

REPORT OF EXAMINATION

OF THE

MARKET CONDUCT AFFAIRS

OF

STARMOUNT LIFE INSURANCE COMPANY

BATON ROUGE, LOUISIANA

AS OF

September 30, 2004

NAIC CODE 68985

NAIC ETS EXAM NO. LA071-M33

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January 17, 2005

Honorable J. Robert Wooley
Commissioner of Insurance
P O Box 94214
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Sir:

Pursuant to statutory provisions and in compliance with your instructions, a target market conduct examination has been made of the affairs of the

STARMOUNT LIFE INSURANCE COMPANY

7800 OFFICE PARK BLVD.

BATON ROUGE, LOUISIANA 70809

as of September 30, 2004 and the report of examination is herewith submitted.

FOREWORD

A market conduct examination was performed of the activities of Starmount Life Insurance Company from January 1, 2001 through September 30, 2004. The examination was performed by test and all tests applied during the examination are included in this report.

PURPOSE AND SCOPE OF MARKET CONDUCT EXAMINATION

In accordance with **LSA-R.S. 22:1301 D**, the market conduct examination of Starmount Life Insurance Company, hereinafter referred to as ("Company"), was a target market conduct examination authorized by the Louisiana Department of Insurance, hereinafter referred to as ("Department").

The purpose of this examination was to review compliance by the Company with Louisiana Insurance Laws, Regulations, Directives and the National Association of Insurance Commissioners ("NAIC") Guidelines. The NAIC Guidelines set the standards of conduct for a life insurer and promote a program of fair treatment of policyholders. The *NAIC Market Conduct Examiner's Handbook, Volume I* was used as a measure of compliance.

The ACL Program, a data manipulation program, provided by the Department was utilized in this examination. Samplings were utilized to test the Company's records and procedures. The ACL Program was used to automatically generate a random sampling of claims records. "Random" is a theoretical concept meaning that all items in a population or file (before selection) have an equal chance of appearing in the sampling.

In instances in which ACL was not used, a systematic (sequential) sampling of certain company record listings was performed.

Generally, a random or systematic sampling size of sixty (60) records will be selected for review. A minimum confidence level of ninety-five percent (95%) with a maximum error rate of five percent (5%) will be used for all samples. Based on a review of the sampling's error rate, additional samplings may be required.

The examination included, but was not limited to, the following areas of the Company's operation:

- Complaint Handling,
- Producer Licensing and Appointments and
- Claims.

COMPANY OPERATIONS

Company History

The Company was incorporated as Goudchaux/Maison Blanche Life Insurance Company under the laws of the State of Louisiana on August 24, 1983, and received its Certificate of Authority on August 31, 1983. The Company was formed to transact all kinds of life, health and accident insurance under the Louisiana Insurance Code.

On October 16, 1989, the Company's Board of Directors amended the Articles of Incorporation to change the name of the Company to Maison Blanche Life Insurance Company. The change was effective on October 18, 1989, and duly approved by the Department.

On February 21, 1992, the Company's Board of Directors again amended the Articles of Incorporation to change the name of the Company to its present name,

Starmount Life Insurance Company. This change was effective March 9, 1992 and approved by the Department.

Parent, Subsidiaries, and Affiliates

The following schedule depicts certain affiliations with the Company. Ownership is denoted by indenture.

Hans J. Sternberg
H & J Capital, LLC
Starmount Insurance Agency, Inc.
Starmount Life Insurance Company
Starmount Financial Corporation

Territory and Plan of Operations

The Company is licensed to transact life, health and accident (disability) insurance business in the states of Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Missouri, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, West Virginia and Wisconsin. The Company's roots are in the individual life insurance market, but the dental and vision products have grown dramatically in recent years. The Company continues to market individual term life insurance. The Company is often able to sell complimenting products associated with the term insurance, such as an accident policy, accident rider, nursing home care riders, conversion to fixed cost term insurance and whole life. The Company currently markets these products primarily through direct mail response.

In addition to individual products, the Company also offers limited benefit group products such as dental, life, accident protection and vision. Group products are solely marketed through independent producers. As noted previously, these products should

continue to be the primary drivers of growth in the coming years. As of September 30, 2004, the Company had approximately one hundred thirty-six (136) independent producers appointed with the Department.

