STATE OF ARIZONA
FILED

JAN 9 2013

DEPT OF INSURANCE
BY

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of: **JOHN ALDEN LIFE INSURANCE COMPANY**, NAIC # 65080, Respondent	Docket No. 13A-009-INS **CONSENT ORDER**

Examiners for the Department of Insurance ("the Department") conducted a targeted market conduct examination of John Alden Life Insurance Company ("JALIC" or "the Company"). The Report of Targeted Examination of John Alden Life Insurance Company, dated as of June 30, 2008, ("the Report") alleges that the Company has violated Arizona Revised Statutes ("A.R.S.") §§ 20-157(A), 20-444, 20-448, 20-448.01, 20-461(A)(1), (3), (4), (15) and (17), 20-462(A), 20-1401.01, 20-2104(B)(1)(b), 20-2106(7)(a), 20-2110(A) and (D), 20-2309(A), 20-2323, 20-2533(D), 20-2535(B) and (D), 20-2536(A) and (B), 20-3102, and Arizona Administrative Code ("A.A.C.") R20-6-201, R20-6-801(F) and (G)(1)(a), R20-6-1203, and two prior consent orders: Consent Order, Docket No. 00A-085-INS dated May 24, 2000 ("Consent Order 2000"), and Consent Order, Docket No. 03A-023-INS dated February 5, 2003 ("Consent Order 2003").

The Company wishes to resolve this matter without formal proceedings, admits that the following Findings of Fact are true and consents to the entry of the following Conclusions of Law and Order.

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FINDINGS OF FACT

1. JALIC, a Wisconsin-domiciled company, is authorized to transact life and disability insurance in Arizona pursuant to a Certificate of Authority issued by the Director.

2. The Director authorized the Examiners to conduct a targeted market conduct examination of the Company. The examination covered the time period from July 1, 2005, through June 30, 2008, and was concluded on September 2, 2010. Based on the examination findings, the Examiners prepared the Report, dated June 30, 2008.

3. With regard to the processing of health insurance claims, the Company:

a. Failed to conduct a timely and reasonable investigation before denying claims;

b. Failed to provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal the adverse decision;

c. Failed to acknowledge Short Term Medical claims submitted by and payable to the insured within ten working days from receipt of the claim;

d. Failed to adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim;

e. Used Explanation of Benefits ("EOB") forms that:

i. Failed to prominently display the notice of the right to appeal;

ii. Stated an incorrect time period of 180 days for filing a first-level appeal;

iii. Failed to provide the correct name of the issuing insurer.

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f. Failed to pay adequate interest on late claims by adopting policies and procedures that precluded the payment of interest on claims paid directly to the insured.

4. The Company used marketing materials, advertising and sales scripts that:

a. Referenced policy benefits without disclosing pertinent policy exclusions, reductions and limitations;

b. Made claims of its "practices" not to cancel small group coverage due to experience, whereas small group coverage cannot legally be canceled due to experience;

c. Used words, phrases, and statements that tend to mislead or deceive prospective insureds;

d. Made vague and ambiguous promises regarding the speed and accuracy with which it processes claims, which promises are not supported by verified statistical data; and

e. Incorrectly stated the Company's years of experience by combining the ages of three affiliates to claim "more than 110 years" or "since 1892" although neither statement applies to this Company.

5. The Company used policy forms that:

a. Contained exclusions of benefits for treatment provided by chiropractic physicians;

b. Incorrectly stated the appeal rights prescribed by Arizona law;

6. The Company failed with regard to one employer group certificate of coverage form to include the notice that states "Notice: This certificate of insurance

may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully."

7. The Company used two group certificate forms that contain subrogation language without a clarification that this provision does not apply in Arizona.

8. The Company failed to provide documents it had archived concerning the declination of small group coverage, when requested to do so by the Examiners in the course of the examination.

9. The Company failed to provide required disclosure forms to employers and certificate holders.

10. The Company used forms during the application process related to HIV information that consist of an unapproved Consent for HIV testing.

11. With regard to adverse underwriting decisions, the Company:

a. Failed to provide applicants with a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party;

b. Failed to provide the reason(s) for an adverse underwriting decision along with a Summary of Rights to individuals who completed an application; and

c. Used a disclosure authorization provision on its applications that failed to limit disclosures to "no more than" the 30-month limit prescribed by law.

12. With regard to appeal procedures, the Company:

a. Failed to send acknowledgments to appeals within five business days; and

b. Failed to resolve the first level appeal within 30 days of receipt.

