premiums were paid by the employer. In two of the files reviewed, it did not appear that waiver of premium was addressed.

PLAIC appears to routinely enter into settlement agreements, regardless of the merits of the case, after the litigation process has ensued for a period of time. In many instances, it was noted PLAIC appears to continue their claim investigation, obtain medical reviews and medical records after the initial denial. These settlement agreements involve a lump sum payment to the plaintiff/claimant with a release from and termination of the long-term disability policy(ies).

This examination determined 14 claimants were forced to institute litigation to receive benefits under the terms of their long-term disability policies.

One lawsuit involves the question of risk coverage. PLAIC terminated benefits due to inadequate support of skill deficits and its determination that risk of relapse was not a covered risk. There were three independent medical examinations (IME's) obtained by PLAIC, two of which indicated the insured could never return to his occupation due the high risk of relapse. It was noted PLAIC did not obtain medical record reviews or IME's by doctors specializing in the insured's cause of disability. PLAIC's response to an examination inquiry cited three Georgia court cases in which the risk of relapse was apparently not covered by policies of three other insurance companies. The examiners noted another case in this sample, in which the courts found, in essence, the risk of relapse was a valid risk covered by PLAIC's policy, if the risk was strong enough. It was determined the insured was compelled to institute litigation.

One claim, being paid on a residual basis, was terminated by PLAIC because a review of the insured's medical records by PLAIC's doctors did not support the insured was unable to perform the material and substantial duties of her occupation. It was noted the description of the insured's duties provided in the referral notice to the IME was not accurate in that it was described as a sedentary occupation. The insured's treating physicians had offered as previous explanations that the insured's condition seemed to be associated with the extreme intensity of her work. Additionally the treating physicians described the insured's work as intense and demanding a great deal of emotional and physical energy. The treating physician considered her totally disabled from her job.

In one file reviewed, the continuation of claim benefits was denied by PLAIC, as the insured no longer met the policy's definition of total disability. Although, an IME

performed by PLAIC indicated the insured might be able to work part time, residual benefits were not considered or offered by PLAIC. During the litigation, PLAIC used the premanifestation argument as one reason for the termination of benefits. The court ruled the premanifestation argument invalid pursuant to the policy's incontestability clause and quoted a decision of the Georgia Court of Appeals, in *Brock*, that would bar PLAIC's attempt to deny coverage. In *Brock* (1985), a three-judge panel of the Court of Appeals rejected the reasoning of *Keaten v. Paul Revere Life Ins. Co.* (5th Cir. 1981) (applying Georgia law), which held that the insurer could deny a disability claim based on a pre-manifested sickness, since the incontestability clause only precluded the company from challenging the validity of the policy. PLAIC settled this suit for a sum substantially less than the liability indicated within documents contained in the file.

PLAIC denied one claim stating the insured's not returning to work was preventive in nature (risk of relapse) and not disabling. The Company had an IME performed which noted the insured was following prescribed treatment and stated actual job limiting restrictions due to the insured's condition. PLAIC documents acknowledge the IME's report of the insured's continuing disability and poor prognosis. PLAIC offered the insured six months of disability payments as full and final payment of the claim and denied any further liability. This case was subsequently settled for an amount substantially greater than PLAIC's initial offering. As discussed above, it was noted the courts, in essence, have held that PLAIC's disability policy does in fact cover the risk of relapse, if the risk is strong enough.

PLAIC denied one claim as pre-existing based on certain symptoms of the claimant prior to the date of loss and within the contestable period, not a diagnosis or any actual treatment of the insured. The insured's attending physician stated the claimant at no time had been diagnosed with the disabling condition and that the symptoms prior to loss were possibly due to factors other than the disabling condition. PLAIC attempted to get this claim tried under ERISA rules, but this motion was denied by the court.

In one claim, PLAIC paid benefits under the sickness policy provision, which limits the benefit period to 60 months. After the 60-month benefit period, PLAIC denied any further benefits. The issue litigated involved whether the condition was sickness or due to an injury, which provides disability benefit payments for life and the policy provision relating to disability from any occupation as the insured had taken a teaching position subsequent to disability. The insured's treating physician stated the disabling condition "... in my experience, and professional opinion, has always been considered an injury." PLAIC tried to force the insured to federal court by claiming ERISA rules governed this case. The case was remanded to state court and was ruled to be non-ERISA.

One claim reviewed was filed for residual disability benefits since the insured continued to work part-time. PLAIC conducted a paper review of the insured's medical records obtained from the attending physician rather than conduct an IME of the insured. The denial letter stated in part, "Our medical staff reviewed all of the medical records that his attending physician provided to us and they did not find support for a disabling diagnosis." The denial letter states later, "It would appear from the medical records

submitted that your clients ability to work on a full-time basis is a choice on his part as his physician believes that if he returns to work full-time, his condition again will relapse." Documents within the file reviewed indicated PLAIC had knowledge the insured was able to work part-time under controlled circumstances. As discussed above, courts have found risk of relapse is a covered risk, if the risk is strong enough.