For the period under examination, the Company's annual statements reflected the following gross premium volume:

<u>YEAR</u>	<u>PREMIUM VOLUME</u>
2001	\$5,367,751
2002	\$8,705,923
2003	\$12,160,029

Comments and Recommendations from Previous Reports

The Louisiana Department of Insurance conducted an examination of the Starmount Life Insurance Company as of December 31, 1999. That examination report did not contain any recommendations relating to the Company's market conduct activities.

COMPLAINT REVIEW

This review was conducted in accordance with the provisions of Louisiana Revised Statute **22:1214 (17)** which states as follows:

"The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: ...Failure to maintain adequate complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this Paragraph, "complaint" shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance."

The Company's complaint procedure was reviewed. It is actually a procedure that covers the handling of grievances and appeals from customers. It does not contain

any procedures for handling complaints received from the Department of Insurance. It is recommended that the procedure be modified to include procedures for handling complaints received from the Department and the response back to the Department.

The Company complaint register was reviewed. The Company maintains two (2) separate registers, one (1) for life and one (1) for dental and vision complaints. The registers contain all of the requirements of the statute except for the total number of complaints. This is not in compliance with **LSA-R.S. 22:1214 (17)** which is shown above. It is recommended that the registers be modified to include the total number of complaints in order to be in compliance with the above statute. According to Company, upon notification by the examiner, the Company revised the complaint register to include the total number of complaints.

The Department's complaint register contains twenty-seven (27) complaints that have been submitted to the Company for investigation. The following table summarizes the complaints for the four (4) -year period under examination by category:

Category	2001	2002	2003	2004 Thru 9/30/04
Claims Handling	3	1	9	6
Underwriting		1		
Policyholder Service	2	2	1	2
Complaint Total	5	4	10	8

The Company's complaint register did contain all of these complaints.

Company, this system helps ensure that future documents will be available in compliance with the statute.

It was found that during the examination period of January 1, 2001 through September 30, 2004, twenty (20) producers received commission payments while they were not appointed. This is not in compliance with **LSA-R.S. 22:1144 C** which states:

“Any insurance producer, unless otherwise prohibited by contract, licensed in this state, may solicit, negotiate, or effect applications for policies of insurance with any insurer lawfully doing business in this state, other than an insurer such producer is licensed to represent, if such producer is under contract with such insurer. However, no commissions shall be paid by such company to the producer until such time as notice of recordation of the appointment with respect to such producer has been received by the producer from the commissioner.”

It is also not in compliance with **LSA-R.S. 22:1144 B (1)** which states:

“An insurer lawfully authorized to transact business in this state shall appoint as its agent any person or persons holding a license issued under the provisions of this Part. To appoint a producer as its agent, the appointing insurer shall file, in a manner prescribed by the commissioner of insurance, a notice of appointment within fifteen days from the date the agency contract is executed. An insurer may also elect to appoint a producer to all or some insurers within the insurer’s holding company system or group by the filing of a single appointment request.”

It is recommended that the Company implement procedures to ensure that all producers are properly appointed in order to be in compliance with the above statutes. According to the Company, upon notification of this issue, they have initiated steps to ensure that all producers will be properly appointed in the future.

During this examination, the Company was reminded of the DOI's Bulletin #99-01 dated June 1, 1999 referencing "Consent for Prohibited Person to engage in Insurance Business". This Bulletin was a notification to all persons and entities engaged in or contemplating being engaged in the business of insurance in this state, that the Louisiana Department of Insurance has enacted guidelines and requirements for granting written consent to engage in the business of insurance for individuals who are considered

"prohibited persons" under The Violent Crime Control and Law Enforcement Act of 1994, Title 18 U.S. Code, Sections 1033 and 1034.

The Company believes its procedures for contracting producers are in compliance with the DOI's Bulletin #99-01.

The Company's procedure for recruiting producers was reviewed. Producer information is logged into Appointpak for license verification, background check and agent and/or agency appointment. Appointpak uses vendors such as GIS (General Information Systems) to do criminal background and credit checks. They check both parish and federal records. The procedure seems adequate.