13. The Company failed to include in the group renewal notice an explanation of the extent to which claims experience of the individuals covered by the plan would affect premium increases.

CONCLUSIONS OF LAW

1. The Company violated A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation before denying claims as "not necessary."

2. The Company violated A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a) by failing to disclose pertinent facts or policy provisions pertinent to a claim and/or by failing to provide a reasonable explanation for the denial of claims.

3. The Company violated A.R.S. § 20-461(A)(2), A.A.C. R20-6-801(E)(1), and Consent Order 2000 by failing to acknowledge first party claims within 10 working days.

4. The Company violated A.R.S. § 20-3102 by failing to adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim.

5. The Company violated A.R.S. §§ 20-461(A)(1) and (15) and 20-2533(D) by failing to prominently display a notice of appeal rights on EOBs and/or by misstating the time limit for filing a first level appeal.

6. The Company violated A.R.S. § 20-461(A)(1) by using letterheads on EOBs and other correspondence that failed to properly identify the issuing carrier.

7. The Company violated A.R.S. § 20-462(A) as well as a previous Order of the Director, by failing to pay the correct interest on claims not timely paid.

8. The Company violated A.R.S. § 20-444 and A.A.C. R20-6-201 by using noncomplying marketing materials, advertising, and sales scripts that failed to provide required information, or in the alternative made unsubstantiated claims about the Company's products, operations, and/or relative strength and experience.

9. The Company violated A.R.S. § 20-461(A)(17) by issuing policy forms that exclude coverage for chiropractors.

10. The Company violated A.R.S. § 20-2533(D) by incorrectly stating appeal rights and procedures within the EOB form.

11. The Company violated A.R.S. § 20-1401.01 by failing to include the required notice on one employer group certificate form issued in the State of Arizona for a policy with situs in other states.

12. The Company violated A.R.S. § 20-157(A) by failing to produce, when requested to do so by the Examiners, documentation to support its declination of small group coverage despite the "guaranteed issue" nature of such coverage.

13. The Company violated A.R.S. § 20-2323 by failing to provide the required disclosure forms to employers and certificate holders.

14. The Company violated A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C) by failing to use approved HIV consent for testing forms.

15. The Company violated A.R.S. § 20-2104(B)(1)(b) by failing to provide the applicant with a Notice of Insurance Information at the time it requested personal information from a third party.

16. The Company violated A.R.S. § 20-2110(A) and (D), Consent Order 2000, and Consent Order 2003, by failing to provide the reasons for a adverse underwriting decision along with the Summary of Rights prescribed by A.R.S. §§ 20-2108 and 20-2109 to individuals who have completed the application process.

17. The Company violated A.R.S. § 20-2106(7)(a) and Consent Order 2003 by failing to limit disclosure of information on applications to no more than 30 months.

18. The Company violated A.R.S. §§ 20-2535(B) or 20-2536(B) and Consent Order 2003 by failing to acknowledge appeals within five business days.

19. The Company violated A.R.S. § 20-2535(D) by failing to resolve first level appeals within 30 days of receipt.

20. The Company violated A.R.S. § 20-2309(A), Consent Order 2000, and Consent Order 2003, by failing to include in the group renewal notice an explanation of the extent to which claims experience of the individuals covered by the plan would affect premium increases.

21. Grounds exist for the entry of the following Order in accordance with A.R.S. §§ 20-220, 20-456, 20-2117, and 20-2508.

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ORDER

IT IS ORDERED THAT:

1. John Alden Life Insurance Company shall:

a. Perform timely and reasonable investigations prior to denying claims;

b. Accurately represent and disclose pertinent facts or policy provisions pertinent to a claim;

c. Provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal the adverse decision;

d. Acknowledge claims submitted by and payable to the insured within ten working days from receipt of the claim;

e. Adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim;

f. Prominently display the notice of the right to appeal on its EOB forms;

g. Provide accurate information concerning the appeal process, including but not limited to the time limits for filing appeals;

h. Use EOB and other claims correspondence forms that identify the correct name of the issuing carrier;

i. Pay adequate interest on late claims by submitted by insureds or providers in accordance with relevant statutory requirements;

j. Use marketing materials, advertising, and sales scripts that:

i. Disclose pertinent policy exclusions, reductions and limitations; reference "practices" not to cancel small group coverage due to experience;

ii. Avoid using words, phrases, and statements that tend to mislead or deceive prospective insureds;