One claim was denied by PLAIC since the insured's medical condition, "... first manifest itself prior to the application and issue of this policy. As a result, we regret that we are unable to provide you with benefits under the terms of this contract." The court ruled the pre-manifestation argument invalid pursuant to the policy's incontestability clause and quoted a decision of the Georgia Court of Appeals, in *Brock*, that would bar PLAIC's attempt to deny coverage.

PLAIC denied one claim reviewed because the insured continued to work for three months after her attending physician stated she was totally disabled. The insured was the sole provider of her family. The policy did not contain a residual or partial disability provision. Although the insured was 55 at the time of her disability, PLAIC did not use the policy language directed to disability at age 55. It was noted PLAIC did not have the insured's claim or medical records reviewed by medical personnel, nor did it request an IME. PLAIC overruled four treating physicians who attested at various times to the insured's disability. The basis for denial of the claim was a file review by an internal disability case manager.

One file as originally received was not complete; upon inquiry missing documents were provided. This file showed the insured had several diagnoses for which disability was claimed. Four treating physicians stated the insured was totally and completely disabled from any job due to these problems. PLAIC terminated benefits by letter stating its doctor had reviewed a copy of a physician's report relating to specific medical tests and had determined that both from a disability standpoint as well as a medical management standpoint, it is imperative that some form of a functional assessment test be performed. PLAIC further stated the insured's functional status was not objectively documented. Functional status is not a term defined in the policy. The file indicates PLAIC had not determined prior to termination of benefits whether the functional assessment test would fall under the definition of an IME as stated in the policy and PLAIC did not appear to research its ability to require such test until August 2000, which was two years after benefits had been terminated. The file documents indicate such functional assessment test would have been performed against the advice of the insured's treating physician.

Additionally, during the evaluation on this same claim, it was noted PLAIC ordered a consumer credit report, a court records search for convictions, public records, a Dun & Bradstreet report on the insured and a search for any real estate owned by the insured. It was also noted the insured's attorney submitted an "ERISA" appeal of benefit termination to PLAIC. Neither the insured nor the attorney were notified of the denial of this appeal until approximately 45 days after PLAIC had rendered its decision.

One insured had a disabling condition for which benefit payments were made by PLAIC. The employer of the insured contacted PLAIC regarding the continuing benefits and stated it had offered a lesser position to the insured, which had not been accepted. Based upon this information, PLAIC terminated benefits. Litigation was initiated. In this case, the court ruled and/or stated as follows: 1) that the facts support the insured's claim that he is entitled to long-term disability benefits under the terms of the group plan; 2) neither of the PLAIC's medical consultants had personally examined the insured or been identified as specialists for the insured's condition; 3) the administrative record suggested PLAIC decided to engage in its searching review of insured's medical condition only after the employer contacted PLAIC and complained that they were very upset because PLAIC was not managing this claim well; and 4) the court believed that a reasonable jury could conclude that PLAIC's decision to terminate the insured's long-term disability payments was as arbitrary and capricious as its selection of medical consultants. The court further stated PLAIC decided to reject the opinion of the insured's long-time physician that the insured's condition was unimproved and that the insured was permanently disabled based upon the evaluation of medical records by a physician who received incorrect factual information about the insured and invalid, incomplete and non-diagnostic test data. This evidence could support a reasonable finding that PLAIC's decision to terminate the insured's benefits amounted to an abuse of discretion.

On one ERISA claim, benefit payments were apparently terminated due to the intervention of the insured's employer. In this case, the court stated that after reviewing the complete claim file that PLAIC evaluated in making its decision to terminate benefits, it became evident that PLAIC had seized certain anecdotal statements to deny the insured's benefits without performing a thorough evaluation of the entire circumstances surrounding the insured's case. As a result, the court decided PLAIC's termination of the insured's benefits was arbitrary and capricious.

One file, incomplete as originally received and reviewed, showed PLAIC paid the claim while the insured was on partial disability but refused to consider total disability benefits as PLAIC determined the insured was not prohibited from working full time. All of the insured's treating physicians attested to the insured's total disability. The file documents indicate PLAIC appeared to hold the insured to a more stringent definition of disability than is contained in the policy and to a higher treatment standard than recommended by the treating physicians. This case was tried by jury. The jury found in favor of the insured on all items including the insured's total disability and bad faith claims handling by PLAIC and awarded the insured attorney fees and penalties.

PLAIC paid one insured for a ten-month period under the reservation of rights provision of the policy. No further claim payments were made as PLAIC claimed the insured was no longer disabled, as evidenced by the review of two doctors, and that risk of relapse of the insured's medical condition was not a covered risk under the terms of the policy. PLAIC's litigation argument also included a premanifestation issue. The court, in essence, ruled the risk of relapse was a covered risk, if the risk was strong enough. The court also ruled against PLAIC on the premanifestation defense.