The Company did not have any producers that had been terminated for cause during the examination period.

CLAIMS REVIEW

Claims Walkthrough

A brief claims walkthrough was conducted on December 10, 2004. The examiner was accompanied by the Chief Operating Officer. Most claims are received by mail and are sorted and delivered to the proper department. There are separate departments for life claims and health claims. Claims are date stamped when received. Claims are scanned into the computer system and are then entered into the system by data entry personnel in the claims department. Claims are then reviewed and processed if clean. If additional information is required, they are pended and a request for information is sent out. When the information is received, the claim is then reviewed and either paid or denied.

Paid Claims Review

The Company provided a listing of all paid claims for the period January 1 through December 31, 2003 in an electronic file. This file was analyzed by ACL and various reports were generated.

These ACL reports are based on the actual number of claims processed and include both clean and unclean claims. The following table shows the breakdown of all paid claims processed by type of claim:

TOTAL CLAIMS PROCESSED

<u>Type</u>	<u>Number of Claims</u>	<u>Amount</u>
Life Claims	31	\$640,609
Dental	73,751	\$6,009,189
Vision	12,996	\$776,920
Total	<u>86,778</u>	<u>\$7,426,718</u>

The following tables show the time it took to process and pay the different types of claims:

LIFE CLAIMS

45% were paid within 30 days
29% were paid within 60 days
6% were paid within 90 days
13% were paid within 120 days
7% were paid 121 days or later

DENTAL AND VISION CLAIMS

54% were paid within 30 days
36% were paid within 60 days
6% were paid within 90 days
2% were paid within 120 days
2% were paid 121 days or later

Paid Claims Sample Review

The Company paid a total of thirty-one (31) life claims during the period of January 1, 2003 through December 31, 2003. All of the paid claims were reviewed to determine the payment time from receipt of proof of death. Also, the claims were reviewed to verify that they were paid in accordance with the terms of the policy. A check of beneficiaries was performed to verify that payment was made to the correct person.

All claims payments in the sample were made within the statutory time limit and were paid in an average of eight (8) days after receipt of proof of death.

ACL was used to select a random sample of sixty (60) paid dental and vision claims to review. The files were reviewed to determine the date of service, the received date, the clean date and the paid date. Also, any comments were noted that might explain any long delays in payment.

It was found that four (4) claims were not paid within the time period allowed by the statutes. This is not in compliance with **LSA-R.S. 22:250.32 A (1)** which states:

“Any claim submitted by a health care provider within forty-five days of the date of service or discharge under a contract for provision of covered benefits with a health insurance issuer shall be paid not more than forty-five days from the date upon which a correctly completed uniform claim form is furnished...”

It is recommended that the Company implement procedures to ensure that all claims are paid within the time limits required by the statutes.

The review showed that claims were paid in an average of thirty-six (36) days after receipt of the claim and twenty-four (24) days after the clean date of the claim.

Denied Claims Review

The Company provided a listing of denied life claims for the examination period January 1, 2001 through September 30, 2004 in an electronic file. There were only five (5) denied life claims during the examination period and they were all selected for review.

The Company provided a listing of denied dental and vision claims for the examination period January 1, 2001 through September 30, 2004, in an electronic file. The file contained one hundred sixteen thousand nine hundred twenty-six (116,926) claims. ACL was used to analyze the file and summarize the reasons for denial. The results are presented below:

<u>Reason for Denial</u>	<u>No. of Claims</u>
Not a covered procedure	32,266
Exceeds usual & customary fee	25,138
In excess of plan benefits	14,673
Exceeds limit per time period	11,709
Duplicate claim	7,783
Exceeds annual maximum	3,048
Services after policy termination	2,460
Emergency not covered w/ other procedure	2,318
Information requested not received	1,666
Waiting period applies	1,329
Invalid code billed	1,038
Benefit adjusted due to COB	918
Miscellaneous	<u>12,580</u>
Total	116,926

Denied Claims Sample Review

The entire listing of five (5) denied life claims was selected for review. The files were reviewed to determine the reason for the denial and to review the general handling

of the claims. Files for two (2) of the claims could not be found. This is not in compliance with LSA-R.S. 22:39 B which states:

“All such original books, records, documents, accounts, and vouchers, or such reproductions thereof, of the home office of any domestic company or of any principal United States office of a foreign or alien company located in this state shall be preserved and kept available in this state for the purpose of examination and until authority to destroy or otherwise dispose of such records is secured from the commissioner. At a minimum all such original records shall be maintained for the period commencing on the first day following the last period examined by the commissioner through the subsequent examination period, or three years, whichever is greater...”