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iii. Avoid making vague and ambiguous promises regard the speed and accuracy with which it processes claims, which promises are not supported by verified statistical data; or

iv. Provide accurate information about the specific Company's relative strength and years of experience in the industry.

k. Use policy forms that provide benefits for treatment provided by chiropractic physicians if the services are within the lawful scope of practice of the physician and the insurance coverage includes diagnosis and treatment of the condition or complaint, regardless of the nomenclature used to describe the condition, complaint or service;

l. Use policy forms that provide an accurate and complete description of the appeal rights and procedures;

m. Provide the required notice on certificates delivered in Arizona for policies issued in other states;

n. Use policy certificate forms that omit subrogation language unless a clarification is included in the policy language that this provision does not apply in Arizona;

o. Provide documents when requested to do so by the Examiners in the course of the examination;

p. Provide required disclosure forms to employers and certificate holders;

q. Use HIV testing consent forms that have been approved by the Director and that contain required notices of information and time limits;

r. Use an authorization for the release of information related to the diagnosis, test results, or treatment for HIV/AIDS that complies with the notice and time requirements prescribed by law;

s. Provide applicants with a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party;

t. Provide the reason(s) for an adverse underwriting decision along with a Summary of Rights to individuals who have completed an application;

u. Use application disclosure authorization provisions that limit disclosures to "no more than" 30 months as prescribed by law;

v. Send acknowledgments to appeals within five business days;

w. Resolve the first level appeal within 30 days of receipt;

x. Adopt policies and procedures that give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail; and

y. Include in the group renewal notice an explanation of the extent to which claims experience of the individuals covered by the plan would affect premium increases.

2. Within 90 days of the filed date of this Order, the Company shall submit to the Arizona Department of Insurance, for approval, evidence that corrections have been implemented and communicated to the appropriate personnel, regarding all of the items listed above in Paragraph 1 of the Order section of this Consent Order. Evidence of corrective action includes but is not limited to memos, bulletins, emails, correspondence, procedures manuals, print screens and training materials.

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3. The Department shall be permitted, through authorized representatives, to verify that The Company has complied with all provisions of this Order.

4. The Company shall pay a civil penalty of $90,000.00 to the Director for deposit in the State General Fund in accordance with A.R.S. § 20-220(B). This civil penalty shall be provided to the Market Conduct Examinations Section of the Department prior to the filing of this Order.

5. The Report of Examination of the Market Conduct Affairs of John Alden Life Insurance Company dated June 30, 2008 including the letter submitted in response to the Report of Examination, shall be filed with the Department after the Director has filed this Order.

DATED in Arizona this 9th day of January 2013.

Germaine L. Marks
Director of Insurance
Arizona Department of Insurance

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CONSENT TO ORDER

1. John Alden Life Insurance Company has reviewed the foregoing Order.

2. John Alden Life Insurance Company admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Findings of Fact, and consents to the entry of the Conclusions of Law and Order.

3. John Alden Life Insurance Company is aware of its right to a hearing, at which it may be represented by counsel, present evidence, and cross-examine witnesses. John Alden Life Insurance Company irrevocably waives its right to such notice and hearing and to any court appeals related to this Order.

4. John Alden Life Insurance Company states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Order and that it has entered into this Consent Order voluntarily.

5. John Alden Life Insurance Company acknowledges that the acceptance of this Order by the Director of Insurance, State of Arizona, is solely to settle this matter against it and does not preclude any other agency or officer of this state or its subdivisions or any other person from any other civil or criminal proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Julia M. Hix, who holds the office of Vice President, Compliance of John Alden Life Insurance Company, is authorized to enter into this Order for it and on its behalf.

JOHN ALDEN LIFE INSURANCE COMPANY

December 31, 2012
Date

By: _____

COPY of the foregoing mailed/delivered
this 9th day of January , 2013, to:

Germaine L. Marks
Director of Insurance
Mary Butterfield
Assistant Director
Consumer Affairs Division
Helene I. Tomme
Market Examinations Supervisor
Market Oversight Division
Dean Ehler
Assistant Director
Property and Casualty Division
Kurt Regner
Assistant Director
Financial Affairs Division
David Lee
Chief Financial Examiner
Alexandra Shafer
Assistant Director
Life and Health Division
Chuck Gregory
Special Agent Supervisor
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Julia M. Hix, Vice President, Compliance
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