Based upon the review of all litigation matters for the period under this examination, it was determined the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear; compelled insured to institute suits to recover benefits; refused to pay claims without a reasonable investigation; obtained consumer credit reports as a part of its claim processing; and did not provide proper notice and/or requests for delays in processing due to extenuating circumstances. Several of the files as originally received from the Company were incomplete. It was only after inquiry that remaining portions of the files were received, if they were able to be located.

PLAIC was in violation of O.C.G.A. §§ 33-2-13(a) and 33-6-34 (1), (3), (4), (5), (6) and (7); Federal Fair Credit Reporting Act, 16 CFR 604 (3)(C)(2), and 29 CFR 2560.503-1(f) and (g).

Provident Life and Casualty Insurance Company

PLCIC was not a party to any legal actions involving residents of the State of Georgia who were insured under long-term disability policies during the period under examination.

SUMMARY OF COMMENTS

Deficiencies were noted in the Company's claims systems in that locator field for claim files were not accurate and duplicate entries could be made into the claim systems for the same claim. Deficiencies were also noted in the claims files in that pertinent documents were not included and/or were not routinely date stamped. The Company was in violation of O.C.G.A. §§ 33-2-13(a) and 33-6-34 (4) and (9).

UNUM, PRLIC and PLAIC were not able to locate or provide claim files selected for review by this examination. Each was in violation of O.C.G.A. § 33-2-13(a).

Delays were encountered in obtaining complete information requested for this examination. Specifically, excessive delays occurred regarding the data files and reconciliations for claim data information. After a significant delay, the Company provided a significantly modified letter of representation. These actions were in violation of O.C.G.A. § 33-2-13(a).

UNUM's complaint register did not include one complaint reported on the records of the Department.

PLAIC did not produce one complaint file for a complaint reported on the records of the Department which was in violation of O.C.G.A. § 33-2-13(a).

The Company's complaint files did not include all pertinent documentation relating to the complaint and its resolution/disposition. The Company was in violation of O.C.G.A. § 33-2-13(a).

In the review of complaints, it was noted UNUM had improperly handled its claims processing for certain insureds. These actions were in violation of O.C.G.A. §§ 33-6-34 (3), (4), (6), and (9).

PRLIC was in violation of O.C.G.A. § 33-6-34(6) as a reasonable investigation was not conducted at the commencement of the claim review for the claim as PRLIC had overturned its original denial with no additional information on complaints.

The review of the claim files for the UNUMProvident Companies revealed numerous practices not in compliance with the Georgia Insurance Code. The Company failed to communicate timely or in a substantive manner to insureds; failed to advise claimants of rights allowed under the provisions of the policy; failed to effectuate prompt, fair and equitable settlements with reasonable promptness; failed to implement procedures for the prompt investigation of claims; refusing to pay claims without conducting a reasonable investigation; and failure to provide forms necessary to file claims within 15 days of a request. Claim files were poorly documented or incomplete. The Company was in violation of O.C.G.A. §§ 33-6-34 (1), (2), (3), (4), (6), (7), (11) and 33-2-13 (a).

Several instances were noted where the Company requested and obtain credit reports and performed other financial searches during its claim processing. These actions were in violation of 16 CFR 604 (3)(C)(2).

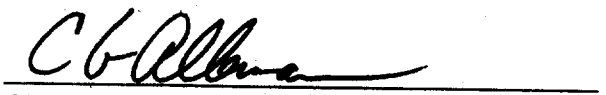
The Company did not properly notify its claimants of delays in reviews of the claim appeals as required under ERISA. The Company was in violation of Title 29 CFR 2560.503 (e)(l) and (f), (g)(1).

It was determined the Company's claim practices compelled certain insureds to institute litigation to recover amounts due under policies. This examination found six instances of this for UNUM, four for PRLIC, and 14 for PLAIC. The Company was in violation of O.C.G.A. § 33-6-34 (5).

ACKNOWLEDGEMENT

In addition to the undersigned, E. Joy Little, CFE; JoAnn Wheaton, CFE (Fraud); William L. Doolittle, CIE, FLMI, CLU; Thomas W. Jones, CLCR; Sharon D. Lawrence; Timothy Nutt, and Wanda M. LaPrath, AIE, FLMI participated in this examination.

Respectfully submitted.



Chauvin G. Alleman, CFE
Examiner-in-Charge
For the State of Georgia
Department of Insurance

HUFF THOMAS

AFFIDAVIT

STATE OF TEXAS }
} ss
COUNTY OF DALLAS }

Chauvin G. Alleman, being duly sworn, deposes and says that the foregoing Report on Market Conduct Examination of UNUM Life Insurance Company of American, The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, and Provident Life and Casualty Insurance Company as of November 30, 2000, subscribed by him, is true to the best of his knowledge and belief.

C G Alleman

Chauvin G. Alleman, CFE
For the State of Georgia
Department of Insurance

Subscribed and sworn to before me on the 1st day of August, 2002.

Nancy K. Self

Notary Public for the State of Texas
My Commission Expires:

NANCY K. SELF
MY COMMISSION EXPIRES
August 04, 2006