It is recommended that the Company implement procedures to ensure that records of claims are maintained in order to be in compliance with the above statute.

The remaining three (3) claims were reviewed and they had been denied for misrepresentation of information on the applications.

A random sample of sixty (60) denied dental and vision claims was selected by ACL from the file provided by the Company. The files were reviewed to determine the reason for the denial and to review the general handling of the claims. The following table lists the number of claims for each reason:

<u>Reason for Denial</u>	<u>No. of Claims</u>
In excess of plan benefits	20
Exceeds usual & customary	18
Not a covered procedure	11
Duplicate claim	4
No coverage on date of service	4
Requested information not received	1
Benefits adjusted due to COB	1
Emergency exam not covered w/ other procedure	1
Total	<u>60</u>

The denied dental and vision claims were handled properly and this review was completed without any exceptions.

COMMENTS AND RECOMMENDATIONS

COMPLAINT REVIEW

The Company's complaint procedure is a procedure that covers the handling of grievances and appeals from customers. It does not contain any procedures for handling complaints received from the Department of Insurance. It is recommended that the procedure be modified to include procedures for handling complaints received from the Department and the response back to the Department.

The Company's complaint registers were reviewed. The registers contain all of the requirements of the statute except for the total number of complaints. This is not in compliance with **LSA-R.S. 22:1214 (17)**. It is recommended that the registers be modified to include the total number of complaints in order to be in compliance with the above statute. According to Company, upon notification by the examiner, the Company revised the complaint register to include the total number of complaints.

PRODUCER REVIEW

The Company was unable to retrieve commission statements for 2001 due to difficulty with the records storage vendor. Therefore, the check of commissions paid to producers was not complete. This is not in compliance with **LSA-R.S. 22:39 B**. It is recommended that the Company implement procedures to ensure that records are maintained and kept available in order to be in compliance with the above statute. According to the Company in 2003, they began implementation of an imaging system which allows documents to be scanned and accessed electronically. According to the

Company, this system helps ensure that future documents will be available in compliance with the statute.

It was found that during the examination period of January 1, 2001 through September 30, 2004, twenty (20) producers received commission payments while they were not appointed. This is not in compliance with **LSA-R.S. 22:1144 C** and **LSA-R.S. 22: 1144 B**. It is recommended that the Company implement procedures to ensure that all producers are properly appointed in order to be in compliance with the above statutes. According to the Company, upon notification of this issue, they have initiated steps to ensure that all producers will be properly appointed in the future.

CLAIMS REVIEW

It was found that four (4) dental claims were not paid within the time period allowed by the statutes. This is not in compliance with **LSA-R.S. 22:250.32 A (1)**. It is recommended that the Company implement procedures to ensure that all claims are paid within the time limits required by the statutes.

Files for two (2) of the denied life claims could not be found. This is not in compliance with **LSA-R.S. 22:39 B**. It is recommended that the Company implement procedures to ensure that records of claims are maintained in order to be in compliance with the above statute.

CONCLUSION

I, Richard S. Robison, do solemnly swear and affirm that I am an examiner for the Commissioner of Insurance of the State of Louisiana and that, as such, I was assigned to conduct an examination of the market conduct activities of

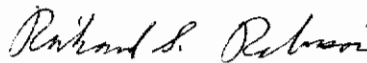
STARMOUNT LIFE INSURANCE COMPANY

BATON ROUGE, LOUISIANA

That I made such examination and the above and foregoing is a true and correct copy of my report of such company and the same is true and correct to the best of my knowledge, information and belief.

I would like to acknowledge the courteous cooperation of the Company's Officers and Employees.

Respectfully submitted,



Richard S. Robison
Louisiana Department of Insurance